



HIV/AIDS HEALTH PROFILE

Asia



Overall HIV Trends

National HIV infection levels in Asia are low compared with those in Africa. However, even though prevalence rates may be low, the large populations of many Asian nations mean that high numbers of people have HIV infection. In Asia, the HIV/AIDS epidemic is largely stable, with an estimated 4.9 million people living with HIV in 2009, about the same as five years earlier. There were 360,000 people newly infected with HIV in 2009, which is 20 percent lower than those newly infected in 2001. AIDS claimed approximately 300,000 lives in the region in 2009 (Joint United Nations Program on HIV/AIDS [UNAIDS], 2010).

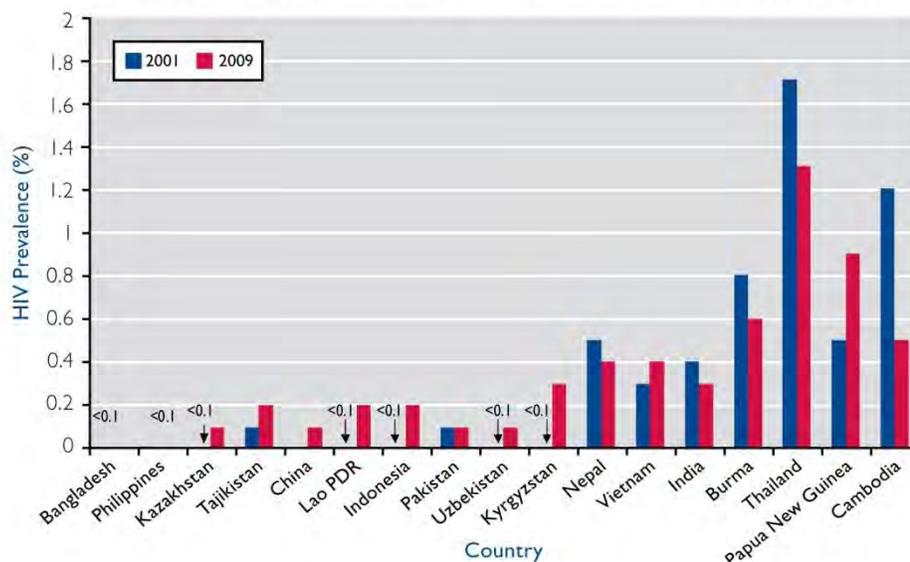
Overall prevalence trends for the region mask important variations among countries. Only **Thailand** has a prevalence rate above 1 percent. In the **Lao People's Democratic Republic (Lao PDR)**, the HIV prevalence rate is one of the lowest in the region at 0.2 percent. In many countries, national epidemics are concentrated in a small number of provinces. In **China**, half the people living with AIDS reside in just five provinces. In **Indonesia**, HIV infection levels in Papua province are 15 times higher than the national average.

The figure below shows recent trends of HIV prevalence in selected Asian countries. **Cambodia** and **Thailand**, two countries that successfully curbed their earlier epidemics, are 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). In **Cambodia**, the adult prevalence declined to 0.5 percent in 2009, down from 1.2 percent in 2001. However, HIV prevalence is increasing in some low-prevalence countries, such as **Tajikistan** and **Kyrgyzstan**, where drug injecting is the main form of transmission. In **Papua New Guinea**, HIV prevalence almost doubled, from 0.5 percent to 0.9 percent.

Risky behaviors (often more than one) continue to sustain serious AIDS epidemics in Asia. At the heart of many of Asia's epidemics lies the intersection of injecting drug use and unprotected, often commercial, sex. The characteristics of transmission, such as the percentage attributed to IDUs or sex workers, vary greatly among and within countries. In **India**, 90 percent of people newly infected with HIV are believed to have acquired the disease during unprotected sex. In some states, however, the use of contaminated injecting equipment is the main mode of HIV transmission. Most infections occur around corridors or areas of development and industrialization, where mobile populations and sex workers are key factors in transmission.

Commercial sex is a major contributor to the region's epidemics. In **Burma**, almost one in five (18 percent) of female sex workers (FSWs) tested positive for HIV. In **Vietnam**, approximately 20 percent of street-based sex workers in three regions (Haiphong, Can Tho, and Hanoi) are HIV positive. At the national level in **India**, trends among FSWs appear to be on the decline, although in some parts of southern India, up to 15 percent of FSWs are HIV positive. In one Indian state, an intensive prevention program for sex workers was highly effective in decreasing HIV prevalence among antenatal clinic attendees, from 1.4 to 0.8 percent. In **China's** Yunnan province, HIV prevalence among sex workers is 20 percent. In **Lao PDR**, there is a continuing low prevalence in the general population, and the level of HIV prevalence among sex workers has mirrored the general population's rate of sexually transmitted infections (STIs). **Indonesia** continues to have low HIV prevalence in the general population, but prevalence among sex workers is 10.4 percent.

Adult HIV Prevalence in Select Asian Countries, 2001-2009



Source: UNAIDS 2010 Report on the Global AIDS Epidemic
No data are available for Turkmenistan or for 2001 in China.

The rate of HIV infections in the region attributed to injecting drug use is growing. In Asia, 4.5 million people – half of them in **China** – are estimated to inject drugs. **Pakistan, India, and Vietnam** also have large numbers of people who inject drugs. An estimated 16 percent of IDUs in Asia are HIV positive, although HIV rates are considerably higher in some countries' IDU populations than others. **Pakistan and Bangladesh** have extremely low prevalence rates in the general population, but 7 percent of male IDUs in Dhaka are HIV positive in **Bangladesh**; in **Pakistan**, 20.8 percent of IDUs surveyed were HIV positive. HIV prevalence in **Cambodia's** general population is declining; however, among IDUs, 24.4 percent surveyed were HIV positive in 2007. In **India**, seven of the country's 49 districts with IDU treatment sites had prevalence rates higher than 15 percent. The highest HIV prevalence was among IDUs in Amritsar at 30 percent, followed by Churachandpur and Chennai at 28 and 27 percent, respectively. The IDU epidemic in **India** is changing due to increased opium production in **Afghanistan and India**. HIV prevalence trends among IDUs vary, with considerable differences among regions. In **Vietnam**, IDUs have the highest prevalence, ranging from 1 percent in Danang to more than 55 percent in Dien Bien and Quang Ninh. Data aggregated from 10 provinces indicated a national prevalence of 18.4 percent among IDUs in 2009. In **China**, HIV prevalence generally ranges from 6.7 to 13.4 percent among IDUs, with an exception of one prefecture in Yunnan province, where 50 percent of IDUs were found to be HIV positive. In **Thailand**, risk behavior surveys of IDUs in Chiang Mai, Songkla, and Samut Prakan demonstrated a large percentage (26 to 53 percent) of IDUs use nonsterile injecting equipment, or allow someone else to use their needles (18 to 34 percent) (United Nations General Assembly Special Session, 2010). Also, HIV is spreading to the female partners of people who inject drugs and the clients of sex workers and their other partners.

Central Asia is at the crossroads of drug trafficking routes between Asia and Europe. High rates of poverty are fueling the drug trade and increasing drug use among the general population, making riskier methods of drug use more common. Although the five Central Asian republics of **Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan** all have relatively low adult HIV prevalence rates of 0.3 percent or less, rates among IDUs reach 17.6 and 14.3 percent in **Tajikistan** and **Kyrgyzstan**, respectively. In **Uzbekistan**, 11 percent of IDUs are HIV positive nationally.

MSM are marginalized, but they are not marginal to the growth of the epidemic. High prevalence among MSM has been reported in several countries across Asia: 29 percent in **Burma**, 5 percent in **Indonesia**, 6 percent in the capital city of **Lao PDR**, and 7 percent in the capital of **Vietnam**. The epidemic among MSM in **Thailand** had largely been ignored until a study uncovered 17 percent prevalence in Bangkok in 2003 and 28 percent prevalence in 2005. A 2006 study cited by UNAIDS indicated 80 percent of HIV-positive MSM had never been tested or thought they were HIV negative. A subsequent study of MSM in 2007 found infection levels had risen to 31 percent. Surveys also found rising HIV prevalence among MSM in **China**, especially in Shandong and Jiangsu provinces and Beijing. In **India**, trends of increasing HIV prevalence among MSM are generating concern, with estimates from the 2008–2009 National HIV Sentinel Surveillance at 7.3 percent in New Delhi, up from 6.4 percent in 2006. Particularly high HIV prevalence among MSM has been reported in parts of southern India (between 7 and 18 percent) and in rural areas of Tamil Nadu state (9 percent). A significant proportion of HIV-positive MSM also have sex with women, which may provide a route of transmission for HIV to spread to their female partners.

In **Papua New Guinea**, there is no biological surveillance in place to monitor the epidemic among the country's most-at-risk populations (MARPs), which include FSWs, MSM, and petroleum development workers. Nonetheless, project-based reports from service delivery providers suggest prevalence rates as high as 7.4 percent among FSWs and 4.4 percent among MSM. Petroleum development workers are at risk of contracting HIV because they live far away from their families, have low levels of comprehensive HIV knowledge (43 percent), and are likely to participate in high-risk sex (43 percent in the last 12 months).

HIV/AIDS is also a highly stigmatized illness in Asia because of its association with drug use and sexual 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, in the **Philippines**, only 29 percent of the men surveyed would be willing to care for a family member who had HIV, whereas more than 95 percent of men in **Nepal** and **Vietnam** would do so. Nonetheless, 50 percent of men in **Vietnam** would keep their family member's HIV status a secret. Failure to redress stigma and discrimination can deter individuals from getting tested, further perpetuating the epidemic.

HIV co-infection with tuberculosis (TB) is a major concern for the Asia region. According to the World Health Organization (WHO), the Asia region has the highest rates of TB in the world, and 11 out of the world's 22 high-TB-burden countries are in Asia. HIV suppresses the immune system, which makes a person more susceptible to TB infection. TB is also one of the main causes of death among HIV-positive persons. It is estimated that 55 percent of worldwide TB cases in 2009 occurred in Asia. The HIV prevalence rate among incident TB cases in the Asia region ranges from .08 percent in **Bangladesh** to 17 percent in **Thailand**.

Although antiretroviral therapy (ART) coverage is increasing across Asia, it remains low in the East, South, and Southeast subregions, where only 47 percent of eligible individuals receive it. This coverage rate is lower than the average 52 percent coverage rate for all low- and middle-income countries. The range for the Asian region varies widely, from a low of 6 percent in **Pakistan** to a high of more than 95 percent in **Cambodia** and **Lao PDR** (see figure below). In Asia, HIV epidemics tend to be concentrated in harder-to-reach populations, who have only limited access to treatment and care services.

Economic and Social Impact of HIV/AIDS in Asia

Illness, disability, and death associated with the HIV/AIDS epidemic have harmful social and economic effects. The 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. In **Kyrgyzstan**, for instance, 54.6 percent of all identified HIV/AIDS cases have occurred among 15 to 29 year olds. This changes a population's demographic structure and poses a challenge to social systems in supporting dependent populations, such as children and the elderly.

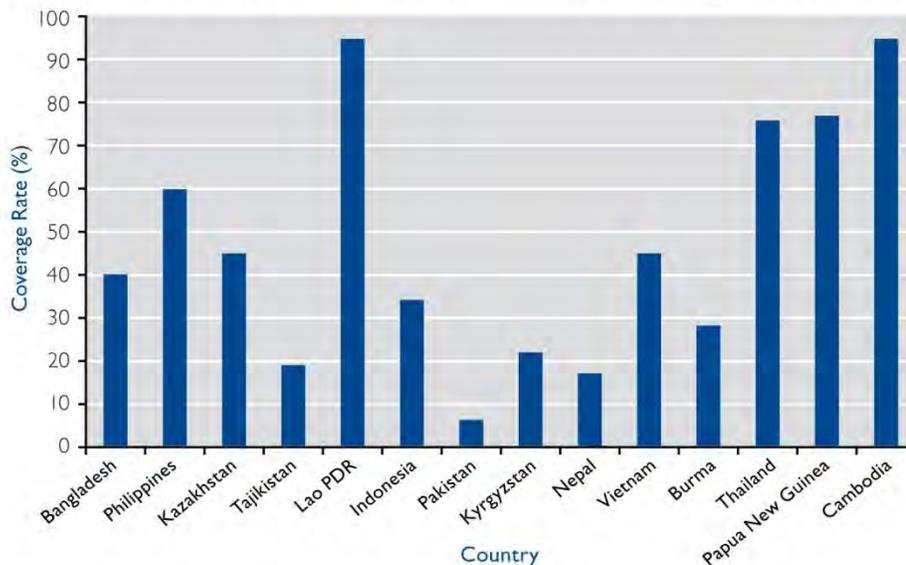
The economic, psychological, and social effects of HIV/AIDS are felt by families, who experience the incapacity and death of loved ones; by providers, who must cope with the burden of caring for the sick and dying, and by businesses, schools, hospitals, and other institutions that suffer the loss of valuable personnel and declines in productivity. HIV-affected households are more likely to borrow money from family members, sell off assets, take out loans, and ration medical care for children (Alkenbrack et al., 2008). The International Labor Organization (ILO) found in 2003 that the average monthly expenditures for families of people living with HIV/AIDS (PLWHA) in New Delhi exceeded their average incomes, in part because of the costs of medications. Another case comparison study examining 8,000 households in **India** in 2006 found medical expenses of HIV-affected households were four times higher than those of non-HIV households (Pradhan, 2006).

HIV/AIDS also affects food security by reducing both food production and the ability of households to afford a nutritious diet. One study in **Cambodia** demonstrated that children in HIV-affected households reported eating fewer meals a day and more frequent hunger than comparison children (Alkenbrack et al., 2008). School enrollments decline, and the payoffs of investments in education are undercut by high death rates among young adults. One study in **India** found school attendance rates for children of widows or widowers living with HIV/AIDS were 15 percentage points lower than for households not affected by AIDS (Das et al., 2006). Girls are also more likely to be withdrawn from schools than boys (Pradhan, 2006).

Furthermore, PLWHA suffer adversities in their personal and economic well-being, and, in many Asian countries, they also experience widespread stigma and discrimination. This makes generating income to support themselves and their families challenging. HIV and AIDS are associated with employment loss or reduced income due to time taken off from work. In India, one study of four states found that average monthly expenditures on food and treatment increased substantially in households affected by HIV/AIDS, while incomes declined by as much as one-third (ILO, 2004). Studies have also demonstrated that unemployment rates among PLWHA are significantly higher than for the respective control groups (Pradhan and Das, 2006). Addressing HIV/AIDS and its effects diverts resources from other important needs and from investments critical to economic development in the health sector as well as other economic sectors. Where health services are limited, people seek care outside of the

formal health care sector, sometimes turning instead to black-market drug sellers who sell medicines that are overpriced, ineffective, or both. Poverty and the breakdown of social and economic systems impair community systems that could help stem the spread of infection. The World Bank estimates that, if unchecked, the growing epidemic in Central Asia would slow economic growth over the next decade by 20 percent in **Uzbekistan** and by 10 percent in **Kazakhstan** and **Kyrgyzstan**.

HIV-Infected People Receiving Treatment in Select Asian Countries, 2009



Source: WHO/UNAIDS/UNICEF, Towards Universal Access, 2010. Coverage estimates are based on 2006 WHO guidelines. No data are available for China, Uzbekistan or India.

The conditions under which people migrate often expose them to greater risk of HIV infection. Vulnerability to HIV is often the result of language barriers, discrimination, and lack of access to health services. According to the United Nations Development Program (UNDP), 67 percent of identified HIV-positive cases in **Bangladesh** are returned migrant workers and their spouses; in **Nepal**, 41 percent of reported cases in 2007 were among migrant workers.

Poor women in the Asia region are particularly vulnerable to HIV/AIDS, given infection patterns and the low socioeconomic status of widows. If women are dispossessed of land or other means of production at home and lack formal skills to participate in economic activities, they may have 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.

As in all of the Mekong subregion countries, human trafficking is increasing in South Asia. **Bangladesh** is a major source country for women and children trafficked for commercial sex. Porous borders between **Bangladesh** and **India** allow for 50,000 Bangladeshi girls to be trafficked each year to **India**. Women trafficked into sex work face an even greater risk of HIV infection. According to UNICEF, 40,000 children from **Bangladesh** are working in the sex trade in **Pakistan** (UNDP, 2010). Trafficked women and children 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.

There is a significant increase in child vulnerability if one or both parents die of AIDS. In the Mekong subregion countries of **Cambodia**, **Lao PDR**, **Burma**, **Vietnam**, and **Thailand**, it is estimated 674,300 children are AIDS orphans, and that figure is projected to increase to 712,700 throughout the subregion by 2015 (Risley and Drake, 2007). AIDS orphans are often 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 childhoods and are forced by circumstances to become income and food producers or caregivers for sick family members. One study in **Cambodia** demonstrated that children in HIV-affected households had more household and employment responsibilities than comparison children (Alkenbrack et al., 2008). Children themselves also suffer from a higher number of 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 Asia 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 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 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.

At the Central Asian Conference on HIV/AIDS in 2001, the governments of **Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan** approved a declaration committing their countries to scaling up national responses and to the following priority actions: HIV prevention among IDUs; prevention of and care interventions for STIs; the development and expansion of health promotion programs for young people, especially those most vulnerable to HIV infection; and the creation of a supportive legal, policy, and cultural environment. Although **Turkmenistan** did not send a representative to the Conference, the country's government endorsed the declaration. In 2007, deputies from **Kazakhstan, Kyrgyzstan, Tajikistan, Uzbekistan, and, for the first time, Turkmenistan** attended a Central Asian interparliamentary conference on HIV/AIDS issues in **Kazakhstan**.

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 persists.

The following are examples of the status of the HIV/AIDS policies and programs of countries assisted by the U.S. Agency for International Development (USAID):

- **India** has taken an aggressive stance toward HIV/AIDS since 2004. In the second phase (1999–2006) of the country's National AIDS Control Program (NACP-II), focus shifted away from raising awareness to interventions promoting behavior change. Currently in its third phase, NACP-III (2007–2012) is designed to reverse the spread of HIV by placing the highest priority on prevention efforts while also seeking to integrate care, support, and treatment strategies. The Indian Government provides free ART to more than 322,000 adults and more than 19,500 children across 28 states and four Union Territories, exceeding its target of providing free ART to 300,000 PLWHA by 2011. However, the need for treatment is still vast among IDUs and pregnant women.
- **Cambodia's** National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS (NSP) for 2001–2005 concentrated on changing individual behaviors and the socioeconomic, legal, and political environment. Currently, the National AIDS Authority is administering the NSP II for 2006–2010, while the National Center for HIV/AIDS, Dermatology, and Sexually Transmitted Infections administers the Strategic Plan for HIV/AIDS and STI Prevention and Care in the Health Sector for 2008–2010. Based on a midpoint review of NSP II, emphasis is focused on further scale-up of prevention programs with MARPs, positive prevention, and increased access to prevention of mother-to-child transmission of HIV (PMTCT) services.
- **Thailand** reinvigorated its HIV/AIDS prevention and control efforts in 2006 through the formulation of the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation for 2007–2011. Thailand's HIV/AIDS activities include conducting a public education campaign; improving STI treatment; increasing uptake of voluntary counseling and testing services; 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.
- **Vietnam's** National Strategic Plan on HIV/AIDS Prevention for 2004–2010 provided the framework for a national response to the epidemic, calling for mobilization of government-, party-, and community-level organizations across multiple sectors. The Law on HIV/AIDS Prevention and Control, which was passed in 2006, provides strong protections for the rights of PLWHA. In 2008 and 2009, the Government worked diligently to continue increasing political commitment to the HIV/AIDS response and improve collaboration among ministries to ensure a multisectoral response. In particular, increased emphasis on prevention programs, both in the general population and among MARPs, created a rapid increase in the number of people accessing HIV prevention, care, and support services.
- **Pakistan's** Medium Term Development Framework for 2005–2010 included among its goals the halving of HIV/AIDS prevalence in MARPs and pregnant women. The new National Strategic Framework for

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. The 2009 National Health Policy also includes HIV/AIDS as a priority area, with specific emphasis on programs for MARPs.

- The Government of **Kazakhstan** has implemented its National AIDS Program for 2006–2010. The Program had three objectives: stabilize HIV prevalence by preventing the spread of infection from MARPs to the general population; reduce the incidence of HIV among MARPs; and ensure at least 80 percent of HIV-infected individuals are covered by medical and social programs. In 2009, Kazakhstan adopted a code on public health and the health care system in which the Government guarantees access to HIV prevention services, diagnosis, and treatment. In order to combat stigma and discrimination, the code also stipulates a number of legal protections for PLWHA.
- **Kyrgyzstan** stands out in the region for its innovative and early response, establishing the Multisectoral Coordination Committee on HIV/AIDS, Tuberculosis, and Malaria in 1997. Activities aimed at countering the HIV epidemic are conducted in compliance with the National Program of Preventing HIV Spread for 2006–2010. Laws related to HIV in general comply with international legal norms and continue to develop while ensuring the human rights of target population groups.
- **Tajikistan's** National Strategic Plan for 2007–2010 included the following elements: a multisectoral approach; confidentiality in testing; integration of HIV/AIDS prevention and care into other health programs; establishment of a national coordinating mechanism; and dissemination of information among youth and other at-risk populations. Prevention, treatment, and care have been included in the United Nations Framework Assistance Program for Development Goals for Tajikistan for 2010–2015, with priority given to improving access to high-quality basic medical services for vulnerable populations, education, and social protection. The country is currently developing national health strategies for 2011–2020, and HIV/AIDS prevention, treatment, and care will be integrated into the strategies.
- In 2005, **Turkmenistan** approved the National Program on HIV/AIDS/STI Prevention for 2005–2010. The Program's goals include preventing HIV and other STIs among at-risk populations; preventing the spread of HIV and STIs through blood transfusions, sexual intercourse, and mother-to-child transmission; and reducing morbidity from STIs.
- **Uzbekistan's** Strategic Program on Responding to HIV/AIDS for 2003–2006 led to the implementation of preventive services for at-risk populations; the integration of HIV-related lessons into educational programming; the completion of second-generation HIV epidemiological surveillance; the launch of ART programs; and the establishment of a network for HIV-infected individuals and centers providing health services for youth. The Strategic Program on Responding to HIV/AIDS for 2007–2011 built upon these successes while addressing major barriers to HIV prevention, treatment, care, and support, such as low demand for condoms and stigma and discrimination. A commission headed by the Prime Minister directed the implementation of the 2009–2011 National Action Plan for Preventing HIV Spread and established five working groups that comprise the heads of relevant ministries, institutions, and public organizations. In accordance with the 2007–2011 Strategic Program, departmental and regional plans were developed to ensure program implementation.

Businesses have a stake in responding to the Asia region's epidemic because it affects their workforces and can reduce the markets for their goods. The private sector is becoming more involved in HIV prevention efforts. In **India**, for example, PepsiCo India partnered with the U.S. Government (USG) and ILO to create an HIV prevention program for employees in all 39 of its in-country locations, covering a workforce of 5,464. Senior management believed the program was important not just for corporate social responsibility, but also because it was essential to retaining a healthy workforce, maintaining productivity, and minimizing turnover and training costs. In addition, the Government of India has partnered with pharmaceutical companies, such as Merck, Johnson & Johnson, and Abbott, and with networks such as GlaxoSmithKlein's TREAT Asia. These partnerships have made significant contributions to PMTCT efforts, pediatric care, and HIV prevention in **Cambodia, China, India, Indonesia, Malaysia, and Papua New Guinea. Cambodia, Vietnam, and Lao PDR** have developed action plans for the transportation sector that require HIV prevention activities to be included in construction contracts in accordance with International Federation of Consulting Engineers guidelines.

The Global Fund to Fight AIDS, Tuberculosis and Malaria also plays a key role in the response to the HIV/AIDS epidemic in Asia. In South and West Asia, the Global Fund has disbursed \$559.2 million in grants for HIV/AIDS programming. Another \$778.5 million has been disbursed to East Asia and the Pacific. Global Fund-supported programs are providing treatment to two-thirds of the 570,000 people on ART in the Global Fund's East Asia and Pacific and South and West Asia regions. The Global Fund's HIV prevention efforts in Asia focus on the people most vulnerable to infection in the region: sex workers, MSM, and IDUs. The USG provides nearly 30 percent of the Global Fund's total contributions worldwide.

USAID Regional and Bilateral Support

USAID's HIV/AIDS programs in the Asia region are implemented as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through fiscal year 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which supports partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

In Asia, USAID works with PEPFAR on HIV/AIDS programs in **Bangladesh, Burma, Cambodia, China, East Timor, India, Indonesia, Kazakhstan, Kyrgyzstan, Lao PDR, Nepal, Pakistan, Papua New Guinea, the Philippines, Tajikistan, Thailand, Turkmenistan, Uzbekistan, and Vietnam.**

Examples of USAID assistance include the following activities and interventions:

- In **Bangladesh**, where the HIV/AIDS epidemic is concentrated among IDUs, USAID strengthened local capacity to address the rehabilitation needs of this high-risk population. In 2008 and 2009, it trained police and prison staff on HIV transmission and drug rehabilitation. This resulted in 937 referrals to IDU rehabilitation centers, where recovered IDUs were offered job skills training and long-term economic rehabilitation to empower themselves to remain drug free and to practice HIV prevention strategies.
- In **India**, USAID focuses on comprehensive HIV/AIDS interventions and technical assistance approaches in 12 high-prevalence districts in Karnataka state and five districts in Andhra Pradesh state. Key achievements include an increase in coverage of comprehensive HIV/AIDS services for rural sex workers from zero percent in 2006 to 81 percent in 2009. In addition, the loss to follow-up among HIV-positive pregnant women receiving PMTCT services was reduced from 23 percent to 4 percent in the same period.
- In **Burma**, USAID works to scale up prevention, care, support, and treatment programs to reach MARPs, enhance program quality, build the capacity of community-based organizations, and strengthen the strategic information base and enabling environments necessary for effective programs. USAID supported a comprehensive package of HIV/AIDS interventions and services for FSWs and MSM in five cities, reaching 80 to 90 percent of the target population.
- In **Lao PDR**, USAID is providing services specializing in sexual health care to transgender people and their partners. During 2009, 3,200 male-to-female transgender individuals and their partners participated in various aspects of USAID's targeted outreach program in Vientiane, Savannakhet, and Luang Prabang cities. With Global Fund and USG funding, three service centers were opened, which significantly expanded access for MSM, transgender people, and their partners to convenient, high-quality HIV/STI prevention information and services.
- In **Thailand**, USAID supported a comprehensive prevention package model for MSM in Bangkok, Chiang Mai, and Phuket, reaching nearly 14,400 MSM at USG-supported clinics.
- In 2010, the USG and Government of **Vietnam** signed a Partnership Framework increasing Vietnam's financial commitment, its country ownership, and the sustainability of the Government's HIV/AIDS program. Also, in 2010, 624,600 individuals received counseling and testing services, and 100,200 HIV-positive individuals received care and support.
- In **Indonesia**, USAID trained 113 Islamic leaders from 15 high-prevalence districts in East Java to increase HIV awareness and compassion, facilitate implementation of HIV policy statements within the Islamic community, and share religious guidance on HIV prevention. Additionally, this program trained 100 Islamic teachers on incorporating HIV issues into life skills courses at Islamic community-based schools. Across the country, 260 Islamic middle schools integrated HIV curricula into three subjects (physical education, social studies, and Al-Islam) to reduce stigma, educate youth about HIV prevention, encourage compassion toward PLWHA, and have a long-term impact on community attitudes and behaviors.
- In **China**, USAID's Regional Development Mission for Asia supports innovative prevention activities in the two high-HIV burden provinces of Yunnan and Guangxi for the development of replicable local implementation models. The focus of more intense efforts in these provinces is on establishing high-quality comprehensive prevention package models that may then be taken to scale in provinces across China through the Global Fund. In 2010, 143,400 individuals received counseling and testing, and 12,900 HIV-positive individuals received care and support.

- In **Kazakhstan**, USAID provides assistance to a pilot program in Almaty to assist with management of HIV-TB co-infection. Almost 1,000 people newly diagnosed with TB or HIV were screened for dual infection and received TB prophylaxis medication. The percentage of people newly identified as HIV positive without TB who received prophylaxis with isoniazid increased from 0 to 50 percent. Additionally, the percentage of people with dual infection who received cotrimoxazole for prevention of opportunistic infections increased from 0 to 40 percent.
- In **Turkmenistan**, USAID continued supporting a youth center in Ashgabat and opened a second one in Dashoguz. During 2009, USAID turned responsibility for financing and operating these centers over to the Youth Union. Before the handover, the two centers had contact with more than 15,000 at-risk youth. Youth were exposed to alternatives to risky behaviors through activities, such as dance clubs, computer classes, table tennis, English and Russian classes, and chess.
- In **Uzbekistan**, USAID, in collaboration with The World Bank, supported development of a national team of *mahalla* (community-based organizations) trainers in five pilot areas to conduct education sessions among the general population. The selected *mahallas* were trained on basic HIV issues, including HIV prevention and reduction of stigma and discrimination. A survey in January 2009 of the five pilot regions where the trained *mahalla* leaders conducted educational activities showed an increase of 26.9 percent in general population awareness of HIV issues.

Important Links

USAID's HIV/AIDS Web site for Asia:

http://www.usaid.gov/our_work/global_health/aids/Countries/asia/hiv_summary_asia.pdf.

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids.

March 2011