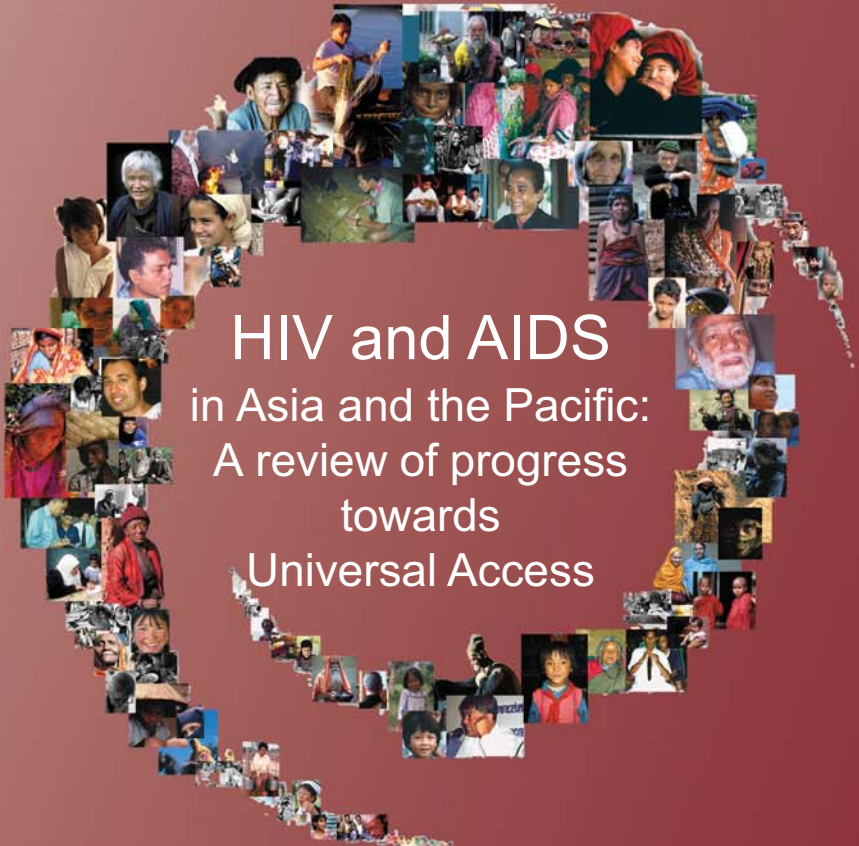


Economic and Social Commission for Asia and the Pacific

DISCUSSION PAPER



HIV and AIDS
in Asia and the Pacific:
A review of progress
towards
Universal Access

ESCAP is the regional development arm of the United Nations and serves as the main economic and social development centre for the United Nations in Asia and the Pacific. Its mandate is to foster cooperation between its 53 members and 9 associate members. ESCAP provides the strategic link between global and country-level programmes and issues. It supports the governments of the region in consolidating regional positions and advocates regional approaches to meeting the region's unique socio-economic challenges in a globalizing world. The ESCAP office is located in Bangkok, Thailand. Please visit our website at <<http://www.unescap.org>> for further information.



The white area of the map represents the members and associate members of ESCAP

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A review of progress towards Universal Access

Bangkok 2009

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Acronyms

AIDS	acquired immunodeficiency syndrome
APCASO	Asia Pacific Council of AIDS Service Organizations
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
FSW	female sex worker
HIV	human immunodeficiency virus
IDU	injecting drug user
MSM	men who have sex with men
NGO	non-governmental organization
UNGASS	United Nations General Assembly Special Session

Introduction

This background paper reviews progress made in the Asian and Pacific region in line with international commitments, with particular attention to the Universal Access targets developed for low and concentrated epidemic countries in Asia and the Pacific through regional and civil society consultations in 2006. Based on these findings, the paper also reviews the main challenges and identifies ways forward in scaling up the response to HIV.

The paper draws on information from the 2008 country reports prepared to measure progress towards the targets set out in the Declaration of Commitment on HIV/AIDS at the United Nations General Assembly Special Session (UNGASS) in 2001. The quality of available data varies and should be considered indicative of progress and trends only. Where appropriate, data is supplemented by information from the UNAIDS 2007 December Epidemic Update and other published sources.

The analysis leans strongly on the Asia AIDS Commission report launched on 26 March 2008. This report provides one of the most comprehensive analyses and a set of clear recommendations for this part of the world. Although the AIDS Commission Report focuses on Asia, some commonality in trends and further analysis allow many of the findings to be extrapolated to the Pacific, and North and Central Asia subregions.

The paper was prepared for discussion at the Expert Group Meeting on “Progress on Declaration of Commitment on HIV/AIDS in the Asian and Pacific region”, held on 12 and 13 May 2008 in Bangkok. The meeting was jointly organized by the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) and the UNAIDS Regional Support Team for Asia and the Pacific. The recommendations produced at the meeting are also included at the end of this document as an Annex.

The objectives of the meeting were to identify and reaffirm key issues in achieving Universal Access in countries in the region for further elaboration and follow-up by the ESCAP Committee on Social Development at its first session in September 2008 and other relevant forums; and to develop key messages from the region for countries in their preparation of their country presentations at the High-level Meeting on HIV/AIDS in New York, June 2008.

I. Progress since 2001 in Asia and the Pacific

The 2001 Declaration of Commitment on HIV/AIDS envisions a global response to AIDS that is grounded in human rights and gender equality, as well as recognition of the factors that increase vulnerability to HIV. The Declaration of Commitment represents the collective vision of 189 Member States and sets out specific targets for the global response by 2010.

The first regional review of progress against the Declaration of Commitment targets in 2005, undertaken by ESCAP, showed that important achievements had been made since the Special Session in 2001, particularly in terms of greater resources, stronger national policy frameworks, wider access to treatment and prevention services and broad consensus on the principles of effective country-level action. However, it was also clear that while selected countries did reach key targets and milestones for 2005, many countries in the Asian and Pacific region were not on track to fulfil the pledges specified in the Declaration of Commitment.¹

Two years later, in 2007, the Asia-Pacific region² as a whole had nearly six million people living with HIV and AIDS, with the South and South-West Asian and South-East Asian subregions accounting for four million of them.³

The estimated number of people newly infected with HIV annually in South Asia and South-East Asia was 340,000 in 2007, which represented a slight decrease from 450,000 estimated in 2001. However, in East Asia, an estimated 92,000 adults and children were newly infected with HIV in 2007, representing a 20 per cent increase from 77,000 people who were estimated to be infected with HIV in 2001. The Pacific also saw an increase in new infections from 3,800 in 2001 to an estimated 14,000 in 2007. Countries in the North and Central Asian subregion likewise observed steady increases in numbers of new infections.⁴

This second regional review is based on the 2008 UNGASS Country Reports from the Asian and Pacific region. Despite the challenges that the region faces in meeting the Declaration of Commitment targets, it is important to highlight that the 2008 UNGASS Country Reports, in themselves, show that progress has been made. Compared to 2005, a significantly higher number of countries submitted reports in 2008 and there was improved reporting against key indicators. Although much remains to be done to improve data quality and consistency in reporting among countries, this is a definite sign that countries in the Asian and Pacific region have been waking up to the realities of HIV and AIDS.

A. South-East Asia

Within the Asian and Pacific region, national HIV prevalence was highest in South-East Asia, though there was a wide range of trends among countries. While Cambodia, Myanmar and Thailand had achieved a decline in HIV prevalence, prevalence numbers in Indonesia and Viet Nam were on the rise.⁵ In this subregion, most-at-risk populations are playing a key role in driving national epidemics.

¹ "Report on the implementation of the Declaration of Commitment on HIV/AIDS, and the Asia-Pacific Leadership Forum on HIV/AIDS and Development", presented at the 61st Session of the Commission, UNESCAP, May 2005.

² The ESCAP region covers 53 Members and 9 Associate Members. The ESCAP subregions include East and North-East Asia, South-East Asia, South and South-West Asia, North and Central Asia, and the Pacific. A full list of the ESCAP membership can be found at <<http://www.unescap.org/about/member.asp>>.

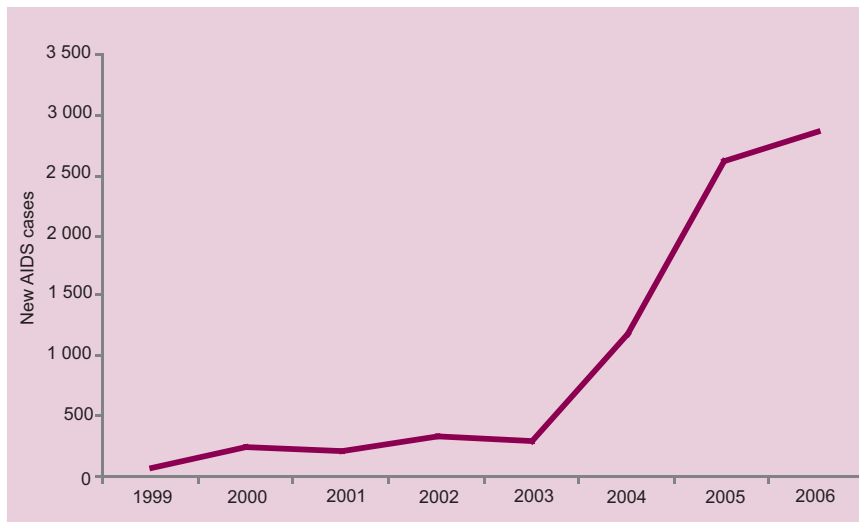
³ HDS/ESID UNESCAP, "Implementation of the Declaration of Commitment on HIV/AIDS Adopted in the Special Session of the General Assembly in June 2001; Review of Progress Made in the ESCAP Region", a draft document, December 2007.

⁴ UNAIDS and WHO, *AIDS epidemic update: December 2007* (Geneva, UNAIDS and WHO, 2007) (hereinafter "UNAIDS 2007 AIDS Epidemic Update").

⁵ Ibid.

The increasing number of new HIV infections in Indonesia made it home to one of the fastest growing epidemics in the region (see figure 1). The majority of HIV infections in Indonesia occurred through the use of contaminated injecting equipment, unprotected paid sex and, to a lesser extent, unprotected sex between men.⁶ When surveyed in 2005, more than 40 per cent of injecting drug users (IDUs), in Jakarta tested HIV-positive.⁷ In Viet Nam, the HIV epidemic was concentrated among IDUs, female sex workers (FSWs) and men who have sex with men (MSM), with the highest prevalence rate found among IDUs (estimated at 28.6 per cent).⁸

Figure 1: Rapid increase in reported AIDS Cases, Indonesia



Source: National AIDS Programme, Ministry of Health, Indonesia, 2006, cited in a presentation by WHO-SEARO at the Global Fund to fight AIDS, Tuberculosis and Malaria, Round 8 preparation meeting, March 2008, Jakarta, Indonesia.

In Lao PDR, despite a low HIV prevalence of 0.1 per cent, there has been evidence of an expanding epidemic among FSWs and their clients, and MSM.⁹ There has also been increasing concern about an acceleration of the epidemic through drug use.¹⁰ In Malaysia, injecting drug use remains the predominant mode of HIV transmission. However, increasingly more new reported cases have been attributed to infection through the sexual route, namely unprotected sexual intercourse by both heterosexuals and MSM. Combined, sexual transmission of HIV is currently responsible for more than a third of new HIV cases, the proportion of which is increasing each year.¹¹

In Thailand and, in more recent years, Cambodia, well-focused prevention efforts have helped reverse the HIV epidemic. In the 1990s, focused evidence-based prevention in sex-work settings established Thailand as a leader in the region. However, more recent prevention strategies have not reflected the need for harm reduction programmes, even when HIV prevalence among IDUs stayed at a level of at least 30 per cent for one decade.¹²

⁶ Indonesia National AIDS Commission, "Country report on the Follow up to the Declaration of Commitment On HIV/AIDS", 2008, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/indonesia_2008_country_progress_report_en.pdf>.

⁷ UNAIDS 2007 AIDS Epidemic Update, supra.

⁸ Viet Nam, "THE THIRD COUNTRY REPORT ON FOLLOWING UP THE IMPLEMENTATION TO THE DECLARATION OF COMMITMENT ON HIV AND AIDS", January 2008, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/viet_nam_2008_country_progress_report_en.pdf>.

⁹ Lao People's Democratic Republic National Committee for the Control of AIDS, "UNGASS Country Report", 2008, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/lao_2008_country_progress_report_en.pdf>.

¹⁰ Ibid.

¹¹ Malaysia, "UNGASS COUNTRY PROGRESS REPORT MALAYSIA", January 2008, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/malaysia_2008_country_progress_report_en.pdf>.

¹² Commission on AIDS in Asia, *Redefining AIDS in Asia* (New Delhi, Oxford University Press, 2008) (hereinafter "AIDS Commission Report"), p.124.

In Cambodia, 2007 estimates show that HIV prevalence among adults aged 15 to 49 decreased to 0.9 per cent in 2006 from a revised estimate of 1.2 per cent in 2003.¹³ Projections indicate that, if interventions are sustained at current levels, HIV prevalence will further decline before stabilizing at 0.6 per cent by 2011.¹⁴

Recent experience from Thailand, where the trend of HIV prevalence has declined with the notable exception of IDUs and MSM, confirms the need to strengthen prevention efforts for these populations. Prevalence among IDUs has remained high, ranging between 30 per cent and 50 per cent over the past 15 years.¹⁵ Similarly, recent studies show increasing HIV prevalence among MSM. Moreover, data indicate linkages of infection among the most-at-risk populations including sex workers, MSM and IDUs.¹⁶

In the South-East Asian subregion, significant progress has been made on the provision of care and treatment, with the Philippines reporting the greatest increase in antiretroviral therapy coverage. In Thailand and Cambodia, coverage was reported at around 80 per cent at the end of 2007. For Cambodia, this has constituted more than double the number of patients on antiretroviral therapy since 2005. In Thailand, the integration of treatment programmes into the national health care and social security systems has helped ensure long-term sustainability of the antiretroviral therapy programme. In Malaysia, the proportion of adults receiving antiretroviral therapy also was reported to have increased by more than double between 2006 and 2007, and in Viet Nam by one and a half times in the same period.

B. Pacific

An estimated 14,000 people acquired HIV in the Pacific in 2007, bringing the total number of people living with the virus in this subregion to 75,000.¹⁷ HIV infections have now been reported in every country or territory in the Pacific island subregion, with the exception of the two of the smallest: Niue and Tokelau.¹⁸ It is important to note that available data for the Pacific is based on very limited HIV surveillance. There is, therefore, concern that the overall number of cases in the Pacific may be significantly underreported.

Over 70 per cent of the total number of people living with HIV in this subregion was in Papua New Guinea. Unprotected heterosexual sex has been the main means of transmission, with perinatal transmission and homosexual sex indicated in a much smaller per cent of cases. By December 2007, the national prevalence was projected to be 1.61 per cent. The majority of infections were identified in rural areas, where 85 per cent of Papua New Guinea's population resides. The urban prevalence was estimated at 1.38 per cent with almost 8,000 people living with HIV. The rural prevalence was estimated at 1.65 per cent, with over 50,000 people living with HIV in areas with few health services, very limited transport and communications, low levels of literacy, and a multitude of cultures and languages, which severely complicates prevention and treatment efforts.¹⁹

¹³ Cambodia National AIDS Authority, "UNGASS COUNTRY PROGRESS REPORT Cambodia", 31 January 2008, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/cambodia_2008_country_progress_report_en.pdf>.

¹⁴ Ibid.

¹⁵ This is potentially because many studies of IDU repeatedly test the same people. AIDS Commission Report, *supra.*; Thailand National AIDS Prevention and Alleviation Committee, "UNGASS COUNTRY PROGRESS REPORT Thailand", 31 January 2008, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/thailand_2008_country_progress_report_en.pdf>.

¹⁶ Ibid.

¹⁷ UNAIDS 2007 AIDS Epidemic Update, *supra.*

¹⁸ Fiji National Advisory Committee on AIDS Secretariat, Public Health Division, Ministry of Health, "UNGASS 2008 COUNTRY PROGRESS REPORT FIJI", 31 January 2008, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/fiji_2008_country_progress_report_en.pdf> (hereinafter "Fiji UNGASS").

¹⁹ The PNG National AIDS Council Secretariat and Partners, "PAPUA NEW GUINEA UNGASS 2008 COUNTRY PROGRESS REPORT", 31 January 2008, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/papua_new_guinea_2008_country_progress_report_en.pdf>.

Australia accounted for the most of the remaining HIV cases in the Pacific, with almost 20,000 people living with HIV at the end of 2006.²⁰ That same year, the number of people living with HIV in New Zealand was estimated at 1,400.²¹ In both countries, HIV continues to be transmitted mainly through unprotected sex between men. In Australia, a significant number of new infections take place among people not born in Australia. In New Zealand, the number of people diagnosed with HIV who reported being infected through unsafe heterosexual intercourse is on the rise, with the majority of infections occurring outside the country.²² Both countries have experienced a steady rise in new infections since 2000, despite prevention efforts.²³

Recorded HIV infection levels were low in the rest of the Pacific island subregion where the total number of reported HIV cases exceeded 150 only in Fiji, French Polynesia, Guam and New Caledonia.²⁴ Fiji reported a cumulative figure of 259 HIV-positive cases (from 1989 to December 2007), with 23 new infections in 2007. About 90 per cent of all HIV cases in Fiji were reported to be acquired through heterosexual transmission.²⁵

In the other countries in the Pacific island subregion, the total number of infections remained very low. In Tuvalu, there were ten reported cases out of a total population of around 9,100; and in Palau only seven persons out of a population of almost 20,000 have been identified as HIV-positive since testing and surveillance were implemented in 1989.²⁶ In the Marshall Islands, only one case of HIV had been confirmed and this person is under treatment.²⁷ In the Federated States of Micronesia, a total of 35 cases of HIV were reported since the first case was detected in 1989.²⁸

The foremost mode of HIV transmission in the Pacific subregion was unprotected sexual intercourse, although the dynamics of this have not yet been fully understood. The high levels of other sexually transmitted infections that have been recorded in some Pacific island countries clearly indicate the existence of significant risk behaviours.²⁹ It is important to emphasize the difference between Asian epidemics and the Pacific epidemic. Whereas, in Asia, epidemics have largely been driven by most-at-risk populations; in the Pacific, HIV transmission has largely taken place through unprotected sex between young people. This is an important distinction that warrants a separate AIDS Commission study for the Pacific.

²⁰ HIV/AIDS and STIs Section, Department of Health and Ageing, "UNGASS 2008 COUNTRY PROGRESS REPORT AUSTRALIA", 15 January 2008, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/australia_2008_country_progress_report_en.pdf> (hereinafter "Australia UNGASS").

²¹ UNAIDS, *2006 Report on the global AIDS epidemic*, accessed on 20 October 2008 from <<http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2006/>>.

²² New Zealand, "UNGASS 2008 COUNTRY PROGRESS REPORT NEW ZEALAND", 18 December 2007, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2007/new_zealand_2008_country_progress_report_en.pdf> (hereinafter "New Zealand UNGASS").

²³ Australia UNGASS Country, *supra*; New Zealand UNGASS Country, *supra*.

²⁴ Secretariat of the Pacific Community, homepage <www.spc.int>.

²⁵ Fiji UNGASS, *supra*.

²⁶ Tuvalu National AIDS Committee, "UNGASS 2008 COUNTRY PROGRESS REPORT Tuvalu", 15 January 2008, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/tuvalu_2008_country_progress_report_en.pdf> (hereinafter "Tuvalu UNGASS"); Palau Ministry of Health/HIV section, "UNGASS 2008 COUNTRY PROGRESS REPORT Republic of Palau", 28 January 2008, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/palau_2008_country_progress_report_en.pdf> (hereinafter "Palau UNGASS").

²⁷ Marshall Islands Ministry of Health/HIV section, "UNGASS 2008 COUNTRY PROGRESS REPORT Republic of Marshall Island", 16 January 2008, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/marshall_islands_2008_country_progress_report_en.pdf>.

²⁸ Micronesia National Department of Health and Social Affairs, "UNGASS 2008 COUNTRY PROGRESS REPORT Federated States of Micronesia", accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/federated_states_of_micronesia_2008_country_progress_repo_en.pdf>.

²⁹ UNAIDS and WHO, *Oceania: 2007 AIDS epidemic update Regional Summary*, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/jc1533_epibriefs_oceania_en.pdf>.

Many underlying social, cultural, economic and demographic conditions in the Pacific island countries indicate the potential for the rapid spread of HIV infections. These conditions include a young population with a high incidence of teenage pregnancies, considerable mobility within and between countries, slow economic growth and socio-cultural practices that influence gender rights and relations.³⁰ Although the epidemics are still in their early stages in most places, it is well recognized that prevention efforts need to be further stepped up as the potential impact of HIV on the relatively small population base could be severe.

In 2007, an estimated 1,200 people died of AIDS-related illnesses in the Pacific subregion.³¹ Treatment in the highest prevalence countries has significantly improved in recent years and antiretroviral therapy is now available in most countries. The Federated States of Micronesia is the most recent country where antiretroviral therapy became available. Since August 2007, it has been provided free to those who need it.

C. South and South-West Asia

In South and South-West Asia, exposure to contaminated injecting drug use equipment is a major risk factor for infection. In Pakistan, HIV prevalence has been increasing among IDUs. In Afghanistan and the Islamic Republic of Iran, exposure to contaminated drug injecting equipment is the main route of HIV transmission.³² Injecting drug use is also a main mode of transmission in Bangladesh and Nepal. In India, where almost 90 per cent of all transmission is sexual, injecting drug use is now emerging as an important mode of transmission, in particular in the northeastern states.³³

Nepal has the highest reported adult prevalence in this subregion at 0.48 per cent.³⁴ The epidemic in Nepal is characterized by exposure through injecting drug use and unsafe sex but there are numerous contributing social, economical and cultural factors that drive the epidemic among the most-at-risk groups.³⁵ Given the nature of Nepal's concentrated HIV epidemic, the focus of the response has been on prevention programmes targeting most-at-risk populations, with coverage in 2007 reported to vary from 23 per cent of MSM to 76 per cent of IDUs. The HIV prevalence among FSWs appears to have stabilized at around 2 per cent and the declining trend in HIV prevalence among IDUs (from 51 per cent in 2005 to 34 per cent in 2007) is also noteworthy.³⁶ Of all adults estimated to be living with HIV, a major proportion of HIV infections have consistently been among returning migrant workers. Also, a significant number of trafficked Nepalese women who returned to Nepal were found to be HIV positive.³⁷

India, with a reported adult prevalence of 0.36 per cent among its more than 1 billion inhabitants, has the largest total number of people living with HIV in the subregion.³⁸ The HIV epidemic in India is mostly concentrated in nature, as HIV prevalence among high-risk groups continues to be high (approximately six to eight times of that among the general population).³⁹ Outside of the north-east of the country, where the use of contaminated

³⁰ Palau UNGASS, *supra*.

³¹ UNAIDS 2007 AIDS Epidemic Update, *supra*.

³² *Ibid*.

³³ India National AIDS Control Organization, Ministry of Health and Family Welfare, "UNGASS Country Progress Report 2008 India", accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/india_2008_country_progress_report_en.pdf> (hereinafter "India UNGASS").

³⁴ Bangladesh National AIDS/STD Programme, Ministry of Health and Family Welfare, "2008 UNGASS COUNTRY PROGRESS REPORT BANGLADESH", 27 January 2008, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/bangladesh_2008_country_progress_report_en.pdf> (hereinafter "Bangladesh UNGASS").

³⁵ Nepal Ministry of Health and Population, "UNGASS COUNTRY PROGRESS REPORT NEPAL", 30 January 2008, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/nepal_2008_country_progress_report_en.pdf> (hereinafter "Nepal UNGASS").

³⁶ *Ibid*.

³⁷ *Ibid*.

³⁸ India UNGASS, *supra*.

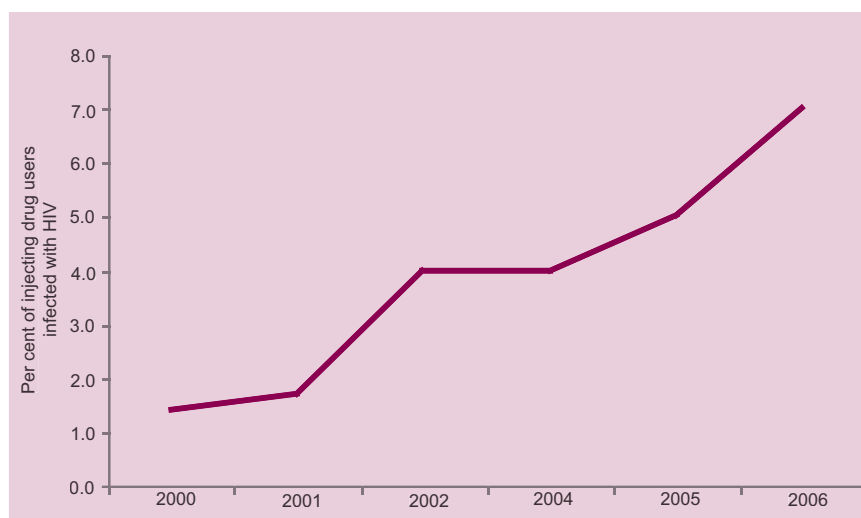
³⁹ *Ibid*.

drug injecting equipment remains a key risk factor, HIV appears to be spreading mainly as a result of unprotected sex between FSWs and their clients, and their respective other sex partners.

Prevention programmes focusing on FSWs have showed some success. HIV prevalence has been declining among sex workers in areas that have been the focus of targeted prevention efforts, especially in Tamil Nadu and other Southern States.⁴⁰ However, prevention efforts vary widely across the different states. While much has been done in the four southern states (Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu), where the large majority of people living with HIV are residing, there is the risk of complacency in states where overall prevalence is still generally low. Already, pockets of high HIV prevalence are emerging in low-prevalence states.

In Bangladesh, HIV prevalence in the general population has been reported to be less than 0.1 per cent. The prevalence in most-at-risk-populations has been estimated to be below 1 per cent except for IDUs, which have seen increases in recent years (see figure 2).⁴¹ Among the possible reasons for the low overall HIV prevalence are: high levels of circumcision among men; until recently, low levels of injecting drug use; a history of non-governmental organization (NGO) targeted interventions with high risk groups; and relatively low levels of risk behaviours.⁴² There is, however, consensus that risk factors for the spread of HIV are present in Bangladesh, including: a significant but somewhat hidden sex industry; low levels of condom use; increasing injecting drug use and persistent sharing practices; and rising HIV prevalence levels among IDUs. There is also little doubt that the country's limited facilities for sentinel surveillance and voluntary counselling and testing, as well as the social stigma and discrimination attached to HIV, contribute to an understatement of the real incidence of HIV.⁴³

Figure 2: Rapid increase in HIV infections among IDUs, Bangladesh



Note: No data for 2003.

Source: National AIDS Programme, Ministry of Health, Bangladesh, 2006, cited in a presentation by WHO-SEARO at the Global Fund to fight AIDS, Tuberculosis and Malaria, Round 8 preparation meeting, March 2008, Jakarta, Indonesia.

In Pakistan, HIV prevalence among the general population was less than 1 per cent. However, the overall seroprevalence of HIV among IDUs in 2007 was 15.8 per cent, with rising infections among groups of IDUs in urban areas. Moreover, in cities with established HIV epidemics among IDUs, rising infections have been recorded among associated MSM populations. While prevalence among FSWs is still low, there is low consistent

⁴⁰ UNAIDS 2007 AIDS Epidemic Update, supra.

⁴¹ Bangladesh UNGASS, supra.

⁴² Ibid.

⁴³ Bangladesh UNGASS, supra.

condom use and knowledge about HIV.⁴⁴ Projections already indicate that the initial IDUs epidemics will be followed by epidemics in other associated most-at-risk-populations.⁴⁵

Sri Lanka remains one of the few countries in the region with a low-level HIV epidemic, despite sharing some of the conditions such as sex work, networks of MSM and a large population of heroin users. High literacy rates, relatively high status of women, good access to health-care services and low prevalence of sexually transmitted infections may all act to protect individuals and communities against HIV infection.⁴⁶ On the other hand, conditions of higher vulnerability in Sri Lanka include conflict, high mobility of military, internally displaced persons, and separation of spouses related to overseas employment. Moreover, new economic developments such as the expansion of internal free trade zones, and broad social changes, such as the increasing migration of young adults from rural areas to large urban centres, could result in expansion of societal vulnerability factors. Returning migrant workers have been increasingly found to be infected and there is the possibility that they seed local networks that could continue transmission.⁴⁷

The South and South-West Asian subregion has made the least progress in terms of increasing treatment coverage. Among the countries in this subregion, India has made the most progress with 137 centres in 31 states providing free antiretroviral therapy in 2007, as well as having second-line treatment available. A total of 96 Community Care Centres have also been established in high prevalence states to increase access to antiretroviral therapy, to provide counselling and follow-up on drug adherence, management of opportunistic infections and to provide pre-antiretroviral therapy care through outreach and home-based services.⁴⁸

In Bangladesh, access to HIV treatment has slowly expanded but remains very limited. To date, five organizations (of which four are civil society ones), all based in Dhaka, provide treatment, care and support services to people living with HIV.⁴⁹ Treatment of opportunistic infections, food and nutrition services and psychosocial support services are also scarce. While some treatment of AIDS is available for adults in Dhaka, no paediatric AIDS treatment or treatment for HIV-positive pregnant women is available in Bangladesh.⁵⁰

In Pakistan, antiretroviral therapy became available in 2005, but in 2007 only a limited number of patients were being treated in the nine treatment centres established under the Government's AIDS Control Programmes.⁵¹ The national antiretroviral therapy programme in Nepal was started only one year earlier, in 2004, with just two antiretroviral therapy sites. By October 2007, more than a thousand patients were on treatment in 16 public sector sites across the country.⁵² Public provision of free antiretroviral therapy began in 2004 in Sri Lanka and more than 100 patients were receiving antiretroviral therapy by the end of 2007.⁵³

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Sri Lanka, "COUNTRY REPORT – SRI LANKA ON FOLLOW UP TO THE DECLARATION ON COMMITMENT ON HIV/AIDS (UNGASS)", accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/sri_lanka_2008_country_progress_report_en.pdf> (hereinafter "Sri Lanka UNGASS").

⁴⁷ Ibid.

⁴⁸ India UNGASS, *supra*.

⁴⁹ Bangladesh UNGASS, *supra*.

⁵⁰ Ibid.

⁵¹ Pakistan National AIDS Control Program, Ministry of Health, "UNGASS PAKISTAN REPORT Progress Report on the Declaration of Commitment on HIV/AIDS For United Nations General Assembly Special Session on HIV/AIDS", 2007, accessed on 20 October 2008 from <http://data.unaids.org/pub/Report/2008/pakistan_2008_country_progress_report_en.pdf>.

⁵² Nepal UNGASS, *supra*.

⁵³ Sri Lanka UNGASS, *supra*.

D. East and North-East Asia

In 2007 there were almost 20 per cent more new HIV infections in East Asia than in 2001.⁵⁴ Most of the new infections in this subregion occurred in China, which had an estimated 700,000 people living with HIV at the end of 2007.⁵⁵ Geographic distribution in China is highly varied but Yunnan Province still has the highest cumulative numbers of reported HIV cases.⁵⁶ The epidemic continues to expand but at a slower rate. Sentinel surveillance data shows that the infection rates among IDUs, FSWs and pregnant women continue to increase - but at reduced rates.⁵⁷

The distribution of the modes of transmission for HIV infections in China is changing. Sexual transmission has replaced injecting drug use as the main mode for the spread of HIV. But the main risk factors for infection continue to be high-risk behaviour within particular sub-populations. In 2006, it was estimated that just under half of all people living with HIV in China were infected while injecting drugs with contaminated equipment, while a similar proportion acquired the virus during unprotected sex. In 2007, reports indicated that less than 30 per cent of new infections were via injecting drug use. While heterosexual transmission now makes up the bulk of new infections, infections among MSM increased eightfold between 2005 and 2007 – with estimates ranging between 3 and 7 per cent of all new infections.^{58, 59}

The overlap of injecting drug use and sex work remains an important factor in the HIV epidemic in China. Increasing numbers of women are injecting drugs and in some places as many as half of those also sell sex. Many male IDUs also buy sex, often without using condoms.⁶⁰

In neighbouring Mongolia, reported prevalence remains low.⁶¹ So far, HIV cases have been concentrated among MSM and sex workers. One of the key prevention measures taken has been to expand the 100 per cent Condom Use Programme to the national level after a successful pilot programme demonstrated a significant reduction in the incidence of syphilis at the pilot site.

While Mongolia remains a low prevalence country, its population is very mobile, with thousands travelling to neighbouring China and the Russian Federation, where there are some of the fastest growing rates of HIV infection in the world.⁶²

The number of people living with HIV in Japan has continued to increase. The main route of infection is sexual contact, in particular MSM, who accounted for the majority of all new infections in 2006. In that same year, injecting drug use and mother-to-child transmission was reported as less than 2 per cent.⁶³

In the Republic of Korea, HIV prevalence has been reported to be less than 0.1 per cent. The cumulative number of new infections, since the first case was detected in 1985, has risen to over 5,000. However, in

⁵⁴ UNAIDS 2007 AIDS Epidemic Update, *supra*.

⁵⁵ China, "UNGASS COUNTRY PROGRESS REPORT P.R. China", 2008, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/china_2008_country_progress_report_en.pdf> (hereinafter "China UNGASS").

⁵⁶ *Ibid.*

⁵⁷ *Ibid.*

⁵⁸ *Ibid.*

⁵⁹ UNAIDS 2007 AIDS Epidemic Update, *supra*.

⁶⁰ *Ibid.*

⁶¹ Mongolia, "UNGASS COUNTRY PROGRESS REPORT MONGOLIA", 31 January 2008, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/mongolia_2008_country_progress_report_en.pdf>.

⁶² UNAIDS 2007 AIDS Epidemic Update, *supra*.

⁶³ Japan, "UNGASS COUNTRY PROGRESS REPORT Japan", December 2007, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/japan_2008_country_progress_report_en.pdf>.

recent years, numbers of new infections have increased. Transmission has taken place primarily through unsafe heterosexual contact, followed by male-to-male sexual transmission. A relatively high number of cases have unidentified transmission routes. The Government of the Republic of Korea conducts education and campaign programmes to raise awareness of HIV and AIDS, in close collaboration with NGOs, civil society, local public health centres and relevant organizations.⁶⁴

Progress on treatment coverage in the East Asia subregion has been mixed and some countries do not report on this at all. In China, a significant increase in treatment coverage was achieved, especially given the large numbers of patients involved. By the end of October 2007, the provision of antiretroviral therapy was reported to have expanded to more than a 1,000 counties in 31 provinces and a pilot on second-line treatment was initiated.⁶⁵ At the same time, neighbouring Mongolia has been one of the few countries in Asia and the Pacific where treatment coverage has reportedly decreased.

E. North and Central Asia⁶⁶

In North and Central Asia, the largest number of estimated new cases has been reported in the Russian Federation where the epidemic continues to grow, although not as rapidly as in the late 1990s.⁶⁷ The most affected groups of the population have been drug users, sex workers and prisoners. Injecting drug use remains the main mode of HIV transmission in the Russian Federation. Among IDUs in 2006–2007, HIV infection prevalence ranged from 8 to 64 per cent in different regions of the country. Based on 2007 data, 6 per cent of sex workers have been infected. Among prisoners tested in 2007, HIV infection prevalence was 5 per cent.⁶⁸

Of the newly registered HIV cases in 2006, where the mode of transmission was known, two thirds were due to injecting drug use and about one third to unprotected heterosexual intercourse. The latter proportion, though, has been increasing steadily since the late 1990s, especially in areas with comparatively mature epidemics. Less than 1 per cent of newly registered HIV cases in 2006 were attributed to unsafe sex between men.⁶⁹

Georgia has been experiencing a steady increase in newly registered cases of HIV and AIDS since 2003 and HIV has reached all areas of the country.⁷⁰ As of 1 January 2007, there were 1,156 officially registered cases of HIV in Georgia. However, estimates are almost five times the official number with actual prevalence estimated at 0.2 per cent.⁷¹ More than half of the registered HIV cases to date were reported in the period 2004–2006.⁷²

Although Georgia is a low-prevalence country, injecting drug use is widespread. Since the epidemic began, almost two thirds of registered cases of HIV were reported to have been infected through injecting drug use, while heterosexual sex has accounted for almost one-third. In addition, there is a great deal of movement to and from higher-prevalence countries, primarily the Russian Federation and Ukraine.⁷³

⁶⁴ Republic of Korea, "UNGASS COUNTRY PROGRESS REPORT", December 2007, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/korea_2008_country_progress_report_en.pdf>.

⁶⁵ China UNGASS, *supra*.

⁶⁶ Although several countries in this UNESCAP subregion completed 2008 UNGASS country Reports, these were not available in English at time of writing and, therefore, not included in this section.

⁶⁷ UNAIDS 2007 AIDS Epidemic Update, *supra*.

⁶⁸ Ministry of Health and Social Development of the Russian Federation, "Country Progress Report of the Russian Federation on the Implementation of the Declaration of Commitment on HIV/AIDS", 2008, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/russia_2008_country_progress_report_en.pdf>.

⁶⁹ *Ibid*.

⁷⁰ Georgia, "Monitoring the Declaration of Commitment on HIV/AIDS", accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/georgia_2008_country_progress_report_en.pdf> (hereinafter "Georgia UNGASS").

⁷¹ MAP, "AIDS in the Commonwealth of Independent States: 2008 MAP Report" (2008) (hereinafter "MAP Report").

⁷² UNAIDS 2007 AIDS Epidemic Update, *supra*.

⁷³ MAP Report, *supra*.

Uzbekistan has the largest epidemic among the Central Asian republics.⁷⁴ The country has seen a significant increase in the number of newly registered HIV cases starting in 2001, with a four-fold jump from 2001–2006. The last two years have remained relatively stable in terms of newly registered cases.⁷⁵ The main route of HIV transmission has been through injecting drug use and IDUs make up almost two thirds of registered people living with HIV. Heterosexual transmission accounts for 16.3 per cent of HIV cases, and has been rising in recent years.⁷⁶

As of 1 February 2007, there were more than 1,000 officially registered cases of HIV in Kyrgyzstan. However, the HIV prevalence in Kyrgyzstan is estimated to be about 0.1 per cent, which would indicate that a considerably higher number of people are living with HIV in the country. Although the number of new cases attributed to heterosexual sex has been on the rise since 2003, the principal route of transmission remains injecting drug use.⁷⁷

In Azerbaijan, almost half of all HIV infections were reported in the period 2005–2006. The majority of the HIV cases registered in Azerbaijan by 2006 were in the capital of Baku, where 13 per cent of IDUs tested HIV-positive in a 2003 survey. High prevalence of HIV and other sexually transmitted infections has been found among FSWs, among whom condom use appears to be infrequent.⁷⁸

In Kazakhstan, which has a recently emerging epidemic, newly registered HIV cases almost tripled between 2004 and 2006, although this increase can be attributed in part to an expansion of HIV testing. Injecting drug use is an important risk factor for the spread of HIV in Kazakhstan; 2005 sentinel surveillance in 23 towns and cities across the country indicated that over 3 per cent of IDUs nationally were infected with HIV. However, localized studies indicate prevalence among IDUs may be as high as 17 per cent in some areas.⁷⁹

Since 2004, Tajikistan has seen a significant growth in the registration of new HIV cases. In fact, the number of new cases jumped seven-fold from 2002 to 2006.⁸⁰ In Tajikistan, injecting drug use remains the predominant route of HIV transmission. HIV prevalence among IDUs increased by one third in selected urban sites between 2005 and 2006. Over the same period, and in the same cities, a five-fold increase in prevalence among sex workers was reported.⁸¹

In Armenia, where almost 3,000 people are estimated to be living with HIV, injecting drug use and heterosexual contact each are the cause of almost half of all infections. However, in the period 2006–2007, the reported new infections through sexual transmission (almost all women) have been nearly double that of reported HIV transmission through injecting drug use (all men).⁸² There are also reported cases of MSM transmission, as well as HIV transmission through mother-to-child means and blood transfusions.⁸³

According to official sources and external estimates, Turkmenistan has the lowest prevalence of HIV in the subregion. Non-sterile instruments for intravenous drug injection is the biggest threat in terms of the growth of the epidemic in the country.⁸⁴

⁷⁴ UNAIDS 2007 Epidemic Update, *supra*.

⁷⁵ MAP Report, *supra*.

⁷⁶ *Ibid*.

⁷⁷ *Ibid*.

⁷⁸ UNAIDS 2007 Epidemic Update, *supra*.

⁷⁹ *Ibid*.

⁸⁰ MAP Report, *supra*.

⁸¹ UNAIDS 2007 Epidemic Update, *supra*.

⁸² Republic of Armenia, "UNGASS COUNTRY PROGRESS REPORT Republic of Armenia", 2008, accessed on 8 August 2008 from <http://data.unaids.org/pub/Report/2008/armenia_2008_country_progress_report_en.pdf>.

⁸³ *Ibid*.

⁸⁴ MAP Report, *supra*.

II. Challenges and Actions Needed

Experiences in Asia and the Pacific have much to reveal about national HIV responses, some good and some not so good. In a few instances, strong and focused efforts have brought striking results on a large scale. Elsewhere, efforts are improving even if the benefits are less apparent. In many cases, the response to HIV has either lagged behind or faltered for long periods. Increasingly, elements of a potentially effective response are being introduced. However, the degree of urgency, coherence, and scale needed to curb the epidemics is not yet evident.⁸⁵ This section reviews efforts made so far, broadly measured against the Universal Access targets established for the Asian and Pacific region (see box 1).

Box 1: Targets and Commitments in the Asia-Pacific Region

In September 2000, 189 countries agreed on a set of eight Millennium Development Goals which range from halving extreme poverty to halting the spread of HIV and providing universal primary education, all by the target date of 2015. In June of the following year, the same countries committed themselves to a more comprehensive set of time-bound and specific global targets in the Declaration of Commitment on HIV/AIDS. The Declaration set 30 targets for 11 areas in the effort to overcome HIV and AIDS, to be achieved by 2010.

In 2005, there was increasing momentum to dramatically scale up the response to AIDS, to define what this means for country programme, and to address the obstacles that have prevented this from happening in the past. At the June 2006 United Nations General Assembly High-Level Meeting on HIV/AIDS, United Nations Member States agreed a massive scaling up of comprehensive HIV prevention, treatment and care services with the aim of coming as close as possible to the goal of Universal Access by 2010 for all who need it.

The commitment to scaling up towards Universal Access is not a target itself. Rather it emphasizes urgency, quality and equity, and involves the development of a comprehensive package of prevention, treatment, care and support relevant to each country. National Governments and stakeholders were encouraged to identify a small set of national targets for moving towards Universal Access, which build on and clarify the Millennium Development Goals and Declaration of Commitment targets, and are in line with national strategic plans. Through a series of consultations, UNAIDS has formulated the following key targets for Universal Access by 2010¹ in low and Concentrated Epidemic Countries in the Asian and Pacific region:

1. A total of 80 per cent of most-at-risk population(s) reached by comprehensive prevention programmes;
2. A total of 60 per cent of behavioural change of most-at-risk populations;
3. A total of 80 per cent of those who are eligible for receiving antiretroviral combination therapy received it;
4. Resources available in countries (both from domestic and international sources) fully met “estimated” resource needs of the country for comprehensive prevention, treatment, care and support programme by 2008, or, resources increased three times from those of 2005;
5. Enabling environment: indicators on civil society engagement and stigma and discrimination;

⁸⁵ Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response* (New Delhi, Oxford Press, 2008) (hereinafter “AIDS Commission Report”), p.121.

6. Percentage of HIV+ pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission;
7. Number of orphans and vulnerable children receiving a basic external support package (such as school fees, shelter and food); and
8. Reduction of new infections in number or percentage in 2010 compared to 2005 levels.

Note: 1. No. 1-3 are non-negotiable quantitative targets as agreed in the Regional Consultation on Universal Access at Pattaya, Thailand, in February 2006 and the civil society consultation in August 2006 in Bangkok, Thailand; No. 4-8 are suggested indicators for countries to define the quantitative targets.

Source: 2006 Annotation, UNAIDS Regional Support Team for Asia and the Pacific.

A. Leadership and strengthening the role of key players

Leaders in the Asian and Pacific region have demonstrated their commitment by signing the United Nations General Assembly Special Session Declaration of Commitment, and later committing their countries to the Universal Access initiative. Unfortunately, in many cases in this region those official commitments have not yet translated into sufficient and tangible actions at the national level, while, at the global level, AIDS has increasingly been placed near the top of the world political agenda. Although political engagement and support has increased overall, leadership is still lacking in addressing the epidemic among those most at risk.

Governments

Strong political commitment and leadership have proved to be prerequisites for setting the agenda and driving a potentially effective response. Such leadership and commitment proved to be key in Thailand's response in the early-to-mid 1990s, and it provided important momentum to the HIV programmes that have subsequently unfolded in countries like Cambodia, China, India, and Indonesia. In those and other countries, far-sighted politicians have built awareness among their constituencies, lobbied for HIV-related legislation, pushed for more HIV resources, or tried to hold their Governments accountable for the national HIV response. Parliamentary committees on HIV have been set up in a few countries.

It is important to understand what prompts political leaders to embrace and then stay committed to HIV advocacy and action. In some cases, strong advocacy and activism have pushed leaders into action. However, generally, political leadership and engagement appear to have emerged from three factors: a mature and pragmatic sensibility among leaders (such as seen in Thailand in the early 1990s), recognition of the urgency of the situation (for example, China and India) and pressure from civil society, like in the Philippines, where the Government has paved the way for a more focused HIV programme by including civil society in its HIV policies.⁸⁶ Elements of demonstrable leadership in Asia and the Pacific included instituting practical policies, ensuring allocation of adequate resources, establishing a strong management structure (such as a National AIDS Commission), and involving civil society in the response.

However, in only a few countries has a Head of State played a meaningful role in the response and officially provided leadership to the national AIDS programme as its chair.⁸⁷ The 2008 Asia Pacific Council of AIDS Service Organizations review of the 2008 UNGASS reports states that while most countries reported that high level (prime ministerial or presidential) statements on HIV were now a regular feature of political discourse, the commitments reflected by budget allocations and planning across government departments and ministries

⁸⁶ Ibid. at p. 121.

⁸⁷ Ibid. at p. 125.

were much weaker. The clear issue of lack of cross ministerial support from key ministries remains a major barrier in realizing comprehensive political commitment. The struggle of the health sector and particularly national AIDS programmes to provide strategic leadership and to gain the attention of more powerful ministries as well as resistance from other sectors (for example, public security) are emphasized as key barriers to change.⁸⁸

To make up for past efforts, Governments must increasingly lead and take greater accountability for the national response; allocating substantially greater resources themselves, actively promoting inclusion of all sectors of society and organizing effective and well-funded communication strategies to promote HIV awareness and alleviate stigma and discrimination. In addition to increasing domestic funding, Governments should actively explore innovative ways of extending existing resources as far as possible, including such avenues as mentoring programmes, strategic partnerships and staff exchange programmes between institutions, and the sharing of technical expertise and experience with other countries.

Donors

While developing countries, especially middle-income countries, should do more to finance the national response to HIV, the world must look primarily to the international donor community to close the resource gap. Just as the launching by the United States Government of the President's Emergency Plan for AIDS Relief initiative and the birth of the Global Fund to Fight AIDS, Tuberculosis and Malaria helped to mobilize greater commitment of resources, other donors must increase HIV funding levels to support a response capable of reversing the epidemic. In the efforts to mobilize the sums needed for HIV programmes, all donors must do their part in providing substantially to the financing of AIDS responses and avoid the majority of financing to a small handful of traditional donor countries.

Donors should also ensure stability of funding through long-term financial commitments and permit flexibility in how the funds are spent to reflect evolving priorities. To increase effectiveness and efficiency of financing, donors must shift away from project-based funding towards funding programmes. For bilateral donors, in particular, it is increasingly important to fund high-impact activities and remove conditions that impede the flow of resources to priority programmes.

Finally, donors across the board must work to implement the "Three Ones" (see section II.E) by aligning their assistance with nationally led strategies and by actively supporting unified national systems for monitoring and evaluation. In ramping up HIV support, donors should prioritize measures to build and sustain national capacity, helping countries to upgrade pay scales to prevent the loss of essential personnel and aiding countries in expanding the roles of all levels of health workers, household members, mid-level providers, community workers and people living with HIV.⁸⁹

United Nations system

The United Nations joined with donors and other stakeholders ten years ago to create the Joint United Nations Programme on HIV/AIDS (UNAIDS), which united the efforts of ten United Nations co-sponsor agencies and a Geneva-based secretariat under a single biennial budget and work plan. The last two UNAIDS unified budgets and work plans have strongly emphasized improved coordination and coherence at the country level

⁸⁸ APCASO, "Asia Pacific Civil Society and 2008 UNGASS on HIV and AIDS", 2008, accessed on 20 October 2008 from <http://www.apcaso.org/Documents/KeyDocuments/UNGASS_AP_Regional_Report.pdf> (hereinafter "APCASO 2008 UNGASS Report").

⁸⁹ *Declaration of Commitment of HIV/AIDS; five years later, Report of the Secretary-General*, 24 March 2006 (A/60/736) (hereinafter "2006 SG Report").

and enhanced technical support, including the creation of regional technical support networks to support rapid programme implementation and scale-up. In December 2005, the Secretary-General directed all United Nations country offices to create a new structure, a joint United Nations country team on AIDS, to address bottlenecks and obstacles to scale-up. The country teams on AIDS would also clarify the division of labour among multilateral institutions for the provision of technical support and enhanced financing for technical assistance.

At present, the United Nations is contributing to the success of the Global Fund by helping many countries to develop evidence-based and solid funding proposals. In response to the shortage of technical resources, UNAIDS is in the process of establishing regional technical clearing houses throughout the world. Normative guidance and technical support by WHO is accelerating treatment scale-up by enabling countries to implement simplified treatment protocols for a public health approach to antiretroviral therapy.⁹⁰ In the same way, many other specialized United Nations agencies are also providing technical assistance in their areas of expertise.

However, much work still lies ahead. The United Nations must play an even larger role in assisting countries in identifying priorities and estimating resource needs, and must encourage donors to fund these priorities. The United Nations system must fully leverage its unique potential to support countries in implementing and expanding effective national responses, including through the development and funding of technical support plans to strengthen national capacity.

The United Nations must also be more accountable for its own activities, including United Nations external actions as well as addressing HIV in its own workplace. It should take bolder actions to promote the fulfilment by countries and donors of their pledges and commitments. The United Nations also must perform better with strategic country coordination of the diverse multilateral partners, particularly through the strengthening of the joint country teams on AIDS. For this, improved and more meaningful coordination within the United Nations system is a *conditio sine qua non*.

Civil society and affected populations

It is now generally accepted that civil society engagement is an essential part of HIV programme implementation and service delivery. Civil society organizations are often less bureaucratic and have been found to be more efficient than their government counterparts. A study of 148 Global Fund grants found that the grant process for Government Principal Recipients lagged behind that of Non-governmental Principal Recipients by more than three months.⁹¹

Civil society is often able to respond to new situations more quickly than government agencies. If programmes piloted by community-based organizations prove successful at the local level, governments can consider scaling them up to national level. For example, in China, MSM set up community hotlines to provide support and information on HIV. By 2007, the Government recognized the importance of working with this group and was funding programmes to support them.⁹²

In some countries in the region, civil society involvement made room for discussion about controversial issues and helped promote greater understanding of HIV among political and social leaders, as NGOs and community-based organizations are often willing to bring up these sensitive issues publicly. It has been demonstrated that community activists can help overcome some of the barriers of stigma and discrimination.⁹³

⁹⁰ Ibid.

⁹¹ AIDS Commission Report, *supra*, at p. 159.

⁹² Ibid. at p. 158.

⁹³ Ibid. at p. 163.

In many countries, civil society partnerships and community engagement have fostered a sense of 'ownership' of the response that tends to be absent when projects are externally run. At its most basic, the participation of communities is essential to reach people with information they are likely to trust. Studies in Asia have shown that in some sites, peer outreach workers succeeded in reaching 80 per cent of drug users, where other conventional government and social mechanisms have failed. Similarly, in a study of over 6,000 sex workers, in the Indian state of Andhra Pradesh, sex workers who did not participate in a sex worker support group were four times more likely to report only occasional or inconsistent condom use, compared with their colleagues who belonged to such groups.⁹⁴

In several countries in the region, participation of people living with HIV has proved to be a highly effective civil society channel to improve national policies, strengthen HIV prevention, and support the scale-up of treatment and care programmes. However, people living with HIV require increased support if they are to have a stronger role in the response. The challenge for many countries in the Asian and Pacific region is to move beyond the 'involvement' of people living with HIV, as described in the 1994 principle of the Greater Involvement of People with HIV/AIDS, to ensure their more active and meaningful participation in AIDS efforts.

One way to give practical and more meaningful expression to the Greater Involvement of People with HIV/AIDS commitment would be for HIV decision-making bodies to formalize the participation of people living with HIV, preferably in designated seats. Moreover, representation on national bodies like National AIDS Commissions or Country Coordinating Mechanisms should involve a process in which communities nominate their representatives, as opposed to *ad hoc* representation by pre-selected individuals.⁹⁵

Box 2: Beyond Greater Involvement of People with HIV/AIDS - Meaningful participation of people with HIV

A study by Horizons and the International HIV/AIDS Alliance has found that the involvement of people living with HIV brings several advantages. They boost service providers' understanding of HIV issues and improve their attitudes towards people living with HIV. People living with HIV can contribute to the success of national treatments programmes through their involvement in health-care facilities, peer-based treatment education and literacy programmes, treatment advocacy, monitoring and research. Since new HIV infections occur when the virus is transmitted from infected to uninfected persons, no prevention programme can ignore people living with HIV. Accordingly, successful 'positive prevention' programmes are now being piloted in several countries. Accountability and transparency can be improved by involving community organizations in monitoring and evaluating HIV programmes.

Source: Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response* (New Delhi, Oxford Press, 2008), p. 160.

In several countries in the region, however, civil society actors have not been adequately involved in the national response. Civil society engagement appeared greatest with respect to HIV planning and budgeting, but less apparent in the monitoring of national efforts and the review of national strategies. In some countries, services delivered by civil society groups were not integrated into the national HIV coordination mechanism. In many countries faith-based organizations were responsible for a large share of health care and education, but were often not included or consulted when national plans and strategies were made.⁹⁶

⁹⁴ Ibid. at p. 156.

⁹⁵ Ibid. at p. 166.

⁹⁶ 2006 SG Report, *supra*.

The 2008 APCASO review of the 2008 UNGASS reporting confirms that participation by the community sector in the development, implementation and monitoring of national strategies remains very limited in many countries, including participation in the periodic review of progress on the implementation of the Declaration of Commitment. The report emphasizes the lack of participation of civil society in the Pacific. The report further notes that participation among civil society agencies can be uneven. Factors which influence this include the ability of groups and organizations to access resources and government-sponsored HIV support, the influence of more dominant civil society actors (for example, established AIDS Councils which have strong relations with government) and lack of access to international agencies operating in-country.⁹⁷

In all countries, civil society must be equal partners in the development, implementation and monitoring of the national response. Governments and donors should prioritize initiatives to build and sustain the capacity of non-governmental and community-based organizations, and networks of people living with HIV to respond to the epidemic. Faith-based organizations are also vital partners in the AIDS response and should be encouraged to collaborate more closely with Governments, AIDS service organizations, groups of people living with HIV and other actors.⁹⁸

Community representatives are often expected to take part in high level planning processes, but are not supported to build capacity or make the maximum use of their experience or skills. Opportunities to use the knowledge and experience generated by community involvement to benefit the UNGASS process, or to expand the quality and reach of essential interventions, are being missed.⁹⁹

National HIV plans and coordinating bodies should take account of services delivered by community-based groups, and national budgets and donor assistance should include the provision of extensive capacity-building assistance to civil society organizations and networks. Provided with adequate resources, civil society can play a major role in monitoring the implementation and effectiveness of national efforts, including national success in achieving the time-bound targets of the Declaration of Commitment and agreed milestones along the road to Universal Access.¹⁰⁰

At the same time, civil society must make a serious effort to strengthen its own capacity and operations. For example, community-based and other civil society organizations should adhere to the *Code of Good Practice for NGOs responding to HIV/AIDS*.¹⁰¹ The creation of independent HIV and AIDS monitoring bodies at national and regional levels could further improve accountability of various actors, from Government ministries and civil society organizations, to external donors and United Nations agencies.

Private sector

In several countries in the region, the private sector has played a key role in recent years in taking on a set of new social responsibilities related to HIV, leading to steady reductions in the price of drugs,¹⁰² a rapid expansion in the number of employees being offered effective treatments and a growing understanding from key players that the workplace has become a central strategic component of the response. An increasing number of private employers have recognized the social and economic costs to their business, leading them to develop workplace prevention and care programmes, which, in some cases, even include providing antiretroviral therapy to employees and their dependants who are in need. Private sector contributions for, and in some case even participation in, community responses to the HIV epidemic have also increased.

⁹⁷ APCASO 2008 UNGASS Report, supra.

⁹⁸ 2006 SG Report, supra.

⁹⁹ APCASO 2008 UNGASS Report, supra.

¹⁰⁰ 2006 SG Report, supra.

¹⁰¹ The NGO Code of Good Practice was developed by NGOs for NGOs to guide their work by establishing a framework to commit and to hold them accountable. More information can be found at <<http://www.hivcode.org>>.

¹⁰² GFATM and ILO, "Co-investment: a central mechanism for establishing Public-Private Partnerships at country level", accessed on 20 October 2008 from <http://www.theglobalfund.org/en/files/factsheets/co_investment.pdf>.

Box 3: Possible areas of public-private sector collaboration, adapted from the Global Fund to fight AIDS, Tuberculosis, and Malaria factsheet “Co-investment: a central mechanism for establishing Public-Private Partnerships at country level”.

Establishing voluntary counselling and testing services

- A key ingredient to any effective prevention and care strategy is the availability of reliable voluntary counselling and testing. It is well documented that employees feel more secure using external voluntary counselling and testing services for ensuring confidentiality. Voluntary counselling and testing is also a central component of any community intervention programme.

Development of community health services

- It is important to establish and support comprehensive prevention care and treatment services and community outreach in areas where a private employer is implementing a programme for employees and a number of dependants.

Procurement of drugs

- The Global Fund, through its buying power, policies and reach, can ensure that partnership results in rational and effective procurement and use of drugs to treat HIV and AIDS, tuberculosis and malaria. Direct benefits include reduced prices, reliable procurement flows as well as quality assurance. Significant savings on the cost of drugs will allow reallocation of funds towards a broader reach of interventions.

Capacity-building and training

- At one end of the spectrum, there are the big multinational corporations running large urban operations with well-developed occupational health services which have been able to take on the challenge at a marginal cost. At the other end of the spectrum, there are small operations in remote areas where community services do not exist. Along this spectrum there are many true opportunities for building bridges between the public and private sectors.
- The training of service providers whether on the private employer side or the community side can be a central component and an expense that can be shared.
- Well-established Occupational Health Services can certainly represent a significant resource for entire communities who cannot wait until public health infrastructure is rehabilitated or established.

Information management and other private sector efficiencies

- It is now demonstrated that complex treatments such as those for HIV infection can be efficiently implemented in low-resource settings with good compliance. A significant contribution to this comes from the utilization of more efficient data management systems in which private partners can play a key role.
- Many more efficiencies can be brought to bear from financial management to operations. Promotion, distribution and monitoring of activities are particular areas where a private or corporate partner can contribute solid expertise.

In some countries, like India, Indonesia, the Philippines and Thailand, individual companies have been able to demonstrate that workplace programmes are cost effective and community programmes fit well within corporate social responsibility strategies. However, looking to the future, there are still many unresolved questions about how these programmes will fit in the larger national response. Sharing the burden in partnership must be seen as a long term commitment in which private and public employers, governments, NGOs and development partners all take a fair share of responsibility.¹⁰³

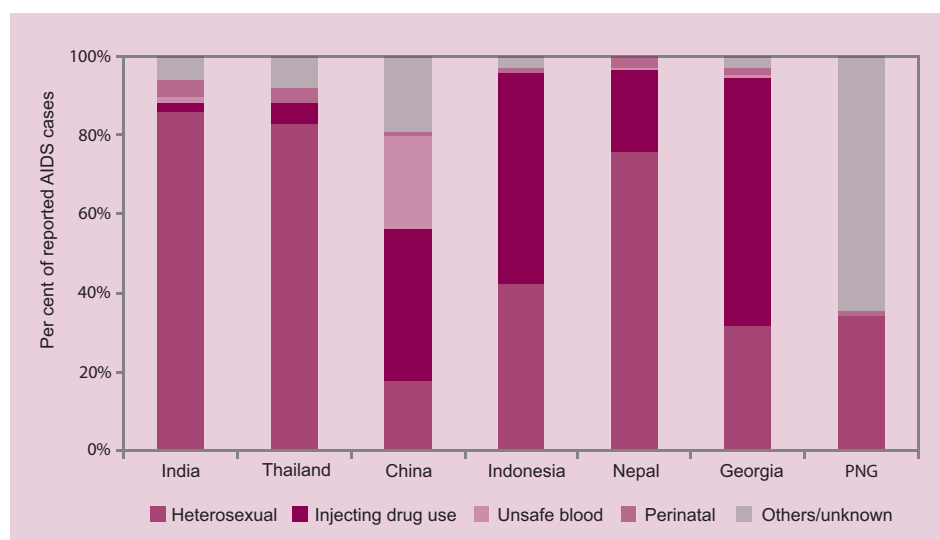
¹⁰³ ILO, *Report, Global Compact Policy Dialogue on HIV/AIDS*, Geneva, 12-13 May 2003, accessed on 20 October 2008 from <<http://www.ilo.org/public/english/protection/trav/aids/events/gcreport.pdf>>.

With few exceptions, national strategic planning in the Asian and Pacific region has so far given little attention to public–private collaboration that might enhance efficiency and financing of a comprehensive AIDS response, especially for ensuring sustainable access to antiretroviral treatment and care services. Of particular concern is the high cost of second- and third-line antiretroviral regimens, which threatens the long-term viability of treatment scale-up. Governments should actively work with their national pharmaceutical industries and other stakeholders to reduce the price of such medications for use in developing countries.¹⁰⁴

B. Scaling up prevention

Although the epidemics vary considerably from country to country in the Asian and Pacific region, they share important characteristics, namely that they are centred mainly around unprotected paid sex, the sharing of contaminated needles and syringes by IDUs, and unprotected sex between men.¹⁰⁵ Unsafe sex and injecting drug use are the two main drivers of the epidemic (see figure 3).

Figure 3: Main modes of HIV transmission



Note: In this and subsequent figures PNG refers to Papua New Guinea.

Source: National AIDS programme, Ministry of Health, SEAR countries, 2007, in a presentation by WHO-SEARO at the Global Fund to fight AIDS, Tuberculosis and Malaria, Round 8 preparation meeting, March 2008, Jakarta, Indonesia; data for China, Georgia Papua New Guinea and the Russian Federation from respective 2008 UNGASS Reports.

Pooling recent calculations from various Asian countries, the Commission on AIDS in Asia estimated that up to 10 million Asian women sell sex and at least 75 million men buy it regularly. Male–male sex and drug injecting add another 20 million to the number of men at high risk of HIV infection once the virus enters those networks. A number of those men, particularly injectors, may also pass HIV on to the women with whom they regularly have sex, which means that several million more women are also at risk.¹⁰⁶

The Commission further estimated that, in Asia, only about one in three sex workers were being reached by HIV prevention services in 2005, while only one in 50 IDUs and about one in 20 MSM had access to prevention services.

Sex workers

The role of the sex trade is crucial. Especially in Asia, those who buy sex, most of whom are from ‘mainstream’ society, are one of the most important driving forces in the HIV epidemics. They constitute the largest infected

¹⁰⁴ 2006 SG Report, supra.

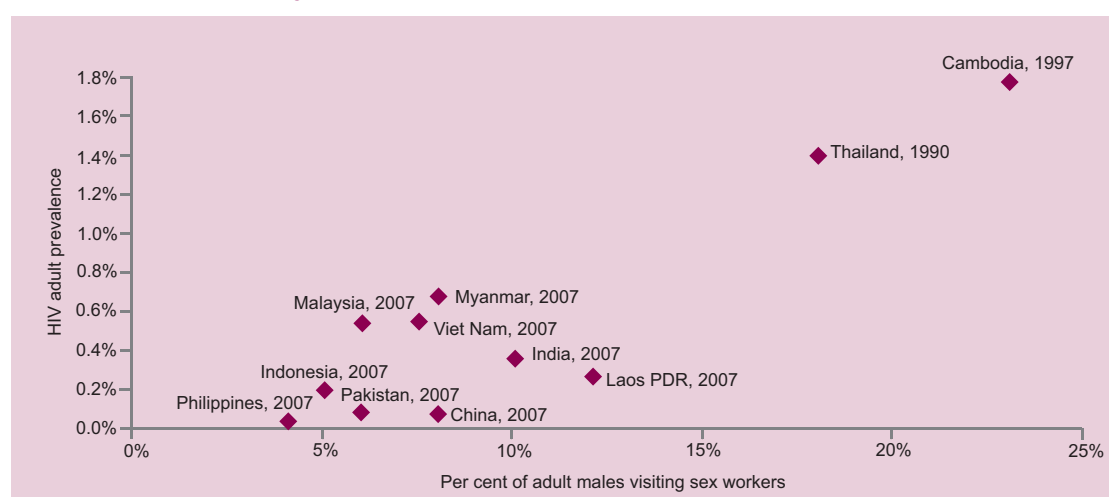
¹⁰⁵ AIDS Commission Report, supra, at p. 23.

¹⁰⁶ Ibid. at p. 23.

population group in South and South-East Asia. Three key factors explain why HIV prevalence has risen so rapidly among sex workers and clients in some parts of Asia, but not in others: first, the proportion of men who visit FSWs; secondly, client turnover; and thirdly, levels of condom use during paid sex.¹⁰⁷

The proportion of men who have unprotected commercial sex is probably the single most important determinant of the potential size of HIV epidemics in most of Asia (see figure 4). It is estimated that up to 37 million men in China buy sex regularly, as do about 30 million in India. Meanwhile, it is estimated that in Indonesia more than three million men buy sex each month. On average, in Asia, there are about 10 male clients for every sex worker.¹⁰⁸ In addition, most men who buy sex from women are either already married or will get married. Significant numbers of supposedly low-risk women who only have sex with their husbands are subsequently exposed to HIV.

Figure 4: In the absence of large scale interventions, levels of HIV prevalence depend on the number of men who buy sex



Source: Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response* (New Delhi, Oxford Press, 2008).

High client turnover, combined with high susceptibility to HIV infection (due to the presence of other sexually transmitted infections, for example) can create a critical mass of infections that can spark the rapid spread of HIV within the sex trade. The more clients a sex worker has in a day or a week, the more opportunities there are for HIV transmission. In many countries, this is further exacerbated by the introduction of HIV into commercial sex networks from other sources, primarily drug injectors. As a result, in some countries, like Indonesia, Viet Nam and parts of China, HIV infection levels have been rising among injecting drug using sex workers and clients.¹⁰⁹

It follows that interventions, such as condom use promotion, which can prevent HIV transmission to and from male clients of sex workers are likely to be the most effective in controlling HIV epidemics. Thailand and Cambodia are good examples of how increased condom use has directly contributed to decreased prevalence rates in target populations, including through a combination of peer education and structural interventions. It is estimated that, had effective measures not been taken, national adult HIV prevalence in these countries could have reached 8–10 per cent by 2020.¹¹⁰

¹⁰⁷ Ibid. at p. 37.

¹⁰⁸ Ibid. at p. 39.

¹⁰⁹ Ibid. at p. 40.


¹¹⁰ Ibid. at p. 33.

Some effective models for HIV prevention among sex workers can be identified. All have, at their core, outreach activities for sex workers, most involving peer educators in the provision of condoms and in the management and treatment of sexually transmitted infections. The aim is to create an enabling environment in which sex workers are safer and have more control.¹¹¹

In many countries, parallel programmes have been mounted to influence the clients' behaviour, most often done through peer education in workplaces, condom social marketing, and the mass media. Working in synergy with programmes for sex workers, client centred programmes help to establish norms of condom use in sex work, encourage expanded treatment for sexually transmitted infections, and ensure the long-term sustainability of the behavioural changes they produce.¹¹²

A recent study has confirmed the impact of a well-designed mass media campaign was a central part of Thailand's HIV prevention programme. In the case of male clients of sex workers, the Thai experience also shows that HIV publicity aimed at most-at-risk groups works best when it is frank and avoids moral judgment. The study concluded that a mass media campaign that is comprehensively designed is a prerequisite for a potentially successful HIV response.¹¹³

In every setting with a flourishing sex trade, achieving and maintaining high levels of condom use in commercial sex will, more than any other intervention, prevent the greatest number of HIV infections in the society as a whole. Once significant behaviour change is achieved among the male clients of sex workers, such change can become permanent. In Thailand and Cambodia, for example, the effects of its HIV campaigns in the early 1990s are still evident in the fact that fewer men visit sex workers and consistent condom use during paid sex has stayed relatively high, despite the fact that prevention efforts subsequently faded, like in Thailand.¹¹⁴

 A review of the 2008 UNGASS Reports for countries in the Asian and Pacific region clearly showed that many such countries have met the 60 per cent behavioural change target for FSWs and condom use (see figure 5). However, it is important to note that progress in many other countries has been challenging and that overall data quality needs verification.

When conducted with adequate intensity and coverage, programmes addressing sex-work risk have been able to produce major behavioural change around Asia. Over a five-year period, such programmes can raise consistent condom use to 80 per cent or more, reduce sexually transmitted infections by more than 50 per cent, and cut the number of infected clients in half. For example, in India, the Sonagachi project, by empowering sex workers, effectively raised condom use among sex workers and decreased sexually transmitted infections in a sustained fashion.¹¹⁵

¹¹¹ Ibid. at p. 75.

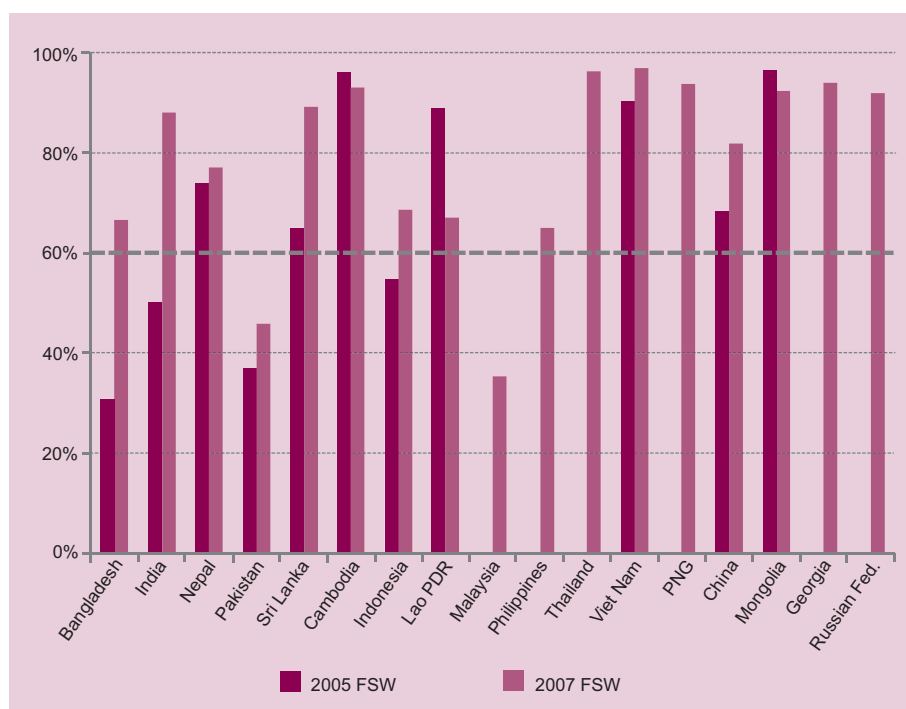
¹¹² Ibid.

¹¹³ Ibid. at p. 106.

¹¹⁴ Ibid. at p. 42.

¹¹⁵ Ibid. at p. 75.

Figure 5: Percentage FSWs reporting the use of a condom with most recent client



Source: Compiled from UNGASS 2005 and 2008 country reports. Data quality varies.

Injecting drug users

IDUs are the largest population group newly infected with HIV across the Asian and Pacific region. In fact, injecting drug use is the main mode of HIV transmission in a number of countries, including Armenia, Bangladesh, Cambodia, China, Indonesia, the Islamic Republic of Iran, Kazakhstan, Kyrgyzstan, Myanmar, Pakistan, the Russian Federation, Tajikistan, Turkmenistan, Uzbekistan and Viet Nam.

Sharing syringes and needles when injecting drugs is the easiest way of HIV transmission and, as a result, HIV prevalence can increase very quickly among drug injectors. Currently, only a few countries in Asia and the Pacific with HIV epidemics among IDUs are providing both needle exchange and drug substitution services through government-funded outlets. Even less of these services involve peer outreach programmes.

Several countries in Asia have seen HIV infection levels among IDUs rise from 0 to 40 per cent or higher in only a few years. In Karachi (Pakistan), HIV prevalence among IDUs increased from under 1 per cent in early 2004 to 26 per cent in March 2005. Myanmar, Nepal and Viet Nam all have localized epidemics among IDUs, with localized prevalence levels over 60 per cent.¹¹⁶

Once prevalence reaches high levels, it can take many years of intensive and wide-scale prevention efforts to bring infection rates down again. Success stories from industrialized countries show that 7-10 years pass before significant reduction in prevalence can be noted. The most effective course of action is to prevent HIV infections among injectors before prevalence soars. In countries and areas where the opportunity still exists, early intervention will be far easier and cheaper than trying to curb a rampant spread of HIV among injectors

¹¹⁶ Ibid. at p. 42.

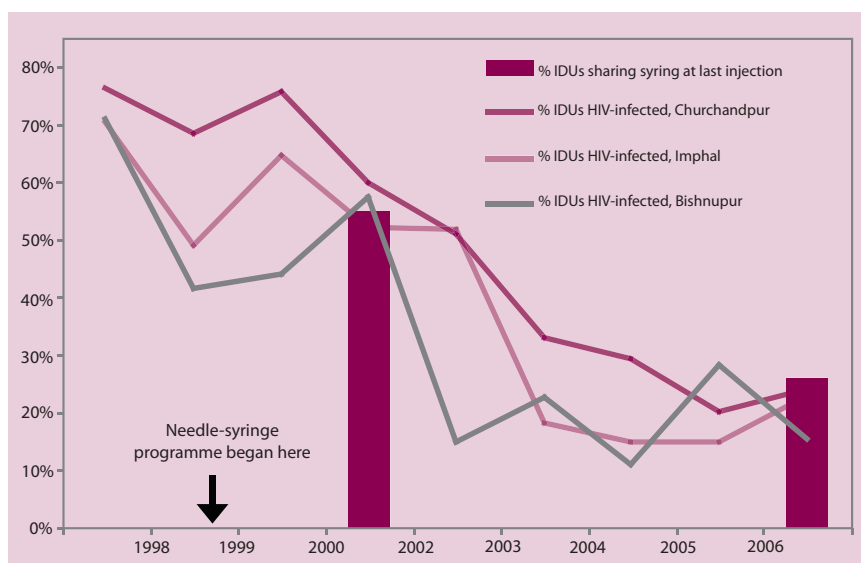
and their sexual partners. Hong Kong, China, opted for this route, and its harm-reduction programme has helped keep HIV prevalence among drug injectors low for many years.¹¹⁷

Countries and cities where HIV prevalence among injectors is still relatively low (including Bangladesh, Pakistan, several cities in eastern China, and some in India and Malaysia) should therefore focus a very substantial part of their HIV prevention efforts on programmes that reduce drug injecting, that promote the use of sterile equipment when injecting does occur, and that encourage safe sex among injectors and their partners.

Experience has clearly shown that effective models exist to do this. Although controversial, the scientific evidence regarding the effectiveness of harm reduction programmes is clear (see figure 6). Safe and consistent access to sterile injecting equipment must be provided as part of a comprehensive harm reduction programme, which includes drug substitution. Such programmes can virtually eliminate the threat of a major HIV epidemic among injectors.

Yet there is still a reluctance to scale up effective harm reduction programmes, to address legal conflicts, or to involve drug users meaningfully in the responses that directly affected them. A study by International Harm Reduction Association even shows a decrease in coverage of harm reduction programmes, with an actual decline in coverage in South-East Asia between 2003-2005 from 5.0 to 3.2 per cent.¹¹⁸

Figure 6: Harm reduction and decreasing HIV prevalence among IDUs in Manipur, India



Source: National AIDS Control Organization, Ministry of Health, India, in "HIV, TB and Malaria situation in SEAR and Priorities for their Prevention and Control", a presentation by WHO-SEARO at the GFATM R8 preparation meeting, Jakarta, March 2008.

Peer outreach is needed to bring drug users to needle syringe or substitution clinics, as drug users are often 'hidden' because of the illegal nature of their behaviour. Finally, these interventions only succeed in the context of an enabling environment with supportive Government policies and with the cooperation from local authorities and police.¹¹⁹ In many countries, including China and Viet Nam, where the majority of HIV infection is still transmitted through injecting drug use, existing drug control laws contain measures used to restrict and interfere with harm reduction and peer outreach activities.¹²⁰

¹¹⁷ Ibid at pp. 42-43.

¹¹⁸ APCASO 2008 UNGASS Report, supra.

¹¹⁹ AIDS Commission Report, supra, p. 76.

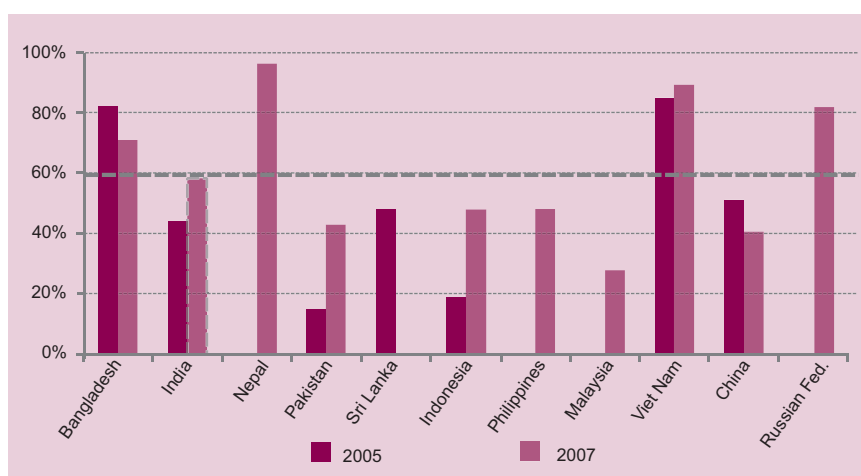
¹²⁰ APCASO 2008 UNGASS Report, supra.

Unfortunately, only a small number of such programmes (for example, in Bangladesh, China, India, Indonesia, Malaysia, Nepal, and Viet Nam) can be found in countries in the Asia-Pacific region and most of these are small programmes with limited impact.

- A review of the 2008 UNGASS Reports for countries in the Asian and Pacific region shows that, overall, only a few countries are reporting over 60 per cent safe injection behaviour (see figure 7). Many countries do not report on this indicator at all.

However, when such programmes reach IDUs, they can cut the levels of sharing by more than half, and can also reduce the overall percentage of shared injections by similar proportions. The combined impact of these behavioural changes greatly reduces the risk of contracting HIV and radically slows the spread of HIV in the relevant group.

Figure 7: Percentage of IDUs reporting use of sterile injecting equipment



Source: Compiled from UNGASS 2005 and 2008 country reports. Data quality varies. For India an arithmetic means is used based on coverage information across survey locations.

Recent results of methadone treatment in China demonstrate the abovementioned point. IDUs in methadone treatment in China reported lower incidence of HIV compared to non-treatment groups and reduced needle sharing compared to their pre-treatment status. Similar success was met with in India (see again figure 6).¹²¹ However, despite signs that countries in the region are becoming more accepting of methadone maintenance treatment, only nine Asian countries provide some degree of treatment and there are considerable barriers to access including lack of access in rural areas and legal restrictions which inhibit scaling up services. The Asian Harm Reduction Network further finds that the broader policy environment affecting harm reduction – notably the development of laws and policies on narcotics control – is also closed to the participation of drug users, harm reduction organizations and others with relevant experience and insight.¹²²

Preventing an HIV epidemic among IDUs can be a very effective way of avoiding a wider HIV epidemic. First, it would prevent a critical mass of infection building up in the sex trade, and second, it would limit HIV being passed on to the non-commercial sex partners of IDUs. However, in several countries, HIV prevalence among this group is already high and infected IDUs are introducing HIV into the sex trade, as buyers or as sellers. In countries like China, Indonesia, Kazakhstan, Uzbekistan, and Viet Nam, the large overlap between injecting

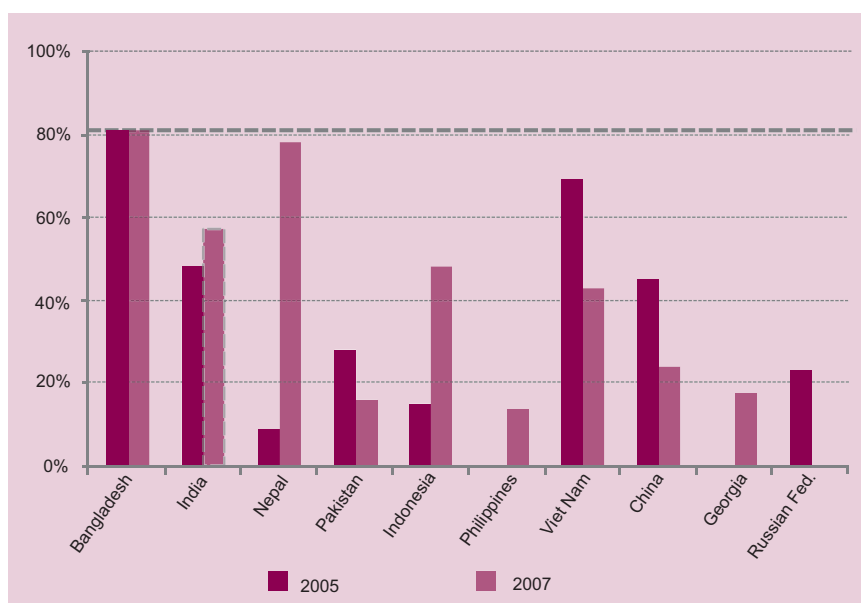
¹²¹ WHO, UNAIDS and UNICEF, *Towards Universal Access: scaling up priority HIV/AIDS interventions in the health sector* (Geneva, WHO, 2007) (hereinafter “WHO, UNAIDS, UNICEF, Towards Universal Access”), p. 41.

¹²² APCASO 2008 UNGASS Report, supra.

drug use and sex work is increasingly linked to the growing HIV epidemics.¹²³ In parts of China, for example, almost half of female IDUs said they sold sex and they were significantly less likely to use condoms with clients than were sex workers who did not inject.¹²⁴

- A review of the 2008 UNGASS Reports for countries in the Asian and Pacific region reveals that IDUs are not being effectively reached by prevention programmes. The best coverage is achieved in South Asia (see figure 8).

Figure 8: Percentage of most-at-risk populations reached with HIV prevention programmes - IDUs



Source: Compiled from UNGASS 2005 and 2008 country reports. Data quality varies. For India an arithmetic means is used based on coverage information across survey locations.

Incarcerated populations

Countries across the region often incarcerate people living with HIV or people vulnerable to HIV infection either in prisons or in other closed settings, often for rehabilitation and re-education purposes. Not only does this limit access to essential HIV and AIDS services, placing populations at high risk of HIV infection together in a closed setting exacerbates HIV transmission. As referenced in the APCASO review of the 2008 UNGASS reporting, the International Harm Reduction Association reports evidence of elevated HIV prevalence amongst prisoners and those held in custodial settings in several Asian countries, with prevalence rates among prisoners at the national level reported around 20 per cent in some countries and prevalence rates among prisoners in facilities in several countries ranging between 3 and 40 per cent.¹²⁵

In Thailand, IDUs who had been jailed were seven times more likely to be HIV-infected than were IDUs who had never been jailed. In Chennai (India), they were more than twice as likely to be infected compared with those who had never been to jail. In Indonesia, men who had recently arrived in jail were only a quarter as likely to be HIV-infected compared with other prisoners.¹²⁶

¹²³ UNAIDS 2007 AIDS Epidemic Update, *supra*.

¹²⁴ AIDS Commission Report, *supra*, p. 44.

¹²⁵ APCASO 2008 UNGASS Report, *supra*.

¹²⁶ AIDS Commission Report, *supra*, p. 46.

According to public health officials, injecting drugs while in jail probably accounts for most of the differences that exist. In Thailand, one in six current injectors said the first time they injected drugs was in jail. The risks do not end there. People who are newly infected in jail are highly infectious. If they then have unprotected sex with other inmates who are not injectors, they are much more likely to transmit HIV. Further, those who are in jail for a short period of time may well be released while they are still highly infectious. Their sex partners outside the prison system are then at a high risk of HIV infection. Thus, jails can act as reservoirs for HIV, while effective prevention programmes inside prisons can help limit the spread of HIV.¹²⁷


Lack of access to HIV services in custodial settings is unfortunately the norm for the majority of countries. This includes extremely limited access to antiretroviral therapy for those living with HIV, and no access to harm reduction services. In countries with a policy of compulsory drug rehabilitation and high levels of HIV among drug users (for example, China, Malaysia and Viet Nam) the lack of services and the disruption to continuity of care between closed and community settings provides the platform for increasing transmission within such settings and undermines the stability necessary to achieve successful treatment outcomes.¹²⁸

Logistically, prisons are among the easiest places to mount HIV prevention programmes. The only real obstacle is political and it can easily be overcome. Several countries in the Asian and Pacific region have introduced prevention programmes in prisons (including the provision of sterilized injecting equipment); these include Australia, the Islamic Republic of Iran and Kyrgyzstan. The Islamic Republic of Iran has taken notable prevention action aimed at IDUs in prisons. By January 2007, the triangular clinics in the country were providing methadone maintenance therapy to 55 per cent of prisoners in need and it was expected that they would cover 80 to 99 per cent within a year.¹²⁹

MSM

Sex between men accounts for an increasing share of new infections in the Asian and Pacific region. MSM are characterized by a particularly high partner turnover. This is further exacerbated by the fact that social taboos and discrimination in many countries mean MSM are seldom an open lifestyle choice; many MSM also have sex with women and may be married. Men with many partners are more likely to encounter a newly infected partner and become infected, and they are also more likely to spread the virus to a large number of other people.¹³⁰

Combined with low condom use, this has led to a rapid rise in HIV prevalence among MSM in several Asian cities. In Bangkok, more than one in four MSM were found to be infected with HIV in a 2005 study; up from 17 per cent in 2003. In Beijing, less than 1 per cent of surveyed MSM were HIV-positive in 2004; two years later, prevalence had reached almost 6 per cent. In Karachi, 4 per cent of surveyed male sex workers were found to be infected in 2005; within two years, that figure had nearly doubled. Among transgender sex workers, HIV infection levels were even higher: 22 per cent in Jakarta in 2002 and 37 per cent in Phnom Penh in 2003.¹³¹

 A review of the 2008 UNGASS Reports for countries in the Asia and Pacific region clearly indicates that the coverage of programmes for MSM in Asia has been extremely limited. Many countries did not report on the percentage of MSM reached with HIV prevention programmes (see figure 9).

¹²⁷ Ibid. at p. 47.

¹²⁸ APCASO 2008 UNGASS Report, *supra*.

¹²⁹ WHO, UNAIDS, UNICEF, *Towards Universal Access*, *supra*.

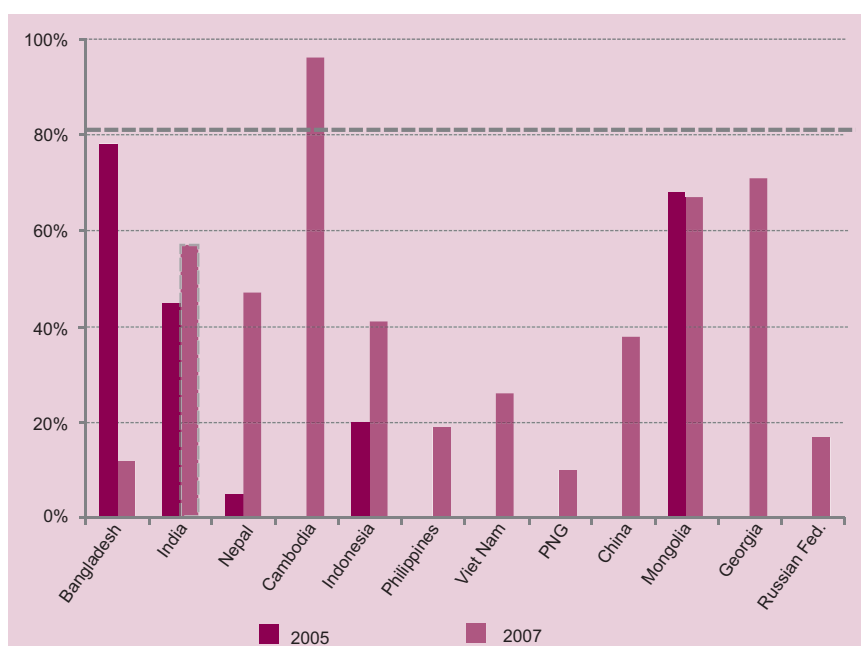
¹³⁰ AIDS Commission Report, *supra*, p. 48.

¹³¹ Ibid. at p. 49.

Only one country (Cambodia) has met the 80 per cent target and three others (India, Georgia and Mongolia) are in range. The 2008 Commission on AIDS in Asia reports that only an estimated 5 per cent of MSM were reached on an aggregate basis in Asia.

However, experience from other regions and smaller programmes in Asia do indicate that peer outreach programmes, management and treatment of sexually transmitted infections, access to condoms and lubricants, and a supportive environment are vital components of effective responses. They help to increase the levels of condom use in anal sex and to reduce the overall numbers of sexual partners.

Figure 9: Percentage of most-at-risk populations reached with HIV prevention programmes - MSM



Source: Compiled from UNGASS 2005 and 2008 country reports. Data quality varies. For India an arithmetic means is used based on coverage information across survey locations.

When HIV prevention services are offered to this group, the uptake tends to be impressive. Community groups of MSM have proved to be energetic and competent partners (and leaders) in HIV prevention in many settings. This can keep costs down, while ensuring high programme coverage. In Indonesia, the Ministry of Health collaborated with non-governmental partners to produce and promote safe sex packs, including condoms, water based lubricant, and information about HIV and sexually transmitted infections, with significant uptake within a two year period. It is evident that high coverage of a service that men appreciate can translate into rapid behaviour change.¹³²

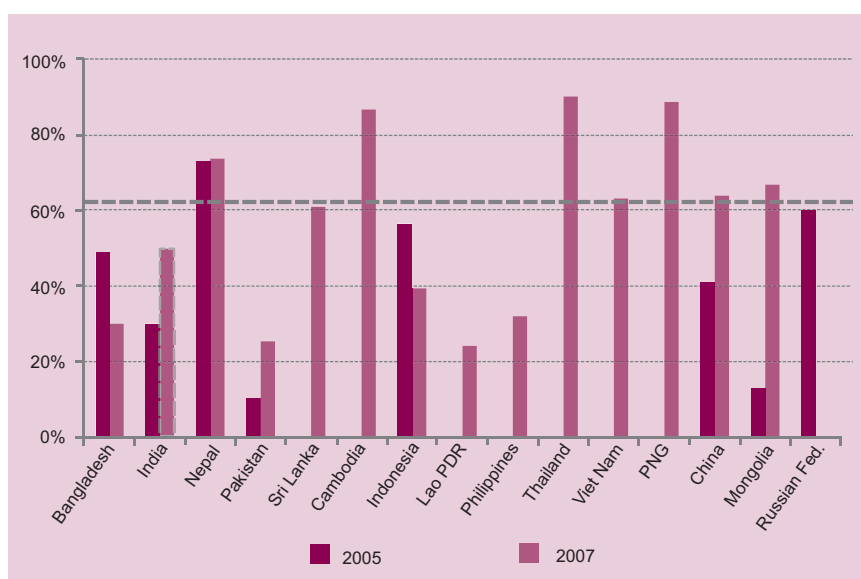
- A review of the 2008 UNGASS Reports for countries in the Asian and Pacific region shows that even with low prevention coverage, several countries in the region report relatively high condom use among MSM at last anal sex (see figure 10).

There are examples of countries from all subregions of Asia and the Pacific that have met the 60 per cent target behaviour change target. Levels of condom use of 80 per cent during anal sex are achievable in relatively short timeframes with aggressive prevention efforts.¹³³

¹³² Ibid. at p. 49.

¹³³ Ibid. at p. 77.

Figure 10: Percentage of MSM reporting the use of a condom the last time they had anal sex with a male partner



Source: Compiled from UNGASS 2005 and 2008 country reports. Data quality varies. For India an arithmetic means is used based on coverage information across survey locations.

Women

Although high-risk behaviours drive the epidemics, an increasing number of women in Asia are becoming infected, even though the majority of them are in steady relationships and practice none of those risk behaviours. One main reason for this is that the low status accorded women in many countries renders them highly dependent on relationships that put them at risk of HIV infection. In many countries in this region, women in relationships cannot abstain from sex, insist that their partner use a condom during sexual intercourse or demand their partner's fidelity. In this way, many women are then infected by husbands and boyfriends who engage in high-risk sex or drug injecting.

Socio-cultural restrictions on women's sexual freedom are one of the reasons why casual sex remains a minor factor in Asia's HIV epidemics at the moment. Given the current sexual behaviour patterns of the vast majority of women in Asia, very few who acquire HIV are likely to transmit the virus to someone else (except when they give birth to an infant). The epidemics, therefore, cannot sustain themselves independently of HIV transmission among most-at-risk groups (that is, sex workers and their clients, IDUs and MSM).¹³⁴

Although the majority of adults living with HIV in Asia and the Pacific are men, the proportion of women in this total has risen gradually. The Commission on AIDS in Asia reports that, for Asia, the number of women living with HIV has increased from 19 per cent in 2000 to 24 per cent in 2007. Those women will have been infected in one of three ways. A very small minority will have acquired HIV while injecting drugs, some will have been infected when selling sex, and most will have been exposed to HIV during sex with a husband or boyfriend who had been infected during paid sex or when injecting drugs. As a conservative estimate, the number of women at risk of falling into the latter category could number more than 50 million for Asia alone.¹³⁵

¹³⁴ Ibid. at p. 31.

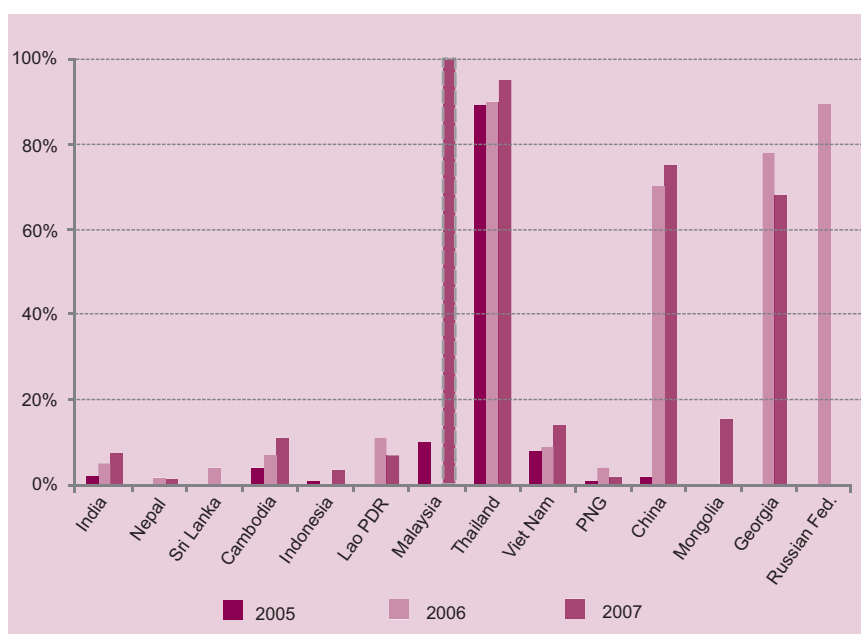
¹³⁵ Ibid. at p. 51.

Clearly, therefore, the best way to prevent most HIV infections in women is to prevent their partners from becoming infected in the first place. The most effective way of achieving this is to prevent infections during paid sex and drug injecting. Unfortunately, public programmes aiming to do that have been too few. As a consequence, large numbers of men in Asia are infected with HIV, and they are putting their regular sexual partners at risk. Typically, those partners are unaware of that risk and are not able to protect themselves against infection.¹³⁶

- A review of the 2008 UNGASS Reports for countries in the Asian and Pacific region shows that the majority of pregnant women in the region are not being reached by the prevention of mother-to-child transmission services (see figure 11). With the exception of a few countries, prevention of mother-to-child transmission remains well below 10 per cent. Although targets for prevention of mother-to-child transmission are left up to the countries, it is evident that much more needs to be done.

In some countries, limited coverage is partly attributable to the lack of institutional services for pregnant women. Countries where women attend antenatal clinics on a large scale should have made good progress in providing prevention of mother-to-child transmission services as demonstrated in Thailand. However, in several countries where antenatal facilities reach a majority of women (such as China and Indonesia, where more than 90 per cent of pregnant women use those facilities), the uptake of prevention of mother-to-child transmission services has barely reached 2 per cent. In addition, in countries where most deliveries occur outside the formal health system (such as Cambodia, India, the Lao People's Democratic Republic and Nepal), prevention of mother-to-child transmission service provision is poor.¹³⁷

Figure 11: Percentage of HIV-positive women on antiretroviral therapy to prevent mother-to-child transmission



Source: Compiled from UNGASS 2005 and 2008 country reports. Data quality varies. The Malaysia country report did not use estimated positive pregnant woman as denominator.

¹³⁶ Ibid.

¹³⁷ Ibid. at p. 133.

Youth

The number of young people living with HIV in Asia and the Pacific is increasing. However, the fact that a large proportion of those who are at high risk of HIV infection are young does not mean that large proportions of young people are at high risk of HIV. The analysis carried out by the AIDS Commission shows that over 95 per cent of all new HIV infections among young people in Asia occur among most-at-risk adolescents. In the Asian and the Pacific region, most young women and men neither sell nor buy sex or inject drugs and are, therefore, not at high risk of HIV infection.¹³⁸

Although evidence shows that casual sex among young people remains a minor factor in Asia's HIV epidemics, significant resources have been aimed at trying to discourage such behaviour among young people, for example by promoting HIV-related sexual health education for young people. An analysis of the unified budgets and work plans of UNAIDS cosponsors (2004–2005) shows that the bulk of their HIV resources for young people are allocated to low-risk young people in school settings or in the form of life skills education that primarily addresses casual sex. Programmes for low-risk youth absorb over 90 per cent of youth prevention resources, but avert less than 5 per cent of HIV infections among young people.¹³⁹


In light of these findings, there is a growing need to shift the efforts among young people to address the causes and consequences of risky behaviour of young people; especially of those adolescents most at risk such as young IDUs, young MSM, and young women who sell sex and their young male clients.

It is important to note here that the reasoning applied by the AIDS Commission regarding HIV and youth does not hold true for the Pacific subregion. In the Pacific, casual sex behaviour among young people makes up a significant number of new infections, as is evidenced by the situation in Papua New Guinea.

C. Scaling up care and treatment

Recognizing that care, support and treatment are fundamental elements of an effective response, the Declaration of Commitment on HIV/AIDS provides that countries will implement national treatment strategies and increase access to comprehensive care. In 2002, WHO and UNAIDS unveiled the “3 by 5” initiative, which was then launched in December 2003. It had as its goal to place 3 million people in developing countries on antiretroviral drugs by the end of 2005. Although the initiative fell short of its target, it strengthened efforts to deliver life-preserving treatments in resource-limited settings.

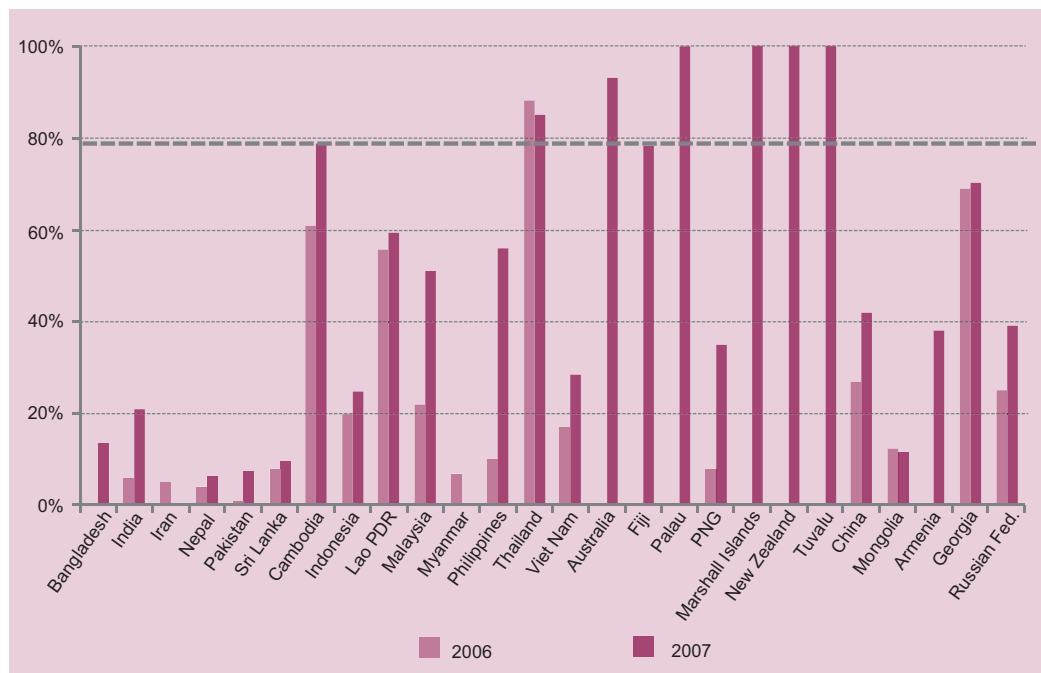
The Universal Access targets for antiretroviral therapy state that, by 2010, all countries must ensure that 80 per cent coverage of those who are eligible for receiving antiretroviral combination therapy receive it.

-  A review of the 2008 UNGASS Reports for countries in the Asian and Pacific region indicates that, although the Asia-Pacific region as a whole falls well short of this target, there is impressive progress in a number of countries (see figure 12). The most visible progress has been made in the South-East Asia subregion

¹³⁸ Ibid. at p. 50.

¹³⁹ Ibid. at p. 146.

Figure 12: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy



Source: Compiled from 2008 UNGASS country reports; the WHO, UNAIDS, UNICEF Progress Report of "Towards Universal Access – Scaling up priority HIV/AIDS interventions in the health sector", April 2007. Data quality varies.

The exceptionally high coverage in the Pacific is largely due to the very small numbers requiring antiretroviral therapy. For example, in Tuvalu, the one person living with HIV is also receiving antiretroviral therapy. Also, in many Pacific countries, increased antiretroviral therapy coverage was recently made possible through a Global Fund grant. It is noteworthy that in the country where the epidemic is most severe, coverage is the lowest.

Lower prices for antiretroviral drugs and increased external support for their provision has helped change the HIV landscape in many countries, and has potentially transformed AIDS into a manageable chronic disease in some. Thailand has clearly demonstrated the feasibility and effectiveness of making antiretroviral therapy available as a public good (see figure 13). It has integrated antiretroviral therapy into its national social insurance system where more than 80 per cent of people in need of antiretroviral therapy are now receiving treatment. Thailand has also issued two compulsory licences for antiretroviral drugs to control the steeply increasing costs related to the provision of and access to such drugs.¹⁴⁰

Georgia has improved access to symptomatic and antiretroviral therapy for people living with AIDS, and is also reaching significant coverage.¹⁴¹ Cambodia has rapidly scaled up availability of antiretroviral therapy, almost reaching 80 per cent coverage; it has also used the opportunity to expand HIV testing.¹⁴²

Despite some success, much more needs to be done. The majority of people in need are still not able to access treatment, and access for highly stigmatized groups remains uneven and in some cases significantly disproportionate to their needs.¹⁴³ Comprehensive AIDS treatment and care involves more than antiretroviral

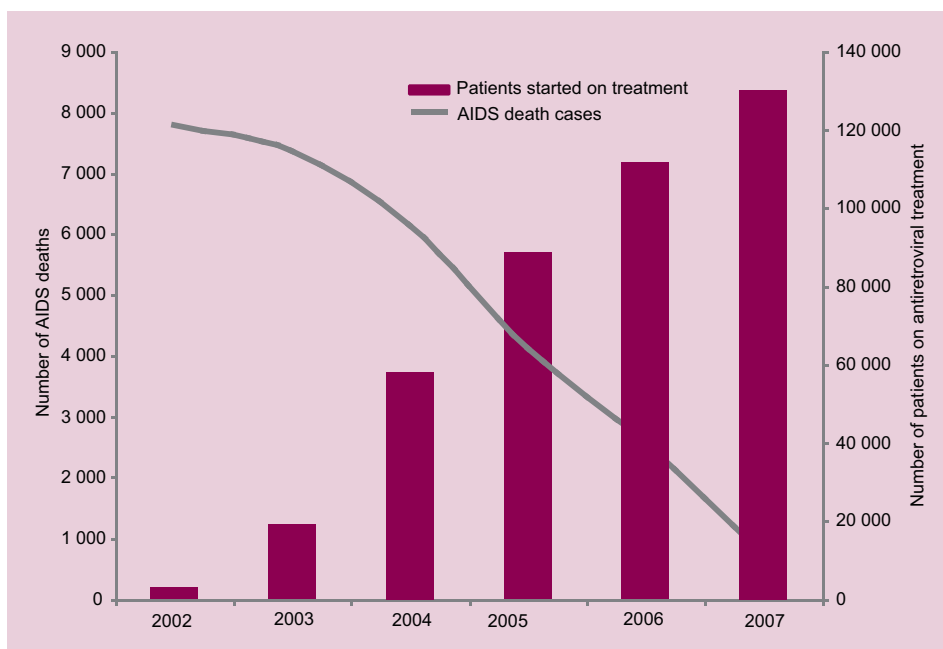
¹⁴⁰ HDS/ESID UNESCAP "Implementation of the Declaration of Commitment on HIV/AIDS Adopted in the Special Session of the General Assembly in June 2001; Review of Progress Made in the ESCAP Region", draft document, December 2007.

¹⁴¹ Georgia UNGASS, *supra*.

¹⁴² AIDS Commission Report, *supra*, p. 133.

¹⁴³ APCASO 2008 UNGASS Report, *supra*.

Figure 13: Rapid expansion of antiretroviral therapy has reduced AIDS mortality in Thailand



Source: Bureau of Epidemiology, Ministry of Public Health, Thailand, in "HIV, TB and Malaria situation in SEAR and Priorities for their Prevention and Control", a presentation by WHO-SEARO at the GFATM R8 preparation meeting, Jakarta, March 2008.

therapy, encompassing the treatment of opportunistic infections, proper food and nutrition, psycho-social care and other essential health and social services. APCASO states that the lack of adequate psycho-social support for people living with HIV and the fact that the UNGASS reports hardly mention it, reflects the absence of the recognition of the significance of such support as well as the lack of resources and care systems.¹⁴⁴ At the same time, in many countries, treatments for common opportunistic infections are frequently unavailable. Individuals co-infected with HIV and tuberculosis often find it difficult to access a comprehensive health service package that addresses the needs of both diseases.

The impact of AIDS is severe. In many of the hardest-hit countries much of the care for those with AIDS is provided at home. Generally, women and girls provide the bulk of home-based care. Most of those who provide this care are unpaid and already quite poor, and the additional financial and emotional burden of administering care frequently pushes them into destitution. Caregivers need more economic, technical, and social support for providing this essential yet too-often unrecognized service. One innovative modality for this was developed by the India HIV/AIDS Alliance for women caregivers in Delhi, Tamil Nadu, and Andhra Pradesh. The Alliance supports NGOs to provide community-based care for people living with HIV, as well as children affected by AIDS. The programme provides psycho-social support, health care, voluntary counselling and testing, economic and food support and skills training.¹⁴⁵

Children orphaned by AIDS require special consideration. Data from high-prevalence countries indicate some progress in the development of child-focused policy frameworks on AIDS, but substantially less success in delivering essential services to children orphaned or made vulnerable by AIDS. Special support (including

¹⁴⁴ AIDS Commission Report, *supra*, p. 133.

¹⁴⁵ The Global Coalition on Women and AIDS, "What's Real?" *SUPPORT WOMEN CAREGIVERS: FIGHT AIDS*, No. 5, accessed on 22 October 2008 from <http://data.unaids.org/publications/IRC-pub07/jc1279-gcwa-5_en.pdf>.

cash transfers or subsidies for education, transport and food expenses) should be available to families fostering children orphaned by AIDS.¹⁴⁶ Also valuable would be the extension of existing insurance and social security schemes to support AIDS-affected households in dealing with the pervasive impact of the disease on daily life (see box 4).

Where such programmes do not exist, AIDS budgets could be used to catalyze social protection schemes to be undertaken by social welfare ministries. Seed money from AIDS budgets could be used to leverage additional resources for social security programmes, as well as catalyse legal changes and affirmative action for women.¹⁴⁷

Box 4: The economic impact of AIDS in Asia

Given the large populations in many countries in the Asian and Pacific region, even low national infection levels mean that many millions of people will endure the epidemic's impact. The most significant impact is experienced at the household level. It is there that the burden of illness, and of income and livelihood losses, is borne by affected individuals and families, and especially by their female members. The economic effects of AIDS-related illness and death tend to be felt most acutely in households living close to or below the poverty line. The AIDS Commission estimates that, by 2015, AIDS will have caused an additional 6 million households in Asia to fall below the poverty line. The loss of income from the principal wage-earner due to AIDS-related illness or death exacerbates the economic costs endured by households, many of which may already be struggling to make ends meet. It has been estimated that each AIDS death represents an income loss of almost US\$ 5,000 — the equivalent of nearly 14 years of income for people earning US\$ 1 per day at current prices.

Source: Commission on AIDS in Asia, Redefining AIDS in Asia: Crafting an Effective Response (New Delhi, Oxford Press, 2008), p. 83-84.

D. Human rights, stigma and discrimination

The Declaration of Commitment on HIV/AIDS emphasizes the centrality of human rights and fundamental freedoms in an effective response to the epidemic. The Declaration calls upon countries to enact legislation barring discrimination against people living with HIV and against vulnerable and at-risk populations. However, to date, significant prejudice remains against groups most at risk and is still embedded in laws, policies, and the operational guidelines of law enforcement agencies.¹⁴⁸

Addressing human rights violations, stigma and discrimination is widely recognized as one of the major challenges in scaling up the AIDS response in Asia and the Pacific, and achieving the Universal Access targets. The APCASO review of 2008 UNGASS reporting states that few of the UNGASS reports document in any detail the human rights dimensions of HIV and AIDS. This is arguably the most sensitive indicator in the reports and the one which provides an important measure of relations between governments and civil society.¹⁴⁹

Human rights violations, and HIV-related stigma and discrimination undermine a comprehensive response to the epidemic, preventing people from using a range of important services. The take-up of HIV testing and

¹⁴⁶ AIDS Commission Report, *supra*, p. 109.

¹⁴⁷ *Ibid.* at p. 110.

¹⁴⁸ *Ibid.* at p. 139.

¹⁴⁹ APCASO 2008 UNGASS Report, *supra*

counselling services is low. Discrimination against people living with or affected by HIV continues to affect their access to employment, housing, insurance, social services, education and health-care services, as well as inheritance rights for women and men. In some countries, strong prejudice against people living with HIV has been found in health services.¹⁵⁰

Such prejudice against people living with HIV stigma and discrimination persist not only with respect to people living with HIV, but also with respect to those most at risk of becoming infected. Reports of human rights violations of MSM, sex workers, and drug users are common across the region and these populations experience a corresponding lack of access to appropriate HIV prevention, treatment and care services. Women typically experience the most severe stigma and discrimination.

In many countries in the Asian and Pacific region, sex work, drug use, and sex between men remain criminalized activities. In Asia, licensed sex work is allowed only in the Philippines and Singapore. The possession of certain narcotics, meanwhile, can carry the death sentence in several countries in the region.¹⁵¹ The criminalization of those groups which are most at risk tends to drive them underground and fosters distrust of state officials and projects. For example, there is evidence in some countries that government crackdowns on substance use have affected attendance at methadone clinics.¹⁵² Harassment not only makes it difficult to supply these groups with HIV services, it often precipitates the risk behaviour itself. For example, in Kolkotta, India, intensified police activity was recorded as the main reason for switching from smoking to injecting drugs, facilitating risk for HIV infection. Harassment also exacerbates prevailing health risks as it can discourage people from carrying condoms or clean syringes. In Indonesia and Nepal, the risk of arrest for being in possession of the needles was cited as the most common reason for not using clean equipment.¹⁵³

In addressing stigma and discrimination, it is useful to bear in mind that the two concepts are quite distinct. Stigma involves an attitude, and often provides the underlying basis for discrimination, which entails an act. Each, in other words, fuels the other. Yet, they are best tackled in ways that reflect those differences.¹⁵⁴

Sensitization

There is an urgent need to sensitize the authorities (including the judiciary, police, politicians, and health professionals) to the realities experienced by most-at-risk populations. Strong involvement of the community in planning and designing is one of the best ways of achieving this. An important way of reducing stigma against people living with HIV and people who engage in high-risk behaviour is to support both their efforts to organize themselves as HIV advocates, educators and activists, and their attempts to forge partnerships with the media, health-care providers, governments and civil society organizations. Without a doubt, people living with HIV often have led the way in forcing HIV into the public realm and by 'putting a face' to the epidemic.¹⁵⁵

Stigma in health-care settings could be reduced by measures such as including HIV education in medical school curricula and ensuring that universal precautions are in place (and post-exposure prophylaxis is available to health-care workers). In addition, community education programmes that provide accurate information about HIV and AIDS, and examples of the ways in which stigma spreads, can go a long way towards reducing the stigma and discrimination associated with AIDS. Curricula for such education interventions have already been developed and tested and now need to be used more widely.

¹⁵⁰ AIDS Commission Report, *supra*, p. 185.

¹⁵¹ *Ibid.* at p. 112.

¹⁵² *Ibid.* at p. 114.

¹⁵³ *Ibid.* at p. 113.

¹⁵⁴ *Ibid.*

¹⁵⁵ *Ibid.*

Legal framework

One of the most important ways of tackling HIV-related discrimination is through legal reform and strengthening of national human rights frameworks. Governments need to remove or revise laws that legitimize HIV-related discrimination, especially those that regulate the labour market, the workplace, access to medical and other forms of insurance, health-care and social services and inheritance rights (particularly of women). More generally, HIV-related discrimination needs to be systematically monitored and publicized by AIDS watchdog organizations.

Most countries in the Asian and Pacific region are now conducting regular reviews and revisions of national HIV and AIDS plans and strategies. Some have enacted HIV-specific legislation which gives legal force to these strategies. However, in addition to the need to bring conflicting legislation on drug control, sex work and homosexuality into line with HIV legislation, there is also the need to create stronger implementing mechanisms including monitoring and enforcement of HIV legal provisions that already exist. The importance of this for the creation of an enabling policy environment is underscored by the tension between harm reduction and demand reduction approaches to drug use and the criminalization of sex work noted in many of the 2008 UNGASS reports.¹⁵⁶ The criminalization of such activities clearly neutralizes otherwise supportive HIV policies, unless law enforcement agencies and the judiciary can be persuaded to cooperate with such policies. This is more likely to be achieved through mature and far-sighted political leadership at the highest levels in combination with sensitization at all levels of the judiciary.

A few countries (notably China and Viet Nam) have already altered their laws to grant drug users a legal right to needle and syringe exchange and drug substitution programmes.¹⁵⁷ However, changing the law can be time-consuming and does not guarantee a change in conduct at the local level. One practical solution would be to introduce legal provisions that provide legal immunity to both beneficiaries and service providers of HIV interventions.

While provisions in national equal opportunity or human rights legislation may be interpreted to apply to vulnerable populations, countries without explicit laws which protect and promote the rights of sex workers, MSM, other sexual minorities, drug users, and people living with HIV and AIDS provide little or no real protection for these populations. In other cases, existing policies or laws remain effective barriers against HIV prevention.

Irrespective of the legal status of behaviours and the nominal rights of people engaging in them, the typical experiences of those people most at risk include harassment, and the violation of their basic human rights. According to APCASO, community based agencies and the constituencies they work for and with (sex workers, MSM and drug users), are bearing the brunt of human rights violations.¹⁵⁸ The experience of MSM in Cambodia (where it is legal) underscores the fact that the legal status of same-sex relations does not necessarily determine the conduct of law enforcement authorities.¹⁵⁹

Where a strong and independent judiciary is in place and able to act progressively in relation to HIV and human rights, the impact can strengthen rights protection as well as add the voice of a powerful actor to calls for legislative review and reform. However, the human rights institutions that should push for this lack capacity in the Asian and Pacific region and have so far played a limited role in law and policy development, as well as facilitating redress in case of violations.¹⁶⁰

¹⁵⁶ APCASO 2008 UNGASS Report, *supra*.

¹⁵⁷ AIDS Commission Report, *supra*, at p. 114.

¹⁵⁸ APCASO 2008 UNGASS Report, *supra*.

¹⁵⁹ AIDS Commission Report, *supra*, at p. 112.

¹⁶⁰ APCASO 2008 UNGASS Report, *supra*.

Political leadership

The lack of effective political leadership in bringing about a change in social attitudes, and implementing an enabling policy and legal environment is one of the major constraints in addressing the AIDS epidemic at a global level. When dealing with issues of stigma and discrimination, and overcoming taboos against the public discussion of sex and sexuality, the role of leaders cannot be underestimated.

This is particularly true in Asia and the Pacific, where the epidemic is largely driven by socially stigmatized behaviours such as injecting drug use, sex work, and sex between men. These are behaviours which 'polite' society frowns upon, yet which are widely disseminated throughout the population-at-large. The enduring stigma associated with HIV and with the behaviours that facilitate HIV transmission often discourages national decision makers from pursuing sound public health and social policies. Leaders can create an enabling environment for addressing these issues by facilitating the involvement of civil society and community groups, mobilizing public opinion or earmarking resources for such activities.¹⁶¹

In addition to addressing the stigma and discrimination experienced by those living with HIV and those most at risk, political leaders must also start paying more attention to disempowered groups of people living with HIV, such as women, poor people and migrants. Underlying factors that lead to discrimination against these groups may require long-term approaches, but in the short term, enabling interventions should be in place to reach, recruit, offer treatment and testing, and provide people in such groups with livelihood security.¹⁶²

E. Strengthening health systems

A health system consists of all organizations, people, and actions whose primary intent is to promote, restore or maintain health. It involves the broad range of individuals, institutions, and actions that help to ensure the efficient and effective delivery and use of the spectrum of products and information for prevention, treatment and care, and support to people in need of these services.¹⁶³ Recognizing and addressing the weaknesses in health systems is essential to improving the response to HIV in the Asian and Pacific region.

Surveillance

Having reliable HIV data is a precondition for gaining a solid understanding of the epidemic. Most of the HIV surveillance systems in Asia and the Pacific are overly dependent on limited data sources. To come to an accurate understanding of the patterns, trends and scales of the epidemics, it is important for countries to examine and collate the multiple sources of data.

Access to data is often a problem. District health offices often do not share their surveillance data with the national health ministry. People collecting behavioural data in one donor-funded project tend to be reluctant or unable to share the information with someone who is funded by a different donor. Sometimes, even national Governments are reluctant to grant international organizations or academic bodies access to data they consider sensitive. It is not unusual for those same Governments to then dismiss data collected by universities or international partners on the pretext that they did not collaborate with the national health system. As a result, varying data sets tend to float about in different state institutions, NGOs and donor agencies.¹⁶⁴

¹⁶¹ AIDS Commission Report, *supra*, at p. 125.

¹⁶² *Ibid.* at p. 116.

¹⁶³ The Global Fund to Fight AIDS, Tuberculosis, and Malaria, "The Global Fund's approach to health systems strengthening," *Global Fund Fact Sheet Series*, 5 of 5, 1 March 2008, accessed on 20 October 2008 from <http://www.theglobalfund.org/documents/rounds/8/R8HSS_Factsheet_en.pdf>.

¹⁶⁴ AIDS Commission Report, *supra*, at p. 61.

However, HIV data collection has improved in several Asian countries over the past decade, largely due to increased pressure from external donors. Several countries now have second-generation surveillance (including Bangladesh, Cambodia, India, Indonesia, Nepal, the Philippines, Thailand and Viet Nam). For example, in India, the number of sentinel surveillance sites increased to more than 1,100 in 2006 (up from 155 in 1998) allowing more extensive coverage of the most-at-risk populations.¹⁶⁵

Even where limited epidemiological findings are available, rigorous analysis is required before the data becomes useful for policymaking and programme design. Solid, trustworthy analysis of the data takes time and the task of collecting, assessing and analyzing data from dozens of sources is best-performed in a centralized manner. Yet this time-consuming, critically important work is seldom entrusted to a single structure or unit with the authority to access all available information and the mandate to gather it into a single system for analysis that informs decision-making.¹⁶⁶

The systems and capacity to analyse the information and channel those findings into policymaking still pose a challenge in many countries. While several international agencies provide country level HIV projections, only a limited number of countries (including Cambodia, China, Indonesia, India, Myanmar, Thailand and Viet Nam) generate their own projections, and even fewer countries (including Bangladesh, China, India and Indonesia) have information that makes it possible to prioritize and focus interventions at the subnational level.¹⁶⁷ However, some good practices are emerging. For example, in Indonesia, HIV surveillance at the district level now documents behavioural risks and disease burdens, allowing planners to identify and zero in on geographic 'hotspots' and anticipate new outbreaks of HIV infection.¹⁶⁸

Human and institutional capacity

Just as good data does not automatically translate into strong analysis, good analysis does not translate automatically into good policy or effective service provision. Nor do increased resources automatically lead to a scaled up response. A range of factors exist to shape a national response, but in many countries a lack of human and institutional capacity is the single biggest obstacle in addressing the HIV epidemic. Addressing capacity barriers is a precondition to make essential HIV services widely available, especially for the poor who are disproportionately affected and rely principally on public services.

An example from China highlights how innovative approaches and strong leadership can be undermined by a lack of human and institutional capacity. In China, the country's HIV programme mobilized significant funding and other resources, and engineered the necessary changes in the judicial and public health systems to establish more than 1,000 methadone substitution and needle and syringe exchange sites. Nevertheless, despite the best efforts and highest commitment from the Government, the programme missed its coverage target at the end of 2006 by 20 per cent, mainly because the plan was not underpinned by the necessary human resources and because operational planning and preparations were poor.¹⁶⁹

The lack of human resources and technical capacity has a critical impact on health service delivery, in particular. Health systems in many countries in the Asian and Pacific region are already overstretched and underfunded. Under these circumstances, it is difficult to expand AIDS-related services such as voluntary counselling and testing, and antiretroviral and opportunistic infection treatment delivery. In many countries in the region, the

¹⁶⁵ UNAIDS 2007 AIDS Epidemic Update, *supra*.

¹⁶⁶ AIDS Commission Report, *supra*, at p. 62.

¹⁶⁷ *Ibid.* at p. 127.

¹⁶⁸ *Ibid.* at p. 121.

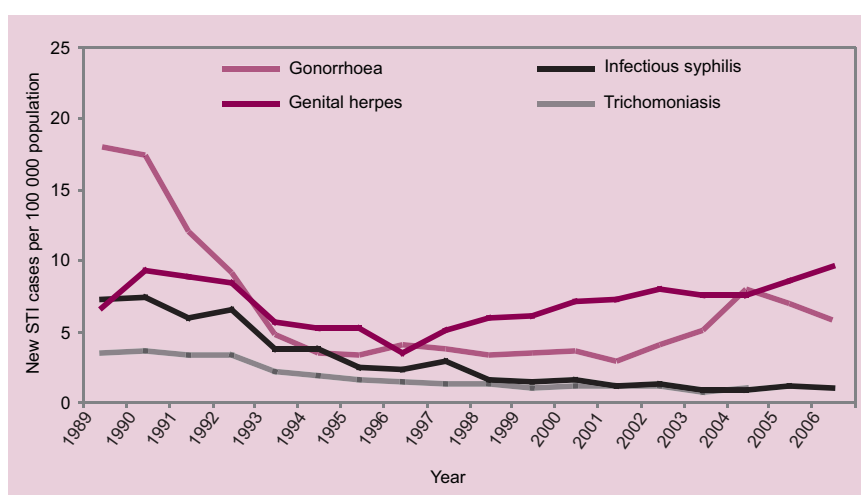
¹⁶⁹ *Ibid.* at p. 130.

challenges of scaling up antiretroviral therapy highlight the persistent fragility of health systems overall, largely attributable to chronically inadequate funding and weak management. This fragility is manifest in weak infrastructure, poorly integrated services and a shortage of personnel fuelled by the ongoing exodus of health workers in many countries from the public to the private health sector and to other countries.

For an effective response to HIV, it is essential that the right national institutions or structures are identified and that they have access to sufficient human and financial resources, and a host of related infrastructure improvements for the health sector as a whole. Furthermore, within the complicated framework of a multi-sectoral and multiministerial response, it is critical that roles and responsibilities are clarified and formalized.

Cambodia is one example where adequate operational planning and financing has enabled a significant improvement of its testing and treatment services, despite both economic and infrastructural obstacles.¹⁷⁰ Sri Lanka is another example of how strong health infrastructure can contribute to improved service delivery and treatment results (see figure 14). It is important to recognize that developing and implementing a successful and institutionalized response to HIV has the potential to strengthen health systems overall. This has recently been recognized by the attention that the Global Fund is drawing to health system strengthening as a cross-cutting priority in addressing the three diseases.

Figure 14: Health infrastructure and access to health services has kept curable sexually transmitted infections at low levels in Sri Lanka



Source: National STD/AIDS Control Programme, Ministry of Health, Sri Lanka, in "HIV, TB and Malaria situation in SEAR and Priorities for their Prevention and Control", a presentation by WHO-SEARO at the GFATM R8 preparation meeting, Jakarta, March 2008.

Coordinating an effective response

The Declaration of Commitment provides that all countries will develop and implement sound national multi-sectoral AIDS strategies, integrate their HIV response into the mainstream of development planning and ensure the full and active participation of civil society, the business community and the private sector.

Strategic plans

Although many countries in the Asian and Pacific region have national strategic plans, the quality of these plans varies significantly. Among countries that have designed plans for effective interventions, for example,

¹⁷⁰ Ibid.

less than half have costed those plans. Consequently, many countries cannot guarantee sufficient programme coverage, adequate financial and human resources or reliable procurement processes for the various drugs and prevention commodities that are needed.¹⁷¹

In numerous countries in the region, resource allocation does not match the highlighted priorities of plans. One essential feature of any successful programme is the need to determine the number of people to be reached. In addition, elements should be further defined in terms of frequency, quantity and coverage. Only with such clearly defined elements and specifications can resource needs be estimated, logistics planned and overall quality monitored and ensured.

Overall, most of the plans lack the key planning components for the operation, management and financing of the response. Many national strategic plans are also not properly balanced between prevention and treatment. Others fail to give priority to those groups most at risk of infection, and still others lack comprehensive plans for antiretroviral treatment and impact mitigation programmes in high prevalence areas.

National AIDS Commissions

Developing and coordinating an effective response requires both leadership and participation at the highest levels, as well as the establishment of supporting structures. As of 2007, many countries have established National AIDS Commissions. However, a brief overview shows that their political status, authority, capacity and responses vary greatly. National AIDS Commissions, on the whole, have not been able to effectively coordinate the AIDS response in their countries. In many countries in the region, they lack the mandate required, the secretarial support and overall direction by the top-level political functionary in the country.¹⁷²

Many countries have also constituted Country Coordinating Mechanisms of the Global Fund for AIDS, TB, and Malaria. In some countries where Global Fund grants contribute substantially to the national programme, the Country Coordinating Mechanisms have become a platform for multi-stakeholder dialogue on the national response to HIV. Clarification and synthesis of the different roles of the National AIDS Commissions and Country Coordinating Mechanisms should be a priority in many countries.

The 'Three Ones'

The need to strengthen coordination of the national response to address the aforementioned problems is reverberated in the 'Three Ones' principle that is aimed at achieving the most effective and efficient use of resources and at ensuring more rapid action. It calls for one agreed HIV Action Framework that provides the basis for coordinating the work of all partners, one National HIV Coordinating Authority, with a broad-based multi-sectoral mandate, and one agreed country-level Monitoring and Evaluation System. It is in implementing the 'Three Ones' principle that countries should increasingly draw on the technical assistance available from the United Nations and other international partners to prioritize and provide technical support to the HIV response.

Strong leadership is required in facilitating the multi-stakeholder process required for achieving the 'Three Ones'. However, there is an opportunity to build on the momentum of many countries that are still in the process of establishing their Universal Access targets and indicators and to integrate 'Three Ones' thinking into these processes. Countries must place priority on building sufficient monitoring and evaluation capacity to increase the transparency and accountability of the national response and to inform future decisions on national policies and programmes.

¹⁷¹ Ibid.

¹⁷² Ibid. at p. 143.

Building an enabling environment

Both independent surveys and information supplied to UNAIDS by low- and middle-income countries indicate that national efforts are not sufficiently prioritizing the delivery of essential, life-preserving interventions to those at greatest risk.¹⁷³ A strictly service-delivery approach to HIV, however, is not enough.

Underlying factors that lead to discrimination against these groups require long-term approaches. The scourge of stigma must be overcome and an 'enabling environment' must be created if HIV interventions are to make a difference. Changes in social policy, the mobilization of opinion leaders at all levels, the cooperation of law enforcement personnel and the involvement of communities are all essential to the creation of such an environment. It is important that HIV budgets make provisions for creating such 'enabling environments'. Substantial funds are earmarked for creating such environments in some interventions in South Asia, including in Nepal and India.¹⁷⁴

Fostering a sense of respect and trust, or providing safe spaces in otherwise unsafe settings, can make a difference. Drop-in centres, for example, provide temporary havens where people can gather, share their experiences and ideas, gain information and link up to relevant services. Such services should also address some of the other pressing, subjective needs of beneficiaries. Providing a crèche for sex workers' children, legal support for dealing with police harassment, safe spaces that offer shelter against violence, providing toilet and resting facilities for street-based sex workers, facilitating the creation of retirement plans with bank-based savings and offering voluntary detoxification services for IDUs not only build trust, but permit people to think beyond their immediate survival needs.¹⁷⁵ Similarly, liaison efforts that aim to reduce the harassment and violence that sex workers and other most-at-risk populations experience at the hands of the police or local power brokers are valuable elements of an HIV intervention.

Box 5: Risk and vulnerability

Risk is defined as the probability or likelihood that a person may acquire HIV infection. Certain behaviours create, enhance and perpetuate risk. Examples of such behaviours include unprotected sex with a partner whose HIV status is unknown, multiple unprotected sexual partnerships and injecting drug use with contaminated needles and syringes.

Vulnerability results from a range of factors outside the control of the individual that reduce the ability of individuals and communities to avoid HIV risk. These may include:

1. lack of knowledge and skills required to protect oneself and others;
2. factors pertaining to the quality and coverage of services, such as inaccessibility of services due to distance, cost or other factors; and
3. societal factors such as human rights violations or social and cultural norms, practices, beliefs and laws that stigmatize and disempower certain populations, either to be able to access HIV prevention, treatment, care and support services and commodities or to use them in their lives. These factors, alone or in combination, may create or exacerbate individual vulnerability and, as a result, collective vulnerability to HIV.

Source: UNAIDS, Practical Guidelines for Intensifying HIV Prevention: TOWARDS UNIVERSAL ACCESS (Geneva, UNAIDS, 2007).

¹⁷³ 2006 SG Report, supra.

¹⁷⁴ Ibid. at p. 116.

¹⁷⁵ AIDS Commission Report, supra, p. 116.

Financing

Resource gap

Overall, Asia has the lowest per capita public expenditure on health in the world. In 2004, UNAIDS estimated that a comprehensive HIV response in Asia would have required an annual investment of US\$ 5.1 billion in 2007. In 2008, the Commission on AIDS in Asia recommended a package of 19 prevention, treatment and impact mitigation interventions, as well as surveillance and programme management activities at a total annual cost of US\$ 6.4 billion for Asia alone (not including Central Asia).¹⁷⁶ However, a projection of current resource availability shows that only US\$ 1.2 billion of the US\$ 6.4 billion needed annually for an effective overall HIV response was available in 2007.

Much of that funding was made available via the Global Fund and the World Bank, as well as bilateral funding agencies. As of April 2008, the Global Fund has approved US\$ 6.24 billion for HIV globally and has emerged as the largest donor in Asia and the Pacific. In the period 2002-2008, the Global Fund has approved more than US\$ 2.6 billion to 28 countries in Asia and the Pacific and one regional programme in the Western Pacific, with the bulk of the funds earmarked for AIDS programmes.¹⁷⁷ The World Bank has currently committed about US\$ 500 million to HIV in the Asian and Pacific region.¹⁷⁸ Other donors include the Gates Foundation, which is investing more than US\$ 200 million in India, while in the United Kingdom of Great Britain and Northern Ireland, the Department for International Development has committed an additional US\$ 45 million to aid Indonesia's HIV response.

The significant amounts available in external funds for HIV programmes make it easier for countries to fund their HIV responses, but also pose difficulties. First of all, medium- to long-term sustainability of some programmes may be compromised if these programmes are dependent on funding flows that are not controlled by national Governments. External funders might also target programme areas that do not correspond to countries' own priorities. Reporting obligations and lines of accountability can become unnecessarily complicated; as a result, Governments' ownership and sense of responsibility for their HIV responses might suffer.¹⁷⁹

Finally, as available resources for funding HIV programmes have increased, the percentage of total HIV expenditure in Asia funded out of national budgets has not only been slower to increase than in other regions, but has actually decreased, according to the Commission on AIDS in Asia. The lack of allocation of domestic resources by low- and middle-income countries to sustain HIV and AIDS services and reduce donor dependency is a significant weakness in any response to HIV and AIDS.¹⁸⁰

Among countries surveyed in Asia, domestic expenditure dropped from 60 per cent in 1996 to 40 per cent in 2004.¹⁸¹ National contributions to the overall programme in Cambodia account for 13 per cent of the total funding of all contributions including international; in Viet Nam, the domestic budget for HIV was US\$ 9.4, while international contributions amounted for US\$ 51 million in 2006, equivalent to 18.5 per cent.¹⁸² There are a few notable exceptions to this trend, including China, India and Thailand, where domestic funding

¹⁷⁶ The Commission has adapted those estimates on the basis of local costs, while retaining the intervention targets used in the earlier calculations. The Commission's work on the local cost also includes the cost of involvement of community based organizations and of the creation of an enabling environment in delivery of services of prevention, treatment and impact mitigation.

¹⁷⁷ The Global Fund to fight AIDS, Tuberculosis and Malaria, accessed on 22 October 2008 from <www.theglobalfund.org/>.

¹⁷⁸ World Bank, "AIDS overview", June 2004, accessed on 22 October 2008 from <http://www1.worldbank.org/hiv_aids/overview.asp>.

¹⁷⁹ AIDS Commission Report, *supra*, p. 136.

¹⁸⁰ APCASO 2008 UNGASS Report, *supra*.

¹⁸¹ AIDS Commission Report, *supra*, p. 120.

¹⁸² APCASO 2008 UNGASS Report, *supra*.

is the main funding source. Governments must increase their own investments in HIV programmes, and middle-income countries in particular must do their fair share of financing a strong national response.

Meeting the right needs

For the foreseeable future epidemics in the Asian and Pacific region will derive most of their momentum from significant levels of HIV transmission during unsafe paid sex, drug injecting and sex between men. This epidemiological reality translates into a major challenge and opportunity.

The common patterns of the HIV epidemics in Asia and the Pacific would seem to simplify the challenge of preventing infections. However, investing public funds in programmes that reduce the health risks associated with commercial sex, sex between men and safer drug injection can be politically, socially, and operationally difficult; even though these are hardly isolated behaviours in Asia and the Pacific or elsewhere. For example, hardly any country is devoting significant resources to programmes for MSM. Even where there seem to be programmes for high-risk groups, they are not always effective; for example, the confinement of drug users in prisons. Across Asia as a whole, only about one in three sex workers were being reached by HIV services in 2005.¹⁸³

The above observation raises the issue of resource allocation for effective and large-scale interventions. Almost all countries in Asia have national strategic plans that recognize specific high-risk behaviours, but only a few of those plans address *all* three groups that are most at risk, and none contains all of the effective intervention elements identified by the AIDS Commission.¹⁸⁴

Cost-effectiveness

In light of the significant resource gap in the Asian and Pacific region, it is important to assess the various activities included in the response in terms of their effectiveness. It is also sensible to limit the management demands placed on over-burdened AIDS programme managers by focusing resources and energies on interventions that have the largest potential impact.¹⁸⁵

The Commission on AIDS in Asia used the Asia Epidemic Model to estimate the cost-effectiveness of various interventions (see figure 15). Its findings highlight the cost-effectiveness of interventions that focus on preventing infections in sex workers and clients; in expanding epidemics, every US\$ 1 invested in appropriate prevention would save up to US\$ 8 in averted treatment costs over the next 20 years.¹⁸⁶

For example, universal precautions and interventions targeting sex workers and their clients tend to be similar in cost but differ considerably with respect to the numbers of HIV infections they prevent. When compared with universal precautions, activities focused on sex workers and clients can prevent 7,000 times more new HIV infections for the same amount of money spent. So, not only are interventions targeting sex workers and clients relatively cheap, they are highly cost-effective.¹⁸⁷

¹⁸³ AIDS Commission Report, *supra*, p. 5.

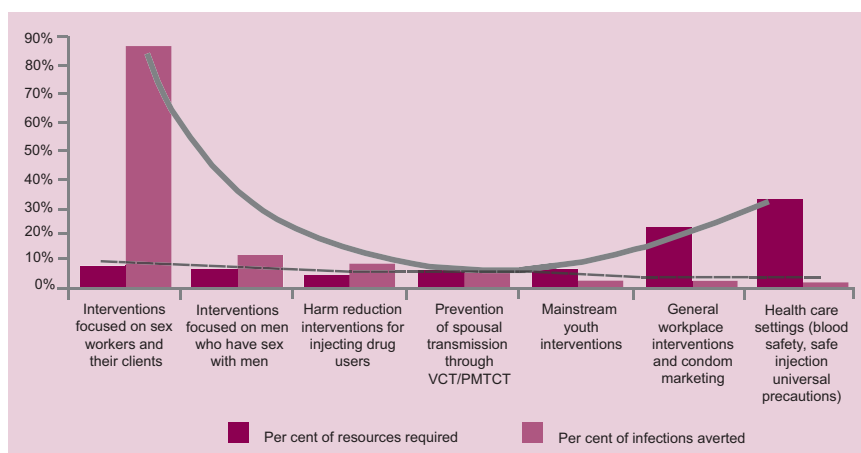
¹⁸⁴ *Ibid.* at p. 130.

¹⁸⁵ *Ibid.* at p. 89.

¹⁸⁶ *Ibid.*

¹⁸⁷ *Ibid.* at p. 90.

Figure 15: Comparison of prevention interventions for Asia, according to distribution of resources and percentage of new infections averted, 2007–2020



Source: Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response* (New Delhi, Oxford Press, 2008).

The Commission also proposed that, irrespective of their cost, interventions of high and known effectiveness should be prioritized and funded out of AIDS budgets. Prevention activities that focus on most-at-risk populations, programmes for preventing mother-to-child transmission of HIV, counselling and testing, and antiretroviral programmes all fit into this category.

The effects of less cost-effective interventions can also still be very positive and substantial. Therefore, the Commission recommends that AIDS programmes advocate, catalyse and leverage additional resources to cover the cost of programmes such as life-skills education, blood safety and universal precautions, which should be managed by the relevant administrative ministries in Governments.¹⁸⁸

A recommended intervention package

Based on cost-effectiveness analysis, the Commission has developed a recommended and costed package for prioritized interventions in Asia. Although this analysis does not include all subregions in the Asian and Pacific region, the argumentation (not the numbers) holds broadly true for the entire region.

This priority package would entail funding only high-impact prevention activities (interventions for sex workers and clients, drug users, and MSM, as well as focused programmes to prevent mother-to-child transmission and transmission within marriages and relationships); a comprehensive treatment package of first- and second-line antiretroviral therapy, including all laboratory testing and subsidies for transportation; impact mitigation, including livelihood security programmes for AIDS-affected women and social protection for children orphaned by AIDS; strategic information, surveillance, and monitoring and evaluation; and investments in programme management.

Such a priority package for Asia would cost about US\$ 3 billion and would aim to achieve: 80 per cent coverage levels for preventing HIV infections in most-at-risk populations and in couples in geographic hot-spots, provision of treatment for 80 per cent of people in need of antiretroviral therapy; and livelihood support to 80 per cent of affected and poor households.¹⁸⁹

¹⁸⁸ Ibid. at p. 89.

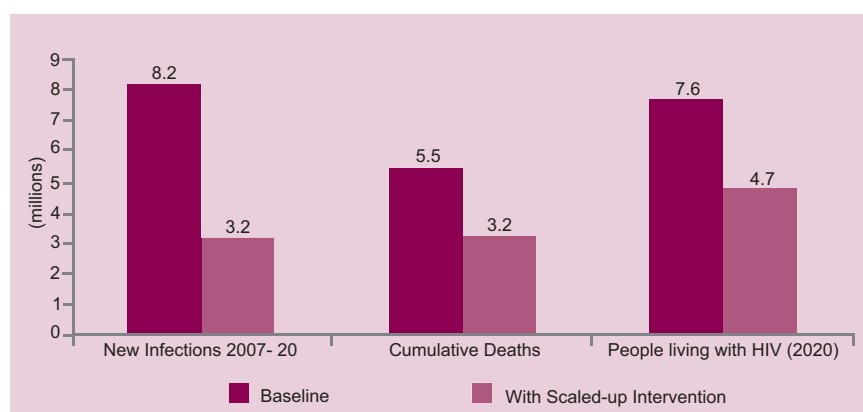
¹⁸⁹ Ibid. at p. 92.

The priority package could avert 60 per cent of new HIV infections and almost 40 per cent of AIDS-related deaths, as well as provide livelihood support to almost one million families (see figure 16). An expanded response package that also includes other long-term, low-impact interventions (along the lines of the resource needs estimates done at the global level and adopted by the Commission to local costs) would cost around US\$ 6.4 billion annually in Asia.¹⁹⁰

Despite the significant funding gap, which is almost US\$ 2 billion for Asia alone, it is important to note that change is possible. Even a full expansion to a comprehensive response package will require expenditure less than 0.2 per cent of total GDP for Asia and approximately 4 per cent of estimated regional spending on health care in 2007. At such small shares, resource mobilization is very feasible, provided that donor assistance can complement public sector efforts in the poorer countries of the region.¹⁹¹

Unfortunately, even at the current accelerated pace of funding commitments, the resource gap for AIDS will still be in the range of 50–60 per cent of what is truly required for a comprehensive response in the region. To reach the current estimated resource needs for the region requires a rapid scale-up of donor commitments.¹⁹²

Figure 16: The projected impact of AIDS in Asia - with and without a comprehensive HIV response, 2007–2020



Source: Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response* (New Delhi, Oxford Press, 2008).

F. Socio-economic determinants in Asia and the Pacific

Neither the behaviours that entail high risks of HIV infection, nor the interventions aimed at reducing them, occur in a social, economic or cultural vacuum. These behaviours are shaped by underlying drivers, which render some people more vulnerable to HIV and its effects. Moreover, the outcomes of HIV interventions are shaped by factors that may hinder or facilitate the delivery and use of those services. In Asia and the Pacific, the dynamics that shape behaviour and affect people's vulnerability to HIV include socio-economic and gender inequality, and migration and mobility.

Socio-economic inequality

In Asia and the Pacific, economic growth for 2008 was estimated to level out at 7.7 per cent, after the fastest growth in a decade in 2007.¹⁹³ However, there are widening income disparities in and among many countries.

¹⁹⁰ Ibid.

¹⁹¹ Ibid. at p. 135.

¹⁹² Ibid.

¹⁹³ UNESCAP, *Economic and Social Survey of Asia and the Pacific 2008: Sustaining Growth and Sharing Prosperity* (Bangkok, UNESCAP, 2008).

At the same time, social reforms and access to basic services are lagging behind economic reforms throughout the region.

Although the links between poverty and HIV are difficult to quantify, it is clear that the HIV epidemic is a development problem, which means that a sound understanding of local socio-economic inequality should be integrated into HIV strategies. For HIV prevention to be most effective, it must recognize and address related determinants of vulnerability. This would indicate a need for a multi-sectoral approach that includes national development planners to enable societies to address deep-rooted vulnerabilities and risks that assist the spread of HIV and weaken responses to it.

Migration

Economic inequality in the midst of rapid development also tends to lead to large-scale migration, which may be associated with sexual risk taking. Men who have disposable incomes, and who travel or migrate to work opportunities outside of family settings, may provide a significant demand for commercial sex. There are some indications that if countries in the region continue to experience rapid economic growth and men's incomes continue to rise, the demand for commercial sex in the region may also rise. In China, for example, the skewed national sex ratio and increased migration (mainly from rural to urban areas) are believed to be contributing to the demand for sex work, and several studies have highlighted sexual risk-taking behaviour among some groups of migrants. A 2003 survey in the south-west of China found that temporary female migrants were 80 times more likely than non-migrants to sell sex.¹⁹⁴

In Viet Nam, high levels of injecting drug use and sex work among young male migrant workers underlines the need for prevention programmes that reach migrants. In Nepal, it is estimated that almost half of all people living with HIV have worked as migrant labourers. Nepalese girls and women who have been sex-trafficked are at especially high risk of HIV infection: an HIV prevalence of 38 per cent has been found among repatriated sex-trafficked females. There are also concerns about the potential role of migrant labour in Pakistan's epidemic. In Lahore, for example, one in ten unmarried male migrant workers reported having had unprotected paid sex in the previous year.¹⁹⁵

It is important to note here that generalizations can mislead. Significant numbers of migrants move with their partners, and HIV-related risk-taking tends to be lower among this group. Equally, there is research evidence that conservative social norms survive longer among migrants than is commonly thought; for example, where paying for sex is seen as unacceptable. It is therefore not the case that all migrants are necessarily at higher risk of HIV infection.¹⁹⁶

It is clear that more research on the dynamics of mobility and economic migration is necessary. However, notwithstanding this, the response to migration and HIV has been unacceptable in many countries in the region. In any situation, migrant workers experience higher levels of discrimination and have little or no access to basic health services, while access to HIV-related services is almost non-existent.

Compulsory testing and deportation of migrant workers by host countries is still a common practice in the region. For example, in Malaysia, female migrant workers are subjected to mandatory screening for more than 15 infectious diseases and conditions including HIV, sexually transmitted diseases, tuberculosis, malaria and

¹⁹⁴ AIDS Commission Report, *supra*, p. 110.

¹⁹⁵ *Ibid.* at p. 111.

¹⁹⁶ *Ibid.*

pregnancy. Should they be found to have tested positive for any of these diseases or be pregnant, they are subject to deportation. Moreover, Malaysia, while recognizing that undocumented, migrant workers and refugees are vulnerable populations, has no formalized programmes or services in place for them.¹⁹⁷

A review of trends of migrant policies across the region by CARAM Asia (Coordination of Action Research on AIDS and Mobility) notes that it is alarming that Cambodia, Indonesia, and Viet Nam who are large sending countries do not recognize returnee migrants as an at risk population and provide little or no support. The destination countries Japan, the Republic of Korea and Singapore also do not recognize migrants as vulnerable to HIV. However, on a more optimistic note, Bangladesh, the Lao People's Democratic Republic, Malaysia, New Zealand, Nepal, Pakistan, the Philippines, Sri Lanka and Thailand recognize migrants as a vulnerable group or a bridging population in need of targeted interventions.¹⁹⁸

In South and South-West Asia, the National AIDS Programmes of Bangladesh, India and Nepal recognize cross-border mobility as an important driver of HIV epidemics. Both India and Nepal now also have prevention interventions to address cross-border mobility. In Thailand, civil society is working closely with government partners and migrant groups to address the vulnerability of migrant workers from neighbouring countries. This is done, for example, through a comprehensive HIV prevention and behaviour change communication programme, funded by the Global Fund which also focuses on labour and basic rights issues of migrant workers. The programme has contributed to a significant reduction in the incidence of syphilis among registered migrants, an important indicator of high-risk sexual behaviour, including HIV. However, it is important to note that only the Philippines has a formalized pre-departure programme targeted at prospective migrants.¹⁹⁹

Gender

In Asia and the Pacific, gender inequalities both compound and contribute to women's vulnerability to HIV, and proportionally increase the social and economic impact of HIV on women. Such inequalities compromise women's economic security and reduce their ability to avoid behaviour that involves high risks of HIV infection. Women generally have more difficulty than men in gaining access to education, credit and support services, and finding formal employment that matches their skills. In many countries, laws and customs and cultural practices prevent them from controlling property and other assets.

Moreover, gender based violence against women and girls, continues to be a major area of concern in the Asia-Pacific region and significantly contributes to HIV vulnerability. Gender based violence and rape is most prevalent in Cambodia, India, Nepal, and Papua New Guinea, but indicated in all countries in the region.²⁰⁰

Human trafficking also increases the vulnerability of many women to HIV infection.²⁰¹ The APCASO review of the 2008 UNGASS reporting states that women and girls are being trafficked to India in large numbers from Nepal to work in brothels. An estimated 22 to 38 per cent of young Nepalese women trafficked to India and returning to Nepal were found to be HIV positive.²⁰²

¹⁹⁷ APCASO 2008 UNGASS Report, supra.

¹⁹⁸ Ibid.

¹⁹⁹ Ibid.

²⁰⁰ Ibid.

²⁰¹ AIDS Commission Report, supra, p. 108.

²⁰² APCASO 2008 UNGASS Report, supra.

Women's unequal social status is also reflected in sexual relationships, where men are more likely than women to initiate, dominate and control sexual and reproductive decisions. As a result, many women are unlikely to negotiate condom use even when they are aware of the risk involved or suspect the HIV status of their husband. It is estimated that for 90 per cent of HIV-infected women in India, and 75 per cent of HIV-infected women in Thailand, marriage was the only factor that put them at risk of HIV infection.²⁰³

At the same time, women carry the highest burden in caring for those who develop AIDS. Generally, women and girls provide the bulk of home-based care. In Viet Nam, for example, women make up 75 per cent of all caregivers for persons living with HIV. They are more likely to take in orphans, cultivate crops and seek other forms of income to sustain households. Gender inequalities tend to aggravate the vulnerability of such households, especially where women are denied equitable access to livelihood opportunities.²⁰⁴

Moreover, there are reports of women whose husbands or fathers fall sick and die of AIDS, or women who sick themselves, often are losing their homes, inheritance, possessions and livelihoods. This is either because of 'property grabbing' by relatives and community members or because of the lack of access to a range of important services due to HIV-related stigma and discrimination. According to a 2006 United Nations Development Programme study in India an estimated 40 per cent of widows left their in-laws' homes after their husbands' deaths due to AIDS and 80 per cent of those women were deprived of their property and inheritance rights.²⁰⁵

Improved social protection policies, especially impact mitigation, for women should be implemented. Some of these measures should also offer opportunities for HIV prevention for women. Legal and other obstacles that prevent women (including those widowed by AIDS) from inheriting assets must be removed. More generally, income support should be available to women in AIDS-affected households, irrespective of whether women are infected with HIV or not.²⁰⁶

²⁰³ AIDS Commission Report, *supra*, p. 108.

²⁰⁴ *Ibid.* at p. 109.

²⁰⁵ *Ibid.*

²⁰⁶ *Ibid.*

III. National and regional collaboration

Overall, preventing HIV infections is the most effective way to curb the HIV epidemics, to avoid the burgeoning costs of treating AIDS-related illnesses and to reduce their impacts on individuals and households. In Asia and the Pacific, prevention focused on key population groups, such as sex workers and their clients, IDUs and MSM, will have the greatest impact on halting the spread of HIV.

In 2005, with the aim of reinvigorating the global AIDS prevention effort, the UNAIDS Programme Coordinating Board endorsed a new global AIDS prevention policy set out in a paper entitled “Intensifying HIV prevention”. The paper recognized that to be effective, HIV prevention efforts must be grounded in what is known to work, achieving sufficient coverage, scale and intensity, being sustained over time and moving beyond the health sector, involving diverse sectors of society.²⁰⁷ Modelling has indicated that about 60 per cent of most-at-risk populations need to adopt safer behaviours if HIV epidemics are to be reversed. Importantly, to achieve that level of behaviour change, service coverage has to reach at least 80 per cent.²⁰⁸

Such scaling up of prevention coverage, while at the same time increasing antiretroviral therapy coverage in the region, will stretch public resources. In addition to the recommendations provided in section II, it is, therefore, critical to ground the national response in multi-sectoral partnerships to enable pooling of competitive advantages, including resources and expertise, and identification of those organizations or agencies best placed to address unmet needs within a given context. Moreover, regional partnerships are essential to enable sharing of experiences, lessons learned and to build critical momentum at an inter-country level.

A. Multi-sectoral partnerships

The multifaceted nature of the epidemic calls into play the need for a multi-sectoral response to HIV. No single sector can respond effectively to HIV. Multi-sectoral partnerships at all levels, from global to local, are essential in bringing together the necessary expertise, skills, leverage and coordination needed to respond effectively to HIV. Governments, public and private sector agencies (such as health, development and scientific communities), donors and a diverse and vibrant civil society, including NGOs and people living with and affected by HIV, are essential to a comprehensive and coordinated approach.

Multi-sectoral partnerships improve programming by building on the existing infrastructure and expertise of different sectors, enabling integration of HIV responses within broader development, health, humanitarian and human rights work, and supporting a comprehensive response in addressing the causes of vulnerability to HIV and its consequences. It is also important to foster partnerships with governments, policy-makers, the media, and public and private sector agencies, in order to promote an enabling environment for effective responses to HIV.²⁰⁹

At the national level, National AIDS Commissions are the key structure to develop and maintain the multi-sectoral partnerships required for a scaled up response to HIV. Their role is to lead and coordinate the national response and they perform a wide range of functions, with varying success. These functions include policy development, strategic planning and guiding the implementation of the National AIDS Plans. They are also responsible for partnership building with stakeholders at all levels, advocating and disseminating best practices and managing monitoring and evaluation of HIV and AIDS programmes.

To enable National AIDS Commissions to perform their role more effectively, it is critical to strengthen the operation of these structures. This means that clarity in roles and relationships, and enabling political, legislative,

²⁰⁷ 2006 SG Report, *supra*.

²⁰⁸ AIDS Commission Report, *supra*, p. 4.

²⁰⁹ NGO Code of Good Practices, “Multi-sectoral partnerships,” *Code of good practice for NGOs responding to HIV/AIDS*, accessed on 22 October 2008 from <<http://www.hivcode.org/search-the-code/organisational-principles/multisectoral-partnerships/>>.

policy and institutional environments are more important than ever. Clear and robust institutional arrangements and legal status are important for National AIDS Commissions to effectively carry out their mandates. In some countries, for example, a lack of adequate human resources is preventing some National AIDS Commissions from delivering on their core work. Constant adaptation of the National AIDS Commission model to better suit local contexts is fundamental to future viability in the increasingly complex aid environment and with regard to evolving HIV responses. This should also take into account ongoing decentralization processes in many countries in the region. Suitable structures that can manage resources and responsibilities at provincial and local levels need to be established while maintaining clear linkages with national processes.

It is also important to reemphasize here the technical support role of the United Nations system, in particular UNAIDS and its cosponsors, to support countries in prioritizing, implementing and expanding effective national responses, with multi-sectoral partnerships as key components. The Office of the UNAIDS Country Coordinator functions as the front-office for a wide range of tailored support available to countries.

B. Regional and inter-country collaboration

Key regional political bodies throughout the world have prioritized efforts to improve regional commitment and coordination on AIDS. In the 2005 World Summit Outcome (resolution 60/1), world leaders formally embraced the goal of aiming for Universal Access to HIV prevention, care and treatment. In its 2005 Doha Declaration, the Group of 77 and China called for enhanced South-South cooperation to implement prevention, treatment, care and support measures. Such bodies provide significant opportunities for leaders from the Asian and Pacific region to demonstrate leadership at the highest levels.

In Asia and the Pacific, regional intergovernmental bodies, particularly the Association of Southeast Asian Nations and the South Asian Association for Regional Cooperation, offer strategic platforms for political advocacy. It may also be timely, given the many actors and agendas and the resultant complexity of responses, for regional political bodies to assume a more prominent role, in addition to the continued engagement on AIDS, as watchdogs that track and assess Member States' HIV responses.

In the Pacific, the Pacific Islands Leaders Forum provides a platform for Pacific leaders to engage on the issue of HIV at the highest levels, taking into account the unique nature of the epidemic and the challenges in formulating a comprehensive response. At present, the second Pacific Regional Strategy on HIV/AIDS 2004-2008 covers all elements of the Declaration of Commitment and reflects the unique needs of the Pacific subregion.

At the regional level, the United Nations plays an important role in pressing for greater financial and political commitments from countries in the Asian and Pacific region. It should also help develop and provide cohesive support for a regional strategy that reflects the dynamics of the HIV epidemics in the different subregions, and that suits the environments in which they occur. As mentioned in section II.A, United Nations agencies must provide coherent technical and managerial support to realize that strategy at country levels.

ESCAP is the highest-level intergovernmental United Nations body in the Asian and Pacific region. As such, ESCAP acts as an important platform for regional cooperation. ESCAP, with its multi-disciplinary approach is in a position to work with Member States and appropriate agencies, such as UNAIDS, in areas such as building political advocacy through highlighting the socio-economic impact of AIDS, and facilitating a regional assessment of the challenges and constraints of scaling up the HIV response.

ESCAP could also play a role in documenting and regional sharing of experiences on issues concerning expanding the coverage of antiretroviral therapy in the region including legal issues and investment in research and development of new and affordable products and technologies for tackling HIV and AIDS, and the expansion of prevention coverage for most-at-risk populations. This would contribute strongly to monitoring the region's progress towards Universal Access.

Conclusion and recommendations

Although the epidemics vary considerably from country to country in the Asian and Pacific region, they share important characteristics, namely that they are centred mainly around: unprotected paid sex, sharing of contaminated needles and syringes by IDUs, and unprotected sex between men. Among these, especially in Asia, unsafe commercial sex and injecting drug use are the two main drivers of the epidemic and current patterns of sexual networking, especially among women, do not support high prevalence HIV epidemics independent of the sex trade and drug injecting.






Progress in the Asian and Pacific region has been mixed, both among the different subregions and at the country level. The region still lacks that much-needed degree of urgency, commitment and coherence in every country to curb the epidemic. While significant progress has been made in scaling up care and treatment, progress on reaching those most at risk with prevention programmes has been more challenging. Key findings from a review of the 2008 UNGASS Reports for countries in the Asian and Pacific region are as follows:

- Available data indicates that condom use among FSWs has increased significantly. Many of the countries in the region appear to have met the 60 per cent behavioural change target for FSWs and condom use and others appear on track. However, it is important to note that progress in many other countries has been challenging and that overall data quality needs verification.
- IDUs are not being effectively reached by prevention programmes and only a few countries are reporting over 60 per cent safe injection behaviour. The best coverage is achieved in South Asia.
- Coverage of programmes for MSM in Asia has been extremely limited. Many countries did not report on the percentage of MSM reached with HIV prevention programmes. However, even with low prevention coverage, several countries in the region report relatively high condom use among MSM at last anal sex.
- The majority of pregnant women in the region are not being reached by the prevention of mother-to-child transmission services. With the exception of a few countries, prevention of mother-to-child transmission remains well below 10 per cent.
- Although the Asia-Pacific region as a whole falls well short of meeting the 80 per cent coverage target for care and treatment, there is impressive progress in a number of countries. The most progress has been made in the South-East Asian subregion. In South Asia, the situation remains most challenging.
- Political engagement and support has increased overall, but leadership is still lacking in addressing the epidemic among those most at risk. Stigma and discrimination among these populations and people living with HIV is persistent.
- The resource gap in the region is still significant. Most finances are contributed through international support, with domestic spending at a very low level. Especially in light of the limited resources available, it is important to give increased priority to resource allocation and cost-effectiveness of the response.

To build on the increasing momentum and address the shortfalls in progress, the following key recommendations are put forward:

- **Focus cost-effective prevention efforts on most-at-risk populations in Asia and the Pacific: sex workers, their clients and sexual partners, IDUs and MSM.** HIV transmission in the region is driven primarily by the three related high-risk behaviours and epidemics in Asia are highly unlikely to sustain themselves in the 'general population' independently of commercial sex, drug injecting,

and sex between men. Governments must demonstrate strong leadership in ensuring that an enabling environment is established for scaled-up prevention among these populations, including strengthening legal frameworks to address persistent stigma and discrimination.

-  **Expand programmes for preventing the mother-to-child transmission of HIV.** These programmes should focus not only on those groups most at risk of infection but on the general population.
-  **Extend treatment and impact mitigation programmes to reach all affected women and children.** The majority of people living with HIV are male clients of sex workers. But it is the wives and sexual partners who suffer extreme stigma and discrimination. Women lose their property and inheritance rights, and children are orphaned in large numbers. Impact mitigation programmes targeting these women and children should be an integral part of the AIDS response in countries of the region.
-  **Address the determinants of vulnerability.** In addition to scaling up prevention and treatment programmes, long-term success on AIDS requires that the global community address the factors that increase vulnerability to HIV, such as illiteracy, socio-economic and gender inequality and all forms of discrimination and social exclusion. To help reverse the epidemic, priority should also be given to poverty-reduction strategies, girls' education, women's economic opportunities and other basic reforms.
-  **Strengthen health-care delivery systems to enable effective and efficient scaling up of the response.** This includes significant human resource and institutional capacity building, scale up of international fund-raising efforts and increased domestic spending, in particular by middle-income countries.
-  **Build national multi-sectoral partnerships and engage actively in regional processes and inter-country collaboration.** This supports implementation of a scaled-up response at the national level, facilitates access to technical assistance and allows the dissemination of best practices and lessons learned.

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