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A scaled-up response to **AIDS** in Asia and the Pacific

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A scaled-up response to **AIDS** in Asia and the Pacific



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INTRODUCTION

The countries of Asia and the Pacific stand at a crossroads, facing two diverging routes to the future. One route is “business as usual”. Though the easiest and cheapest route to take at the beginning, it ends up in rising levels of HIV infection and a toll far higher than the estimated 500 000 AIDS-related deaths that occurred in the region during 2004. The other route is one of determined prevention and care initiatives. Harder and more expensive at the beginning, it ends up stopping the epidemic in its tracks, and minimizing both its human and economic costs.

While some countries have already made their decision and begun to scale up effective AIDS programmes, in others there is still hesitation. Yet standing still is no longer an option: a choice has to be made.

This report summarizes the AIDS challenge in Asian and Pacific countries. Using the best available evidence, it discusses the reasons why critical services currently reach only a fraction of those in need. It also outlines the action needed that will allow the region to seize this key moment of opportunity.

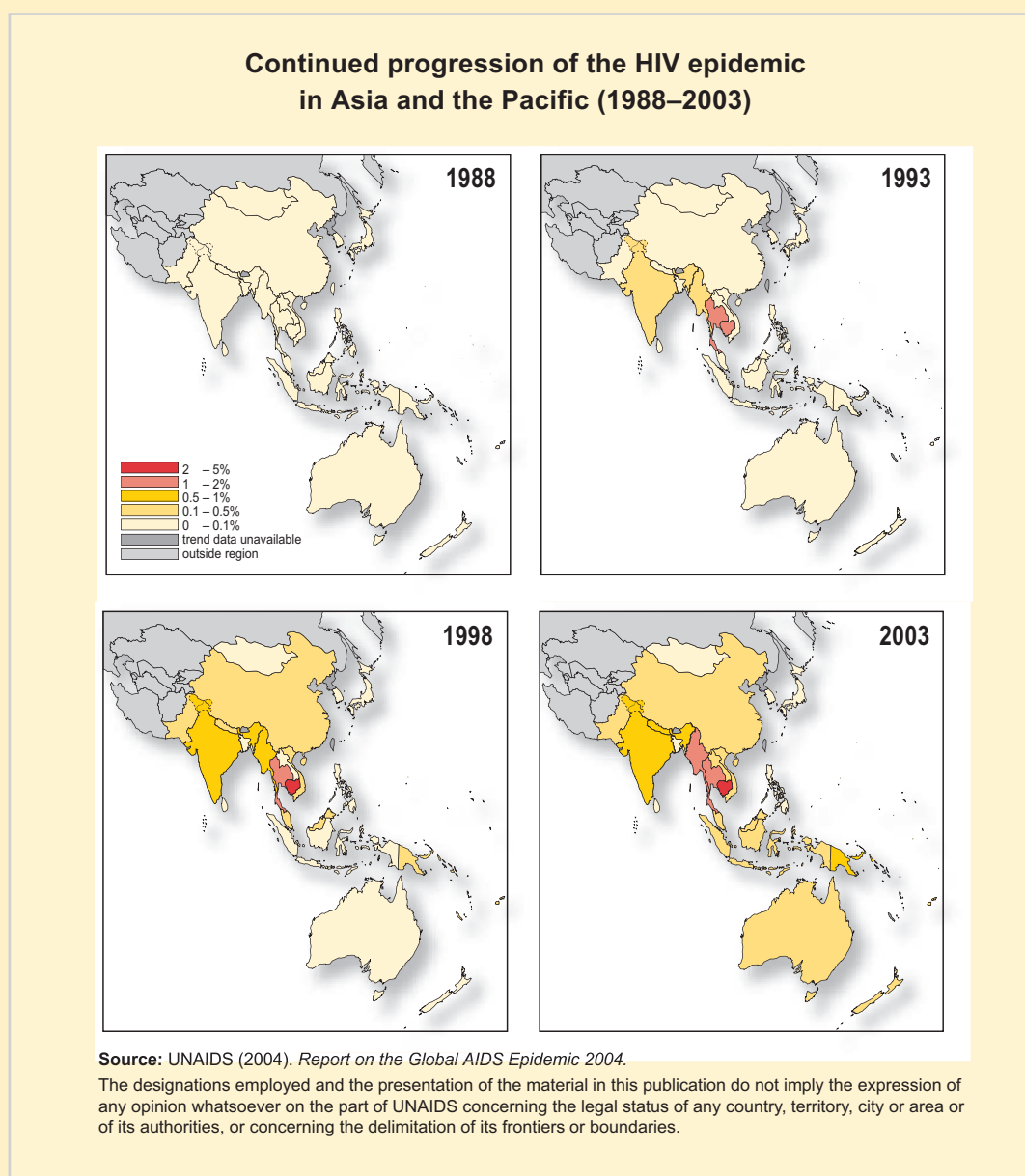
Finally, the report makes recommendations for urgent implementation of strategies known to work, by global, regional and national political leaders, by international donors, the UN system, civil society and other key stakeholders in Asia and the Pacific.

A growing and diverse epidemic

Asia and the Pacific are now home to rapidly expanding epidemics. In 2004, an estimated 8.2 million adults and children were living with HIV. About 540 000 people died of AIDS.

In countries as diverse as China, India, Indonesia, Malaysia, Nepal, Pakistan, Singapore and Viet Nam, national epidemics are centred among key vulnerable populations, such as sex workers and their clients, injecting drug users, men who have sex with men, and certain mobile populations. However, the virus could move into the general population unless determined action is taken now.

Figure 1



Rising prevalence

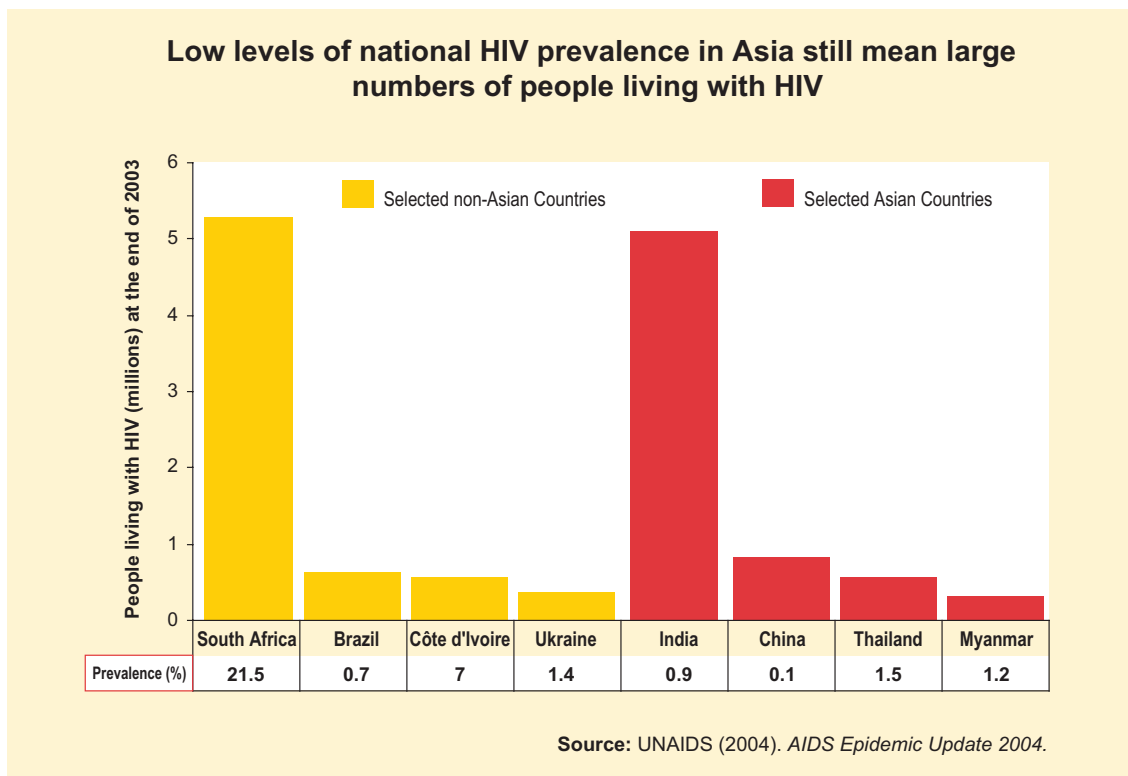
The expansion of the epidemic in Asia and the Pacific since 1988 is illustrated in Figure 1. While Thailand experienced a rapid growth of HIV infection starting in the late 1980s, and was followed by Cambodia, most countries were largely untouched at a time when the epidemic was rapidly escalating in sub-Saharan Africa and the Caribbean. Today, Asia and the Pacific not only have the second largest number of people living with HIV infection, but their share in the global epidemic is growing. While Asian and Pacific countries accounted for 21% of all people living with HIV in 2004, they also showed 24% of the world's new HIV infections. In East Asia, the epidemic is expanding faster than anywhere else in the world, with HIV prevalence increasing by 24% in 2004 alone.

Because of the magnitude of Asia's population, the relatively low prevalence of HIV in the region (0.4% of the adult population) still translates into millions of cases. Figure 2 shows that India, with adult prevalence under 1%, has nearly as many people living with HIV as South Africa where prevalence exceeds 20%. Although HIV prevalence in China is one seventh the rate in Brazil, China is home to more HIV-infected people.

Among 28 countries in Asia and the Pacific, three currently have HIV prevalence greater than 1% among adults. The highest is in Cambodia, where an estimated 1.9% of the adult population was living with HIV in 2003 according to the most recent analysis by National Center for HIV/AIDS, Dermatology and STD (NCHADS). The others are Myanmar, where the epidemic is still expanding, and Thailand, where the number of new infections has steadily declined for more than a decade. Meanwhile, a severe epidemic has been unfolding in Papua New Guinea, where the adult prevalence was 1.7% in 2004 according to a recent national report.

The potential for rapid growth of HIV infection—even in areas of extremely low HIV prevalence—is apparent from the experience of Indonesia. As recently as 1998, surveys indicated that HIV prevalence was under 0.1%, including among female sex workers. Beginning in 1999, however, surveys began to detect a sharp increase in infection—as high as 6% in some sentinel sites for sex workers. Studies also found marked increases in infection among injecting drug users, reaching 48% in Jakarta. Because sex workers and injecting drug users can provide HIV with a “bridge” to other populations via their sexual partners, Indonesia now confronts the real risk of a major expansion of the epidemic.

Figure 2

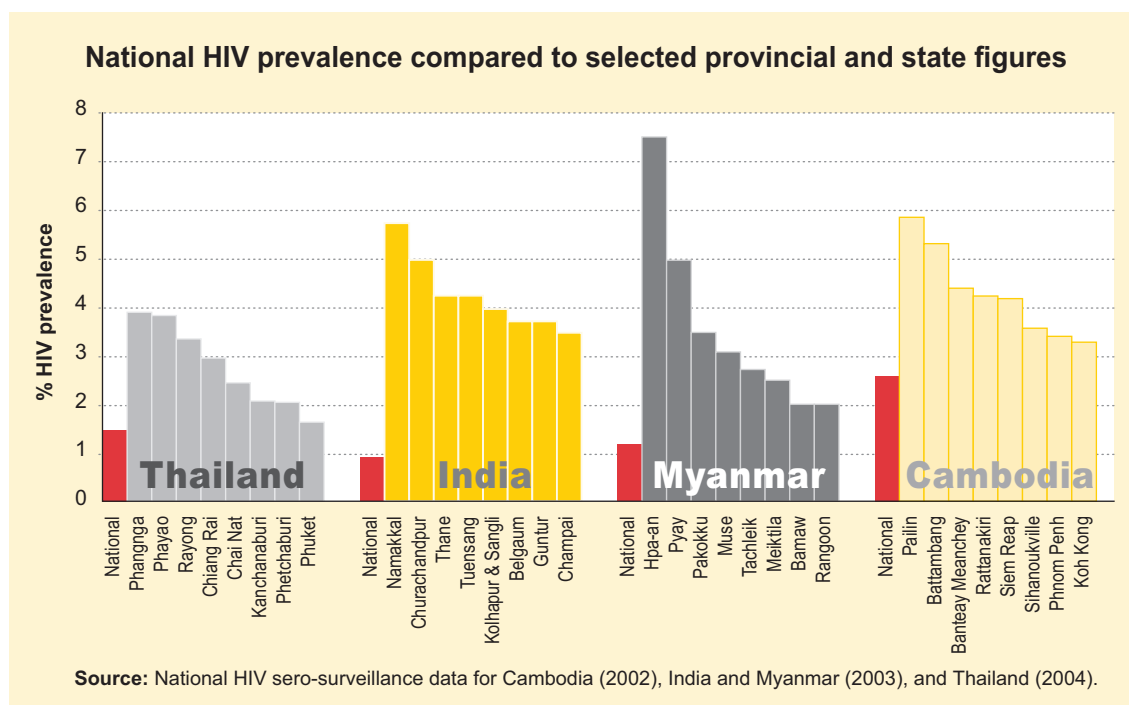


Sub-national epidemics

Regional and national prevalence figures do not tell the full story, however, and potentially obscure the seriousness of the Asian epidemic in specific states or provinces (Figure 3). For example, while overall adult prevalence in India is less than 1%, more than 5% of adults are infected in certain districts such as Namakkal and Guntur. A similar picture is apparent in Cambodia, Myanmar and Thailand, where some provinces have infection rates that are significantly higher than the national average.

In provinces with high HIV prevalence, the epidemic already exacts a toll on life expectancy comparable to that in certain parts of Africa. In the southern Indian state of Andhra Pradesh, some projections have suggested that the epidemic, at its peak, may reduce life expectancy by 3.8 years, compared to 0.2 years for India as a whole. A similar phenomenon has been reported in Cambodia and in Thailand, where the epidemic's impact in Chiang Mai is far greater than for the country as a whole.

Figure 3



AIDS and poverty

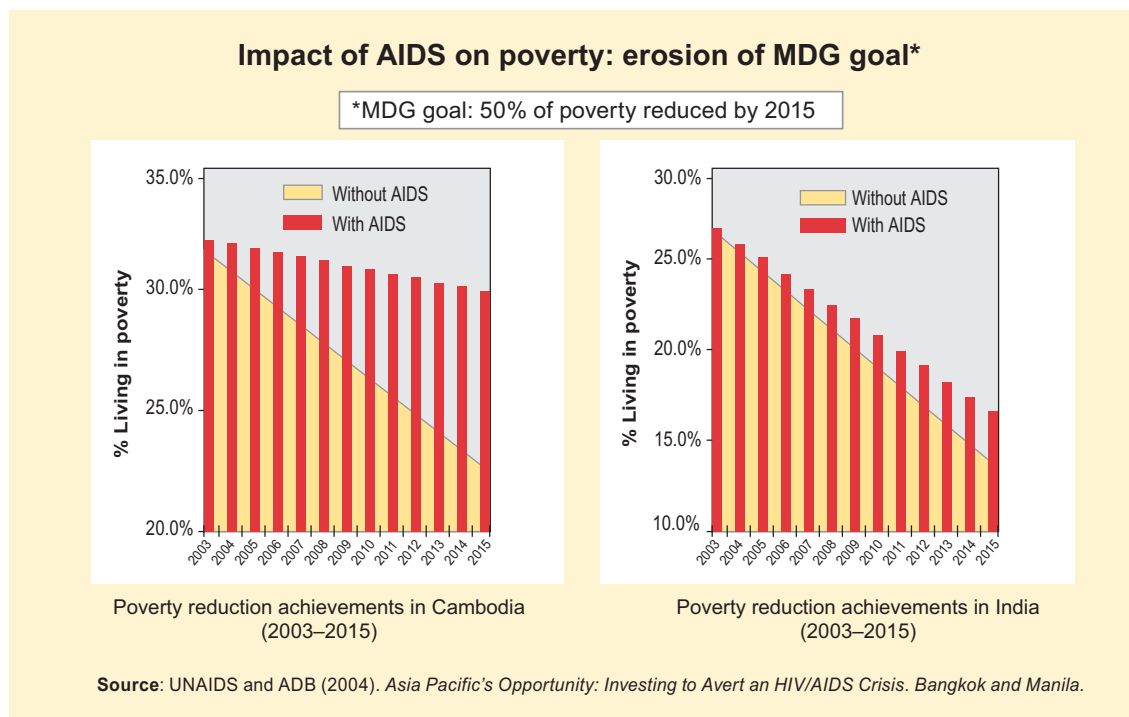
Despite its relatively low prevalence on a regional level, the epidemic is causing serious injury to the region’s economy. In the year 2001, when HIV was less widespread in Asia than it is today, the epidemic already caused estimated annual economic losses of US\$ 7.3 billion, according to the Asian Development Bank.

As the vast majority of AIDS-related costs are borne by poor households, the epidemic pushes millions of households further into poverty each year. In this way the epidemic is undermining regional efforts to meet the Millennium Development Goals (MDGs) of halving by 2015 the number of people who live in hunger or on less than one dollar per day. As Figure 4 illustrates, HIV’s impact on this goal will be severe if current trends continue and a comprehensive response is not carried out.

Especially vulnerable populations

Some populations are especially vulnerable to infection due either to higher rates of risk behaviour or to the conditions under which they live and work.

Figure 4



Injecting drug users

Injecting drug use is widespread and multiple use of non-sterile needles is common throughout much of Asia and the Pacific. Introduction of HIV into networks of injecting drug users can result in the rapid spread of HIV. The danger of infection outside these networks is clear from the fact that many injecting drug users also engage in sex work and are frequently clients of sex workers.

Sex workers and their clients

High-risk behaviour with sex workers is an important mode of transmission for HIV. Figure 5 shows that over 40% of men in some occupations have contact with sex workers. As well, recent studies in five Asian countries suggest that sex workers are the first sex partners for 17% to 50% of young men.

The most vulnerable sex workers are women and girls illegally trafficked across borders for the sex trade. Within the South Asia region, India and Pakistan are the main destination for trafficked girls aged less than 16 years, especially from Bangladesh and Nepal. Studies have shown that brothel sex workers who have been trafficked are most likely to become infected during the first six months of their stay.

Young people

As in other regions, young people are at high risk of infection. Some of these young people are involved in the sex trade or use injecting drugs. In Myanmar, for example, one of the few countries reporting HIV prevalence in high-risk groups by age, the highest prevalence in 2003 was among sex workers and injecting drug users under age 25. The proportion of women under age 25 who work in brothels and other high-risk environments in selected South-East Asian countries ranges from 41% in Indonesia to 76% in the Lao People's Democratic Republic.

In many countries, rapid social change is accompanied by sharp increases in sexually transmitted infections, which significantly increase the probability of sexual HIV transmission. Recent research indicates that rates are increasing among both adolescents and adults who have casual sex with multiple partners.

Double jeopardy for women in Asia

Although men constitute the large majority of people living with HIV, the proportion of women is steadily increasing. Gender inequalities, often institutionalized by national policies, contribute to the spread of HIV by increasing the vulnerability of women and girls. With low socioeconomic status and limited educational opportunities, women and girls often lack basic information about HIV. Taboos against speaking about or showing knowledge of sex make it unlikely they will seek or receive information from their elders or peers.

Marriage is far from being a guarantee of safety from HIV for many women. In Cambodia, India and Thailand, studies have found that husbands represent the primary source of HIV infection for women. Tragically, once women become HIV-infected, prevailing gender norms also increase the likelihood that they will be ostracized and rejected by their families.

Figure 5



Population mobility

Population mobility has a proven (if complex) association with increased vulnerability to HIV infection, and this is especially relevant in Asia, where an estimated 5%–10% of the population moves within each five-year period, typically within their own countries. As regional economic development accelerates, inequities in wealth are growing, feeding massive rural-to-urban migration in many countries. In recent years, for example, more than 120 million people in China have relocated from rural to urban areas in search of work. India, Nepal and Cambodia also have highly mobile populations within their borders, moving from state to state. Having left their families, communities and the accompanying social constraints behind, many economic migrants find themselves in situations where opportunities for risky behaviour are more frequent.

Some mobile workers are especially vulnerable, depending on where they travel and their working conditions. For example, many domestic workers who work outside their countries are at higher risk of coercion into sexual activity by employers. Other professions that involve constant travel—e.g., traders, sailors, contract labourers, and truckers—are also associated with relatively high vulnerability due to frequent risk behaviour. For example, a 2002 survey in southern India found that 16% of truck drivers on a specific route were HIV-positive. Much of this is attributable to truckers' high rates of contact with sex workers. Survey data shows that 54% of truck drivers in Bangladesh and 31% in the Lao People's Democratic Republic reported recent contact with sex workers.

Emergency situations

Countries in Asia and the Pacific regularly face crises, such as floods, earthquakes, and armed conflicts. Frequently massive displacements of population result. Besides severing traditional channels of information and services, such upheavals may force people to engage in survival sex, and often increase the risk of sexual violence which substantially increases the risk of contracting HIV.

A generalized epidemic in Papua New Guinea?

While virtually all national epidemics in Asia and the Pacific are concentrated in discrete high-risk populations, Papua New Guinea is an exception. There, the situation exhibits characteristics of a generalized epidemic. An estimated 1.7% of adults were living with HIV in 2004 according to a recent national report, and men and women are equally likely to be infected. More than 50% of adult men report multiple sex partners. The virus is spreading most rapidly in rural areas.

The challenges of mounting an effective response to AIDS in Papua New Guinea are daunting—the country has a large number of ethnic groups, multiple languages, and a poorly developed communications infrastructure. Yet the complexity of these challenges must not deter national and regional leaders from implementing the prevention approaches proven to slow the rate of new HIV infections.

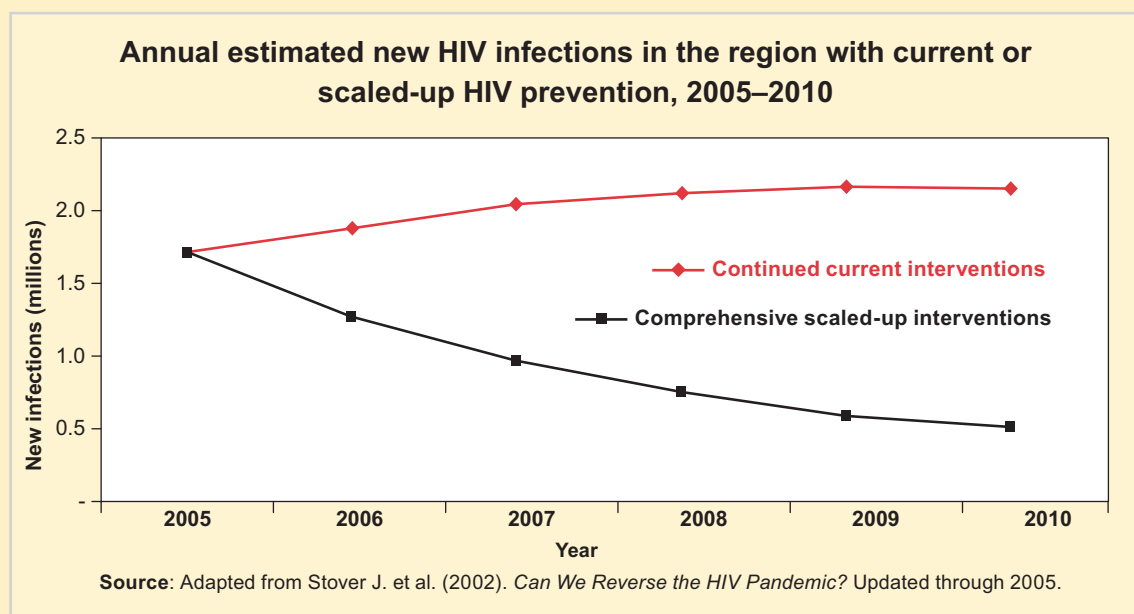
A critical moment

Despite the potential for rapid growth of the epidemic, current low levels of prevalence in most countries mean that they still have the opportunity to carry out effective responses at relatively low cost—if they act now. Sustained evidence-based prevention measures, coupled with targeted care and treatment initiatives for people living with HIV, can reduce and reverse further growth of the epidemic while mitigating its impact on AIDS-affected households and communities.

Prevention and treatment: the value of comprehensive responses

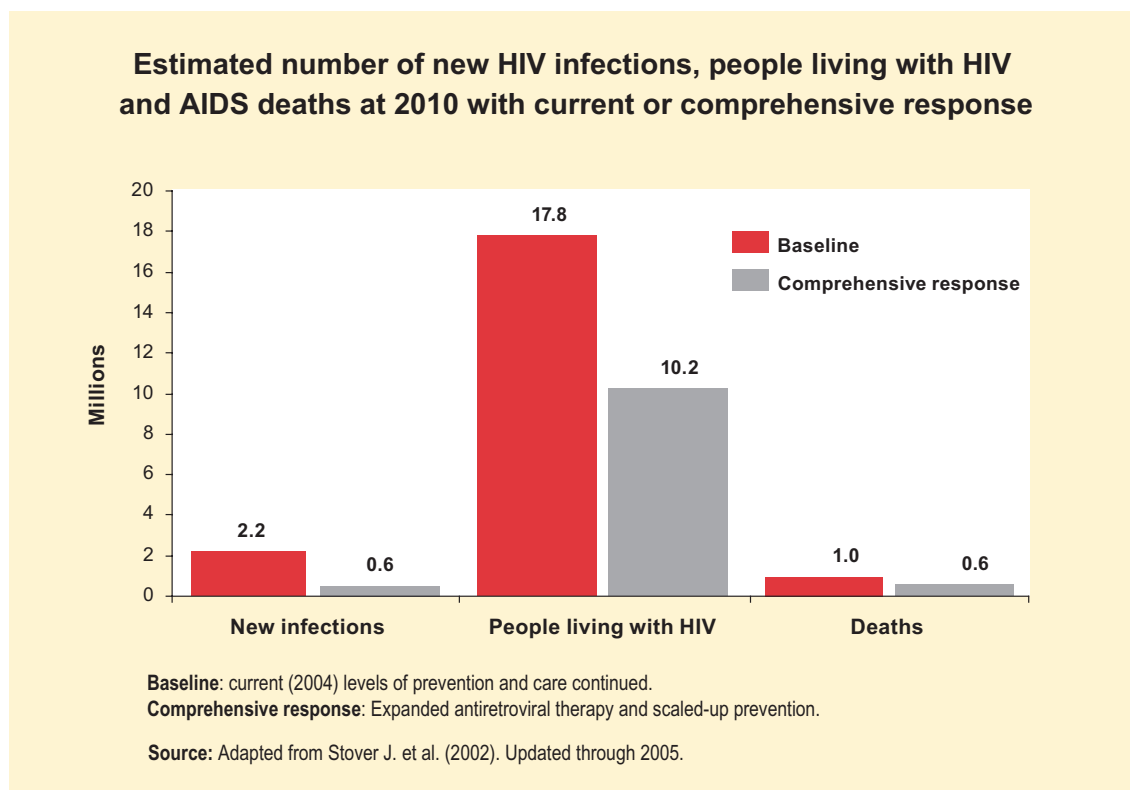
If national responses remain as they are today, it is conservatively estimated that around 12 million new infections could occur in Asia and the Pacific between 2005 and 2010. In contrast, achieving optimal levels of prevention coverage could prevent nearly 50%—about six million—of these infections. As Figure 6 illustrates, the region could, by bringing prevention programmes to scale, cut the annual rate of new infections by three quarters in 2010.

Figure 6



The impact of a scaled-up prevention effort will be magnified if prevention is accompanied by increased access to antiretroviral therapies and other treatments for people who are HIV-positive. As illustrated in Figure 7, it is estimated that by simultaneously bringing prevention and treatment to scale, the region could cut the annual AIDS death rate in 2010 by nearly 40% and the total HIV prevalence by over 40%, compared to the baseline of no change in current national responses.

Figure 7

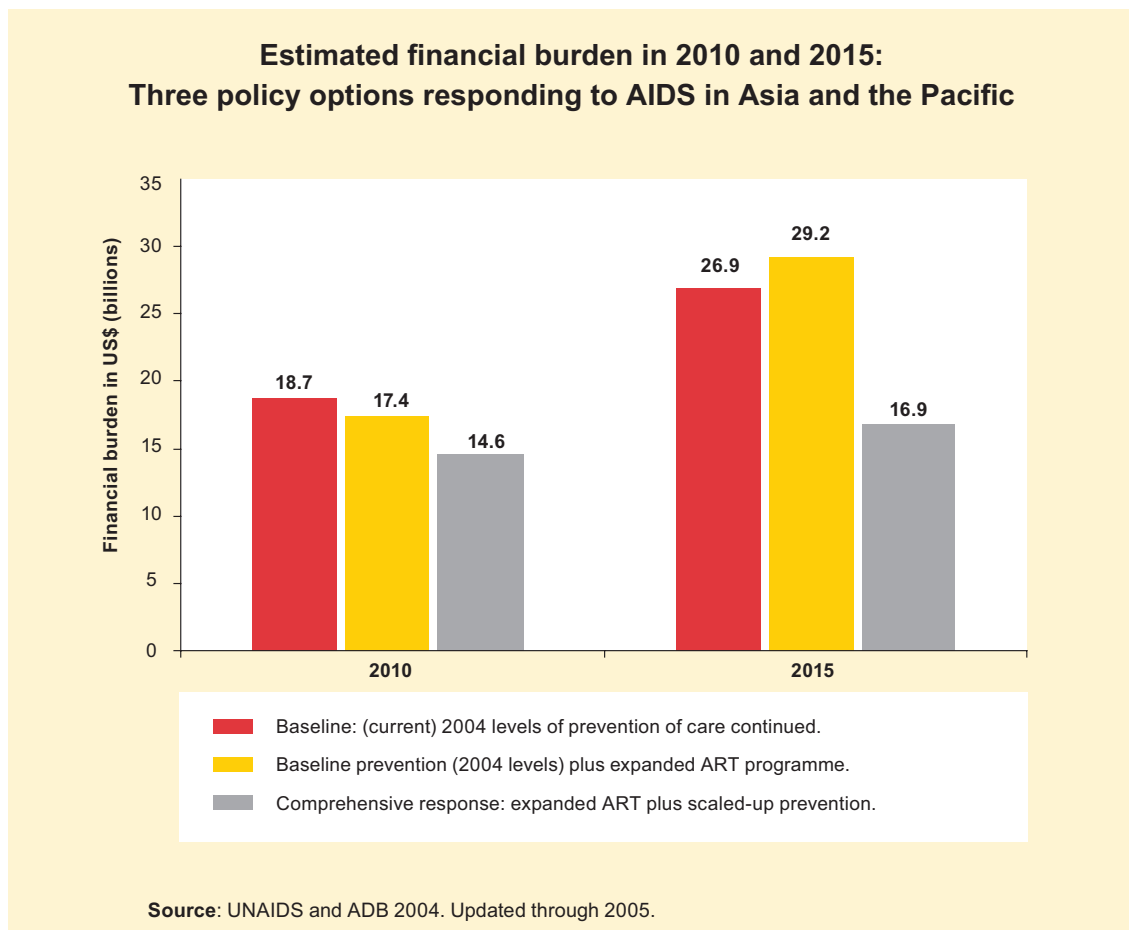


Economic benefits

In addition to saving lives, a comprehensive response could also save billions of dollars regionally by averting or delaying substantial medical expenses, preserving productivity, and reducing the economic and social burden on households.

As shown in Figure 8, UNAIDS and the Asian Development Bank project that continuation of current infections trends (the “baseline” projection) could result in annual economic losses of US\$ 18.7 billion in 2010 and US\$ 26.9 billion in 2015. However, by simultaneously bringing both prevention and treatment to scale (the “comprehensive response” projection), the region could cut annual AIDS-related costs nearly by over US\$ 4 billion in 2010, and over US\$ 10 billion by 2015. (In the middle projection, “baseline plus ART”, it can be seen that the ongoing costs of antiretroviral care may eventually raise the total bill to US\$ 29.2 billion in 2015 if prevention efforts are not strengthened and expanded.)

Figure 8



Maximizing prevention effectiveness

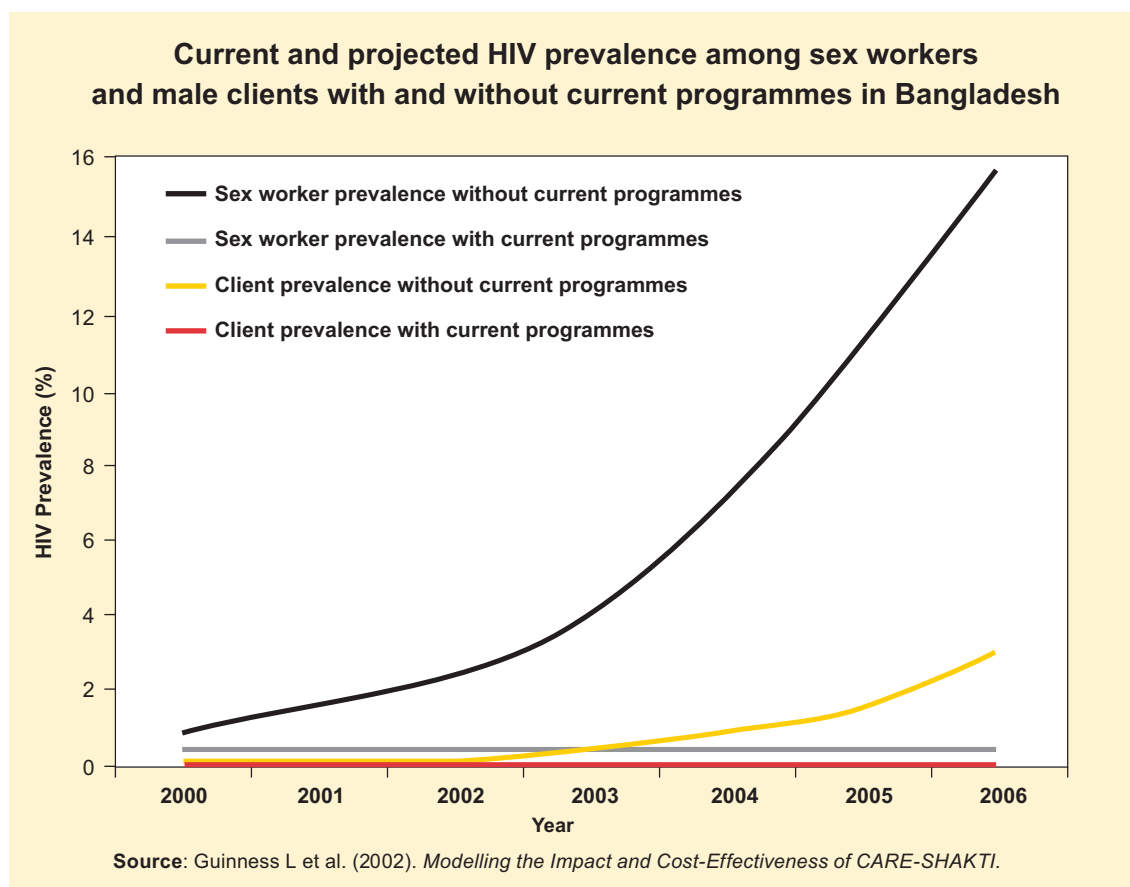
In the epidemic's third decade, it is clearer than ever that available prevention strategies are highly effective in reducing the risk of HIV transmission¹. Indeed, Asia accounts for some of the world's best examples of effective national-prevention measures. Faced with rapidly escalating infection rates in the 1980s, Thailand reversed its national epidemic through an energetic multifaceted prevention effort that included its 100% condom programme in brothels, broad public awareness campaigns, and strong support from national leaders. More recently, Cambodia has also achieved notable reductions in HIV prevalence and incidence following implementation of brothel-based and mass media HIV-prevention programmes.

¹ Effective prevention measures include preventing mother-to child transmission of HIV, promoting behavioural changes including abstinence, reduced number of sexual partners and use of condoms, preventing HIV transmission through injecting drug use (including harm reduction measures), ensuring the safety of the blood supply, preventing HIV transmission in health care settings, promoting greater access to HIV testing and counselling, focusing on HIV prevention among young people, providing HIV-related information and education to enable individuals to protect themselves from infection, and confronting and mitigating HIV-related stigma and discrimination.

To ensure maximum effectiveness of available prevention tools, countries should prioritize evidence-based interventions that respond to their own national circumstances. In most countries, the bulk of prevention resources should focus on initiatives that are carefully targeted to key vulnerable populations such as sex workers and their clients, injecting drug users, men who have sex with men, young people, and country-specific populations with higher levels of behavioural risk.

In Bangladesh, where the government has provided political support for nongovernmental organization-led interventions among highly vulnerable groups such as sex workers, the country has locally succeeded in both reducing the epidemic’s burden on these groups and preventing the spread of HIV to the broader population. It is estimated that in the absence of these prevention measures, HIV prevalence would have been 10% among sex workers and 2% among their clients in 2005—substantially higher than the 1% or less currently reported for these populations (see Figure 9).

Figure 9



What is holding the response back?

Despite some progress in individual countries (see next chapter), Asia and the Pacific have yet to mount a response that is capable of reversing the epidemic. While 100% prevention coverage for the entire population is neither feasible nor necessary to reverse the epidemic, proven interventions must at least achieve critical coverage thresholds that allow public health strategies to affect the epidemic's trajectory.

Lack of programme coverage

Coverage is one of the critical issues in prevention efforts. Modelling suggests that with ensuring 60% of safe behaviour among key populations—sex workers and their clients, injecting drug users and men who have sex with men—the epidemic could be reversed among those groups.

Unfortunately, the region is falling far short of this target even though it is well within reach of existing capacity.

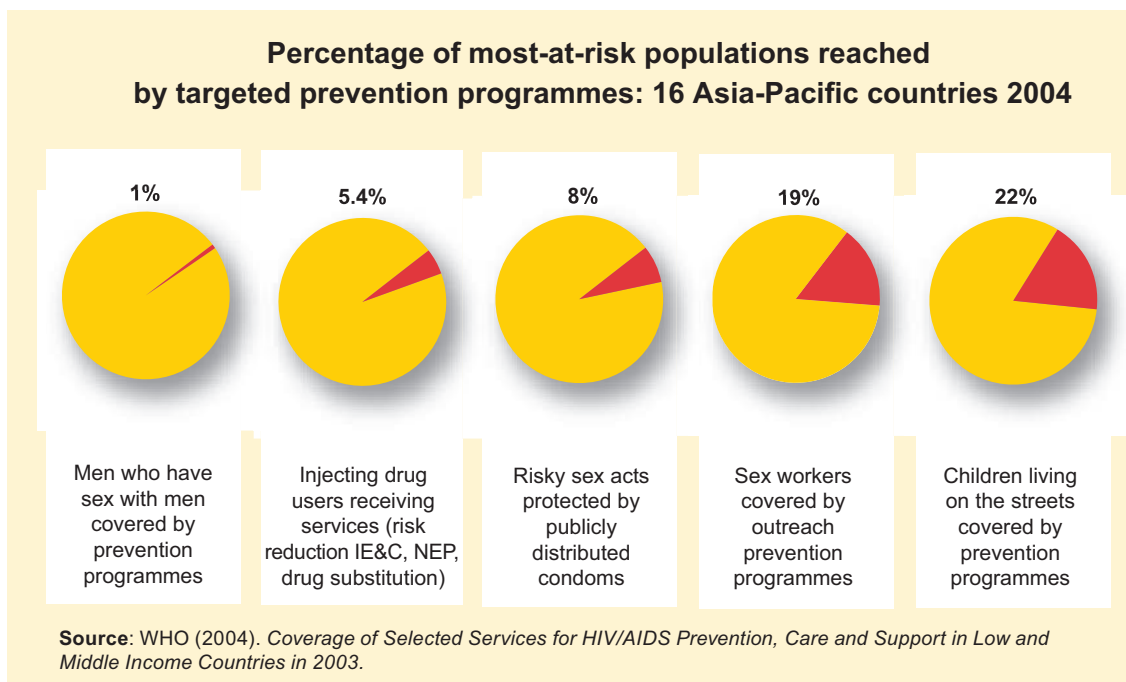
Vulnerable populations insufficiently served

Most countries in the region lack large-scale prevention programmes designed for the most vulnerable populations. Overall coverage figures for these populations are shown in Figure 10. For example, HIV-prevention programmes reached only 19% of sex workers in South and South-East Asia and only 11% in the Western Pacific. No more than 2% of men who have sex with men in the region have access to such programmes. Even though injecting drug use is an important driving force behind the spread of HIV in much of the region, proven prevention measures are available only to 5.4% of injecting drug users in South and South-East Asia and to 2.9% in the Western Pacific.

Condom promotion and access is inadequate

Although condom availability has recently increased substantially in many countries—often through social marketing initiatives—condoms were used in only an estimated 8% of risky sex acts in South and South-East Asia in 2003. Condom use also remains dangerously low in sex work in countries that have not adopted strategies such as the 100% condom policy pioneered by Thailand. Manufacturing of condoms is improving in the region, with countries such as Nepal and Viet Nam now meeting more than 50% of national condom needs through local production, but it is not clear that quality control always meets international standards—an important issue in building a population's confidence in condom promotion initiatives.

Figure 10



Most people at risk are unaware of their HIV serostatus

In Asia and the Pacific, knowledge of serostatus is low, and testing rates are far below the global average. In the 2003 coverage survey by UNAIDS and its research partners, so few people in these regions were tested that it was impossible to measure coverage statistically. In Indonesia, only 1% of females surveyed have *ever* received an HIV test, while in Cambodia only 3% of females have ever been tested.

The picture is better in urban areas of countries such as Cambodia, Thailand and the Philippines, which have achieved somewhat higher coverage for testing than the regional average, reaching an estimated 5% of adults. China, India and Thailand are strongly encouraging counselling and testing as part of national efforts to expand utilization of antiretroviral therapy. Unfortunately, the most vulnerable populations have testing rates comparable to the minimal levels reported for the general population. In particular, fear of discrimination and the absence of culturally appropriate services deter many vulnerable populations from accessing voluntary testing and counselling.

Young people lack skills to prevent HIV infection

While strides have been made to integrate basic AIDS education into secondary schools—reaching 64% of secondary school students in South and South-East Asia and 33% in the Western Pacific—the impact of these educational programmes in changing behaviour is unknown. In most countries, youth-friendly services are absent, or do not provide reproductive or sexual health programming. The problem is especially critical among especially vulnerable children. As shown above in Figure 10, only about one in five children living on the streets—22% in South and South-East Asia and 20% in the Western Pacific—are reached by HIV-prevention programmes.

Prevention of mother-to-child transmission still underdeveloped

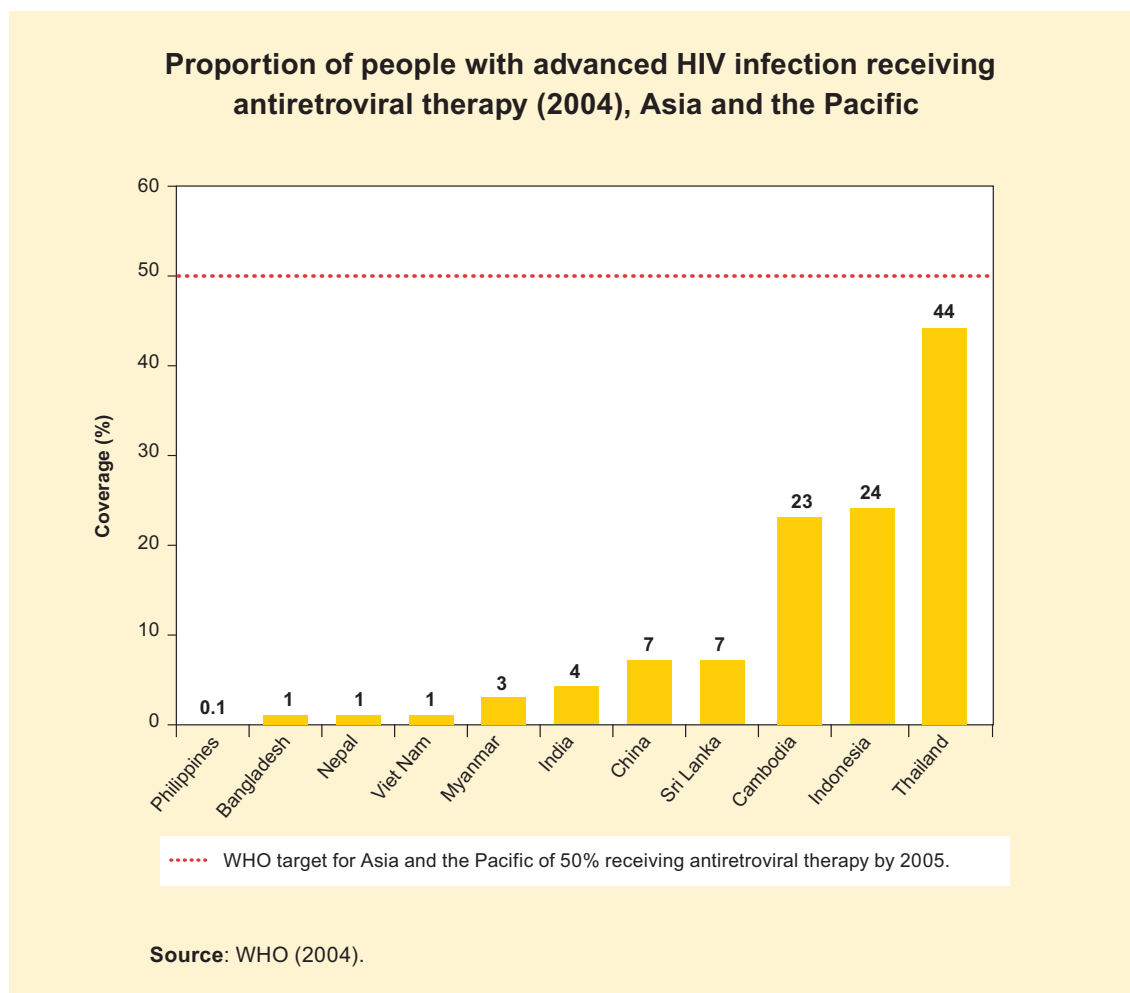
In 2003, only 8% of pregnant women in South and South-East Asia, and only 3% in the Western Pacific, were offered HIV testing and other services to reduce the risk of transmission to their newborn babies. The current coverage levels in the region are substantially below those recommended by UNAIDS and other experts.

Lower drug costs, but access still scarce

With sharp declines in the prices of antiretroviral drugs in low- and middle-income countries over the last five years, countries have the opportunity to forge a comprehensive AIDS response that links prevention and treatment. Several countries—including Indonesia, Nepal and Sri Lanka—have now embarked on major efforts to bring AIDS treatment programmes to scale. Between mid-2003 and 2005, antiretroviral utilization increased ten fold in Cambodia, reaching an estimated coverage of 32% of people who need such therapy. In Thailand, the number of new patients receiving antiretroviral treatment is increasing by 3000 each month, as the country expands treatment access to all health districts. With support from the national government and the Global Fund, China was providing antiretrovirals to 15 000 patients by mid-2005.

Throughout South-East Asia, however, only 5% to 6% of HIV-infected individuals who need antiretrovirals were receiving the medications, and coverage was only slightly better (12%) in the Western Pacific. Although India has a thriving pharmaceutical industry and the second largest number of HIV-infected people in the world, no more than 5% of individuals who need antiretroviral therapy currently receive these life-preserving treatments. As shown in Figure 11, with the exception of Thailand, access to antiretroviral therapy throughout the region at the end of 2004 fell substantially short of the global goal of 50% coverage by the end of 2005.

Figure 11



Care and treatment

Other types of care and treatment are also inadequate. As recently as 2003, access to prophylaxis against common opportunistic infections was rare in South and South-East Asia and only infrequently available in the Western Pacific. In the same year, only 4% of AIDS-affected households in South and South-East Asia received home-based services, such as counselling, medical care, help in obtaining food and clothing, assistance with household work, money for school fees, and other financial and legal support.

Institutional obstacles

Across the region, national responses primarily remain confined to small-scale projects, with few broad-scale national programmes capable of making a dent in the epidemic. This can be attributed to a number of factors that are explored below.

Institutional structures for leadership

Where institutional mechanisms have been established to lead and coordinate the national AIDS response, they often lack the political clout and administrative resources to be effective. In only two countries in the region does the Head of State or Prime Minister preside over the National AIDS Committee or Council. This is a critical shortcoming, as international experience overwhelmingly indicates that active and vocal leadership at the highest level is an essential ingredient of successful national programmes.

Limited engagement of sectors other than health

The success of multisectoral responses in the countries that have decisively addressed the epidemic shows that the health sector alone should not be the only part of society to take responsibility for dealing with AIDS. National responses in Asia and the Pacific require the active engagement and leadership of education systems, business, transport, and other sectors that have the ability to contribute to the national fight against the epidemic. In general, however, national responses remain centred in the health ministry. While nine countries in Asia and the Pacific have developed multi-ministerial policies on AIDS, only in four countries do these ministries have their own budgets and programme targets on AIDS.

Action from the armed forces

The growing engagement of national uniformed services in the AIDS response is an example of the potential of multisectoral AIDS efforts. The Philippines, the Lao People's Democratic Republic, Cambodia and Thailand have been leaders in integrating AIDS into national military training. The military in Bangladesh established an HIV/AIDS working group in 2004, while the Vietnamese People's Army is working with UNAIDS to deliver HIV peer education to new recruits. In 2005, UNAIDS and the Indian Defence Minister signed a memorandum of understanding to deliver HIV education and prevention services to 2.5 million military personnel, who in turn can serve as change agents for countless additional millions in their families and home communities. A similar agreement is also being negotiated in Papua New Guinea.

Lack of support for civil society organizations

In all successful national responses to HIV, civil society has helped lead national efforts on prevention and care. Nongovernmental organizations are especially vital to reach marginalized and sometimes "hidden" at-risk populations, such as sex workers, injecting drug users, men who have sex with men, and migrant workers. They are also essential in reaching young people. Unfortunately, many countries lack a strong nongovernmental organization sector due to the nature of national political systems or the traditional structure of the society. In general, the full potential of civil society, including organizations of people living with HIV and AIDS, has yet to be realized.

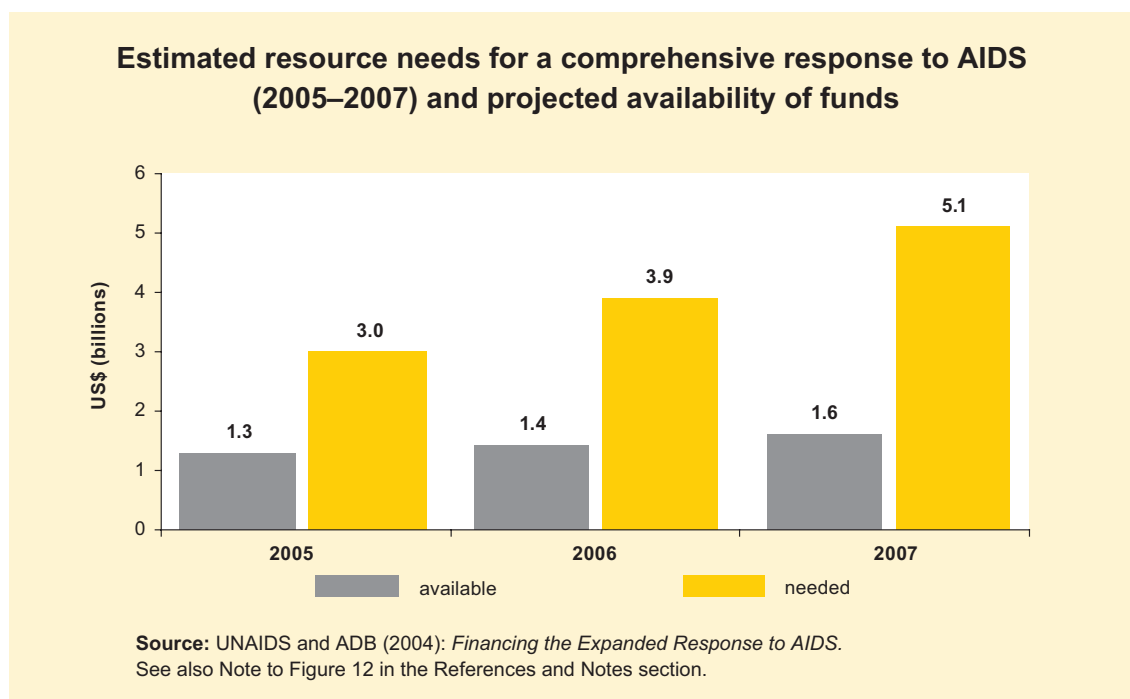
In many countries, the impact of nongovernmental organization activities is hampered by their small size and lack of integration with broader national efforts. For example, nongovernmental organizations in Malaysia that work in vulnerable communities have seen their funding decrease, while national support for nongovernmental organizations in Thailand, a key component of the country’s earlier success in the response to AIDS, has not been sustained. Where funding is available for nongovernmental organizations, it often underwrites only specific activities and does not extend to building their capacity to improve or extend services.

Insufficient and poorly allocated financial resources

Although government and donor spending on AIDS programmes in the region has increased in recent years, most of the money spent on care and treatment comes from the out-of-pocket expenditure of AIDS-affected households, many of them already desperately poor (Thailand is the notable exception). Prevention too is under-funded. According to a survey of national programmes, the estimated US\$ 200 million available from the public sector for prevention and treatment programmes in 2003 covered only 20% of needed resources.

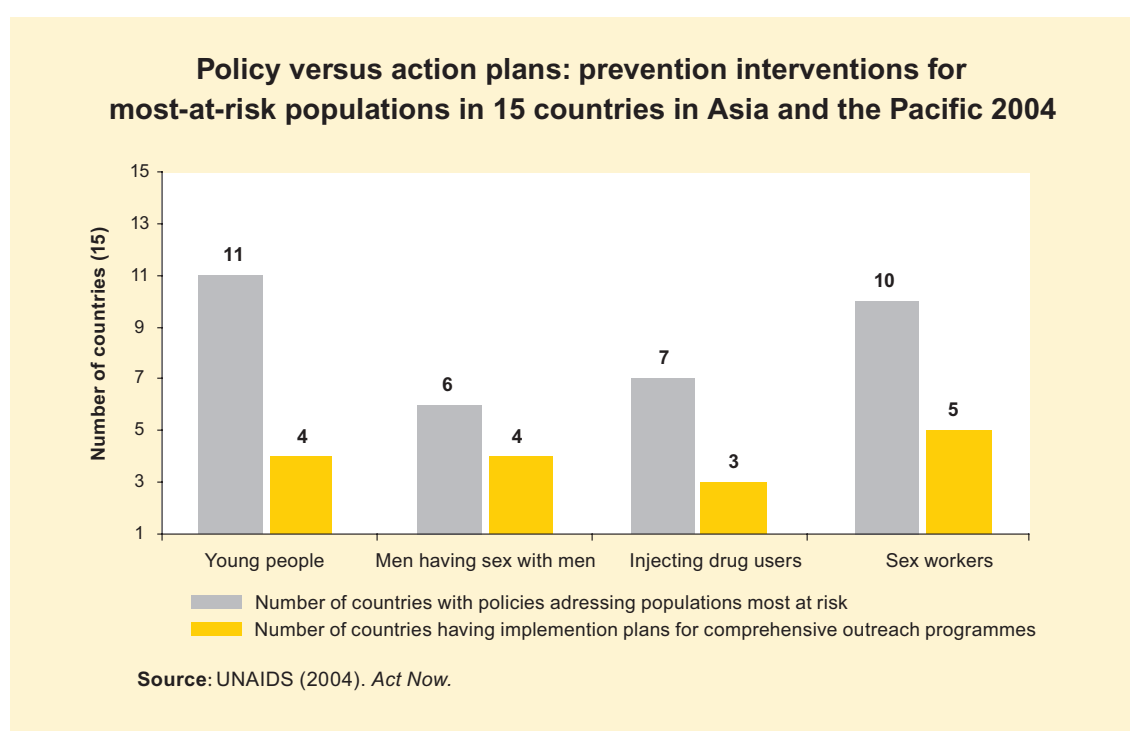
Even if all financing sources including out-of-pocket spending are considered (and even assuming optimistically that all available resources are used to support evidence-based AIDS programmes in line with strategic national needs) it is clear that available resources are far short of amounts needed to finance an effective response (see Figure 12). Given the growing backlog of prevention, care and treatment needs, the level of resources required to mount a comprehensive response is growing from year to year, and future years will require substantially greater resource levels than those currently available.

Figure 12



When resources are available, allocation is often poorly focused, diminishing the strategic impact of national AIDS efforts. In too many cases, countries with heavily concentrated epidemics are not prioritizing programmes for marginalized populations, opting instead to allocate scarce resources toward less cost-effective initiatives for the general population. While most countries in the region have articulated policy frameworks for key populations (e.g., young people, men who have sex with men, injecting drug users, sex workers), few have implementation plans that include comprehensive outreach efforts for such groups (see Figure 13).

Figure 13



Weak surveillance systems

To some extent, the failure to allocate resources to populations at highest risk stems from the weakness of national surveillance and information systems. National AIDS responses are only as strong as the evidence on which they are based. Accurate and timely information is essential to ensure that limited funds are used as effectively as possible, and to monitor the impact of AIDS interventions.

Currently, however, surveillance systems in many countries are too weak to support an optimally effective response. Second-generation surveillance (which includes surveillance of behaviour as well as sexually transmitted diseases and HIV among key populations, along with evaluation of interventions) is not routinely conducted in many countries except among women attending antenatal clinics. Few countries actively collect essential information from sex workers and other

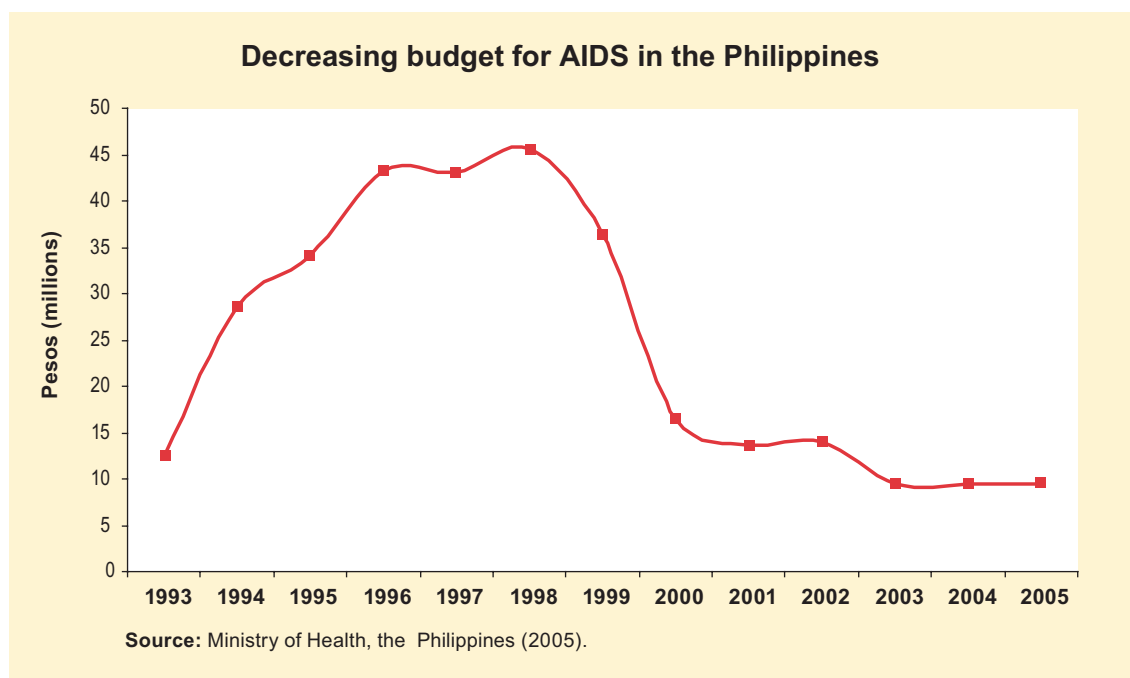
heavily affected populations with high-risk behaviour. A recent survey of 19 Asian and Pacific countries found that only six conducted annual HIV and behavioural surveillance among sex workers, three among injecting drug users, and two among men who have sex with men.

Complacency about the need for prevention programming?

HIV prevention requires ongoing reinforcement and adaptation to changing needs and risk behaviours. Unfortunately, there are signs that some countries that have avoided major epidemics are reducing official support for their national AIDS response, particularly prevention programming. As shown in Figure 14, the national AIDS budget in the Philippines has fallen sharply since 1998.

In Thailand—where an early commitment to prevention made the country one of the world’s greatest AIDS success stories—there are fears that reduction of prevention efforts may provoke a resurgence of HIV. For example, even though injecting drug use continues to account for a great deal of HIV transmission in Thailand, prevention programmes for injecting drug users have received only limited government funding. Similarly, programmes aimed at men who have sex with men have received little prevention support, notwithstanding rising infection rates in this population.

Figure 14



Stigma and discrimination

Perhaps the greatest obstacle to a successful response is that stigma and discrimination against people living with HIV remain the norm in many Asian countries. For instance, high levels of HIV-related stigma and discrimination deter many individuals from accessing the services they need. Surveys in India, Indonesia, the Philippines and Thailand indicate that more than one in four people with HIV—nearly one in two in the Philippines—have experienced HIV discrimination in health-care settings. More than one third have had confidentiality about their HIV status breached, and 15% have been refused medical treatment once health care staff learned they were HIV-positive.

According to a 2003 assessment of national AIDS responses in all regions, Asian countries scored lower on human rights-related issues than in any other category of response component (e.g., prevention, care and impact mitigation). Commitments on paper frequently do not translate into real protection for HIV-positive people. For example, while roughly one half of countries surveyed in Asia and the Pacific have adopted legal frameworks to prevent HIV-related discrimination, only one third have legal measures in place prohibiting it. Moreover, most countries with national anti-discrimination laws lack institutionalized human rights monitoring systems capable of routinely detecting and reporting violations to national authorities.

Seizing the opportunity

In 2005, the challenge is to extend prevention successes from a limited number of national examples throughout Asia and the Pacific, while scaling up care and treatment services, particularly antiretroviral therapy. Encouraging signs in response to AIDS include growing political commitment, increasing financial resources, and the active engagement of civil society in national efforts to respond to the epidemic.

Political commitment

In the last few years, many political leaders have begun to emphasize the threat posed by AIDS. The Government of China has embarked on a national effort to ensure widespread access to antiretrovirals and worked with the UNAIDS Secretariat and Cosponsors to complete a joint assessment of the national response. India created a National Council on AIDS, chaired by the Prime Minister, while Papua New Guinea relocated the National AIDS Council to the Prime Minister's Department and prioritized a stronger national response through a Special Parliamentary Committee on HIV/AIDS. Bangladesh and Viet Nam recently inaugurated national AIDS strategies. In Philippines, HIV/AIDS was incorporated as part of the Medium Term Philippine Development Plan for 2005–2010. Some presidents have started to address AIDS directly in their speeches.

Myanmar: collective investment through a UN initiative to fight AIDS

Myanmar demonstrates how stronger national responses can be forged even in delicate political environments. In 2003, following discussion with the national government, civil society, international nongovernmental organizations, and international donors, the Expanded UN Theme Group on AIDS formed the Joint Programme to Fight AIDS in Myanmar, 2003–2005. The collaborative initiative provides a framework for cooperative planning, resource mobilization, and advancing “Three Ones” principles², in particular through a set of common indicators. The UN mobilized US\$ 24 million for AIDS programmes from the United Kingdom Department for International Development (DFID), the Swedish International Development Cooperation Agency (SIDA) and other donors, and contributed to a national platform for development of a successful grant application to the Global Fund to Fight AIDS, Tuberculosis and Malaria. While significant progress has been made in the country—increasing treatment of sexually transmitted diseases by 65%, expanding condom availability three fold in the last five years, and expanding a needle exchange programme—a concentrated epidemic is still unfolding that requires a dramatically-enhanced national response.

² The “Three Ones” principles were devised to help countries to achieve the most effective and efficient use of resources, rapid action and results-based management. They are: One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners, One national AIDS coordinating authority, with a broad-based multisectoral mandate; and One agreed country-level monitoring and evaluation system.

Leadership is also being demonstrated at regional level. In 2004, the South Asian Association for Regional Cooperation (SAARC) formally declared prevention and treatment of HIV and other infectious diseases a regional priority. The Association of South East Asian Nations (ASEAN) helped influence regional financial institutions to integrate AIDS responses in infrastructure development efforts, and is currently developing a new multi-year work plan to guide and strengthen regional AIDS control efforts. The largest financial institution in the region, the Asian Development Bank (ADB), has signed a Memorandum of Understanding with UNAIDS to work together to engage political leaders and various sectors in the response to AIDS, strengthen national capacity, and generate additional funds for AIDS in the region.

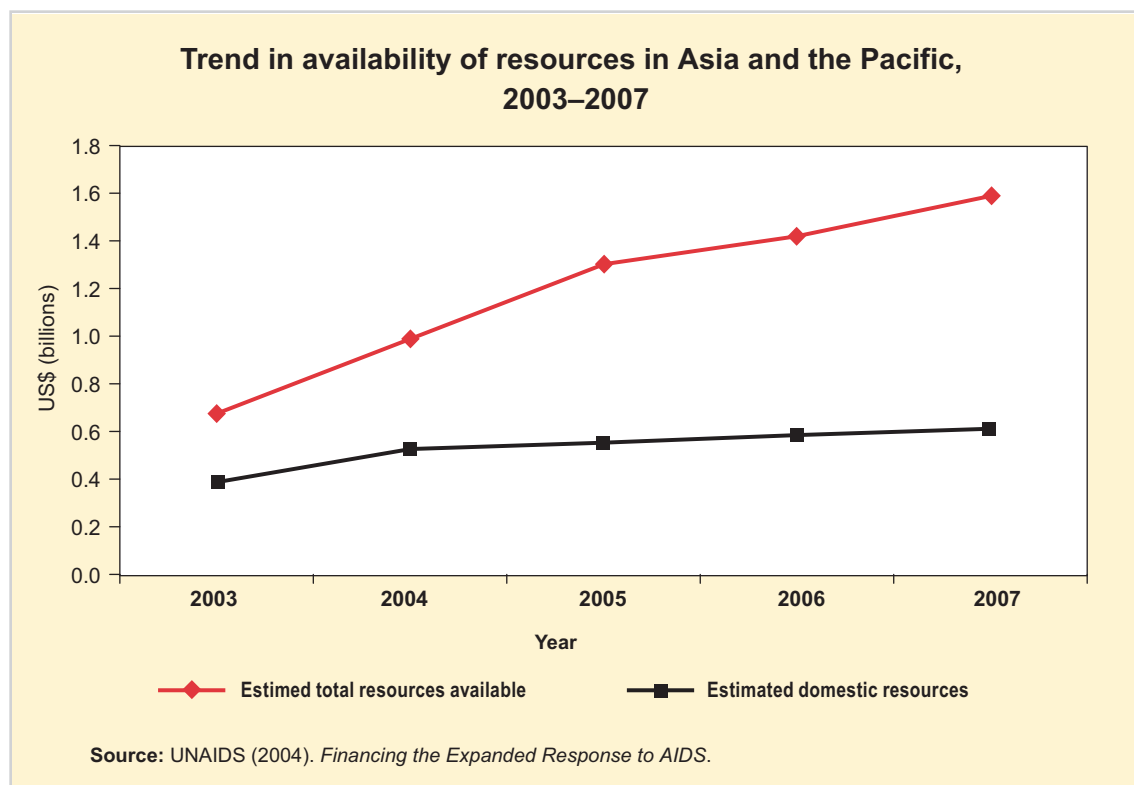
At the XV International AIDS Conference in Bangkok in 2004, the Royal Thai Government hosted ministers from 38 countries in Asia and the Pacific at a summit meeting on intergovernmental cooperation in the response to the epidemic, which generated a strong statement of collective commitment. In Fiji, at the invitation of Fiji's Great Council of Chiefs, leaders from 16 Pacific island countries developed a joint advocacy strategy to strengthen regional cooperation and commitment on AIDS.

Financial resources

Although Asia has benefited from the global growth in financial resources for AIDS, the increase in AIDS spending in the region has been slower than in other parts of the world, even as the epidemic accelerates. Nonetheless, as shown in Figure 11, between 2003 and 2007 the availability of resources for AIDS programmes in the region is expected to increase from roughly US\$ 681 million to more than US\$ 1.6 billion.

The majority of these funds are expected to come from sources such as bilateral donors, foundations, and international institutions. In 2004, the Asian Development Bank decided to reserve US\$ 140 million for grants to countries to implement and sustain programmes for AIDS and other health conditions. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is supporting treatment scale-up in Viet Nam, while in India the Bill & Melinda Gates Foundation has committed US\$ 200 million to support a multi-year HIV-prevention initiative in six states. In 2005, DFID committed an additional US\$ 45 million for Indonesia. Since 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria has approved approximately US\$ 600 million for 18 countries of Asia and the Pacific with the majority of funding allocated for AIDS.

Figure 15



Viet Nam: signs of growing commitments

Viet Nam is faced with a rapidly growing epidemic. Fortunately, there are strong signs of growing national commitment to respond to the epidemic. These include the national declaration of 2005 as the “Year of HIV Implementation”; a 75% increase in national spending on AIDS programmes over the past year; and a growth in external AIDS assistance from US\$ 7–8 million in 2003 to a projected US\$ 50 million in 2006 (including the PEPFAR initiative). The 12-million-member Viet Nam Women’s Union is leading national efforts to combat HIV-related stigma and discrimination and to increase awareness of the epidemic’s impact on women and girls. One development has been the gradual replacement of the highly stigmatizing “social evil” approach to drug use and sex work in favour of prevention programmes based on sound public health principles.

Civil society

Growing political and financial support for AIDS efforts has been accompanied—and in some cases preceded—by stronger civil society engagement. Organizations of people living with HIV and AIDS are advocating for increased access to treatment and care, and working to alleviate the stigma associated with the disease.

In Cambodia, civil society organizations and people living with HIV joined with the national government and international donors to develop a national AIDS treatment plan. Nongovernmental organizations created by former drug users have initiated drug-substitution programmes in India and organized harm-reduction services in South-East Asia. Sex worker advocacy groups have created and expanded programmes in Bangladesh, India, Cambodia and Thailand, while programmes by and for men who have sex with men have emerged in Pakistan, Nepal, the Philippines and Thailand. In some countries, lawyers’ collectives have taken up legal battles to fight instances of discrimination against people living with HIV.

The private sector is beginning to play a significant role. For example, leading media outlets in Indonesia have joined together to create a national AIDS media initiative, while AIDS-related media coverage in India increased in 2004. Corporate leaders have joined together in a number of countries to form national business coalitions on AIDS. And in several countries, social marketing campaigns by the private sector are increasing access to condoms.

Strengthening surveillance in Indonesia

Indonesia has recently improved the strategic information available from its HIV and AIDS surveillance system by collecting biological and behavioural data among populations most at risk of exposure to HIV and by estimating the size of these populations in each Indonesian province. The country now conducts HIV and behavioural surveillance in key populations, including injecting drug users, women attending antenatal clinics, clients of sex workers, male sex workers, and men who have sex with men. Data from all sources are analysed together to generate clear priorities for HIV prevention among these groups at provincial level.

Recommendations

The countries of Asia and the Pacific—home to half the world’s population—will in many respects determine the future of the AIDS epidemic. To seize the fast-disappearing opportunity to prevent a major expansion of the HIV epidemic in the region, national, regional and global leaders should consider the following recommendations:

1. Governments in Asia and the Pacific should move from commitment to action.

- Political leaders should speak out, openly and repeatedly, about AIDS and about the behaviours that fuel the epidemic’s spread. In particular, leaders should spearhead national efforts to overcome stigma, discrimination and gender inequality.
- As a clear indication of the increased political priority given to AIDS, countries in Asia and the Pacific should embark on an “emergency-level response” to the AIDS epidemic. This will help to ensure a better coordinated flow of funds, guarantee visibility and leadership at a national level, and help mobilize international support.
- Countries in the region should back up their increased commitment by increasing national financial expenditures on AIDS programmes.
- Countries should legislate and implement laws and regulations that combat stigma and discrimination against people living with HIV.
- National AIDS programmes should assign roles to all ministries and sectors with comparative advantages to contribute to the national response. All key ministries should have clear budgetary allocations for AIDS with an implementation plan that includes performance milestones and indicators.
- Countries should adopt the “Three Ones” principles to ensure the national response has one AIDS action framework, one effective national AIDS coordinating authority and one monitoring and evaluation system.

2. National AIDS programmes should adopt a comprehensive approach to national responses that includes a balance of HIV prevention, care and treatment, and impact mitigation programmes tailored to national conditions.

- Clear, time-bound coverage targets should be set for all key HIV-prevention services. Key services should include but are not limited to abstinence, reduction in partners, fidelity, condom promotion, treatment for sexually transmitted infections, voluntary testing and counselling, harm reduction services for injecting drug users, prevention of mother-to-child transmission, blood safety, and effective infection control in health-care settings.
- Responses should target vulnerable populations or geographic areas of high prevalence. Coverage targets should be set for populations most at risk, such as migrants, sex workers and clients, injecting drug users, and men who have sex with men. Countries should pay particular attention to the prevention needs of young people.

- Bridging the “treatment gap” (lack of access to treatment) should be adopted as a key priority with a clear time-bound coverage target. Sharp declines in the prices of antiretrovirals and the availability of international technical assistance make introduction of antiretroviral treatment feasible for all countries in the region.
 - Countries should increase the capacity of their evaluation and surveillance systems in order to guide the selection, prioritization and targeting of interventions, as well as to monitor the course of the epidemic.
- 3. Countries should increase support to civil society organizations’ involvement in national responses.**
- National AIDS committees should involve local and international nongovernmental organizations, community-based organizations, care providers, faith-based groups, and people living with HIV. In particular, ensuring the full participation by people living with HIV is of the utmost importance.
 - Countries should identify and implement viable and effective mechanisms for financing, building capacity and promoting coordination of civil society organizations. These include, among others, legal recognition, tax incentives, streamlined contracting regulations, and financial support to build effective and accountable community-based institutions.
- 4. The response to AIDS in Asia and the Pacific should become an international priority.**
- Regional bodies in Asia and the Pacific should articulate milestone-driven action plans to accelerate intergovernmental cooperation, development and implementation of strategic plans to strengthen the regional response, and mobilization of financial and technical resources.
 - Global leaders should place strengthening the response to AIDS in Asia and the Pacific high on the agenda at international meetings such as the high-level summit in 2006 to review progress in implementing the *Declaration of Commitment on HIV/AIDS*.
 - International donors should significantly increase overall financial assistance to enable countries in Asia and the Pacific to scale up HIV prevention, treatment and care, and impact mitigation simultaneously.

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Notes

Note to Figure 12: The resource needs figures used for the region come from estimates agreed by 19 countries' representatives (New Delhi, September 2003) in a technical workshop organized by UNAIDS, the Futures group and ADB (UNAIDS and ADB 2004). Resource availability figures are quoted from *Financing the Expanded Response to AIDS* (UNAIDS 2004). A multiagency Global Task Team is currently re-examining estimates of resource needs at global level, including regional estimates. A report is expected to be available at the end of 2005.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

A scaled-up response to **AIDS**

in Asia and the Pacific

Asia and the Pacific stand at the crossroads in their response to the AIDS epidemic. While overall HIV prevalence remains relatively low in most countries, the cost in human and economic terms is high. In 2004 alone, AIDS caused more than 500 000 deaths and cost billions of dollars in lost productivity.

It is still possible to prevent a major expansion of the epidemic, since more than 99% of people in Asia and the Pacific remain uninfected. However, immediate and extraordinary action will be required. Unless prevention efforts in particular are radically scaled up, at least 12 million new infections are projected to occur between 2005 and 2010.

This report summarizes the AIDS challenge in Asian and Pacific countries. Using the best available evidence, it examines why critical services currently reach only a fraction of those in need. It also outlines actions that will allow countries to seize this key moment of opportunity.

The report then makes recommendations for urgent implementation of strategies known to work, by global, regional and national political leaders, international donors, the UN system, civil society and other key stakeholders in Asia and the Pacific.



Joint United Nations Programme on HIV/AIDS

UNAIDS

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