

AIDSMARK

REGIONAL LESSONS LEARNED

Asia

Asia is home to 60 percent of the world's population and the epidemiology and prevalence of HIV in this region vary dramatically by country. While most Asian countries currently have concentrated epidemics, large populations translate into millions of people living with HIV/AIDS (PLHA): India's has an adult HIV prevalence of 0.36 percent and approximately 2.5 million PLHA (1).

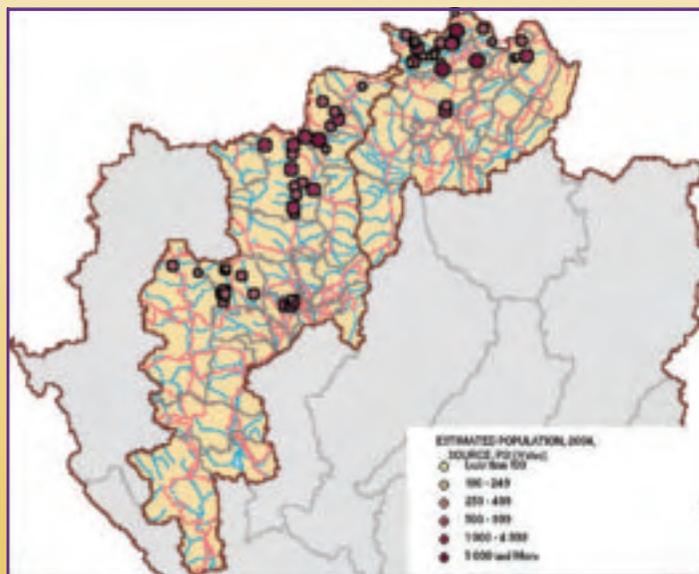
AIDSMark responded with funding and technical assistance to HIV epidemics in 13 Asian countries: **Azerbaijan, China, Georgia, Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan, Laos, Myanmar, Nepal, India, Thailand and Vietnam.** The HIV epidemic in Asia tends to be concentrated among high risk groups such as commercial sex workers (CSWs), men who have sex with men (MSM) and injecting drug users (IDUs). Diversity within these groups presents a challenge to HIV prevention programming, but the marginalization of these groups presents a far more intractable problem: Many of these activities are illegal in Asian countries, driving the behaviors underground and rendering high risk groups harder to reach.

Lessons Learned

Mapping high risk groups using geographic information systems (GIS) can enhance program design and help monitor program effectiveness.

In Nepal, a 2004 survey of CSWs identified perceived lack of access to condoms as a barrier to use (2). With AIDSMark support, Population Services International (PSI) used GIS to identify "hot zones" where high-risk sexual activity is negotiated or conducted (2). This information was used to develop a refined and targeted marketing strategy focused on ensuring that condoms were readily available in these areas (2). A GIS platform was also used to monitor target group access to condoms (2). A follow-up survey in 2005 (after 15 months) found significant increases in perceived availability of condoms (by 17 percent) and consistent condom use (by 19 percent) among CSWs (2).

In 2004, AIDSMark supported PSI/Thailand to map areas with high concentrations of IDUs in the northern provinces of Chiang Mai and Chiang Rai using GIS. In addition, health service providers and facilities offering medication-assisted therapy (MAT) were mapped to evaluate IDU access to HIV prevention and drug treatment services. Mapping analysis revealed that many isolated and scattered IDU communities lacked easy access to services (i.e., services were located more than five kilometers away) (3). This information allowed PSI/Thailand to make evidence-based and strategic decisions about where to provide MAT centers. The study also found that 19 out of 72 IDU communities had easy access to facilities where MAT services



For more information contact us at:

PSI
1120 19th Street, NW
Suite 600
Washington, DC 20036
Phone (202) 785-0072
Fax (202) 785-0120

www.psi.org

were offered (i.e., facilities were located within a five-kilometer radius) (3). However, secondary data analysis revealed that enrollment in MAT services remained very low, suggesting that geographic accessibility may not be the most important barrier to service utilization in these areas (3). Further research is required to determine the impediments and motivators to seek MAT services – including the role of government policy and a quality assessment of existing MAT services.

Drop-in centers can be a powerful HIV prevention tool; however, more research is needed to determine their utility in HIV prevention efforts targeting IDUs.



Several programs used drop-in centers to provide a safe space for populations most at risk for HIV, such as MSM, CSWs, IDUs and transgenders in Myanmar, China and Thailand. Drop-in centers can serve as a gateway to a comprehensive package of interventions that meet HIV prevention needs, such as sexually transmitted infection (STI) treatment, HIV counseling and testing, methadone maintenance treatment, basic medical care and HIV support groups. These services can be provided at the drop-in center itself or, more often, through referrals to complementary organizations and partners.

Like most prevention strategies, drop-in centers have had conflicting results on prevention efforts among most at-risk populations. For example, in Myanmar, drop-in centers provided health information through peer educators, on-site STI treatment and HIV counseling testing, access to female and male condoms (and lubricant) and referrals to other necessary services. Drop-in centers were a central part of PSI/Myanmar's programs for CSWs, and PSI/Myanmar saw a significant increase in consistent condom use within this target population, from 66.2 percent in 2003 to 83.9 percent in 2005. Moreover, CSWs with high exposure to the PSI program were significantly more likely to use condoms consistently than those with no or low exposure to the program (4).

In contrast, in China, where AIDSMARK supported program overhead allowing for the implementation of injection drug use prevention activities, an evaluation of the effectiveness of drop-in centers targeting IDUs proved inconclusive. While IDUs accessing the drop-in centers and reporting high exposure to PSI's program were significantly more likely to report consistent condom use with regular partners and increased levels of HIV prevention knowledge compared with those reporting no or low exposure, they were also significantly more likely to share other injection equipment, such as vials, cotton and rinse water (5).^a One possible explanation is that center staff did not adequately emphasize the risks associated with sharing other injection equipment besides needles (5). However, these results can also be interpreted as evidence of highly effective targeting (i.e., that drop-in centers reached those who were more likely to share injecting equipment) (5). More sophisticated research instruments are required to discern the true impact of drop-in centers on HIV prevention efforts targeting IDUs.



^a The study found no significant change in needle sharing for the month prior to entering the detox center.

Lubricant social marketing to high-risk groups can increase condom use.



Water-based lubricant is a complementary HIV prevention product because it increases the effectiveness of condoms by preventing breakage (6). A survey conducted in 2004 by PSI/Laos among *katoey*,^b or male-to-female transgenders, found that lubricant use was a significant predictor of condom use: Approximately two-thirds of both consistent condom users and nonusers indicated that they would be more likely to use condoms with regular or casual partners if water-based lubricant were available (7). As a result, AIDSMark supported lubricant social marketing in Laos. In fact, PSI/Laos collaborated with the *katoey* community and their partners to design an entirely new condom specifically for them, branded *Number One Deluxe Plus*, in a package including

two male condoms and two sachets of lubricant. In Thailand, AIDSMark supported a lubricant social marketing program between 2002 and 2004. Following this program, PSI/Thailand's 2005 annual behavioral surveillance survey of *katoey* found that the belief that water-based lubricant makes sex with condoms more enjoyable was a significant predictor of consistent condom use with casual partners (8). Thus, evidence suggests that lubricant is an effective complementary HIV prevention product that is popular among high risk groups. Lubricant social marketing, communications and delivery should, therefore, continue to receive support from stakeholders, program managers and donors.

Targeting existing IDUs with behavior change messages as part of drug demand reduction (DDR) programs may be an important strategy to prevent nonusers from initiating injecting drug use.

AIDSMark funded a DDR program in Kyrgyzstan as part of a three-country program that was also implemented in Uzbekistan and Tajikistan.^c In a survey conducted among IDUs in Kyrgyzstan in 2006, injecting drug use initiation was found to be a highly social activity (9). IDUs reported that prior to initiation they had frequently seen others injecting and had heard about the “benefits” of injecting (9). Moreover, 85.9 percent of IDUs reported that they were helped by an experienced IDU the first time they injected drugs (9). Contrary to popular belief, the new injector is often the person who puts pressure on the experienced drug user to help him or her learn how to inject (10). In fact, many IDUs regret initiating injecting drug use themselves and are therefore willing to help prevent others from initiating (10). “Break the Cycle,” a DDR program implemented in Central Asia, enlists the support of existing drug users by helping them learn how to resist such requests. Break the Cycle trains outreach workers and drop-in center staff from governmental and non-governmental organizations working with IDU populations to use motivational interviewing to encourage IDUs not to model injecting drug use in front of nonusers. In addition, IDUs are encouraged not to help nonusers initiate injecting drug use or discuss the “benefits” of injecting drug use in front of nonusers. The World Health Organization (WHO) currently has



^b *Katoey* are biological males who self-identify as female and are sexually active with men.

^c USAID funded the Uzbekistan and Tajikistan arms of the program. Lessons were shared across the three countries and frameworks were developed for designing and monitoring DDR programs.

no recommendations for programs to prevent vulnerable youth from initiating injecting drug use. An evaluation of the effectiveness of Break the Cycle, which is currently underway, could provide the data needed for the WHO to develop its first global guidelines on preventing initiation of injecting drug use.

References

1. UNAIDS, "2.5 million people in India living with HIV, according to new estimates," available at <data.unaids.org/pub/PressRelease/2007/070706_indiapressrelease_en.pdf>, accessed October 15, 2007.
2. PSI/Nepal, *End of Project Report* (Kathmandu, Nepal, 2005).
3. Population Services International, *HIV/AIDS Risk among IDUs in Northern Thailand: Mapping Needle-Sharing, Experience with Drug Treatment, and Condom Use: Results of Baseline Survey* (Bangkok, Thailand, 2004).
4. PSI/Myanmar, *Tracking Survey: Female Sex Workers and Male Sentinel Occupational Groups* (Yangon, Myanmar, 2005).
5. PSI/China. *HIV/AIDS TRaC Study among Injecting Drug Users in Kaiyuan City, Kunming City, and Yingjiang Town, Yunnan Province. Second Round* (Washington, D.C., 2006).
6. A. M. Smith et al., "Does additional lubrication affect condom slippage and breakage?" *International Journal of STDs and AIDS* 9(6) (June 1998):330–335.
7. PSI/Laos, *Condom Use among Katoey and Their Partners*, The PSI Dashboard: Social Marketing Research Series (Washington, D.C., 2004).
8. PSI Research Division, *Thailand (2005): HIV/AIDS TRaC Study among Transgenders in Pattaya: First Round* (Bangkok, Thailand, 2005.)
9. Rob Gray, "No More Dallying Around" presentation at PSI/Washington (May 25, 2007).
10. "USAID Funded Drug Demand Reduction Program in Uzbekistan, Tajikistan and the Ferghana Valley of Kyrgyzstan," available at <www.ddrprogram.org/newsletter_eng.pdf>, accessed October 17, 2007.

This report was made possible through support provided by the Global Bureau of Health/HIV-AIDS, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-97-00021-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.

© 2007 by AIDSMARK.

All rights reserved.

Photo credits:

Sean Hobbs, Ko Yoe