

REDEFINING AIDS IN ASIA
Crafting an Effective Response

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Report of the Commission on
AIDS in Asia

Presented to
Mr. Ban Ki-moon,
UN Secretary General,
on 26 March 2008

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Contents

<i>List of Figures, Tables, and Boxes</i>	ix
<i>Preface</i>	xiii
<i>Acknowledgements</i>	xvii
<i>Common Abbreviations</i>	xix
Executive Summary	1
The State of the AIDS Epidemic in Asia	1
National Responses to HIV and AIDS	3
Community Involvement	5
The Future of the Epidemic in Asia	6
The Many Impacts of HIV	8
Addressing Contextual Factors	8
How Much Money is Needed to Curb HIV in Asia?	9
Policy Recommendations	11
Strategies and Programme Implementation	15
1. The Challenges Ahead	21
An HIV Response and Unfolding Realities	21
The Commission on AIDS in Asia: A Fresh Perspective	22
What Makes Asian Epidemics Unique?	23
How can Asian Countries Prevent the Spread of Their HIV Epidemics?	24
What Should Asian Countries do to Care for People Living with HIV and Their Families and Mitigate the Impact of the Epidemic?	25
Making a Difference: A Call for Strong and Mature Leadership	26
2. The Future of HIV in Asia	29
Chapter Summary	29
Asian Epidemics Present Major Challenges and Opportunities	31

Drug Injecting Spreads HIV Rapidly	42
...and Jump Starts the Epidemic in the Sex Trade	44
Sex between Men: A Fast Growing Epidemic	48
The Best Way to Protect Women in Asia is to Prevent Their Husbands from Becoming Infected	51
Classifying Asia's Epidemics to Tailor Effective Responses	52
Might Changes in Sexual Behaviour Alter the Course of the Epidemics?	58
More Men Buying Sex?	59
Will Casual and Premarital Sex Lead to a Rise in HIV Epidemics?	59
Solid Data and Analysis is Needed to Understand and Respond to the Epidemic	61
Improving the Analysis of HIV Data Requires Resources and Time	62
Technical Note: Four Scenarios for Prioritizing Interventions	65
3. Reducing the Cost of HIV in Asia	71
Chapter Summary	71
AIDS will Remain a Major Cause of Death for Working Age Adults	73
Focused Interventions can be Particularly Effective in Asia	77
Impact of AIDS in Asia is Largely Felt at the Household Level	78
The Human Face of AIDS—Losses, Foregone Opportunities, and Societal Rejection	80
AIDS Pushes Many into Poverty	84
The Epidemic has a Wider Impact	84
Curbing HIV in Asia is both Affordable and Achievable	86
Prioritization is Essential to Design a Cost-Effective Programme	88
Classifying Interventions by Cost and Impact	89
With the Right Choices, HIV Epidemics in Asia can be Effectively Contained	93
Technical Note	94
4. Towards a More Effective HIV Response	101
Chapter Summary	101
The Complexity of the Underlying Links between Societal Factors, Environment, and HIV	103
'An Enabling Environment' can Quickly Reduce many Barriers to Prevention and Care	104
Information and Knowledge Enables People to make Better Informed Choices about their Sexual Behaviour	105
Poverty and Inequality Limit Access to Essential HIV Services	107
Gender Inequality Enhances the Risk of HIV for Women	108
In Some Places, Migration Contributes to the Demand for Sex Work	110
Stigma and Discrimination Fuels HIV Epidemics	111

Create an Environment to Facilitate Services for Most-at-Risk Groups	115
Striking the Right Balance—Address Immediate Priorities and Catalyse Long-term Actions	116
5. National HIV Responses in Asia	119
Chapter Summary	119
Current Responses Fall Short in Making a Major Impact	121
Political Engagement Needs to be Strong	124
HIV Programmes and Strategic Plans Still Lack Key Planning Components	126
Urgent Need: More Resources and Making the Money Work	133
Civil Society and Community Involvement is Critical	139
Policy and Legal Environments for HIV-Positive Persons and Groups Most at Risk Need to be More Supportive	139
Institutional Structures and Governance are Strong Determinants of an Effective Response	140
For Technical Support, the United Nations System Should Deliver as One	144
Technical Note: Stages of National Response	147
6. The Need for Meaningful Community Engagement	151
Chapter Summary	151
Responses Often Begin at the Community Level	153
Communities and Community Organizations: How They Differ	154
Engaging Communities is Essential to Strong Responses	155
Accountability is Essential for Both Government and Communities	160
Stronger Partnerships between Government and Communities can Build Commitment and Mutual Trust	162
Stigma and Discrimination Block Community Participation in Policymaking	163
Build a Tradition of Community Involvement in Countries with Limited Civil Society Presence	164
Public–Private Partnerships Ensure Fast Disbursement of Funds for Community Programmes	164
Government has the Principal Responsibility to Make Community Involvement ‘Meaningful’	165
Community Organizations Need Support to Build Their Capacity for Engagement	167
7. Findings and Recommendations	169
Key Findings	169
Policy Recommendations	178
Strategies and Programme Implementation	197

8. The Way Forward	219
<i>Bibliography</i>	223
<i>Annex 1: List of Countries Covered by this Report</i>	231
<i>Annex 2: Terms of Reference of the Commission on AIDS in Asia</i>	232
<i>Annex 3: List of Commission Members</i>	235
<i>Annex 4: Contributors to the Report</i>	237

Figures, Tables, and Boxes

FIGURES

2.1 : Male clients of female sex workers: a key actor in Asia's HIV epidemics	32
2.2 : Sexual behaviour of women around the world: percentage of 15–19 never married in urban areas having sexual intercourse in the last 12 months	33
2.3 : The Asian Epidemic Model directly compares its calculations with observed trends of HIV transmission in all key populations affected by the epidemics	35
2.4 : The Asian Epidemic Model makes it possible to examine the proportion of new HIV infections in each most-at-risk population	36
2.5 : In the absence of large scale interventions, levels of HIV prevalence depend on the number of men who buy sex	38
2.6 : HIV spreads most quickly in settings where sex workers have large numbers of clients each week	39
2.7 : HIV can rise very quickly among drug injectors, and reach very high levels	43
2.8 : Projected total number of HIV infections in various population groups, 2000–20	45
2.9 : Injection and commercial sex interact in many ways	46
2.10 : In Indonesia, HIV did not spread in the sex industry until a few years after it had reached very high levels among drug injectors	48
2.11 : HIV prevention programmes among men who have sex with men can achieve behaviour change	49

x Figures, Tables, and Boxes

2.12	: Estimated number of annual new infections and proportion of casual sex in a typical 100-million population setting in Asia	50
2.13	: Estimated number of annual new HIV infections in different populations, Cambodia, 1985–2020	52
2.14	: Projected trend of Asia's HIV epidemic up to 2020	56
2.15	: Adult males and females living with HIV in Asia	56
2.16	: Annual new HIV infections in adults by population group: a decline from early prevention successes, an increase from current failures	57
2.17	: Early and effective prevention can avert a large-scale epidemic in latent epidemic scenario countries	65
2.18	: Effective prevention can significantly reduce infections in expanding epidemic scenario countries	66
2.19	: Effective prevention can significantly reduce infections in maturing epidemic scenario countries	68
2.20	: If effective prevention is not sustained, infections will rise, even in declining epidemic scenario countries	69
3.1	: Projected annual deaths caused by various diseases in the Asia region among 15–44 year-old age group, 2002–2020	73
3.2	: Projected annual disability-adjusted life years (DALYs) lost to various diseases in the Asia region among 15–44 year-old age group, 2002–2020	74
3.3	: The projected impact of AIDS in Asia—with and without a comprehensive HIV response, 2007–2020	78
3.4	: Reduced life expectancy due to AIDS for various countries in Asia, 2005	80
3.5	: AIDS and SARS: A comparison of costs	81
3.6	: Impact of focused prevention package recommended by the Commission on the regional epidemic	82
3.7	: New infections if we implement best practice intervention packages for sex workers and clients, MSM, and IDUs on a regional basis	83
3.8	: Estimated number of people living with HIV, by risk group, in 100 million population, 1990–2020	86
3.9	: Comparison of prevention interventions, according to distribution of resources and percentage of new infections averted, 2007–2020	88

3.10 : Prevention interventions: Cost per disability-adjusted life year (DALY) saved	90
4.1 : Association between HIV and income inequality is unclear	107
5.1 : Review of national HIV responses in 14 Asian countries, 1996–2006	123
5.2 : Shifts in political leadership on AIDS	126
5.3 : Coverage of most-at-risk groups by HIV prevention services in Asia, 2005	131
5.4 : Coverage of HIV treatment services in Asia, 2005	131
5.5 : Coverage must reach 80 per cent to initiate the 60 per cent behaviour change needed to reverse the epidemic	132
5.6 : Global fund disbursements for AIDS in the Asian region, 2003–7	134
5.7 : Resource commitments from countries compared with normative estimates of resource needs	136
5.8 : National budgets as a proportion of total AIDS funding in 12 Asian countries, 1996 and 2004	137
5.9 : Spending priorities in Thailand are strongly biased toward treatment	138
5.10 : Percentage of new HIV infections in young people, and allocation of resources for young people by UNICEF, UNFPA, and UNESCO	145

TABLES

2.1 : HIV epidemics: stages, sources, and responses	54
3.1 : Resource needs estimates for 2007 for Asia, by intervention category	87
3.2 : Classifying HIV interventions according to cost and impact	91
3.3 : Priority interventions, programme and related costs (USD millions) across the Asia region	92
3.4 : Cost and elements of prevention interventions for high-risk populations	97
3.5 : Cost and elements of spousal transmission	97
3.6 : Unit costs of prevention, treatment and impact mitigation, and programme management needed for an effective response	98
3.7 : Estimation of a priority resource needs in the region, according to scenario	100

xii Figures, Tables, and Boxes

5.1 : Status of National AIDS Commissions	141
5.2 : Capacity of National AIDS Commissions	141
5.3 : Comparison of three leadership scenarios for National AIDS Commissions	143
7.1 : Illustrative programme structure for HIV interventions	218

BOXES

2.1 : The Main Pathways of Asia's HIV Epidemics	32
2.2 : The Asian Epidemic Model: Analysing the Implications of HIV Policies in Asia	34
2.3 : A New Look at the Economics of an Old Trade	41
2.4 : HIV behind Prison Walls: A Less Understood Epidemic	46
2.5 : Is Casual Sex among Young People Driving Asia's HIV Epidemics?	50
2.6 : The Current Course of HIV in Asia: A History of Successes and Failures	55
2.7 : Are Current Surveillance Systems Overestimating HIV in Asia?	62
2.8 : Improving Understanding of Asia's HIV Epidemics by Addressing Data Needs	64
3.1 : Changing Behaviour—The Impact of Effective Prevention	74
3.2 : A Sense of Scale—Like a SARS Epidemic every 5 Years	81
3.3 : What Can we Hope to Accomplish?	82
4.1 : Harm Reduction—Learning from Successes and Failures	114
5.1 : Signs of Progress, but Much Remains to be Done	121
5.2 : National Responses in Asia are Evolving Unevenly	122
5.3 : Programmes That are Effective have Several Components	128
5.4 : Challenges of Resource Mobilization and the Role of the Global Fund (GFATM)	134
5.5 : Reaching Young People Who are Most at Risk	145
6.1 : The Meaning of Community	153
6.2 : 100 Per Cent Condom Use Programmes: The Need for Sex Worker Involvement	157
6.3 : The Importance of Involving People Living with HIV	159
6.4 : Funding Often Bypasses Community Organizations: A Case of Sex Workers' Organization in Bangladesh	167

Preface

A few years after the first reported case of AIDS in the USA, the Human Immunodeficiency Virus (HIV) had also established itself in Asia. It spread quickly and by the early 1990s, HIV infections were being reported in every country of Asia. In some, notably Thailand, major epidemics were underway.

A little more than two decades later, an estimated 9 million people in Asia have been infected with HIV, and millions of them have died of AIDS-related illnesses. Even these high numbers cannot convey the suffering and pain experienced by people living with HIV, and their families. Along with the shock of sudden failing health and mysterious illnesses, came public shame and humiliation. Infection did not elicit compassion but condemnation and rejection.

HIV seemed to stoke and focus deep-rooted social prejudices, not least because it was associated with behaviours deemed taboo in 'polite society': drug injecting, sex between men, and commercial sex. Consequently, the initial reactions across Asia tended to be either denial or moral panic.

In most places, the factors driving the epidemics, and the patterns and trends of HIV transmission in Asian societies, were poorly researched. This had two effects. In some quarters, it fed the complacent belief that the dominant values in Asian societies would protect them against HIV, and that epidemics would be confined to marginalized groups of people who engaged in taboo behaviours. At the same time, the burgeoning epidemics underway in East and southern Africa sparked fears of similar relentless HIV spread in Asia, and evoked doomsday scenarios in which 10 per cent or more of adults would soon be infected with HIV.

Over the past decade, our understanding of HIV epidemics in Asia has improved to the point where we can safely say that both those prognoses were wrong.

But do we know what HIV holds in store for Asia? What are the driving factors in Asia's HIV epidemics, and how may these change? What damage are the epidemics wreaking in the countries of this region? How high are prevalence rates likely to become and who will bear their brunt? What are the best strategies for overcoming the epidemics? And are those strategies viable and realistic in Asia today?

Those questions, for the most part, have eluded clear-headed enquiry and satisfactory answers. They prompted the Executive Director of the Joint UN Programme on HIV/AIDS (UNAIDS), Dr Peter Piot, to propose a comprehensive study of the realities and the impact of AIDS in Asia.

That task was entrusted to an independent Commission on AIDS in Asia, which was set up in June 2006 and assigned an 18-month mandate to study and assess the impact of AIDS in Asia, and to recommend strategies for a stronger response to HIV and AIDS. The Commission's terms of reference and its composition are provided in the annexes to this Report.

We thank UNAIDS and its two cosponsors, UNICEF and UNDP, for the initiative and interest in this work and for the financial and technical support provided to the Commission.

The complexities of the epidemic and its challenges were evident to the Commission from the outset. At its first meeting in July 2006, however, it also realized that significant gaps existed in the available information on the epidemics' advance across Asia and their impact on societies. In some respects, the research was of inadequate quality, in others it appeared to be largely absent.

The Commission therefore initiated two important research initiatives. One examined the epidemiology of Asia's HIV epidemics and sought to describe their likely future progression. The other analysed the medium- to long-term impact of AIDS on societies and economies in Asia. Almost three dozen research papers were produced.

The first project was funded with grants made to the Commission, while the second was financed by the Asian Development Bank (ADB) which harmonized its own research agenda on AIDS with that of the Commission. We thank the ADB for this valuable support.

The Commission also explored the roles played by communities that are at the centre of the epidemics. Some 600 individuals and community organizations across Asia were contacted and in-depth interviews were conducted with key activists and civil society organizers. The findings were sobering. Community participation in HIV responses was found to be limited, as was the capacity of communities to manage and sustain their work on HIV. The Commission gratefully acknowledges the contributions of civil society and community based-organizations in



identifying ways in which community involvement in Asia's HIV response can be strengthened.

In addition to this research, the Commission also conducted two field missions (to Bangladesh and the Philippines), hosted an in-depth policy options workshop in Bangkok, and engaged with numerous political leaders, Government officials, AIDS practitioners, researchers, donors, United Nations, and civil society representatives from across Asia. This Report gathers the insights and findings of this 18-month exercise.

The Commission believes the Report deepens and refines the understanding of Asia's pandemic, and pinpoints the critical components of a viable and sustainable long-term response that can curb AIDS in Asia.

The Report includes key implementation strategies at both the policy and operational levels. The challenge now lies in translating these into effective action throughout the region.

During its deliberations, the Commission was often asked for whom this Report was intended. Was it for planners, or policy designers, or politicians, or opinion-makers, or activists, or the media? The answer is: all these and more.

The findings and recommendations contained in this Report are intended for people from all walks of life who care about the societies they live in and the people they share them with.

To such thinking and discerning people of Asia, we present this Report.

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Common Abbreviations

ADB	Asian Development Bank
AEM	Asian Epidemic Model
AIDS	acquired immunodeficiency syndrome
ASEAN	Association of South East Asian Nations
CBO	community-based organization
CCM	country coordinating mechanisms
CDC	communicable diseases control
CSO	civil society organization
DALY	disability-adjusted life year
DfID	Department for International Development
DHS	Demographic Health Survey
GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GTT	Global Task Team
HIV	human immunodeficiency virus
IDU	injecting drug user
MDG	Millennium Development Goal
M&E	monitoring and evaluation
MoH	Ministry of Health
MSM	men who have sex with men
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NFHS	National Family Health Survey
NGO	non-governmental organization
PEPFAR	President's Emergency Plan for AIDS Relief
SAARC	South Asian Association of Regional Cooperation
SARS	severe acute respiratory syndrome
STD	sexually transmitted disease

 xx Common Abbreviations

STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
UBW	Unified budget and work plan
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNGASS	UN General Assembly Special Session
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

The realization that Asia's response, overall, has neither matched nor kept pace with the unfolding realities of the HIV epidemics led to the creation of the Commission on AIDS in Asia in June 2006. The Commission's principle mandate was to conduct an analysis of the developmental consequences of the AIDS epidemic in the region, and its medium to long-term implications on the socioeconomic environment. The Commission has reviewed over 5,000 papers; commissioned almost 30 new studies in a range of areas; engaged more than 30 specialists to examine and propose new and innovative ways to address the epidemics in Asia; surveyed over 600 members from community-based organizations and other members of civil society; and staged two sub-regional workshops and five country missions, listening to testimonies on the HIV situation and response from Government and civil society representatives.

THE STATE OF THE AIDS EPIDEMIC IN ASIA

As a percentage of the region's large population, HIV prevalence rates in Asia may seem low but the absolute figures are high. According to UNAIDS and WHO estimates, 4.9 million (the range being 3.7 million–6.7 million) people were living with HIV in Asia in 2007, including the 440,000 (210,000–1.0 million) people who became newly infected in that year. Approximately 300,000 (250,000–470,000) people died from AIDS-related illnesses in 2007.¹

Overall, an estimated 9 million Asians have been infected with HIV since it first appeared in the region more than 20 years ago. Approximately 2.6 million men, more than 950,000 women, and almost 330,000 children have died of AIDS-related diseases.

¹UNAIDS/WHO (2007), *2007 AIDS Epidemic Update*, Geneva: UNAIDS.

2 Redefining AIDS in Asia

Despite the progress made in many of the countries in Asia and the declining trend of new HIV infections in a few of them, AIDS currently accounts for more deaths annually among 15–44 year-old adults than do tuberculosis and other diseases.

Speculation over the likely trajectories of HIV epidemics in Asia has ranged from dire warnings that they would reach the scale and intensity of some of the worst affected African countries, to the rather complacent view that social norms and mores would hold HIV in check throughout the region. As this Report shows, neither view is correct and both have led to confusion, resulting in half-hearted or inappropriate and misdirected response to HIV and AIDS.

Although the epidemics vary considerably from country to country, they share important characteristics, namely that they are centred mainly around: unprotected paid sex, the sharing of contaminated needles and syringes by injecting drug users, and unprotected sex between men. However, men who buy sex, most of who are from ‘mainstream’ society, are the single most powerful driving force in Asia’s HIV epidemics and constitute the largest infected population group. Because most men who buy sex either are married or will get married, significant numbers of ostensibly ‘low-risk’ women who only have sex with their husbands are exposed to HIV. Effective means of preventing HIV infections in the female partners of these men have yet to be developed in Asia, but are clearly essential.

Pooling recent calculations from various Asian countries, the Commission estimates 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 or so to the number of men at high risk of HIV infection once the virus enters those networks. A portion 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.

Because relatively few women in Asia have sex with more than one partner, the chain of HIV infection tends to end once the wives and girlfriends among them become infected. Some might transmit HIV to their unborn or newborn infants. But the probability of those women passing HIV to another man is generally very small. This means that currently, HIV epidemics in Asia are highly unlikely to sustain themselves in the ‘general population’ independently of commercial sex, drug injecting, and sex between men. And, most critically, it means that prevention efforts that drastically reduce HIV transmission among

and between these most-at-risk populations will bring the epidemics under control.

HIV-related stigma and discrimination undermine Asia's responses to the epidemic, preventing people from using a range of important services. The take-up of HIV counselling and testing services, for example, is low. Discrimination against people living with HIV affects their access to employment, housing, insurance, social services, education, health, and inheritance rights for women and men. In some countries, strong prejudice against people living with HIV has been found in health services. Furthermore, those groups that are most at risk of HIV infection are already discriminated against, marginalized, and in some countries criminalized.

NATIONAL RESPONSES TO HIV AND AIDS

Although there are examples of effective and focused HIV responses in Asia, for instance Cambodia, Thailand, and a few states in India in many cases the response has lagged behind or faltered for long periods. There is still not that needed degree of urgency and coherence in every country to curb the epidemic.

In Asia, political engagement and support has moved from low to medium and high levels in several countries, indicating a much higher level of commitment over the past ten years. Exceptionally far-sighted politicians have increased awareness among their constituents. They lobbied for HIV-related legislation, pushed for more resources for interventions, and/or tried to hold their Governments accountable for their countries' responses to the epidemic. However, in only two Asian countries has a Head of State played a prominent role in the response and officially provided leadership to the national AIDS programme.

Political engagement and support are vital prerequisites for setting the agenda and driving a potentially effective response. 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. Clearly political leadership on HIV in Asia holds the key.

Many Asian countries have established National AIDS Commissions (NAC) but 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; too often they lack the mandate required, the secretarial

support and overall direction by the top-level political functionary in the country.

The Country Coordinating Mechanisms (CCM) of the Global Fund for AIDS, TB, and Malaria have been fairly successful in compiling strong funding proposals, but the implementation of these programmes has been poorly monitored. Also, the CCMs could have functioned more effectively as representative bodies of important stakeholders, especially the affected communities. Their representation has been mostly tokenistic and their participation in decision-making, ineffective.

The Commission's review of the responses in 14 Asian countries showed that all have national strategic plans but the quality of these plans varies significantly. In some, resource allocation does not match the plan's highlighted priorities. Overall, most of the plans lack key planning components for the operation, management, and financing of the response.

Some national strategic plans are not properly balanced between prevention and treatment. Others fail to prioritize those groups most-at-risk of infection, and still others lack comprehensive ART plans and impact mitigation programmes in areas of high prevalence. 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. Hardly any country is devoting significant resources to programmes for men who have sex with men. Across Asia as a whole only about one in three sex workers were being reached by HIV services in 2005. Only 26 per cent of the people in need of antiretroviral treatment in Asia are receiving it.

The extent of coverage is vital if prevention programmes are to be effective. Modelling indicates 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.

HIV data collection has improved in several Asian countries over the past decade, and eight countries now have second-generation surveillance. The systems and capacity to analyse the information on HIV still pose a challenge to many countries.

Some Asian countries are adopting HIV strategies that are informed by the specific characteristics of their own epidemic, such as harm reduction programmes for IDUs. But prejudice against such groups remains, and is embedded in many laws, policies, and operational guidelines of law enforcement agencies. Reports of harassment of men who have sex with men, sex workers, and drug users are common across

the region. In most Asian countries, sex work, drug use, and sex between men remain criminal activities. 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 political leadership at the highest levels.

COMMUNITY INVOLVEMENT

In almost all countries, organized responses to AIDS have begun at community level and have been driven by the efforts of people living with HIV, their loved ones and carers, and activists. It is now generally accepted that community engagement is an essential part of HIV programme implementation and service delivery.

Unfortunately, such involvement is uneven in Asia and in many places is tokenistic. 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.

Community involvement can open space for discussion about controversial issues and help promote greater understanding of HIV among political and social leaders. NGOs and community-based organizations are often willing to broach these sensitive issues publicly. Also partnerships and community engagement can foster a sense of 'ownership' of the response that tends to be absent when projects are externally run.

The smaller size of community-based organizations makes them less bureaucratic than their Government counterparts, and gives them the flexibility to respond quickly to new situations. 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 men who have sex with men set up community hotlines to provide support and information on HIV and other issues. By 2007, the Government recognized the importance of working with this group and was funding programmes to support them.

In some countries, community activists have helped overcome some of the barriers of stigma and discrimination such as national legislation making certain behaviours illegal. But stronger efforts are needed to effect legal reform and strengthen the human rights framework.

The involvement of community-based organizations also increases the efficiency of service delivery. A study of 148 Global Fund grants found that the grant process for Government Principal Recipients (PRs) lagged behind that of non-governmental PRs by more than three months.

THE FUTURE OF THE EPIDEMIC IN ASIA

Beyond the basic shared features of most-at-risk groups, the HIV epidemics in Asia vary from country to country, and within countries. In order to have a proper assessment of the spread and impact of HIV throughout the region, it is important to understand who are most at risk of becoming infected, and in the future, which behaviours are most likely to lead to large numbers of infections.

The Commission has used the Asian Epidemic Model to prepare a set of projections for Asia, forming the basis of some policy analyses in the Report. This model, developed by the East-West Center and its Asian collaborators, is a policy tool based on the common regional patterns of HIV spread. Using country-specific data on the sizes and behaviours of the groups most at risk of infection (sex workers and their clients, injecting drug users, men who have sex with men, and the wives of these most-at-risk groups), country-specific models are developed that capture the diversity of the factors driving the epidemics in different Asian countries. As well as projecting HIV trends, the model provides detailed information on how new infections are distributed among different key populations. This will help in showing where prevention efforts can have the greatest impact.

The role of the sex trade is crucial. In Asia, men who buy sex from women far outnumber drug injectors and men who have sex with men, so this group of men is probably the most important 'determinant' of future rates of HIV. A high proportion of Asian men buy sex; on average, there are about ten male clients for every sex worker. Client turnover is a major factor in the spread of HIV; when turnover is high, it can create a critical mass of infections that spark the rapid spread of HIV within the sex trade.

Low levels of condom use during paid sex contribute to increasing HIV infection. In countries such as Thailand, where the authorities launched a major campaign in 1991 to encourage the use of condoms, research shows that as condom use rose among certain groups of men

and among sex workers, rates of HIV prevalence decreased. Programmes for increasing use of condoms with sex workers will do more than any other intervention to control HIV infections in Asia.

Drug injectors are another important at-risk group. It is clearly more effective to prevent infection among this group in the first place. In China, Hong Kong Special Administrative Region, a harm reduction programme has helped keep HIV prevalence among drug injectors low for many years. So countries that still have relatively low prevalence rates among this group should focus on prevention efforts to reduce drug injecting, promote the use of sterile equipment, and encourage safe sex between drug users and their sexual partners.

Unfortunately, only a small number of such programmes, usually 'boutique programmes', are to be found in Asian countries. Preventing an HIV epidemic among drug injectors can be a very effective way of avoiding a wider HIV epidemic. But in several countries, it is too late; HIV prevalence among this group is already high and infected drug injectors are introducing HIV into the sex trade, as buyers or as sellers. In parts of China, for example, almost half of female drug injectors said they sold sex and were significantly less likely to use condoms with clients than were sex workers who did not inject.

Sex between men accounts for an increasing share of new infections in Asia and can no longer be treated as a taboo subject. Same-sex monogamy is fairly rare in Asia; social taboos and discrimination mean many men who have sex with men also have sex with women and may be married. Also many men who have sex with men have high numbers of male partners and low condom use. In many Asian cities this has led to a rapid rise in HIV prevalence among men who have sex with men. However, when HIV prevention services are offered to this group, the uptake tends to be impressive.

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.

Although three out of four adults living with HIV in Asia are men, the proportion of women has risen gradually—from 19 per cent in 2000 to 24 per cent in 2007. Most of these women got infected through having sex with husbands or boyfriends who were themselves infected during paid sex or through injecting drugs.

Thus, the most sensible way to prevent HIV infection rising among women is to prevent their husbands from becoming infected in the first place. Unfortunately there have been few attempts to provide the relevant prevention programmes.

Unlike in many African countries, no country in Asia has experienced the spread of HIV as a ‘generalized’ epidemic where it is thought necessary to target the entire sexually active population with prevention efforts. Nowhere in Asia has HIV spread independently of drug injecting, sex between men, and/or commercial sex. The international classifications of ‘low-level’, ‘concentrated’, and ‘generalized’ epidemics do not express the actual nature and dynamics of Asia’s epidemics. This particular weakness has been known for a long time but no attempt has been made to improve the classification. The Commission recommends developing and validating a new scheme of classification, according to the predominant risk behaviours and their relative contribution to new infections. Until that is done, the Commission has presented four epidemic scenarios for Asia: latent, expanding, maturing, and declining epidemics. A detailed analysis of these scenarios is given in the Technical Note at the end of Chapter 2.

THE MANY IMPACTS OF HIV

The epidemic has an impact at many levels. *At the household level*, the impact is most dramatic with an annual cost of around USD 2 billion. The Commission estimates that the immediate introduction of a comprehensive intervention package would reduce this figure by 50 per cent over the next decade.

A great deal of the epidemic’s damage is concentrated on poor families who have no cushion against the consequences of AIDS-related illness, nor do they have the support of formal social protection schemes. Children often abandon education in order to care for parents; wives caring for HIV-infected husbands are ostracized, and widows are forced to leave their homes and land. Women and children in Asia bear a disproportionate impact of the epidemic.

By 2015, AIDS will have caused a further 6 million households in Asia to fall below the poverty line at the current rate of response. Every death from AIDS represents the loss of income of almost USD 5000—the equivalent of nearly 14 years of income for people earning USD 1 per day at current prices. In fact, economic cost associated with AIDS over the next two decades would be equal to the cost of fighting a SARS epidemic every five years.

ADDRESSING CONTEXTUAL FACTORS

A crucial concern for poorer people and marginalized groups such as sex workers, drug users and men who have sex with men is access to

HIV-related services. This aspect is often neglected in the HIV literature and programme design. The successful implementation of HIV programmes demands, first of all, addressing barriers at community level, thus creating an 'enabling environment'. Such an environment removes local hindrances to access to services. Also, political action can create such an environment for most-at-risk groups by decriminalizing sex work, homosexuality, and the use of needles and syringes for drug use. It demands thoughtful advocacy and bridge-building with local authorities and powerbrokers. Barriers should also be removed by providing subsidized transport to clinics, free antiretroviral treatment, and the involvement of community groups and NGOs in bringing poor households into the treatment network.

HOW MUCH MONEY IS NEEDED TO CURB HIV IN ASIA?

The Commission has classified HIV interventions into four categories, according to their effectiveness and cost: high-cost/high-impact, low-cost/high-impact, low-cost/low-impact, high-cost/low-impact. Governments should prioritize programmes with a high-impact, whether they are low-cost or high-cost.

It is possible to evolve a normative standard of expenditure for a priority response in Asia. It varies from USD 0.50 per capita to USD 1.00 per capita for most countries in Asia, depending upon the stage of the epidemic in each country.

Although there has been a major increase in external funding available to countries for fighting their HIV epidemics, domestic investment has not grown at a similar pace. Domestic spending in Asia has increased at a slower rate than in other regions. Admittedly, external funding can pose difficulties. Medium- to long-term sustainability of programmes may be compromised if they are dependent on funding flows not controlled by national Governments. External funders may also target programme areas that do not correspond to the countries' own priorities—for example, funding an awareness education programme for young people whilst ignoring the need for prevention programmes for sex workers. Funding priorities should match the patterns and trends of the epidemic. Here countries in Asia have an opportunity to improve their performance.

Fund-raising efforts should not be relaxed. An analysis of current resources available for Asia shows that only USD 1.2 billion of the USD 6.4 billion needed every year is available. It is essential to assess possible interventions in terms of their effectiveness. Using the Asia Epidemic Model, the Commission highlights the cost-effectiveness of interventions

that focus on preventing HIV among sex workers and their clients. Such programmes can prevent 7,000 times more new infections than can universal precautions—for the same amount of money spent. Other programmes that are known to be highly effective, and should be prioritized, are the prevention of mother-to-child transmission, focused counselling and testing, and antiretroviral treatment programmes.

On the basis of existing evidence, the Commission believes that the focused prevention package recommended in this Report will:

- raise condom use among sex workers and clients to over 80 per cent;
- halve STIs among sex workers and clients;
- halve needle sharing among injecting drug users (IDUs) and halve the percentage of actual injections they share; and
- raise condom use among men who have sex with men to 80 per cent or more.

If such levels of behaviour change are achieved regionally, new infections will fall steadily and regional prevalence rates will begin to fall slowly (the fall would be steeper except that antiretroviral treatment will save many lives). Such a package, between 2008 and 2020, is expected to achieve:

- a reduction in cumulative infections by five million;
- a reduction in the number of people living with HIV in 2020 by 3.1 million;
- a reduction in the number of AIDS-related deaths by 40 per cent; and
- a steady decline in HIV prevalence in the region.

Such a response is affordable for most countries in Asia. Also, effectively addressing HIV brings a range of wider public health benefits and helps to strengthen social development. The only question is whether Asia has the political will to become the first global success story in reversing a regional pandemic.

Leaders of Governments across Asia need to understand that effective policies and programmes will not only spare many millions of lives, they will also save large amounts of funding which would otherwise have to be spent on antiretroviral treatment and impact mitigation. Preventing an HIV infection costs a lot less than treating, caring for, and providing livelihood assistance to someone living with HIV. The Commission's analysis has shown that USD 1 investment in appropriate prevention can save up to USD 8 in treatment costs for expanding epidemic countries.

Leaders of Governments in Asia should clearly demonstrate their resolve and commitment to halt the spread of HIV in the region in time to achieve the Millennium Development Goal of reversing it by 2015.

This cannot be done in one swift move. It requires a concerted plan of action—from policy to strategy to implementation.

The argument for adequate investment in the HIV response is thus compelling. This will be possible if decisive steps are taken to implement the following recommendations.

POLICY RECOMMENDATIONS

Leadership

1. Political leaders need to acquire a deeper understanding of the dynamics of the epidemic and its impact on individuals and families. Given the important role that politicians can play in supporting the HIV responses, the Commission strongly recommends that they set up HIV committees in their parties and parliaments. The time has come to translate political resolve into effective action.
2. Besides Governments, business leaders need to assume a more proactive role in the HIV response.
3. AIDS programmes should be implemented through well-defined and efficient governance structures that are backed by strong political leadership and meaningful community involvement.
4. The mandate and membership of National AIDS Commissions should be focused on policy-making, coordination, monitoring, and evaluation. National programmes should be managed by strong leaders to expedite decentralized decision-making, and supported by a capable technical team to effectively and strategically respond to the epidemics.
5. The Country Coordinating Mechanisms under Global Fund have an important role in the performance of prevention and treatment programmes undertaken by Government and civil society organizations.
 - Reform of the Country Coordinating Mechanism process is needed to ensure that they operate in a more democratic and transparent manner, and encourage more meaningful involvement by civil society partners.
 - Global Fund funding decisions should be solidly grounded in the epidemiological realities of countries.
 - Linkages between the Country Coordinating Mechanisms and National AIDS Commissions should be clearly and explicitly defined for stronger and more effective coordination and management at country-level.

6. Countries should understand their epidemics and tailor the response accordingly. Each country has to strengthen its epidemiological and behavioural information systems to achieve the best possible, up-to-date understanding of its epidemic. The methodologies used to achieve such understanding should be regularly re-assessed (including through peer review) with a view to constant improvement. HIV policies and programmes must be guided by country-owned HIV and AIDS estimations and projections, and by the sound analysis of evidence relevant to successful prevention, treatment, care, and impact mitigation programmes.
7. A Regional Reference Group for Asia should support, review, and validate country estimates and projections on HIV infections and resource needs, as well as set appropriate standards to guide programmes and policies.
8. Each country should conduct a biennial HIV Impact Assessment and Analysis through a high-level Government body. That body should:
 - review the latest epidemiological evidence;
 - identify new HIV 'hot-spots';
 - analyse factors (including rapid economic and social changes) that can increase HIV transmission and hinder effective responses;
 - assess the current HIV response (across various sectors); and
 - project the impact of the epidemic (from the household level onward).

Environment

9. Legal provisions should not hamper or disrupt effective efforts to control or treat HIV. Rather than trying to address HIV risk and transmission among groups most at risk as a legal issue, health-enhancing services should be made available or improved. Governments should remove legislative, policy, and other barriers to strengthen their access to services. They may also issue legislative and/or administrative directives to the police, correctional, and judicial services to facilitate the provision of HIV-related services to people most at risk. Similarly, donors must remove conditionality or policies that prevent their partners from supporting organizations that work with sex worker organizations.
10. Governments should repeal or amend laws or regulations that enshrine HIV-related discrimination, especially those that regulate

the labour market, the workplace, access to medical and other forms of insurance, healthcare, educational and social services, and inheritance rights (particularly of women).

11. 'AIDS watchdog bodies' should be established to monitor and address HIV-related discrimination in healthcare settings, in workplaces and educational institutions, and in the wider society.
12. One proven way of reducing stigma against people living with HIV is by enabling and supporting their efforts to organize themselves as HIV advocates, educators and activists—as well as to forge partnerships with the media, healthcare providers, governmental and other civil society organizations.
13. Given the high imprisonment rates of people who are most at risk, Governments are advised to ensure that prisons and other correctional institutions provide prisoners with HIV information and essential prevention services.
14. Promoting and supporting AIDS activism and civil society advocacy are important. Activism and advocacy, through HIV champions, community-based organizations, social movements, civil society, and voter constituencies, are essential to prevent HIV from falling off the priority of political agendas.

Impact of Interventions

15. Current HIV programmes can be classified into four categories: Low-cost/High-impact, High-cost/High-impact, High-cost/Low-impact, and Low-cost/Low-impact. High-impact interventions, such as prevention focused on populations at risk and antiretroviral treatment, should constitute the core of the HIV response.

Resources

16. If countries committed resources to the response of the order of USD 0.50–USD 1.00 per capita range as proposed in Chapter 3, HIV epidemics in Asia could be reversed, 40 per cent of AIDS-related deaths could be averted (through the provision of antiretroviral therapy), and 80 per cent of women and orphans could be provided with social security protection and livelihood support.
17. Additional resources should be mobilized to leverage and support activities that address some of the underlying drivers of the HIV epidemics, such as:

14 Redefining AIDS in Asia

- the prevention and treatment of sexually transmitted infections (aimed at the general population, as opposed to most-at-risk groups),
 - condom promotion and provision for the general population,
 - health systems strengthening measures, such as blood safety and universal precaution systems,
 - sex education for school students,
 - strengthening social and health sector infrastructure, and
 - women's empowerment programmes.
18. Governments should reduce their dependency on external financial support and invest more in their national HIV response.

Interventions

19. Interventions that can have the quickest, largest, and most sustainable effect on reducing HIV transmission and the impact of the epidemic must be given priority in allocating HIV resources. When the essential elements of prevention interventions are defined with clear criteria for monitoring and provision, interventions could be scaled-up to the level needed to reverse the epidemic.
20. Governments must assume responsibility for ensuring that free antiretroviral therapy is available and accessible to all who need it. A comprehensive package and continuation of effective treatment (that is, first and second-line antiretroviral drugs) should be accessible to those who need it. Antiretroviral treatment programmes should be integrated into the general health care systems of countries.
21. Asian Governments should include impact mitigation as an integral part of their national HIV responses. By integrating treatment and impact mitigation programmes into existing national social security systems, HIV provides countries with a valuable opportunity to strengthen their social protection programmes against catastrophic health and other expenditures.
22. At a minimum, impact mitigation programmes should have at least four components: women-friendly income support programmes for affected households; support for families caring for children orphaned by AIDS; care for AIDS-affected people incorporated into social security schemes; and laws to guarantee inheritance rights for both women and men.

Community Involvement

23. Community and civil society involvement should be ensured at all stages of policy, programme design, implementation, monitoring,

and evaluation. Accountability to such responsibilities should be strengthened through greater transparency, democratic governance, and improved preparedness.

24. Community organizations should establish systems and structures to support effective participation and ensure accountability of their conduct and performance. Through the formation of national alliances, community organizations can assign representatives to national bodies such as Country Coordinating Mechanisms and National AIDS Commissions on the basis of an open and transparent selection process. Community organizations need to develop procedures and policies to inform collaborative processes, including the selection of representatives and accountability procedures.
25. Regional inter-governmental organizations, like ASEAN and SAARC, should take leadership in enhancing HIV responses and serve as platforms for promoting new understanding and approaches across the region. They should assume a stronger role in negotiations on antiretroviral drug prices, and regular monitoring of the AIDS response in member countries in high-level political forums.
26. The UN should continue to advocate for greater financial and political commitment from countries, based on its comparative advantage in this area.
27. UNAIDS should develop and support a strategy that pertains specifically to Asia's HIV epidemics and responses, and should ensure that UN agencies provide coherent technical and managerial support to realize such a strategy at country and regional levels.

STRATEGIES AND PROGRAMME IMPLEMENTATION

A. Prevention

28. Prevention programmes must focus on interventions that have been shown to work and that can reduce the maximum number of new HIV infections. Governments can do the following:
 - Facilitate and support the introduction of integrated, comprehensive harm-reduction programmes that provide a full range of services to reduce HIV transmission in drug injectors: The harm reduction package should include needle-exchange, drug substitution, and condom use components, as well as referral services (for HIV testing and antiretroviral treatment).
 - Increase the consistent use of condoms during paid sex: More sex work interventions based on peer education should be introduced and scaled up. Government has a key responsibility

to ensure that condoms are available, accessible, and affordable to sex workers and their clients. Female condoms (especially in paid sex) should be encouraged as an empowering measure for women and should be introduced where the operational feasibility of so doing has been demonstrated.

Political and social leaders should be involved in mass information campaigns to educate the public about the numerous public health benefits of condom use.

- Reduce HIV transmission among men who buy sex: clients of sex workers must be a central focus of HIV prevention programmes in Asia. Interventions should target clients of sex workers through powerful mass media campaigns, which can instil a virtual and lasting norm of condom use during paid sex.

To reach clients of sex workers, HIV education and services (such as treatment for sexually transmitted infections, and condom promotion) should be provided in work settings that tend to be associated with demand for sex work.

Programmes targeting commercial sex clients should not be morally judgemental but pragmatic, providing clients with the necessary information and services to protect them and others against HIV infection.

- Reduce HIV transmission during sex between men: A comprehensive programme to prevent infections among men who have sex with men should include intensive HIV education (especially peer education), provision of condoms and water-based lubricants, access to services for managing sexually transmitted infections, as well as support for local advocacy and self-organization.
- Protect wives of men who buy sex, inject drugs or have sex with other men: High-quality operational research is needed to improve HIV interventions aimed at reaching those women who are likely to be exposed to HIV by their husbands.

Reproductive health services should be used as an entry point to increase women's access to HIV prevention, testing, and referral services.

Improvements in the accessibility and quality of antenatal care and institutional delivery are needed to improve access to HIV (as well as other health care) services.

29. Creation of an enabling environment for HIV interventions is an essential prerequisite to an effective response. An enabling environment at the local level requires advocacy with opinion

leaders and law enforcement authorities, so that sex workers, drug injectors, and men who have sex with men are allowed to form networks, while also being protected from harassment and violence.

30. Activities related to creating an 'enabling environment' must be costed for HIV interventions, particularly at the project level; such 'enabling' activities need to be factored into intervention costs.
31. Avoid programmes that accentuate AIDS-related stigma and can be counterproductive. Such programmes may include 'crack-downs' on red-light areas and arrest of sex workers, large-scale arrests of young drug users under the 'war on drugs' programmes, and mandatory testing for HIV.
32. Other prevention programmes, like the following, can be highlighted by AIDS but must be incorporated into the relevant sectoral programmes to ensure long-term sustainability:
 - Providing sex education in schools and colleges to equip young people with the information that can help them avoid or reduce risky behaviours.
 - Ensuring that HIV media campaigns are forthright, accurate, and effective through close monitoring of and collaboration between advertising and media professionals and AIDS experts/specialists.
 - Protecting healthcare workers who are exposed to HIV infection, through provision of post-exposure prophylaxis.

B. Treatment and Care

33. The conduct of HIV testing and counselling should aim to strike a balance between individuals' rights to privacy, confidentiality and choice on the one hand, and the public health need for strategic information about infected populations on the other.
34. Governments must establish and maintain systems that provide continuous and sustainable access to antiretroviral therapy for all who need it, by ensuring the following:

Affordability: Reducing the cost of antiretroviral drugs, including pooled procurement, joint negotiations, and tiered or differential pricing, as well as risk-pooling mechanisms, such as insurance and social security programmes. Strategies to reduce drug prices should also be explored, including invoking compulsory licensing for second-line drugs and using parallel importation.

Availability: Making both first- and second-line antiretroviral drugs meet international quality standards and are available in sufficient quantities to meet national needs.

Accessibility: Ensuring antiretroviral therapy, laboratory tests and related treatment services are accessible to all, through subsidizing transport and other essential costs to ensure that the poor enjoy equitable access to treatment programmes; and by integrating outreach providers from communities into antiretroviral programmes, and to create an enabling environment to improve access for marginalized groups.

Adherence: Maintaining adherence to treatment regimens, through support systems or groups, to sustain the effectiveness of antiretroviral therapy and limiting the emergence of drug resistance.

35. Strengthen the linkages between HIV and tuberculosis diagnosis and treatment to boost service delivery under both programmes.

C. Impact Mitigation

36. Impact mitigation programmes should be an essential component of national HIV responses, keeping particular focus on poor households, affected women and children. Impact mitigation programmes must reach and serve the needs of affected households, through income-generation and livelihood security for affected women, and cash transfers and education subsidies for foster families to children orphaned by AIDS.
37. Governments should review and, if necessary, amend insurance regulations so that people infected with HIV have equitable access to life and health insurance coverage.

D. Organizational Issues

38. A policy and programme analysis unit should be established and appropriately located within the national AIDS infrastructure, to make maximum use of available data to guide, monitor, and evaluate responses. The unit should collate existing sources of data (epidemiological, behavioural, response indicator, financial, etc.), assess their quality, build country-specific epidemiological models, and use the data and models to determine the relative costs and effectiveness of various strategic options.

39. Streamlining of funding flows to community projects is needed through the creation of public–private partnership structures. An autonomous board or trust, with both Government and community representatives, could collect funds from Government and donors, and disburse those funds to community groups for implementing programmes.
40. Supporting and building the capacity of organizations that represent most-at-risk populations and people living with HIV is important for scaling up HIV programmes and ensuring their sustainability. Donors and Governments must ensure that community organizations receive adequate technical and financial support to assist in programme design and implementation.
41. It is important to address appropriate service delivery mechanisms to ensure a suitable mix of focused and integrated approach, in the following manner:
 - Prevention services for most-at-risk populations should be entrusted to community-based and other civil society organizations, with strong administrative and financial support from Government or other institutions and should be directly implemented by them. Resources should be earmarked to build the capacity of these organizations.
 - Better integration is needed of programmes for preventing mother-to-child transmission of HIV, HIV counselling and testing, and treatment and care into healthcare systems.
 - Programmes for prevention, treatment, and impact mitigation should all have a focused delivery component, directly supervised by the AIDS programme, while other components should be embedded in the existing programmes in different sectors.

Governments must fulfil the commitment they have made via international political instruments such as the Declaration on Universal Access for prevention, treatment, care and support by 2010 as well as Millennium Development Goal 6 to halt and reverse the epidemic by 2015.

The Commission is optimistic and believes that Governments in Asia have the information, the institutions, and the means to achieve huge reductions in new HIV infections. If they deploy their money, staff and partnerships effectively, they will be able to meet these optimistic targets.

The most important ingredient is political will. If the Governments of Asia choose to meet the challenge and take the decisive steps set out in this Report, then the battle against HIV in Asia can be won.

I

The Challenges Ahead

AN HIV RESPONSE AND UNFOLDING REALITIES

Asia can pride itself on being home to some of the world's most dynamic economies and rapidly changing societies. It has distinguished itself in the past by confronting health challenges in a pragmatic fashion, that is, in its responses to outbreaks of SARS and H5N1 avian influenza. The same pragmatic approach is needed if Asian countries are to gain the upper hand over HIV epidemics.¹

According to UNAIDS and WHO estimates, 4.9 million (the lower and upper estimates are 3.7 million and 6.7 million respectively) people were living with HIV in Asia in 2007, including the 440,000 (210,000–1.0 million) people who became newly infected in that year. Approximately 300,000 (250,000–470,000) people died from AIDS-related illnesses in 2007.²

Overall, an estimated 9 million Asians have been infected with HIV since it first appeared in the region more than 20 years ago. Approximately 2.6 million men, more than 950,000 women—many of them in their 20s and 30s—and almost 330,000 children have died of AIDS-related diseases.

AIDS will cause a total loss of 180 million years of healthy and productive life in Asia between 2002 and 2020—more than any other disease (see Chapter 3).³

Despite the progress made on prevention and treatment in many countries in Asia and the declining trend of new HIV infections in some,

¹The countries surveyed are provided in Annex 1 to this Report.

²UNAIDS/WHO (2007), *2007 AIDS Epidemic Update*, Geneva: UNAIDS.

³This estimate is based on the number of disability-adjusted life years (DALYs) and potential years of life lost due to premature death. DALYs measure the equivalent years of 'healthy' life lost due to poor health or disability, and potential years of life lost due to premature death. One DALY equals one lost year of 'healthy' life.

AIDS currently accounts for more deaths annually among 15–44 year-old adults than does tuberculosis and other diseases.⁴

The likely trajectories of the HIV epidemics in Asia have been the subject of much speculation. At one extreme, dire warnings have been given that the populous countries of the region could see their epidemics spin out of control and approach the scale and intensity of those raging in parts of Africa. At the other end, complacency seems to prevail, and it is argued that social norms and mores in Asian societies will hold HIV in check, even with minimal prevention efforts.

As our understanding of HIV epidemics in Asia improves, it becomes clear that neither of those scenarios fit the actual picture, and they may actually lead to further confusion.

Indecisive or misdirected HIV responses have been one outcome of this confusion. The importance of focusing resources on effective programmes has sometimes been neglected. Another consequence has been the failure to recognize the socioeconomic impact epidemics are having on households and communities in Asia.

Overall, Asia's response has neither matched nor kept pace with the unfolding realities of HIV epidemics.

THE COMMISSION ON AIDS IN ASIA: A FRESH PERSPECTIVE

It was this realization that led to the creation of an independent Commission on AIDS in Asia. This body was asked to review the scientific evidence surrounding the spread of HIV in Asia, assess the medium- and long-term impact of AIDS on Asian societies, and propose practical HIV responses that can have the maximum effect on Asia's HIV epidemics.

Since its establishment in June 2006, the Commission on AIDS in Asia has collected a mass of data and evidence, which has formed the basis of its Findings and Recommendations. The Commission's work has included:

- reviewing over 5,000 papers and commissioning almost 30 new studies in the areas of epidemiology, socioeconomic impact and resource allocation, the role of civil society, the status of different national responses, and best practices;
- engaging more than 30 specialists to examine and propose new and innovative ways to address the epidemics in Asia;

⁴Based on estimates derived from the Asian Epidemic Model, 2007.

- convening sub-regional workshops and country missions where the Commission heard testimonies on the HIV situation and responses from Government and civil society representatives.

WHAT MAKES ASIAN EPIDEMICS UNIQUE?

Chapter 2 is central to the Report. It examines the epidemiology of HIV in Asia in some detail and outlines the policy implications of these findings. Crucially, it emphasizes the need for HIV responses that focus on those population groups that are most-at-risk of getting infected with HIV and most likely to transmit the virus to others.

Although HIV epidemics vary considerably from country to country in the Asian region, they share important characteristics, and are centred mainly around:

- unprotected paid sex,
- the sharing of contaminated needles and syringes, and
- unprotected sex between men.

It shows, in particular, that men who buy sex are the single-most powerful driving force in Asia's HIV epidemics. Since most men who buy sex are either married or will get married, significant numbers of ostensibly 'low-risk' women who only have sex with their husbands are exposed to HIV. In several Asian countries currently, as many as 25–40 per cent of new HIV infections are among spouses and girlfriends of men who got infected during paid sex, injecting drugs, or having sex with other men. Effective means of preventing HIV infections in female partners of most-at-risk men have yet to be developed in Asia, but such prevention is clearly a crucial piece of the puzzle.

The Commission estimates that up to 10 million Asian women sell sex and at least 75 million men buy it regularly. The fact that HIV circulates freely among those commercial sex networks means that millions of women who are or will be married to current or past male clients of sex workers are potentially at risk of HIV infection.

Male–male sex and drug injections add another 20 million or so to the number of men at high risk of HIV infection once the virus enters those networks. A portion of those men, particularly injectors, may pass HIV on to the women they have sex with regularly, which means that several million more women are then also at risk.

But because relatively few women in Asia have sex with more than one partner, the chain of HIV infection tends to end once wives and girlfriends become infected. Some might transmit HIV to their unborn

children, but the probability of those women passing HIV to another man is generally very small.

HOW CAN ASIAN COUNTRIES PREVENT THE SPREAD OF THEIR HIV EPIDEMICS?

HIV epidemics in Asia are highly unlikely to sustain themselves in the 'general population' independently of commercial sex, drug injecting, and sex between men. The most effective way to protect women who, ostensibly, should be at low risk of HIV infection is by preventing their husbands and boyfriends from getting infected. And, most important, prevention efforts that drastically reduce HIV transmission among and between these most-at-risk groups of people will bring the epidemics under control.

The basic components of such programmes are known and have been shown to be effective in various countries around the world, including in Asia. The technical and institutional design of such programmes is not a significant obstacle. Nor are the financial costs a major hurdle, as the analysis in Chapter 3 confirms. And yet, as Chapter 5 shows, only a handful of countries in Asia have introduced such programmes.

The main constraint, it seems, is the lack of effective political leadership in bringing about a change in social attitudes. Asia's HIV epidemics are centred primarily on behaviours which 'polite' society frowns upon, yet which are widely disseminated throughout the population-at-large. As many as one in five Asian men have purchased sex at some point in their lives. Other directly affected groups—such as sex workers, injecting drug users, and men who have sex with men—are often socially stigmatized and harassed.

Admittedly, some Governments find it uncomfortable devoting resources to help people protect themselves from the health consequences of behaving in a manner that is illegal or that society scorns. This is why mature and far-sighted political leadership is so important for establishing and championing the policies and priorities for programmes that can reverse HIV epidemics.

A strictly service-delivery approach to HIV, however, is not enough. 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.

Countries need to carefully re-assess their epidemics and risk profiles on a regular basis to determine which prevention interventions should be prioritized. Because of the broad commonalities in the way HIV spreads in Asia, the question ‘what should we be doing’ will always be guided by the stage each country’s epidemic has reached, as discussed in Chapter 2.

As Chapter 3 argues, Governments also have a material interest in ensuring that effective HIV prevention is in place. Prevention can reduce the number of people who will need to be provided with treatment and care in the future, and can also reduce the potential impact of the epidemic on individuals, families, and societies as well, sparing millions of lives. The key point is that preventing an HIV infection costs a lot less than treating, caring for, and providing livelihood assistance to a person who is infected.

WHAT SHOULD ASIAN COUNTRIES DO TO CARE FOR PEOPLE LIVING WITH HIV AND THEIR FAMILIES AND MITIGATE THE IMPACT OF THE EPIDEMIC?

Chapters 4 and 5 examine some of the social, economic, and cultural factors that promote risky behaviours and that tend to undermine effective prevention, treatment, and impact mitigation programmes. Chapter 4 is particularly concerned with what might be called the ‘social drivers’ of HIV, for example, poverty, income and gender inequality, inadequate education, the stigmatization of groups most at risk, and so on. Chapter 5 looks at different national responses to the epidemics in the Asian region. Together, the chapters suggest how these areas must be addressed in order to achieve large-scale and effective provision of HIV prevention, treatment, and care services.

Even those Governments that provide only rudimentary health services have pledged to ensure widespread access to treatment and care for HIV-positive persons. That is an expensive undertaking. Although the cost of most commonly used antiretroviral drugs has fallen dramatically in recent years, such drugs are still far more costly than prevention services. Second-line drugs⁵ are much more expensive.

In the short- to medium-term, the demand for treatment will remain considerable. In the longer-term, irrespective of the success of prevention

⁵Second line’ drugs are required when patients develop resistance to the original drugs used.

efforts, much more can be done to reduce the costs of treatment and care. For example, Governments should negotiate price reductions more forcefully and make more effective use of the flexibilities inscribed in international trade agreements (such as compulsory licensing)—all of which can reduce the costs of antiretroviral and other pharmaceutical drugs. Partnerships with civil society, as examined in Chapter 5, could boost those efforts.

Chapter 6 discusses the key roles that community organizations must play in this respect. In general, a ‘top-down’ solution can never be fully effective unless accompanied by strong community involvement. But although everyone agrees in principle with the notion of community involvement, clarity is needed about which communities need to be involved and how Governments and international organizations can best aid this process.

With regard to the treatment of those already infected, although most Governments meet a significant share of treatment costs, it is sometimes forgotten that many other costs associated with chronic illnesses and death of adults of working age are borne mainly by their families. These impacts are disproportionately felt by the poor, who are least able to afford them. There is an urgent need for Governments to provide access to treatment and stronger social and economic protection for these households—and especially for women and children who disproportionately bear the impact of the epidemic.

Ultimately, those welfare obligations will be reduced as access to antiretroviral treatment increases and more and more people affected by AIDS remain productive, employed, and care for their families. The costs of treatment will be more than offset by the benefits of keeping people healthy and productive. Investing in a solid and sustainable treatment programme is one of the effective ways of mitigating the impact of the epidemic on people living with HIV and their families.

MAKING A DIFFERENCE: A CALL FOR STRONG AND MATURE LEADERSHIP

The Commission recognizes that Asian Governments are increasingly responsive to the global nature of infectious diseases. The recent outbreaks of SARS and avian influenza have underscored the fact that pragmatic methods based on sound science are the most effective ways of dealing with infectious disease and other public health challenges.

After reviewing and analysing scientific and other evidence of Asia's experiences with HIV, the Commission has compiled a detailed set of recommendations which is presented in Chapter 7.

The Commission believes that Governments in Asia have the information, the institutions, and the resources to considerably reduce new HIV infections. The unique nature of Asian epidemics, the currently low prevalence, the strength of public and private systems, and economic prosperity in the region create an opportunity unavailable in many parts of the world. If Governments in Asia deploy their financial and human resources prudently, and strengthen partnerships with non-Government and community sectors, they will be able to halt and reverse the epidemic within the time-frame set in global declarations on Universal Access and achievement of the Millennium Development Goals (MDGs). All these recommendations are pragmatic, feasible, and affordable.

The most important ingredients for success are the Governments' leadership and commitment in mounting effective prevention and care efforts, together with the involvement of affected communities and other civil society entities. If the Governments of Asia choose to meet these challenges and put in place the steps outlined in this Report, the battle against HIV in Asia can be won.

2

The Future of HIV in Asia

CHAPTER SUMMARY

- Almost 5 million Asians are currently infected with HIV; in 2007 itself some 440,000 people were infected with HIV and 300,000 died of AIDS-related diseases.
- Asia's HIV pandemic is now entering a second growth phase, which could push HIV prevalence to almost 10 million by 2020 if expanded prevention efforts are not introduced.
- Both the doomsday scenarios of ever-expanding epidemics and the notion that Asia's epidemics will automatically 'run out of steam' are misplaced.
- HIV epidemics in Asia continue to grow, but HIV responses in many countries still do not reflect the urgency of the situation.
- Reliable HIV data is a precondition for taking effective action against the epidemics. Countries should assess the epidemics regularly and adapt their responses accordingly.
- Current HIV surveillance systems are overly dependent on limited data sources. Countries need to examine multiple sources of data to come to an accurate understanding of the patterns, trends, and scale of the epidemics. Even where limited epidemiological findings are available, they are not used to inform policy and implementation strategy.
- HIV transmission in Asia is driven primarily by three high-risk behaviours: unprotected commercial sex, injecting drug use, and unprotected sex between men.
- HIV programmes should aim to prevent the maximum number of new HIV infections and this means focusing interventions on population groups that are *most-at-risk* of getting infected.

- But, Asia's epidemics are not limited to these most-at-risk populations. In many countries, adult men who buy sex, and their female partners, constitute the largest group of people living with HIV.
- Three out of four adults living with HIV in Asia are men, but the proportion of women infected with HIV has also risen gradually. Most of them are in steady relationships, and are being infected by husbands and boyfriends who, currently or in the past, engaged in high-risk sex or drug injecting.
- The most sensible way to prevent HIV infections in women is to prevent their husbands from becoming infected through paid sex and drug injecting.
- Dynamic economic and social changes are underway in Asia, and high-quality research is needed to know what effects these may have on the evolution of HIV epidemics. But in most Asian countries, an increase in casual and premarital sex among women, by itself, is unlikely to lead to a net increase in new HIV infections.
- A new method of analysis of the various stages of the epidemic has been recommended. This will help Asian countries understand the stages of the epidemic better—than through the existing epidemiological classification of 'low', 'concentrated', and 'generalized' epidemics—and to tailor the responses accordingly.



ASIAN EPIDEMICS PRESENT MAJOR CHALLENGES AND OPPORTUNITIES

This chapter examines the characteristics of Asia's HIV epidemics, sketches the likely futures of those epidemics, and proposes a framework for addressing them.

When expressed as a proportion of the region's large population, HIV prevalence in Asia seems low. Nevertheless, the absolute numbers are large. Almost 5 million Asians are currently infected with HIV, some 440,000 people got infected with HIV and 300,000 people died of AIDS-related diseases in 2007.¹ Regionally, AIDS is estimated to be the single largest cause of death and morbidity due to disease for adults aged 15–44 years.^{2,3}

Our understanding of epidemics in Asia has improved considerably in recent years. It is now clear that HIV transmission in this region is driven primarily by three high-risk types of behaviour: unprotected commercial sex, injecting drug use, and unprotected sex between men.⁴

Other important insights have also emerged. Although the epidemics are not confined to marginalized populations, the doomsday scenarios of ever expanding epidemics in Asia, are, on current evidence, quite misleading. The epidemic is predominantly concentrated among particular groups, and it can be contained if policies are targeted accordingly.

Although high-risk behaviours drive the epidemics (see Box 2.1), an increasing number of women in Asia are becoming infected—even though the majority of them are in steady relationships and practise none of those behaviours. Most of these women are infected by husbands and boyfriends who engage in high-risk sex or drug injecting.

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, drug injectors, and men who have sex with men).

Nevertheless, the extent of risky behaviours means that national adult HIV prevalence could potentially reach 5–10 per cent in some Asian

¹UNAIDS/WHO (2007), *2007 AIDS Epidemic Update*, Geneva: UNAIDS.

²Estimations and calculations of death and morbidity due to AIDS for Asia are detailed in the Technical Annex.

³Estimations and calculations of death and morbidity for other diseases are based on C. Mathers and D. Loncar (2006), 'Projections of Global Mortality and Burden of Disease from 2002 to 2030', *PLoS Medicine*, 3 (11), pp. 2011–30. Country figures made available by Mathers and Loncar.

⁴The Commission estimates that these high-risk behaviours account for 75 per cent or more new infections in the region.

countries.⁵ There is no evidence at present that these patterns of HIV spread will change substantially in the foreseeable future. At the same time, dynamic economic and social processes leading to changes are taking place in many Asian countries (as discussed below) and it remains

Box 2.1: The Main Pathways of Asia's HIV Epidemics

Generally in Asia, once HIV becomes well-established in a country, the epidemic's evolution depends largely on two key factors: the extent and frequency with which men buy sex and the sexual behaviour of women (outside of commercial sex).⁶

Male client's behaviour determines epidemic speed and severity

As Figure 2.1 illustrates, the larger the number of men who buy sex and the more often they do so, the bigger the HIV epidemic is likely to become.

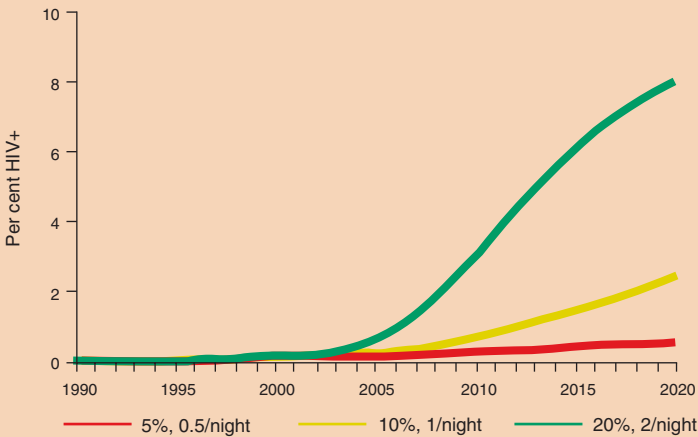


Figure 2.1: Male clients of female sex workers: a key actor in Asia's HIV epidemics

Source: Modelling using the Asian Epidemic Model (see Box 2.2)

Note: Percentage denotes male clients of female sex workers as a percentage of adult male population; number per night denotes average number of clients per sex worker per night.

⁵The Commission's research and projections (using the Asia Epidemic Model) show that had there been no change in condom use and the number of men visiting sex workers in Thailand and Cambodia, national HIV prevalence could have reached as high as 8–10 per cent by 2007.

⁶The partially protective role of circumcision has been factored into these calculations. However, in the current context of Asia, the Commission does not consider circumcision

For example, where 20 per cent of adult men visit female sex workers at least once a year (such as in Cambodia and Thailand), had effective measures not been taken, it is estimated that by 2020 national adult HIV prevalence could have reached 8–10 per cent. Similarly, where 10 per cent of adult males buy sex (as is the case in several Chinese provinces and Indian states), national adult HIV prevalence could potentially reach 5 per cent.⁷

...and puts wives and other female sexual partners at risk

Currently in Asia, most HIV infections in women who do not sell sex are attributable to their husbands' risky behaviour.⁸ The social and cultural limits placed on women's sexuality in most Asian societies means that a majority of women abstain from sex until married, after which they tend to be monogamous.⁹ By far the majority of women in the countries studied in Asia have reported only one sexual partner in the last year compared with multiple partners reported in Africa,¹⁰ as shown in Figure 2.1. As a result, a small minority of women who are infected with HIV are likely to transmit the virus to someone else (besides their newborns).

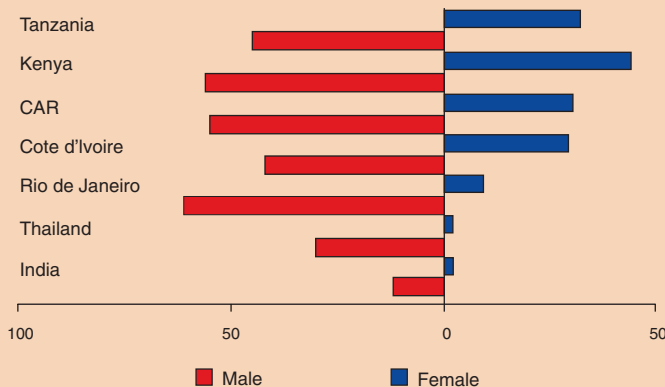


Figure 2.2: Sexual behaviour of women around the world: percentage of 15–19 never married in urban areas having sexual intercourse in the last 12 months

Source: Adapted from M. Carael (1994), with additional data from NFHS India.

to be a priority prevention measure when projecting the likely outcomes of comprehensive intervention scenarios.

⁷For more details, please refer to the Technical Annex.

⁸R.R. Gangakhedkar, *et al.* (1998), 'Spread of HIV infection in married monogamous women in India', *Journal of the American Medical Association*, 278 (23), pp. 2090–2.

⁹The possibility of under-reporting of self-reported sexual behaviour of women across major parts of the world does not change the main conclusion.

¹⁰M. Carael (1995), Chapter 4, 'Sexual Behaviour', in J. Cleland and B. Ferry (eds), *Sexual Behaviour and AIDS in the Developing World*, London: Taylor & Francis.

uncertain what effects such changes might have on the evolution of HIV epidemics in the region.

For the foreseeable future, then, Asia's epidemics will derive most of their momentum from significant levels of HIV transmission during unsafe paid sex, drug injecting, and/or sex between men. This epidemiological reality translates into a major challenge and opportunity.

These generic patterns of the HIV epidemics in Asia 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 drug injection safer can be politically, socially, and operationally difficult—even though these are hardly isolated behaviours in Asia, or elsewhere in the rest of the world.

It bears repeating that in Asia, close to 100 million men and as many as 10 million women engage in at least one of these risky behaviours, and many more women may be at indirect risk because their husbands or boyfriends inject drugs or practise unsafe sex, or did so in the past.¹¹

Box 2.2: The Asian Epidemic Model: Analysing the Implications of HIV Policies in Asia

HIV epidemics in Asia share many similarities. The large number of commercial sex clients creates fertile ground for HIV to spread. The sharing of needles among injecting drug users causes HIV to spread rapidly, while men who have sex with men contribute an increasing number of new infections as the regional epidemic among them grows. The size of these populations, their levels of risk behaviour, and the starting points of HIV transmission vary from country to country. But the overall pattern tends to be consistent across the region.

In 1998, the East-West Center and its Asian collaborators began developing the Asian Epidemic Model, a policy tool based on the common regional patterns of HIV spread. The model incorporates the key populations affected by HIV epidemics in Asia: clients and sex workers, injecting drug users, men who have sex with men and the wives of these most-at-risk men. Using country-specific data on the sizes and behaviours of these groups, the model simulates the transmission of HIV from one person to the other

¹¹The estimate is derived from a synthesis of estimated population size of different most-at-risk population groups in the countries of the region. References for the data sources are available in the Technical Annex.

through unprotected sex, needle-sharing, and mother-to-child transmission. This allows for the development of country-specific models that capture diversity in the factors driving the epidemics in various countries of the region.

One important feature of the Asian Epidemic Model is that it directly compares its calculations of HIV levels against the observed trends, as shown in Figure 2.3, which provides a valuable check on how well the model is reproducing actual trends. The Center and its collaborators have applied

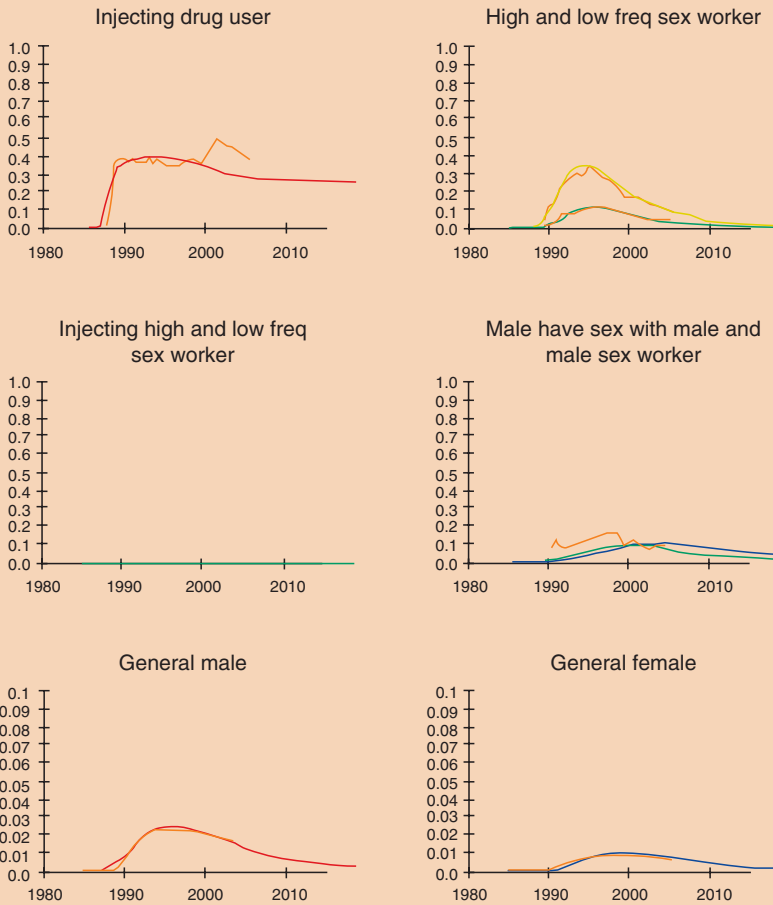


Figure 2.3: The Asian Epidemic Model directly compares its calculations with observed trends of HIV transmission in all key populations affected by the epidemics, as shown in this figure for Thailand

Source: Asian Epidemic Model. Full details of the model are provided in the Technical Annex.

the Asian Epidemic Model and found close agreement between the predicted and observed HIV trends in settings as diverse as Cambodia, Thailand, Jakarta (Indonesia), Ho Chi Minh City (Viet Nam), and Guangxi and Yunnan provinces in China.

The model projects future HIV trends based on the population sizes and risk behaviours that are provided as inputs. This makes it a powerful tool for policy analysis. One can use it to generate ‘what if’ scenarios: What if Cambodia had not increased condom use between sex workers and clients to 90 per cent in the 1990s? What would have happened if the injecting drug user epidemic in Jakarta had never occurred? Examples of these types of analyses are included in this chapter.

In addition to projecting HIV trends, the Asian Epidemic Model also provides detailed information on how new infections are distributed among different key populations. In doing so, it can help pinpoint where prevention efforts can have the greatest impact on the national epidemic (see Figure 2.4).

By estimating the extent of behaviour change resulting from different prevention programme packages, a user of the model can also explore the effectiveness of programme choices on future epidemic trends. Coupling those effectiveness data with estimates of the costs of prevention also provides valuable guidance on maximizing the effectiveness of responses. Chapter 3 presents such analyses in more detail.

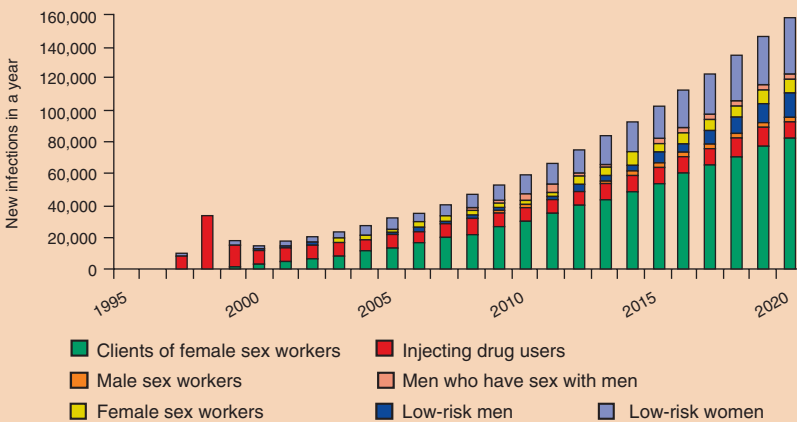


Figure 2.4: The Asian Epidemic Model makes it possible to examine the proportion of new HIV infections in each most-at-risk population. This graph illustrates the major contribution of sex work client infections in an epidemic which initially affects injecting drug users (such as in China and Viet Nam)

Source: Asian Epidemic Model for a typical Asian country, details available in the Technical Annex.

Using the Asian Epidemic Model, the Commission has prepared a set of projections for Asia, which form the basis of some of the policy analyses presented in this Report. Chapters 3 and 4 use those analyses to examine which responses in Asia are the most cost-effective and bring out the best results. The Technical Annex to this Report describes the Commission's projections and analyses in detail.

Behavioural variations explain the diversity of HIV epidemics in Asia

Beyond their basic, shared features, HIV epidemics occurring in Asia vary considerably. The extent and the pace at which they evolve differ from country to country. Often there are also significant variations *within* countries. In some areas, HIV is circulating mainly among drug injectors and their sexual partners, in others it has become entrenched in the sex trade, while elsewhere the virus has not yet established a strong presence. Those variations depend primarily on differences in the extent and types of risk behaviour being practised and the point at which HIV was introduced in these places. Notwithstanding such diversity, efforts to reduce the spread and impact of HIV in Asia have to start by examining two questions:

- Who is currently most likely to become infected with HIV?

The answer to this question requires an understanding of current levels of HIV infection and risk practices in most-at-risk groups, as well as some knowledge of the absolute numbers of people who engage in such high-risk practices. What is needed, therefore, is reliable HIV-related information.

- In the future, which behaviours are most likely to produce large numbers of HIV infections?

Here the answer requires a solid understanding of the dynamics of the epidemic: how the various groups most at risk interact with one another, and how HIV is transmitted from one group to another.

The next section explores these questions.

The risks of the sex trade

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 female sex workers; secondly, client turnover; and thirdly, levels of condom use during paid sex.

Men who buy sex outnumber drug injectors and men who have sex with men, by a large margin in Asia. It is estimated that up to 37 million men in China buy sex regularly,¹² as do about 30 million in India.¹³ Meanwhile, Indonesia estimates that more than three million men buy sex each month.¹⁴ On an average, in Asia, there are about 10 male clients for every sex worker.¹⁵ In addition, most men who buy sex from women are either already married or will get married. Infected clients or former clients potentially put more people at risk than any other population group. 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.

It follows that interventions which can prevent HIV transmission to and from male clients of sex workers are likely to be the most effective

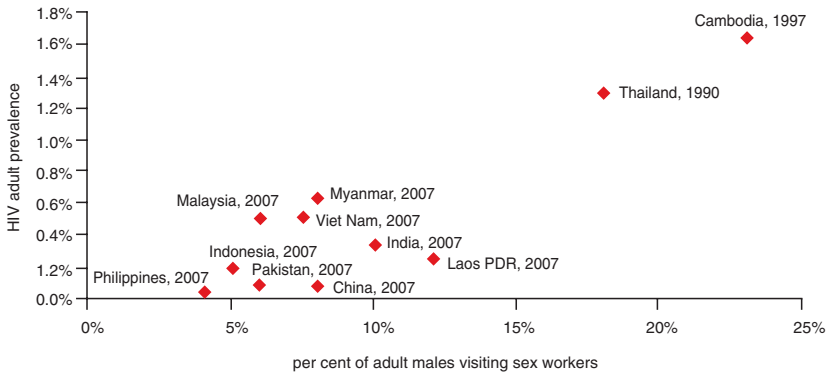


Figure 2.5: In the absence of large scale interventions, levels of HIV prevalence depend on the number of men who buy sex

Source: Graph is based on estimated national adult HIV point prevalence, the percentage of men who visit sex workers (obtained from country-specific secondary data sources). Details are available in the Technical Annex.

Note: Both male clients and HIV data for Cambodia and Thailand are for scenarios in which major interventions have not yet been introduced.

¹²F. Lu, *et al.* (2006), 'Estimating the number of people at risk for and living with HIV in China in 2005: methods and results', *Sexually Transmitted Infections*, 82 (supplement 3), pp. iii 87–iii 91.

¹³India estimates are compiled from several sources, including detailed mapping and estimations provided by the Avahan project.

¹⁴Behavioral Surveillance Survey (BSS) result in Indonesia 2004–5, Jakarta, BPS-Indonesia, Central Bureau of Statistics and Ministry of Health, 2005.

¹⁵Estimates are derived from a synthesis of estimated sizes of various most-at-risk groups in the countries of the region. References for the data sources are available in the Technical Annex.

in controlling HIV epidemics in Asia—a conclusion underlined by Cambodia and Thailand’s experiences.

Once significant behaviour change is achieved among the male clients of sex workers, such change can become permanent. In Thailand, 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 waned.¹⁶

The second factor relates to the turnover of clients. The more clients a sex worker has in a day or a week, the more opportunities there are for HIV transmission.¹⁷ 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 sex trade.

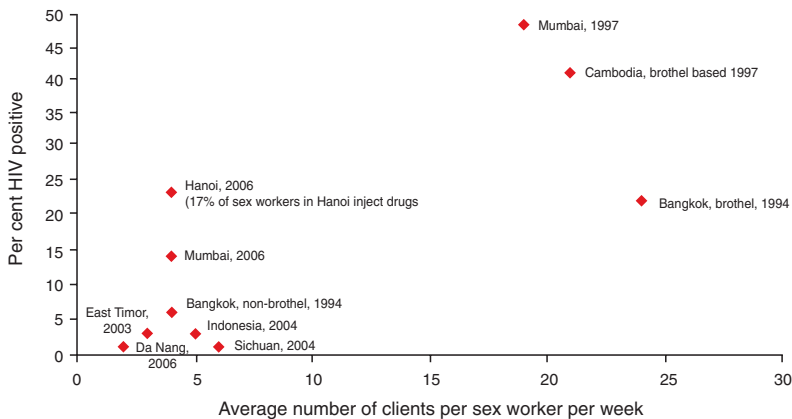


Figure 2.6: HIV spreads most quickly in settings where sex workers have large numbers of clients each week

Source: National HIV and behavioural surveillance systems

Note: Data on client turnover and HIV prevalence among sex workers are drawn from various data sets. Detailed references are provided in the Technical Annex. This graph depicts an ecological analysis and does not establish causality.

¹⁶UNDP (2004), *Thailand’s Response to HIV/AIDS: Progress and Challenges*, Bangkok: UNDP.

¹⁷The period during which HIV infectivity is highest is relatively brief, but recently infected sex workers will expose many more men to HIV during that period if their client turnover is high. To illustrate this, compare a sex worker in Mumbai (average 12 clients per week in 2006, down from 20 a few years earlier) with one in Manila (average 2 clients per week). If we assume that the period of high infectivity lasts about three months, then the Indian sex worker will expose 144 men to a very high risk of HIV

Does this mean that HIV prevalence among sex workers and their clients will stay low as long as the volume and turnover of clients is relatively low? Although HIV prevalence is unlikely to become very high among sex workers in places with low client turnover, this is true only if clients are uninfected. Many countries are seeing an infusion of HIV into commercial sex networks from other sources, primarily drug injectors. As a result, in Indonesia, Viet Nam and parts of China, for example, HIV infection levels have been rising among sex workers and clients. This rise is probably due to the large proportion of male drug injectors who buy sex (between 28 per cent and 52 per cent in four Indonesian cities in 2004, between 14 per cent and 43 per cent in seven cities in Viet Nam in 2006, and around 25 per cent in a number of sites in southwest China in 2004).¹⁸ This relationship is discussed in detail below.

The third factor involves condom use. Alarmed by a rapid rise in HIV prevalence among sex workers, the Thai authorities in 1991 launched a pragmatic campaign to encourage the use of condoms, especially in commercial sex. More clients began to use condoms more often. In northern Thailand, condom use among 21-year old men (selected by ballot for military service), rose from 63 per cent in 1991 to over 90 per cent in 1995. Simultaneously, HIV prevalence dropped among these young men (from 11 per cent in 1991 to 7 per cent in 1995)¹⁹ and among sex workers (from an 58 per cent in 1991 to a still-high 44 per cent eight years later in the northern Thai city of Chiang Rai, for example).²⁰

Similar programmes have had comparable results elsewhere. In Cambodia, HIV prevalence among 'direct' sex workers fell from 39 per

if condoms are not used, while the Filipina sex worker will expose only 24 clients. Indeed, HIV prevalence among sex workers in Mumbai rose from zero in 1987 to above 50 per cent just six years later. Among sex workers in Manila, HIV prevalence did not exceed 1 per cent. Early in Thailand and Cambodia's epidemics, when client turnover levels were similar to those in Mumbai, HIV also rose very quickly among sex workers—more than one-third of whom were infected in several cities.

¹⁸Behavioral Surveillance Survey (BSS) result in Indonesia 2004–5, Jakarta, BPS-Indonesia, Central Bureau of Statistics and Ministry of Health, 2005; National Institute of Hygiene and Epidemiology, Viet Nam Ministry of Health, and Family Health International (2005–6), *Results from the HIV/STS Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam*; China data obtained by E. Pisani, courtesy of the China UK HIV/AIDS Prevention and Care Programme, 2007.

¹⁹K. Nelson and D. Celentano (1996), 'Decline in HIV infections in Thailand', *New England Journal of Medicine*, 335 (26), pp. 1998–9.

²⁰Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health, Thailand, *HIV Serosurveillance in Thailand: Result of the 6 and 17 Rounds, 1991 and 1999*, Bangkok.

cent to 21 per cent between 1996 and 2003, and among 'bar girls' who sometimes sell sex, it declined from 18 per cent to 12 per cent over the same period.²¹ HIV prevalence among female sex workers in the Indian city of Chennai fell from 8.2 per cent in 2000 to 2.2 per cent in 2006, with some 90 per cent clients claiming they used a condom during commercial sex.²²

Box 2.3: A New Look at the Economics of an Old Trade

Commercial sex exists in every region, and Asia is no exception. In most Asian countries, female sexuality is tightly controlled, with women expected to preserve their virginity until marriage. Conversely, young men are not expected to remain celibate until married. Since the vast majority of women are not available for sex until marriage, an obvious supply/demand imbalance occurs.^{23,24,25}

Historically, sex workers have addressed that imbalance. Thus, a small number of women perform sexual services for a much larger number of men. Epidemiologically, this increases the probability of HIV transmission. Once the virus is introduced into this network of people who buy and sell sex, infection levels can rise rapidly among women who sell sex to large numbers of men (who have a high 'client turnover'). Women infected with HIV transmit the virus to clients, who in turn transmit the virus back into the small but increasingly infected pool of sex workers.

In some quarters, preventing sex work has been seen as a politically appealing way to control HIV transmission. However, such an approach only tackles one part of the equation (supply) while leaving the other (demand) untouched. This is why some researchers argue that greater sexual freedom for women may reduce the demand for commercial sex and limit HIV transmission in Asia.²⁶

²¹Cambodian national surveillance data (2005) (National Center for HIV/AIDS Dermatology and STDs Cambodia 2006).

²²Indian Council of Medical Research and Family Health International 2007; AIDS Prevention and Control Project (2006).

²³M. VanLandingham, *et al.* (1995), 'Friends, wives and extramarital sex in Thailand: A qualitative study of peer and spousal influence on Thai male extramarital sexual behaviour and attitudes', available at: <http://www.psc.isr.umich.edu/pubs/abs.html?ID=970>.

²⁴J.M. Knodel, *et al.* (1996a), *Sexuality, sexual experience and the good spouse: views of married Thai men and women*, Chiang Mai: Silkworm.

²⁵J.M. Knodel, *et al.* (1996b), 'Thai views of sexuality and sexual behaviour', *Health Transition Review*, 6, pp. 179–201.

²⁶M. Kremer and C. Morcom (1998), 'The effect of changing sexual activity on HIV prevalence', *Mathematical Biosciences*, 151 (1), pp. 99–122.

Whether through peer education (as in the Sonagachi programme in India and the SHAKTI project in Bangladesh)²⁷ or structural interventions targeting brothel managers (as in Cambodia and Thailand), increasing the rate of consistent condom use in sex work to more than 50 per cent can significantly reduce HIV transmission.^{28,29} 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.

DRUG INJECTING SPREADS HIV RAPIDLY

Sharing syringes and needles when injecting drugs is the easiest way of HIV getting transmitted. As a result, HIV prevalence can increase very quickly among drug injectors.

Several countries and areas in Asia have seen HIV infection levels soar from zero to 40 per cent or higher in only a few years. In the Nepalese capital, Kathmandu, HIV prevalence was 68 per cent among injecting drug users in 2003, while in Viet Nam's northern port city of Hai Phong, 66 per cent tested HIV positive in 2006. In Lashio, close to Myanmar's border with China, 60 per cent of drug injectors were found to be infected in 2004. In Karachi (Pakistan), HIV prevalence among injecting drug users rose from under 1 per cent in early 2004 to 26 per cent in March 2005.³⁰

Unfortunately, HIV prevalence in drug injectors does not decline as swiftly as it rises. 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

²⁷Further details on these programmes are provided in Chapter 5.

²⁸S. Jana and B. Banerjee (eds) (1997), *A dream, a pledge, a fulfilment: Five years' stint of STD/HIV intervention programme at Sonagachi*, Calcutta: All India Institute of Hygiene & Public Health.

²⁹L. Guinness, *et al.* (2005), 'Does scale matter? The costs of HIV-prevention interventions for commercial sex workers in India', *Bulletin of the World Health Organization*, 83 (10), pp. 747–55.

³⁰National Centre for AIDS and STD Control, Ministry of Health, and Family Health International (2004). *National Estimates of Adult HIV Infections: Nepal*; National Institute of Hygiene and Epidemiology, Viet Nam Ministry of Health, and Family Health International (2005–2006). *Results from the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam*; Data obtained by E. Pisani, courtesy of the China UK HIV/AIDS Prevention and Care Programme, 2007; F. Emmanuel, C. Archibald, A. Altaf (2006), 'What drives the HIV epidemic among injecting drug users in Pakistan: A risk factor analysis', Abstract MOPE0524, XVI International AIDS conference, 13–18 August, Toronto.

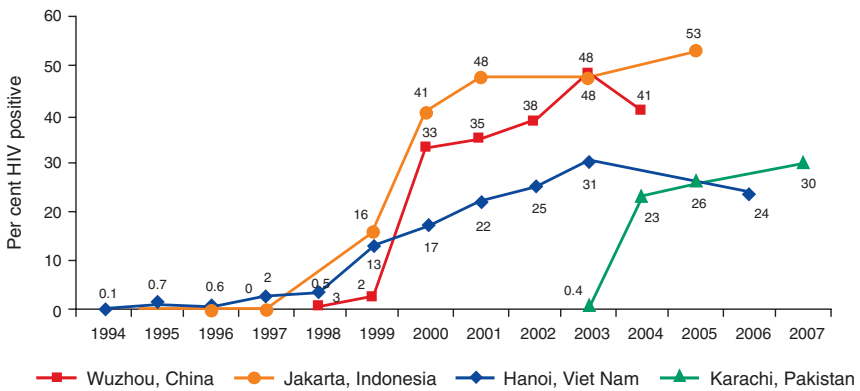


Figure 2.7: HIV can rise very quickly among drug injectors, and reach very high levels

Source: National surveillance reports from each country (cited elsewhere in the Report).

show that it takes 7 to 10 years before a substantial drop in prevalence is observed.^{31,32}

The most effective course of action is to prevent HIV infections among injectors before prevalence soars. In countries and regions where the opportunity still exists, early intervention will be far easier and cheaper than trying to curb rampant HIV spread among injectors and their sexual partners. In China, Hong Kong Special Administrative Region (Hong Kong SAR) opted for this route, and its harm-reduction programme has helped keep HIV prevalence among drug injectors low for many years.³³

Countries and areas where HIV prevalence among injectors is still relatively low (including Bangladesh, Pakistan, several cities in eastern

³¹C.D. Des Jarlais, *et al.* (2000), 'Behavioral risk reduction in a declining HIV epidemic: injection drug users in New York City, 1990–1997', *American Journal of Public Health*, 90 (7), pp. 1112–16.

³²A.G. Davies, R.M. Cormack, and A.M. Richardson (1999), 'Estimation of injecting drug users in the City of Edinburgh, Scotland, and number infected with human immunodeficiency virus', *International Journal of Epidemiology*, 28 (1), pp. 117–21.

³³Hong Kong SAR has also shown that widespread access to opioid substitution therapy can be effective. Heroin is the most commonly injected drug throughout Asia. Synthetic substitutes for heroin, such as methadone and buprenorphine (which can be taken orally) can reduce frequency of injection. They also reduce the likelihood that people will share needles when they do inject, as substitute drugs reduce craving, and injectors say it is the hunger for an immediate fix that often pushes them into situations where they share needles.

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. This should be done immediately.

Several countries in Asia (for example, Bangladesh, China, India, Indonesia, Malaysia, Nepal, and Viet Nam) have started programmes to provide sterile needles and methadone or other oral substitutes to heroin injectors. These are important steps forward. But most of these programmes are small and reach only a fraction of the people who require such services; limited coverage means limited impact on the HIV epidemic.

Only in parts of India and China (notably Hong Kong SAR) are HIV prevention programmes for drug injectors currently being implemented on a scale large enough to have an effect on HIV spread at the national level.

Preventing an HIV epidemic among drug injectors 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 drug injectors.

However, at the current stage of the epidemic, the option of preventing it among networks of drug injectors is no longer available; for example, in Indonesia, Malaysia, Myanmar, Nepal, Thailand, Viet Nam, and parts of China and India. In those places, HIV prevalence among injecting drug users is already high, and a substantial proportion of new HIV infections are the result of the sharing of contaminated injecting equipment or unprotected sex with an infected injector.

...AND JUMP STARTS THE EPIDEMIC IN THE SEX TRADE

Injectors who buy sex

Infected drug injectors can introduce the virus into the sex trade in two ways: as buyers (male injectors buy sex from sex workers whom they infect), or as sellers (female drug injectors sell sex to male clients, whom they infect).

Reconstruction of the evolution of the HIV epidemic in Jakarta (Indonesia), shows that the roughly 40,000 people who inject heroin in that city can have a dramatic effect on the HIV epidemic, as illustrated in Figure 2.8 below. Over the course of 20 years (2000–2020), a failure to prevent HIV infections among drug injectors could lead to some 1.6 million people becoming infected with HIV, fewer than half of whom would be injecting drug users.

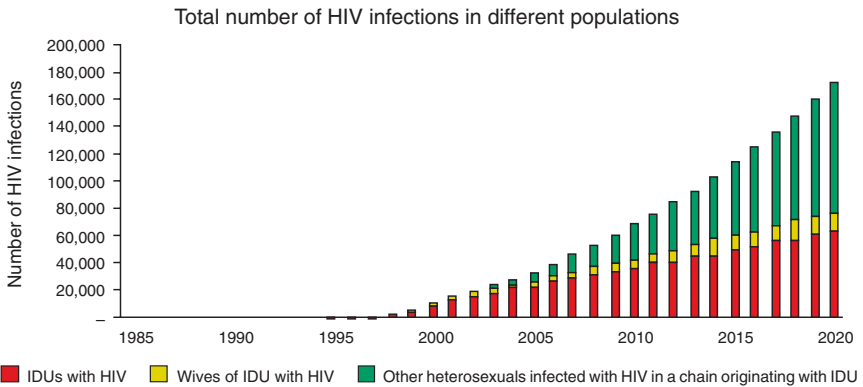


Figure 2.8: Projected total number of HIV infections in various population groups, 2000–20

Source: Asian Epidemic Model projections using Jakarta data.

Injectors who Sell Sex

Drug injectors who finance their addiction by selling sex tend to have a high turnover of partners. Male injectors sometimes sell sex, but female injectors do so quite often. Studies in Viet Nam's Ho Chi Minh City have found that up to one quarter of the city's 12,000 or so street-based sex workers inject drugs. In Hanoi and Can Tho, about 17 per cent of sex workers said they injected drugs, according to a 2005/2006 survey. Sex workers who injected drugs were between 3.5 and 31 times more likely to be HIV-infected, compared with those who did not inject.³⁴

In parts of China, almost half (47 per cent) of female injectors said they sold sex, and they were significantly less likely to use condoms with clients, compared with sex workers who did not inject. This information prompted HIV planners in southwest China to increase their focus on reaching female injectors with safe sex programmes, and with some success. In 2003, just 38 per cent of injecting sex workers said they had received free condoms in the previous year, compared with 53 per cent of non-injecting sex workers. By 2005, after outreach workers had focused on helping injectors adopt safer practices, 94 per cent of injecting sex workers were receiving free condoms. Consistent condom use with clients among injecting sex workers rose from 32 per cent in 2003 to 71 per cent in 2005.³⁵

³⁴National Institute of Hygiene and Epidemiology, Viet Nam Ministry of Health, and Family Health International (2005–2006). *Results from the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam*.

³⁵Data obtained by E. Pisani, courtesy of the China UK HIV/AIDS Prevention and Care Programme, 2007.

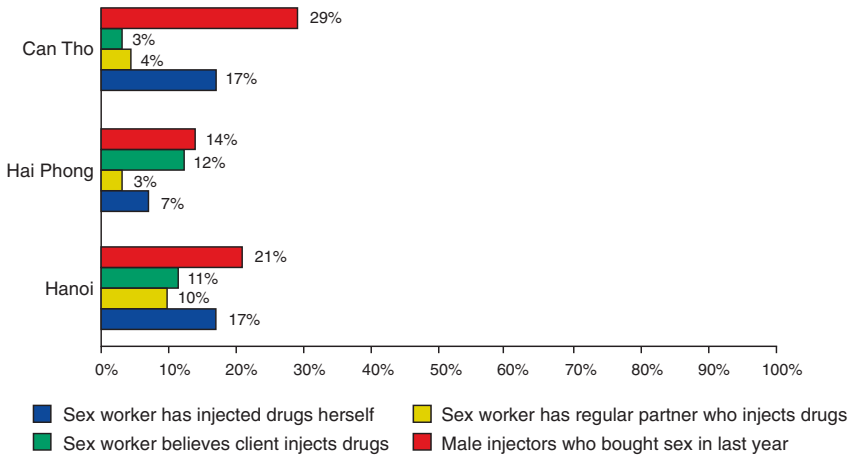


Figure 2.9: Injection and commercial sex interact in many ways

Source: National Institute of Hygiene and Epidemiology, Viet Nam Ministry of Health, and Family Health International (2005–2006), *Results from the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam*.

Box 2.4: HIV behind Prison Walls: A Less Understood Epidemic

As in much of the rest of the world, narcotic use is illegal in Asia, and drug users are jailed frequently (not only for their drug-using habits but also for crimes committed to finance their addictions). Because sterile needles are not freely available in prisons, it is common to share injecting equipment. Close to 30 per cent of Indonesian injectors have spent time in jail, according to national surveillance findings, and a high proportion of them injected while behind bars.

In Thailand, drug injectors who had been jailed were seven times more likely to be HIV-infected than were injectors who had never been jailed.^{36,37} In Chennai (India), they were more than twice as likely to be infected compared with those who had never been to jail.³⁸ And in Indonesia, men who had

³⁶S.F. Vanichseni, *et al.* (2004), 'Risk Factors and Incidence of HIV Infection Among Injecting Drug Users (IDUs) Participating in the AIDS VAX® B/E HIV Vaccine Efficacy Trial, Bangkok.' Abstract TuPpC2043, XV International AIDS Conference, Bangkok, Thailand.

³⁷A.K. Buavirat, *et al.* (2003), 'Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok, Thailand: case-control study', *British Medical Journal*, 326 (7384), p. 308.

³⁸S.M. Panda, *et al.* (2005), 'Risk factors for HIV infection in injection drug users and evidence for onward transmission of HIV to their sexual partners in Chennai, India', *Journal of Acquired Immune Deficiency Syndrome*, 39 (1), pp. 9–15.

recently arrived in jail were only a quarter as likely to be HIV-infected compared with other prisoners.³⁹ According to public health officials, drug-injecting while in jail probably accounts for most of those discrepancies. In Thailand, one in six current injectors said the first time they injected drugs was in jail.⁴⁰

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. And 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 high risk for HIV infection. Jails can act as reservoirs for HIV.

Effective prevention programmes inside prisons can help limit HIV spread. 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 have introduced prevention programmes in prisons (including the provision of sterilized injecting equipment); these include Australia, Iran, Kyrgyzstan, and many countries in Europe. In Germany, for example, new infections in prison fell to zero after sterile needles were made easily available to inmates.^{41,42,43,44,45}

The lesson is clear. When infected drug injectors are also involved in commercial sex trade (as buyers or sellers), HIV epidemics can occur very quickly. If condom use is low—as in Indonesia—high HIV infection levels among drug injectors can start an epidemic which then spreads to commercial sex networks (see Figure 2.10). But if condom use is already high when infected drug injectors buy or sell sex (as in Thailand),

³⁹Annual HIV Surveillance Report, 2007 (in Bahasa-Indonesia), Republic of Indonesia, Jakarta: Ministry of Health, courtesy of E. Pisani.

⁴⁰C. Beyrer, *et al.* (2003), 'Drug use, increasing incarceration rates, and prison-associated HIV risks in Thailand', *AIDS Behaviour*, 7 (2), pp. 153–61.

⁴¹WHO, UNAIDS, and UNODC (2007), 'Effectiveness of Interventions to Manage HIV in Prisons: Needle and syringe programmes and bleach and decontamination strategies', Geneva, World Health Organization, UNAIDS, UNODC.

⁴²K. Dolan, *et al.* (2007), 'HIV in prison in low-income and middle-income countries', *Lancet Infectious Diseases*, 7 (1), pp. 32–41.

⁴³R. Heimer, *et al.* (2006), 'Methadone maintenance in prison: evaluation of a pilot program in Puerto Rico', *Drug and Alcohol Dependency*, 83 (2), pp. 122–9.

⁴⁴K. Dolan, S. Rutter, and A.D. Wodak (2003), 'Prison-based syringe exchange programmes: a review of international research and development', *Addiction*, 98 (2), pp. 153–8.

⁴⁵K. Stark, *et al.* (2006), 'A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin, Germany', *Epidemiological Infection*, 134 (4), pp. 814–19.

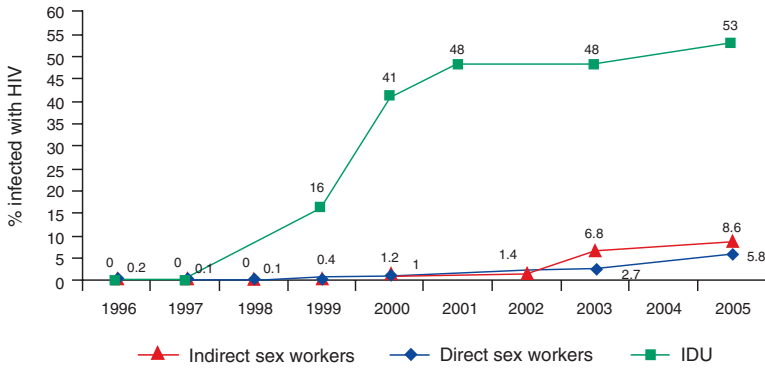


Figure 2.10: In Indonesia, HIV did not spread in the sex industry until a few years after it had reached very high levels among drug injectors

Source: Directorate-General of Disease Control and Environmental Health, Ministry of Health, Jakarta, Indonesia.

HIV will not spread as widely and as quickly into commercial sex networks, even if HIV prevalence among injecting drug users is high.

SEX BETWEEN MEN: A FAST GROWING EPIDEMIC

Although there is an emerging gay scene in some cities, same-sex monogamy remains relatively rare in Asia. Social taboos and discrimination means that many men who have sex with men still disguise their sexual preference by also having sex with women (in marriage or otherwise).⁴⁶

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. In a study in Bangkok in 2004, HIV-negative men reported anal sex with an average of 41 men in their lives, while HIV-positive men averaged 54 life-time partners.⁴⁷ In Ho Chi Minh City, some 8 per cent of men who had sex with other men said they had had anal sex with three or more consensual partners in the previous month.⁴⁸ Partner turnover in Phnom Penh was higher,

⁴⁶UNAIDS (2007), 'Men who have sex with men: the missing piece in national responses to AIDS in Asia and the Pacific', Bangkok: UNAIDS RST-AP.

⁴⁷F. van Griensven, *et al.* (2005), 'Evidence of a previously undocumented epidemic of HIV infection among men who have sex with men in Bangkok, Thailand', *AIDS*, 19, pp. 521-6.

⁴⁸National Institute of Hygiene and Epidemiology, Viet Nam Ministry of Health, and Family Health International (2005-6). *Results from the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) in Vietnam*.

with 21 per cent of the men saying they had sex with six or more partners in the previous month (and almost half of those men exchanged sex for money at least once in the previous week).⁴⁹

Such high partner turnover, combined with low condom use, has led to a rapid rise in HIV prevalence among men who have sex with men in several Asian cities. In Bangkok, more than one in four (28 per cent) men who have sex with men were found to be infected with HIV in a 2005 study, up from 17 per cent in 2003.⁵⁰ In the Chinese capital, Beijing, fewer than 1 per cent of surveyed men who have sex with men were HIV-positive in 2004; two years later, prevalence had reached almost 6 per cent. In Karachi (Pakistan), 4 per cent of surveyed male sex workers were found to be infected in 2005; within two years, that figure had nearly doubled.⁵¹ Among transgender sex workers, HIV infection levels were higher: 22 per cent in Jakarta in 2002 and 37 per cent in Phnom Penh in 2003.⁵²

When HIV prevention services have been provided in Asia to men who have sex with men, uptake of those services tends to be impressive. In Indonesia, the Health Ministry 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. Figure 2.11 shows levels of condom and lubricant use before

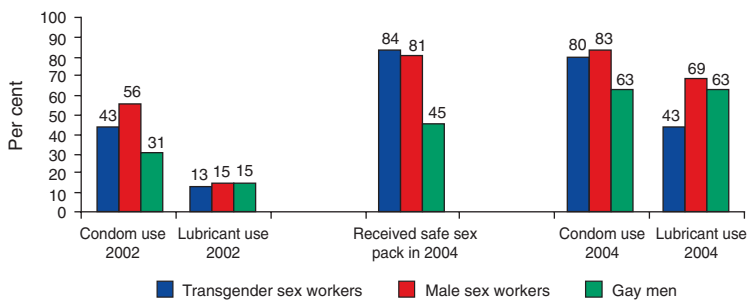


Figure 2.11: HIV prevention programmes among men who have sex with men can achieve behaviour change

Source: Behavioral Surveillance Survey (BSS) result in Indonesia 2004–2005, Jakarta, BPS-Indonesia, Central Bureau of Statistics and Ministry of Health, 2005.

⁴⁹Cambodian national surveillance data 2005 (National Center for HIV/AIDS Dermatology and STDs Cambodia 2006).

⁵⁰F. van Griensven, *et al.* (2005), 'Evidence of a Previously undocumented, epidemic ...'

⁵¹F. Emmanuel (2007), 'Changing pattern of HIV/AIDS in Pakistan: Low prevalence to concentrated Epidemic among IDUS', 8th International Conference on HIV/AIDS in Asia and the Pacific, Colombo, Sri Lanka.

⁵²P. Girault, *et al.* (2004), 'HIV, STIs, and sexual behaviors among men who have sex with men in Phnom Penh, Cambodia', *AIDS Education and Prevention*, 16 (1), pp. 31–44;

and after the prevention programmes started. Clearly, high coverage of a service that men appreciate can translate into rapid behaviour change.

Community groups of men who have sex with men 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.

Box 2.5: Is Casual Sex among Young People Driving Asia's HIV Epidemics?

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. But even increases in unprotected casual sex are unlikely to lead to larger HIV epidemics in the foreseeable future, as Figure 2.12 shows. Yet, in several Asian countries, significant resources are invested in trying to discourage unsafe casual sex among young people.

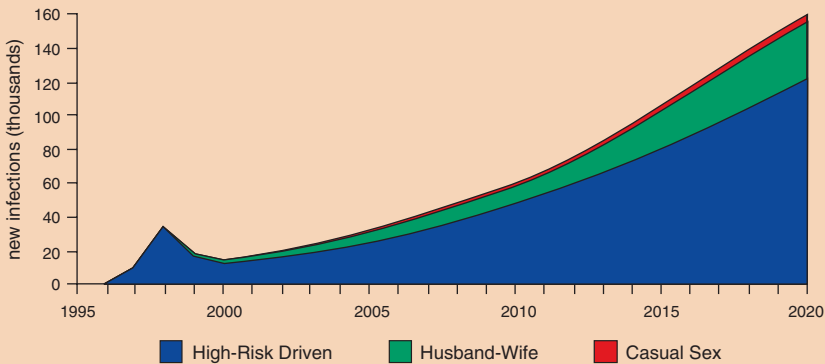


Figure 2.12: Estimated number of annual new infections and proportion of casual sex in a typical 100-million population setting in Asia

Source: Asia Commission estimate based on Asian Epidemic Model, using regional averages.

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. In every country in Asia, at least 98 per cent of young women and 90 per cent of men—and usually far more—neither sell nor buy sex or inject drugs. They are therefore not at high risk of HIV infection.

E. Pisani, *et al.* (2004), 'HIV, syphilis infection, and sexual practices among transgenders, male sex workers, and other men who have sex with men in Jakarta, Indonesia', *Sexually Transmitted Infections*, 80 (6), pp. 536–40.

THE BEST WAY TO PROTECT WOMEN IN ASIA IS TO PREVENT THEIR HUSBANDS FROM BECOMING INFECTED

Although three out of four adults living with HIV in Asia are men, the proportion of women in this total has risen gradually—from 19 per cent in 2000 to 24 per cent in 2007.⁵³

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 in Asia.⁵⁴

Clearly, therefore, the best way to prevent most HIV infections in women, therefore, is to prevent their husbands from becoming infected in the first place. And the most effective way of achieving that 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.

Note, though, that even when countries reduce HIV transmission in the sex industry or among drug injectors, there will remain a phase in which most new infections will occur in women who have unprotected sex with their infected husbands. Cambodia is now in such a phase, as Figure 2.13 shows. This does not mean that the epidemic now sustains itself independent of the sex industry or injecting drug use.

An estimated one-third of all new infections in Cambodia in 2007 (up from 13 per cent in 1992) will have been among women who are not sex workers. But the absolute number of new infections in women infected by their husbands is much smaller compared with the period when the epidemic peaked: only an estimated 330 women will have been infected by their husbands in 2007, compared with more than 7,500 in 1996.⁵⁵ If sustained, effective programmes to curb HIV transmission in commercial sex, drug injection, and male–male sex are established,

⁵³Derived from Asian Epidemic Model estimates for Asia; complete details of the model and its results are provided in the Technical Annex.

⁵⁴The estimate is derived from a synthesis of the estimated size of various most-at-risk and low-risk population groups, in the countries of Asia. References for the country-specific data used to arrive at this regional estimate are available in the Technical Annex.

⁵⁵Estimates are based on Asian Epidemic Model calculations for Cambodia.

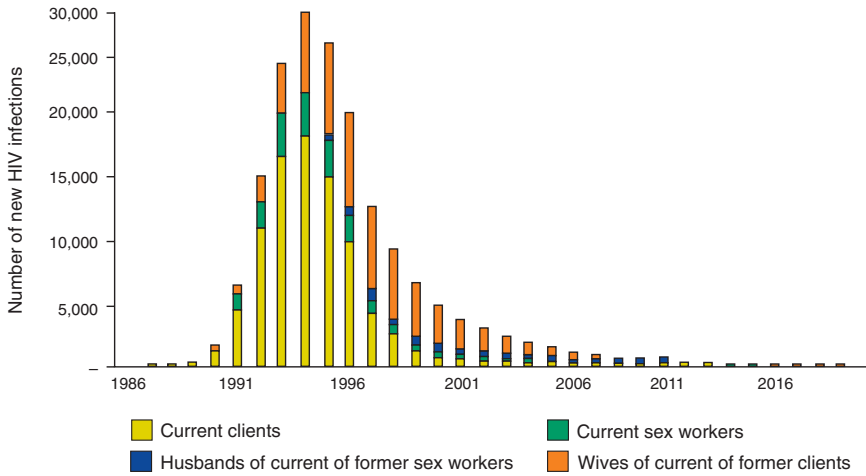


Figure 2.13: Estimated number of annual new HIV infections in different populations, Cambodia, 1985–2020

Source: Asian Epidemic Model estimates for Cambodia.

countries will see a steady decrease in spousal transmission and become a minor factor in an overall epidemic that also declines.

CLASSIFYING ASIA’S EPIDEMICS TO TAILOR EFFECTIVE RESPONSES

HIV can only spread through society independently of commercial sex, drug injection, and sex between men if the immediate sexual partners of people at high risk of infection also have unprotected sex with several other people in a short space of time.

Such epidemics are now commonplace in East and southern Africa, and in parts of West and Central Africa. They have been termed ‘generalized epidemics’, and a numerical threshold is usually attached to that term: once HIV prevalence among pregnant women in urban areas exceeds 1 per cent, countries are deemed to be experiencing a ‘generalized epidemic’.

It is usually assumed that in such epidemics, prevention efforts have to reach the entire sexually active population, and emphasis is often placed on reaching young people with those interventions. But this categorization may not be appropriate everywhere.

Nowhere in Asia (nor anywhere in Europe or the Americas) has HIV spread through societies independently of drug injecting, sex between

men and/or commercial sex. 'Generalized epidemics' require a high prevalence of multiple, concurrent sexual partnerships among both men and women—and these patterns are very rare in Asia.

So, the standard classification of 'low-level', 'concentrated' or 'generalized', based on the HIV prevalence in pregnant women, does not capture the actual nature and dynamics of Asia's epidemics.

The 'low-level' label disguises a rising trend in HIV infections in places where interventions are not in place, and can lead to complacency.

The 'concentrated' epidemic implies equal weight to all populations—whether they are migrants, sex workers, or injecting drug users—whereas in Asia, the early prioritization of prevention for injecting drug users in many settings can make a significant difference to the outcome of the epidemic.

The 'generalized' epidemic label has led some countries in Asia to shift mistakenly from focused prevention interventions to generalized awareness campaigns for their entire populations.^{56,57}

The Commission proposes that Asia's epidemics can be better understood if they are classified according to the predominant risk behaviours and their relative contribution to new infections, rather than according to national HIV prevalence. Such a scheme offers broad guidance that can assist countries and donors in selecting and prioritizing their HIV interventions more appropriately. The Commission recommends that UNAIDS and WHO further develop and validate this scheme.

The Commission proposes four epidemic scenarios or categories for Asia, namely: Latent, Expanding, Mature, and Declining (see Table 2.1 and the Technical Note at the end of this Chapter). Countries should themselves assess into which categories their epidemics fit, guided by using characteristics such as those listed in Table 2.1. In the case of large and populous countries, the epidemic might match more than one category.

Table 2.1 shows how the various scenarios can be matched against HIV and behavioural information to indicate the most appropriate package of interventions. Note, however, that HIV epidemics are dynamic and require regular assessment. A robust system on strategic information and surveillance is therefore an essential prerequisite for a successful response, which is discussed later in the chapter.

⁵⁶MAP (2004), *AIDS in Asia: Face the facts*, Monitoring the AIDS Pandemic Network, Bangkok. Available at http://www.mapnetwork.org/docs/MAP_AIDSinAsia2004.pdf.

⁵⁷K. Ruxrungtham, *et al.* (2004), 'HIV/AIDS in Asia', *The Lancet*, 364 (9428), pp. 69–82.

Table 2.1: HIV epidemics: stages, sources, and responses

Scenarios		Expanding	Late Expanding	Declining
Characteristics	Latent	Expanding	Late Expanding	Declining
Trend of the epidemic	Low but slowly increasing prevalence	Epidemic has accelerated, High prevalence of HIV reported among sex workers with steady increase in infection levels	Increasing level of infection to spouse of clients of sex workers with continued high prevalence levels among sex workers and clients	Declining levels of prevalence among sex workers Spousal transmission is increasing and the wives of clients make up majority of new infections
Level of prevention interventions	Low coverage of most-at-risk populations	Low coverage of sex workers and their clients	Inadequate coverage of sex workers and their clients	Optimal coverage of sex workers and clients in place
Biological Marker (HIV prevalence)	Female sex workers < 5%	Female sex workers > 5% Antenatal clinics < 1% at most sites	Female sex workers > 5% Antenatal clinics > 1%	Marked decline in prevalence among female sex workers, with trend falling over the last 3 years
Primary source of new infection (based on behavioural studies and epidemiological analysis)	Injecting drug users or sex workers and clients or men who have sex with men (in combination or separately)	Mainly sex workers and clients Others include men who have sex with men	Mainly clients of sex workers and their wives and children Others include: sex workers, and in some settings may include injecting drug users, men who have sex with men	Mainly wives of clients of sex workers, clients of sex workers, and children Others include: sex workers, and in some settings may include injecting drug users, men who have sex with men
Interventions with the highest impact	Sex worker/clients intervention injecting drug user intervention	Sex workers/clients intervention men who have sex with men, injecting drug user interventions prevention of mother-to-child transmission in tertiary hospital (through opt-in testing at antenatal clinics)	Sex worker/client intervention men who have sex with men, injecting drug user interventions sexually transmitted infection Opt-out testing at antenatal, sexually transmitted infection and tuberculosis clinics Prevention of mother-to-child transmission	Sex worker/client intervention Opt-out testing at antenatal, sexually transmitted infection and tuberculosis clinics Injecting drug users, men who have sex with men (if still unaddressed)

Box 2.6: The Current Course of HIV in Asia: A History of Successes and Failures

In order to assess the current state of the epidemics of Asia, the Commission prepared a set of country projections using the Asian Epidemic Model (see Box 2.2). Individual country projections were prepared and then combined to produce a regional overview of the epidemics' course.

The projections assume that the prevalence of key behaviours that shape Asia's epidemics (such as levels of condom use during paid sex, client turnover, and the numbers of men who buy sex) will remain as they were in 2007.⁵⁸

Figure 2.14 shows the overall projection for the HIV epidemic in Asia. In 2007, just over 5.1 million adults and children in the region were living with HIV and 375,000 people were newly-infected. These figures agree closely with the latest UNAIDS estimate that 4.8 million people in Asia were living with HIV in 2007. More than 2.6 million men, 900,000 women and over 300,000 children have died of AIDS-related causes in the region since the epidemic began.

Cambodia, Myanmar, and Thailand and the high-prevalence states of India dominated the first decade of the Asian HIV pandemic. However, in these places, the sex work components of the epidemics were brought under control, and HIV prevalence has now started to decline. Despite those achievements, however, these high-prevalence areas are experiencing substantial ongoing HIV transmission among men who have sex with men and injecting drug users. But the combined effect of measures to combat risks in the sex trade in these epidemics has resulted in a slowdown in the rate of growth of the regional epidemic, starting in the early-2000s.

The future of Asia's epidemics will be decided mainly by developments in the epidemics of countries which are today experiencing relatively steady growth in new HIV infections. That group includes some of the world's most populous countries: Bangladesh, China, Indonesia, and Pakistan. Their epidemics are likely to dominate the next phase of the regional pandemic.

Figure 2.14 depicts the resultant, post-2010 upswing in the regional pandemic we can anticipate. After a period in the mid-2000s, when new infections declined slightly, the Asian HIV pandemic is now entering a secondary growth phase, which may push HIV prevalence to almost 10 million by 2020 *in the absence of expanded prevention efforts*.

⁵⁸The extent of other behaviours, including the sharing of contaminated injecting equipment by drug injectors and sex between men was also kept at 2007 levels. It was also assumed that antiretroviral treatment would reach 50 per cent of those in need by 2010 and 80 per cent of those in need by 2020. In some countries where coverage has expanded rapidly and infrastructure is strong (such as Thailand), higher levels of antiretroviral coverage were assumed.

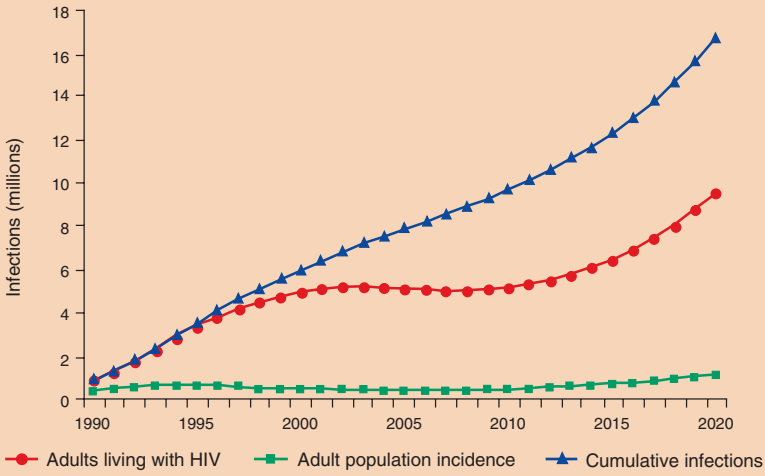


Figure 2.14: Projected trend of Asia's HIV epidemic up to 2020

Source: Asian Epidemic Model estimates for the Asian region.

As Figure 2.15 shows, males continue to dominate the epidemics, with about two males infected with HIV for every female who acquires the virus. This trend is likely to continue into the future. By the late 2010s, the male-female ratio will start to rise somewhat as the epidemics among men having sex with men and injecting drug users assume a larger role in the epidemic.

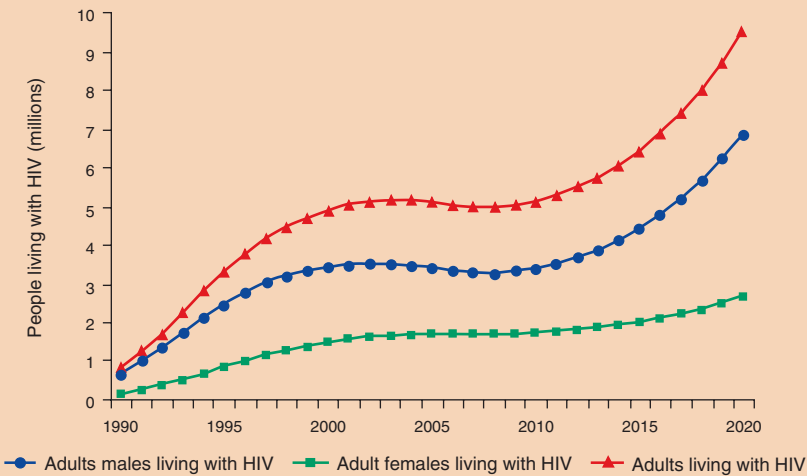


Figure 2.15: Adult males and females living with HIV in Asia

Source: Asian Epidemic Model estimates for the Asian region.

If one looks at the pattern of new HIV infections in various population groups (Figure 2.16), one sees a dynamic and evolving regional pandemic. New infections in Asia peaked at over 600,000 in the mid-1990s, but effective condom promotion for sex workers and clients subsequently reversed that trend. New infections have continued to decline as condom use has increased also in other countries.

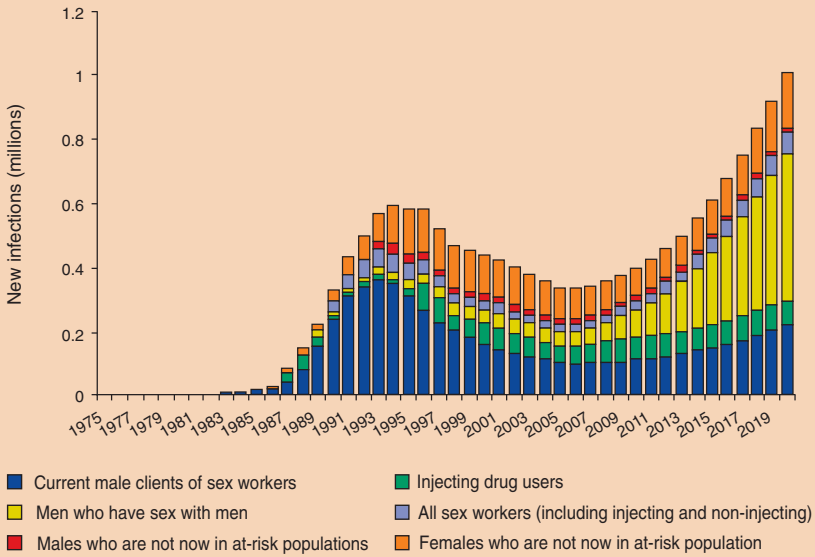


Figure 2.16: Annual new HIV infections in adults by population group: a decline from early prevention successes, an increase from current failures

Source: Asian Epidemic Model estimates for the Asian region.

At the same time, low coverage of HIV interventions has meant that infections are not being prevented as effectively in other groups, such as injecting drug users, men who have sex with men, and the wives of sex work clients or other higher risk men. Consequently, their relative contribution to the total number of new infections is increasing, even as the overall numbers decline. Note, however, that this decline is coming to an end. Unless further prevention success is achieved, it is likely that new HIV infections will rise again as the number of sex work clients increases, transmission among drug injection continues, the epidemic among men who have sex with men grows, and infected men continue to transmit the virus to their wives and girlfriends.

WHAT CAN WE LEARN FROM THESE PROJECTIONS?

The region must address all aspects of the epidemic

Regionally in 2007, as Figure 2.16 shows, all the population groups were contributing substantially to new HIV infections—whether sex workers and clients, husbands and wives, injecting drug users or men who have sex with men. This means that prevention efforts are urgently needed and needed for all those populations if Asia is to avoid forfeiting the gains made in the late-1990s.

Individual countries should assess their epidemics and adapt their responses accordingly

Some countries have largely brought HIV transmission in sex trade under control, but still need to tackle transmission among drug injectors and men who have sex with men, and between husbands and wives. Other countries have not yet made inroads into their epidemics in the sex trade. Whatever the case, countries need to tailor their responses to the local epidemiological situation.

The lull after the first phase in the pandemic's evolution is ending, and a new wave of infections seems imminent

The projections depict a regional success story that lasts from the early 1990s to about 2005 in those countries where the epidemics grew quickly early on. But we run the risk of seeing those achievements fade. Complacency must be overcome, and resources should be targeted effectively and appropriately to avoid the maximum numbers of new infections.

MIGHT CHANGES IN SEXUAL BEHAVIOUR ALTER THE COURSE OF THE EPIDEMICS?

Many Asian economies are booming. Between 1985 and 2005, per capita gross domestic product in Asia tripled in real terms. Per capita income in China, for example, rose five-fold over the period, while in India it increased by 126 per cent and in Viet Nam by 166 per cent.⁵⁹ However, although overall wealth is increasing in much of Asia, poverty is not

⁵⁹GDP data calculated from GDP per capita adjusted for purchasing power parity, in constant year 2000 USD, Organization for Economic Cooperation and Development (OECD) database.

being reduced at the same pace. As a result, income and other inequalities (for example, in access to certain services and resources) are growing in several countries.

It is impossible to say exactly how economic and social changes will affect HIV epidemics in Asia. But one way of approaching the question is by exploring possible changes in two of the factors that currently define the epidemics: the number of men who buy sex, and the sexual networking patterns of women.

MORE MEN BUYING SEX?

The future of Asia's epidemics depends to a considerable extent on what happens to men's incomes and their mobility outside family settings. Men who have disposable income, and who travel or migrate to work opportunities, provide most of the demand for commercial sex.⁶⁰ If countries in Asia continue to experience rapid economic growth and men's incomes continue to rise, the demand for commercial sex in the region is also likely to rise.

A surge in new HIV infections in the sex trade is most likely if the pool of male clients expands faster than the pool of women selling sex. If the pool of sex work clients increases but the numbers of female sex workers stay unchanged, then the average sex worker will have more clients. As a result, client turnover will increase. In such a scenario, HIV prevalence will probably also increase. A similar trend is likely if the numbers of male clients remain steady but *fewer* women sell sex. In that case, client turnover will also increase and so will HIV prevalence.

In all such scenarios, the future of Asia's epidemics still depends on whether opportunities for HIV transmission during paid sex can be reduced.

WILL CASUAL AND PREMARITAL SEX LEAD TO A RISE IN HIV EPIDEMICS?

Current patterns of sexual networking in Asia do not support high-prevalence HIV epidemics independent of the sex trade and drug injecting. But economic changes lead to changes in social relations. As economies develop, women gain greater access to education and employment opportunities and assert their rights more effectively. It is sometimes argued that improved educational and career opportunities for women lead to a relaxation in the socio-cultural restraints placed on

⁶⁰This hypothesis is yet to be validated in a scientific study.

women's sexual freedom. Internationally one typical outcome is a rise in the age of marriage, which tends to correspond with more premarital sex.⁶¹ Will such a shift in Asia lead to a rise in HIV epidemics?

In Asia's richest countries, sexual behaviour among young people now mirrors that in Western countries. In a national survey conducted in Japan in 1999, only about 5 per cent of women in their 40s and early 50s had had sex with five or more men in their lifetimes. But about 40 per cent of young women aged 18–24 years had already had five or more sexual partners in total, and about the same percentage of young women said they had sex with two or more men in the previous year.⁶² A similar, though somewhat less pronounced trend, was observed in rural areas. According to a study among university students, condom use with regular partners was high (about 70 per cent), but it was much lower with casual partners (around 50 per cent).

Yet such high levels of sexual activity and modest levels of condom use have not led to an HIV epidemic among young heterosexuals in Japan, any more than they have in Europe or the Americas. A large part of the reason could be that where men have more opportunities for casual sex, they are less likely to visit sex workers.⁶³

This suggests that in most Asian countries an increase in casual and premarital sex among women in itself is unlikely to lead to a net increase in new HIV infections because there probably will be a corresponding reduction in commercial sex, which is one of the main drivers of the epidemic.

None of this warrants complacency. An increase in casual sex heralds other challenges and risks, even if it is unlikely to trigger larger HIV epidemics in Asia. Young people will need information about how to avoid unwanted pregnancies and how to protect them and their partners against sexually transmitted infections, including HIV. They will need

⁶¹A. Greenspan (1992), *Asia-Pacific Population & Policy*, 22, Honolulu, East-West Center.

⁶²M. Ono-Kihara, *et al.* (2002), 'Sexual practices and the risk for HIV/STDs infection of youth in Japan', *Journal of the Japan Medical Association*, 126 (9), pp. 1157–60.

⁶³In both Thailand and Tamil Nadu (in India), a reduction in the number of men who visit sex workers was associated with increased casual sex but not necessarily with increases in HIV transmission. In both cases, this occurred in the wake of large-scale HIV interventions which promoted condom use and the reduction of risky behaviours. This also occurred amid relatively strong economic growth, expanded education opportunities, and greater sexual freedom. However, no systematic study has been carried out to investigate such correlation or establish possible causality between development and changes in sexual behaviours in Asia.



sex education and services to help them lead healthy sex lives. In both scenarios, women's sexual behaviour is a key variable that will shape the future of HIV in Asia.

SOLID DATA AND ANALYSIS IS NEEDED TO UNDERSTAND AND RESPOND TO THE EPIDEMIC

Having reliable HIV data is a precondition for gaining a solid understanding of the epidemic but rigorous analysis is required to develop that understanding. Unfortunately, on this front—the careful scrutiny and analysis of data—many countries in Asia still fall short.

The reason for this is largely institutional. The task of collecting, assessing, and analysing 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.

Instead, various data sets tend to 'float' about in the public health system in different state institutions, non-governmental organizations and donor agencies. 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, national Governments are reluctant to grant international organizations or academic bodies access to data they consider sensitive (and it is typical to regard HIV surveillance data as 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.

A further layer of complexity (and sensitivity) is added when programme data are included in the analysis. Obviously, before deciding how best to allocate programme resources, it seems prudent to conduct an assessment of which prevention services are available where, how many people have access to them at what levels of coverage, and what demonstrable effects they are having. But information on service delivery is rarely shared between service providers (whether non-governmental or state), between donors, or by Governments. Attempts to rectify this state of affairs (such as the UNAIDS-backed Country Response Information Service) are often seen as externally driven and of limited relevance to national needs, and service providers therefore have little incentive to contribute information to those systems.

IMPROVING THE ANALYSIS OF HIV DATA REQUIRES RESOURCES AND TIME

All countries can achieve a robust analysis of HIV-related data (including information on HIV, sexually transmitted infections, risk behaviours, risk population sizes, and service delivery), and they can do so with relative ease.

What is required is an understanding of the epidemiology of HIV and sexually transmitted infections, a critical appraisal of the quality of data, solid computing skills, and curious minds. Furthermore, it is essential that somebody—an institution or structure—takes responsibility for coordinating this effort, and acquires the resources and the time to do it properly. Solid, trustworthy analysis of the data takes time.

This is why Governments should put in place institutional and budgetary mechanisms to create permanent posts for senior-level analysts with the authority to access all available information and the mandate to gather it into a single system for analysis and to provide relevant policy analyses to key decision makers so they can make the right choices.

All this is readily achievable, but it makes the challenge a little tougher to meet. Just as good data do not translate automatically into strong analysis, good analysis does not translate automatically into good policy or effective service provision. A range of factors (institutional, political, financial, practical, ideological, and socio-cultural) shape those outcomes. Chapter 4 discusses some of the contextual factors that need to be addressed in order to achieve an effective response to HIV, while Chapter 5 examines some of the financial issues.

Box 2.7: Are Current Surveillance Systems Overestimating HIV in Asia?

Recent population-based surveys of HIV in Cambodia and India have led to lower estimates of the numbers of people living with HIV in those countries.

In the case of India, the new estimate is dramatically lower than before: 2.5 million (2 million–3.1 million) adults in India were believed to be living with HIV in 2006, compared with the 5.2 million (3.1 million–8.7 million) estimated in 2005.^{64,65}

⁶⁴UNAIDS/WHO (2007), *AIDS Epidemic Update*, December 2007, Geneva.

⁶⁵UNAIDS (2006), *2006 Report on the global AIDS epidemic*, Geneva.

Earlier estimates of the number of people living with HIV had been based mainly on data collected at public clinics where pregnant women receive antenatal care. Most of those clinics are in urban or peri-urban areas. But a survey of 100,000 households in 2006 showed that antenatal clinic data tended to overestimate prevalence among women (possibly because a higher proportion of women who are more likely to be infected with HIV use public rather than private facilities). India's national estimates were revised downwards to reflect this information, and are now in line with earlier population-based HIV data which had suggested that state-level and national prevalence estimates based on sentinel surveillance might have been overestimated.⁶⁶

In Cambodia, a 2005 household HIV survey showed that HIV prevalence among women was more than three times higher in urban than in rural areas. HIV estimates based largely on urban sites therefore would have overestimated national prevalence. Cambodia's HIV estimates have been adjusted accordingly and are now more accurate than before.

In Ho Chi Minh City (Viet Nam), the discrepancy between HIV prevalence estimates based on epidemiological models and those based on a national household HIV survey turned out to be smaller. This was mainly because the household survey data did not include those drug injectors and sex workers interned in 're-education' camps (among whom HIV prevalence tends to be very high).

Household HIV surveys have undoubtedly improved our knowledge about absolute levels of HIV in the population, but they are time-consuming and expensive. And their samples do not necessarily include populations that are most-at-risk of HIV infection. Planners in Asia need to weigh the additional benefits of gathering data in this manner against their costs and limitations.

Where surveillance systems show that HIV prevalence and risk behaviours are high among particular populations, the priority must always be to ensure that the people affected have access to effective prevention and treatment services. In terms of preventing HIV infections, such an approach is more valuable than arriving at a perfect count of the total number of infections nationwide.

⁶⁶Research in the Guntur district in the southern state of Andhra Pradesh showed that HIV infection levels found in a population-based study were about half as high as those based on sentinel surveillance. See L. Dandona, *et al.* (2006), 'A population-based study of human immunodeficiency virus in south India reveals major differences from sentinel surveillance-based estimates', *BMC Medicine*, 4 (31).

Box 2.8: Improving Understanding of Asia's HIV Epidemics by Addressing Data Needs

On the whole, Asia probably leads the world in gathering reliable information about the prevalence of HIV and risk behaviours in some of the groups most likely to be exposed to the virus (especially among sex workers). Many countries also collect valuable behavioural information on clients of sex workers (though fewer have HIV prevalence information for clients). A growing number of Asian countries have also adapted their national surveillance systems to gather information on risk behaviour among drug injectors. Generally, though, men who have sex with men remain neglected in terms of both HIV and behavioural surveillance.

There are other gaps, too. Assume that HIV prevalence in Group A is 40 per cent, but only 0.01 per cent of the population belongs to Group A and those persons are unlikely to transmit the virus persons outside that group. Group A probably will not contribute significantly to the HIV epidemic. But at the turn of this century, no country in Asia had well-documented, data-based estimates of the numbers of people who engage in particular high-risk behaviours. Fortunately, the situation has improved subsequently. Such estimates now exist in many countries, and they are constantly being refined.

Public health surveillance is a core function of national Governments. Yet, legislation and budgeting do not always reflect its importance, especially in countries that are undergoing rapid market transition. In many places, this has disrupted public health data systems, and it is compromising those countries' capacity to understand and respond appropriately to public health crises such as AIDS.

Data collected at district or provincial levels are not always passed on to the national level for analysis. And national HIV prevention policies are not always enforced at provincial or district levels which, increasingly, control decisions about which services will be funded, and how public employees use their time.

HIV surveillance is often institutionally and geographically fragmented. Health ministries usually set up HIV surveillance systems, but the work is often done by other institutions (many of them outside Government). In addition, many international donors fund data collection processes that occur entirely outside of Government systems. Those data, although potentially valuable, then tend to be under-utilized in the analysis of national trends, and prevention and care needs.

TECHNICAL NOTE: FOUR SCENARIOS FOR PRIORITIZING INTERVENTIONS

Latent epidemic

In this phase, HIV prevalence is still very low. Early and effective action on prevention will avert a large-scale epidemic.

Trend: HIV prevalence is very low among the adult population, and few if any prevention programmes are in place.

Biological indicator: In the absence of prevention efforts, prevalence of HIV and other sexually transmitted infections among female sex workers is below 5 per cent.

Source of new infections: Most new infections are among injecting drug users and men who have sex with men. Female sex workers account for a smaller number of new infections.

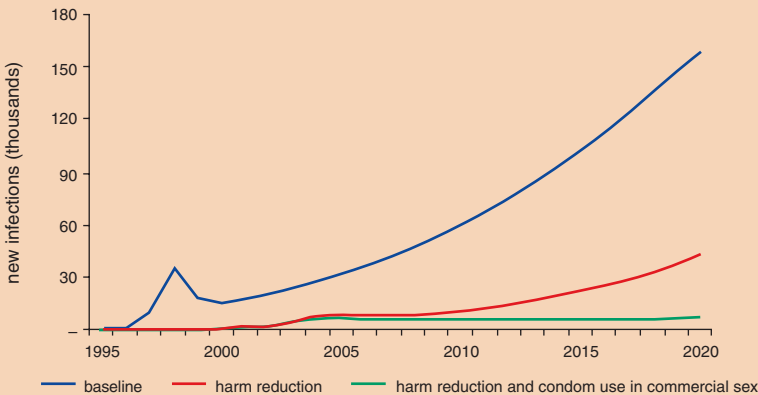


Figure 2.17: Early and effective prevention can avert a large-scale epidemic in latent epidemic scenario countries

Source: Commission's estimates for hypothetical Asian population in latent phase, based on Asian Epidemic Model using regional averages.

Most effective package: Without expanded prevention programmes, the epidemic will grow as shown by the blue line. If a high-coverage, focused, and successful harm reduction package for injecting drug users is put into place, the epidemic in the sex

trade will be delayed, leading to an epidemic that starts to grow several years later (red line). If programmes also achieve consistent condom use in the sex trade, then the epidemic can be averted almost entirely (green line). If men having sex with men are contributing substantial numbers of new infections in a country, programmes should be expanded to include them.

Expanding epidemic

HIV prevalence is still relatively low but growing. Without immediate and effective prevention, the epidemic is likely to grow to significant levels.

Trend: HIV prevalence is low among the adult population but has already started rising among sex workers and their clients. Prevention programmes are either absent or inadequate.

Biological indicator: In the absence of prevention efforts, prevalence of HIV and other sexually transmitted infections among

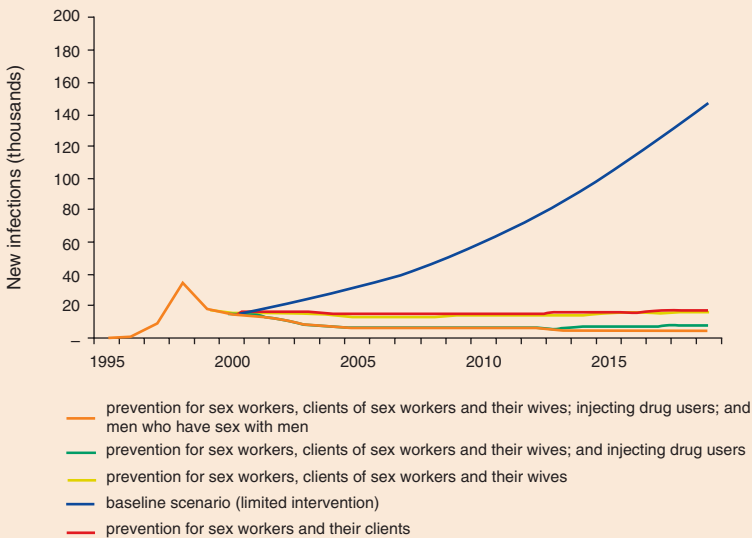


Figure 2.18: Effective prevention can significantly reduce infections in expanding epidemic scenario countries

Source: Commission's estimates for hypothetical Asian population in expanding phase, based on Asian Epidemic Model using regional averages.



female sex workers is above 5 per cent, while HIV measured in antenatal clinics remains low (under 1 per cent).

Source of new infections: Most new infections are among female sex workers and their clients. The overall benefit of early harm reduction intervention is reduced in this phase because infections in injecting drug users (and men who have sex with men in most settings) likely account for a smaller number of new infections.

Most effective package: Without expanded prevention programs, the epidemic will grow as shown by the blue line. If a sex trade package achieves consistent condom use, the number of new infections will drop greatly (red line). Adding a package to prevent husband-to-wife transmission will further reduce infections (yellow line). Further addition of a harm reduction package for drug users (green line), and risk reduction package among men who have sex with men (orange line) will bring the epidemic to extremely low levels.

Maturing epidemic

In this phase, HIV prevalence has been rising for several years, and HIV is spreading in the general population (mainly to sex work clients and their wives).

Trend: HIV prevalence is increasing in the adult population and is high in specific sub-populations, but few if any prevention programmes are in place.

Biological indicator: In the absence of prevention efforts, prevalence of HIV and other sexually transmitted infections among female sex workers is above 5 per cent and HIV measured in antenatal clinics is relatively high, exceeding 1 per cent.

Source of new infections: Most new infections will be among clients of sex workers and the wives of those men, while new infections in sex workers, injecting drug users and men who have sex with men will likely account for a smaller but still significant number of new infections.

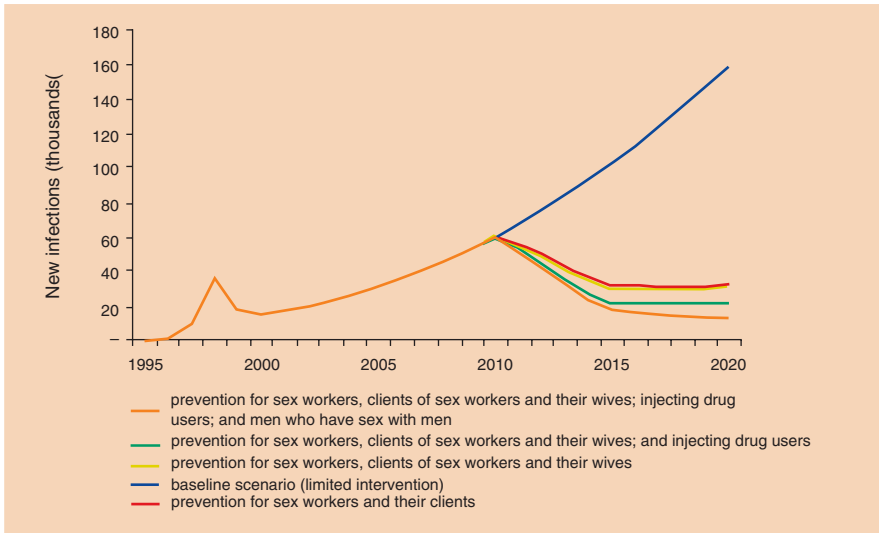


Figure 2.19: Effective prevention can significantly reduce infections in maturing epidemic scenario countries

Source: Commission's estimates for hypothetical Asian population in Asian maturing phase, based on Asian Epidemic Model using regional averages.

Most effective package: The most effective package here will be similar to that in the Expanding phase. Without expanded prevention programmes, the epidemic will grow as shown by the blue line. If a sex trade package achieves consistent condom use, the number of new infections will drop greatly (red line). Adding a package to prevent husband-to-wife transmission will further reduce infections (yellow line). Further addition of a harm reduction package for drug users (green line), and risk reduction package among men who have sex with men (orange line) will bring the epidemic to extremely low levels.

Declining epidemic

Effective condom-use programmes have curbed the sex trade epidemic, but sex work clients who were infected earlier are still transmitting HIV to their wives. Programmes for injecting drug users and men having sex with men remain at the pilot level (for example, this is the situation in Thailand today).

Trend: HIV prevalence is falling as a result of successful sex worker and client prevention programmes, but new infections will soon rise again as a major epidemic among men having sex with men takes hold.

Biological indicator: With successful condom use programmes, prevalence of HIV and other sexually transmitted infections among female sex workers may still exceed 5 per cent, but there will be a declining trend.

Source of new infections: Many new infections will be among the wives of clients of sex workers, injecting drug users will provide a steady source of new infections, and the contribution of men who have sex with men will be growing rapidly. Female sex workers and their clients will account for a smaller number of new infections because of the effectiveness of programmes.

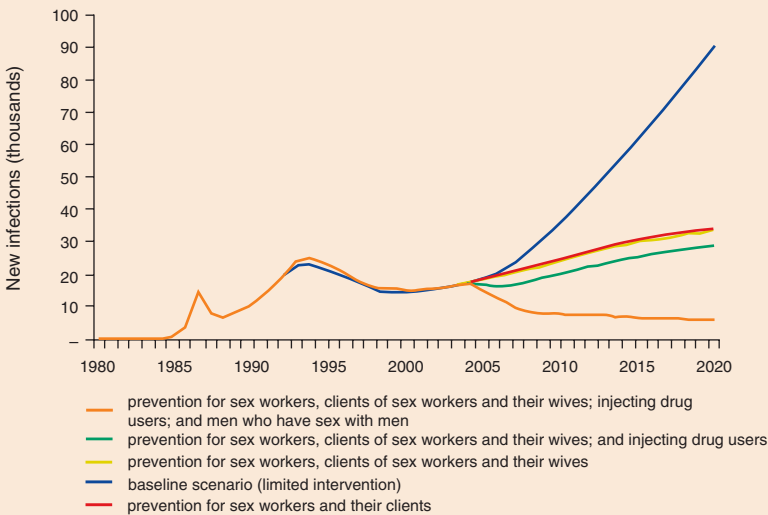


Figure 2.20: If effective prevention is not sustained, infections will rise, even in declining epidemic scenario countries

Source: Commission's estimates for hypothetical Asian population in declining phase, based on Asian Epidemic Model using regional averages.

Most effective package: If the package does not sustain high levels of consistent condom use in the sex trade, prevalence will

rise rapidly again (blue line) rather than rising more gradually due to the growing epidemics among men having sex with men and injecting drug users (red line). Adding a package for prevention of husband-to-wife transmission by expanding mother-to-child transmission programmes and voluntary counselling and testing will reduce infections a little (yellow line). Adding harm reduction for drug users will reduce new HIV infections by a steady amount (green line). However, the addition of a package for men having sex with men will produce the largest reduction in new infections in this phase if sex trade successes are maintained (orange line).

3

Reducing the Cost of HIV in Asia

CHAPTER SUMMARY

- AIDS is the single-largest disease-related cause of death in Asia among 15–44 year-old adults.
- The Commission projects that AIDS will cause a total loss of 180 million years of healthy and productive life in Asia between 2002 and 2020—more than any other disease specific to this age group.
- While the epidemic patterns of HIV spread in Asia demand *prevention* efforts that focus to a large extent on most-at-risk populations, the epidemic's *impact* is much more diffuse. Most of the economic and social consequences of AIDS are borne by persons in the general population, including women and children.
- The most significant impact is being experienced at the household level. It is there that the burden of illness, and of income and livelihood losses, is carried by affected individuals and families, especially by women.
- AIDS is pushing poor households deeper into poverty. Each AIDS death represents an average income loss of almost USD 5,000—the equivalent of nearly 14 years of income for people earning USD 1 per day.
- The Commission proposes that, irrespective of the cost, interventions of high and known effectiveness should be prioritized and funded out of AIDS budgets.
- A comprehensive response to AIDS in Asia would cost about USD 6.4 billion per year. However, an annual investment of USD 3.1 billion would be able to halt and reverse the epidemic in the region. Most countries should be spending USD 0.50 to USD 1.00 per capita.

- The economic costs associated with AIDS over the next two decades would be equal to the cost of fighting a SARS epidemic every five years.
- Only about USD 1.2 billion annually is currently available for fighting AIDS in Asia. Resources are constrained. In light of this, it makes even more sense to prioritize interventions in terms of their effectiveness.
- The kind of *focused* response recommended in this Report could prevent 5 million new infections, avert over 2 million deaths, and provide impact mitigation support to 80 per cent of affected women and children.
- If Asian countries adopt the approach recommended by the Commission, the benefits would be immense, in terms of lives spared, hardship averted, and resources saved. The Commission is convinced that Asia has the resources and capacity to make this a reality.
- Addressing AIDS effectively also brings in a range of wider public health benefits and serves as a platform for social sector reforms in Asia.

AIDS WILL REMAIN A MAJOR CAUSE OF DEATH FOR WORKING AGE ADULTS

As Asia’s economies continue to grow, one of the big unknowns is how infectious disease epidemics will affect the region’s economic and social development.¹ Avian influenza and Severe Acute Respiratory Syndrome (SARS) have already provoked acute concern in Asia and beyond.

The WHO 2006 study on the burden of disease for Asia shows that between 2015 and 2030, AIDS will be the single-largest disease-related cause of death among adults aged 15–44 years. Adjusting for the recent revision of HIV prevalence estimates for Asia, the Commission found that in the year 2020 alone, almost 0.4 million people in Asia aged 15–44 years are likely to die of AIDS-related illnesses if current levels and types of HIV interventions continue—more than the projected number of deaths attributable to heart disease in the same year and age group (see Figure 3.1).

Expressed in more compelling terms, the Commission has projected that AIDS will cause a total loss of 180 million person-years of healthy and productive life in Asia between 2002 and 2020—more than any other disease (Figure 3.2).² Even in the short term—for example by 2015, the

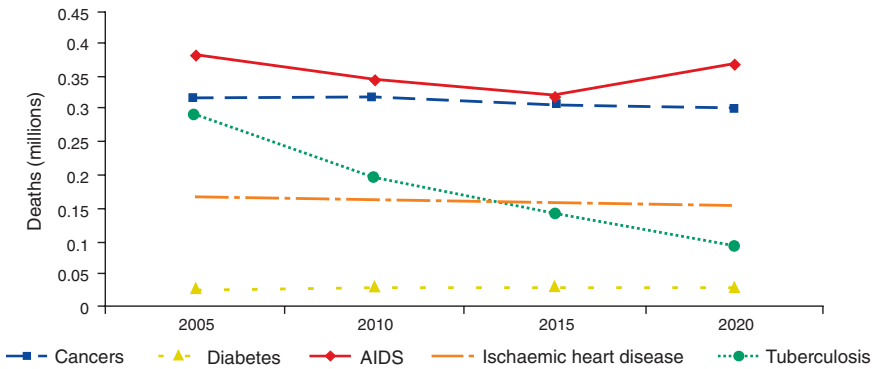


Figure 3.1: Projected annual deaths caused by various diseases in the Asia region among 15–44 year-old age group, 2002–2020³

¹This chapter incorporates detailed research and analysis, which is available in the Technical Annex.

²This estimate is based on the number of disability-adjusted life years (DALYs) and potential years of life lost due to premature death. DALYs measure the equivalent years of ‘healthy’ life lost due to poor health or disability, and potential years of life lost due to premature death. One DALY equals one lost year of ‘healthy’ life.

³The estimates presented here are based on the apex study on burden of disease carried out by WHO and published in 2006 (C. Mathers and D. Loncar, *Global Mortality*

deadline for achieving the Millennium Development Goals—the number of deaths attributable to AIDS will probably match those caused by cancer, as Figure 3.1 shows.

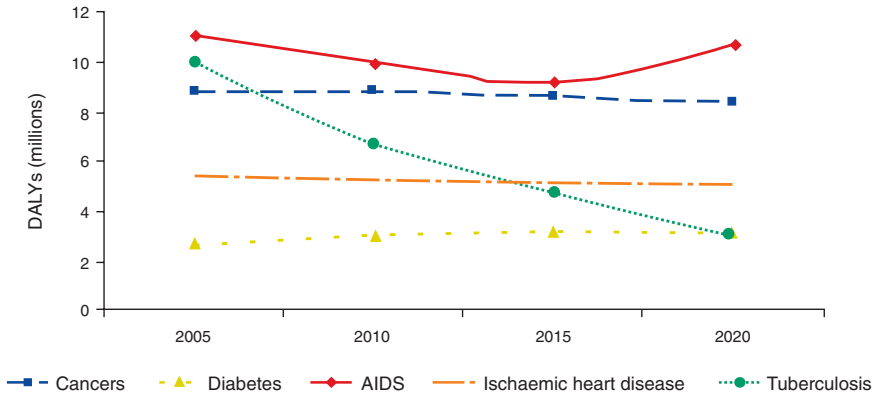


Figure 3.2: Projected annual disability-adjusted life years (DALYs) lost to various diseases in the Asia region among 15–44 year-old age group, 2002–2020

Box 3.1: Changing Behaviour—The Impact of Effective Prevention

As discussed in Chapter 2, prevention focused on key population groups such as sex workers and clients, injecting drug users, and men who have sex with men, will have the greatest impact on halting the spread of HIV in Asia. Two decades into the epidemic, we have a good sense of the elements that make such programmes work well and of the behavioural changes they can bring about in a relatively short period of time.

Working with sex workers and clients—increasing condom use and reducing sexually transmitted infections (STIs)

Several effective models for HIV prevention among sex workers have been developed in Asia. All have, at their core, outreach activities for sex workers, most involving peer educators in the provision of condoms and

and Burden of Disease Projections 2002–2030, *PLoS Medicine*, 3 [11], pp. 2012–30). That study did not yet take into account the subsequent revisions of HIV figures in Asia, principally in India. Applying a downward adjustment in line with the revisions for India and Cambodia, and using Asian Epidemic Model projections, AIDS remains the largest cause of death and disability-adjusted life years (DALYs) lost due to disease in Asia, in the absence of effective prevention and treatment interventions.

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. In many countries, parallel programmes have been mounted to influence the clients' behaviours. These are most often done through peer education in workplaces, condom social marketing, and mass media. Working synergistically with the programmes for sex workers, these 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.

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 STIs 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 STIs in a sustained fashion.^{4,5} In Thailand and Cambodia, structural interventions under the 100 per cent condom programme were coupled with extensive efforts to reach clients.^{6,7} As a result, in Thailand, the consistent use of condoms rose from 32 per cent in 1990 to almost 60 per cent in 1993 and to almost 90 per cent in 1997.^{8,9,10} In Cambodia, similar results were observed.¹¹ In behavioural surveillance between 1997 and 2003, males reported a steady increase in consistent condom use from 54 per cent levels in 1997 to 87–94 per cent levels in 2003. The percentage of adult male clients visiting sex workers has also come down significantly in both these countries.

⁴S. Jana and B. Banerjee (1997), *A dream, a pledge, a fulfillment—Five years stint of STD/HIV intervention programme at Sonagachi*, Calcutta: All India Institute of Hygiene and Public Health.

⁵I. Basu, *et al.* (2004), 'HIV Prevention Among Sex Workers in India', *Journal of Acquired Immune Deficiency Syndrome*, 36 (3), pp. 845–52.

⁶W. Rojanapithayakorn and R. Hanenberg (1996), 'The 100 per cent condom programme in Thailand [editorial]', *AIDS*, 10 (1), pp. 1–7.

⁷UNAIDS-AIDS Division, Ministry of Public Health, Thailand (2000), *Evaluation of the 100% Condom Programme in Thailand*, Geneva: UNAIDS, available at http://data.unaids.org/Publication/IRC-pub01/JC274-100pCondom_en.pdf.

⁸W. Sittitrai, *et al.* (1994), 'A survey of Thai sexual behaviour and risk of HIV infection [letter]', *International Journal of STD and AIDS*, 5 (5), pp. 377–8.

⁹V. Thongthai, and P. Guest (1995), 'Thai sexual attitudes and behaviour: results from a recent national survey', *Gender and sexuality in modern Thailand*, Australia National University, July.

¹⁰UNAIDS (2001), Case Study, Geneva, Joint United Nations Programme on AIDS (UNAIDS) AIDS Division, Thailand: Ministry of Public Health, 1–47.

¹¹National Centre for HIV/AIDS, Dermatology and STDs (2003), Cambodia Behavioural Surveillance Survey.

Injecting Drug Users (IDUs)—reducing needle sharing and shared injections

Needle and syringe exchange programmes that provide clean and safe injection for drug users are essential. Synthetic substitutes such as methadone and buprenorphine (which can be taken orally) can reduce the frequency of injection,¹² because substitute drugs reduce craving, and injectors say it is the hunger for an immediate fix that often pushes them into situations where they share needles. In combination, needle exchange and substitution therapy can virtually eliminate the threat of a major HIV epidemic among injectors. 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.¹³

When such programmes reach injecting drug users (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 HIV spread in the relevant group. For example, the CARE-SHAKTI intervention in Bangladesh achieved significant levels of behaviour change among IDUs between 1997 and 2001, a 4-year period.¹⁴ Over this period, sharing among IDUs dropped from 74 per cent to 29 per cent, and the percentage of shared injections among injectors fell from 50 per cent to 30 per cent. This particular programme included peer outreach, needle-syringe exchange, and enabling environment components. Even more might have been achieved had it contained a substitution component.

Recent results of methadone treatment in China demonstrate this point. Injecting drug users in methadone treatment in China reported lower incidence of HIV (0 per cent) compared to non-treatment groups (3–9 per cent) and reduced needle sharing (90 versus 2 injections per month) and their pre-treatment status.*

**(Note this refers to existing footnote #12)*

¹²Z. Wu and Z. Chengzheng (2007), 'Update of Harm Reduction in China', presented at the International Conference on Harm Reduction, Warsaw.

¹³C. Hangzo, *et al.* (1997), 'Reaching out beyond the hills: HIV prevention among injecting drug users in Manipur, India', *Addiction*, 92 (7), pp. 813–20.

¹⁴A.M. Foss, *et al.* (2007), 'Could the CARE-SHAKTI intervention for injecting drug users be maintaining the low HIV prevalence in Dhaka, Bangladesh?', *Addiction*, 102 (1), pp. 114–25.

Protecting men who have sex with men—promoting condom use and treating STIs

The coverage of programmes for men who have sex with men in Asia has been extremely limited, with only 5 per cent of men who have sex with men reached on a regional basis. 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.¹⁵

Levels of condom use of 80 per cent during anal sex are achievable in relatively short timeframes with aggressive prevention efforts. As pointed out in Chapter 2, after a programme for men who have sex with men in Jakarta, condom use rose to levels of 80 per cent or higher for male sex workers and *waria*,¹⁶ and more than doubled from 31 per cent to 63 per cent among men who have sex with men as a whole.

One essential feature of any successful intervention 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/specifications can resource needs be estimated, logistics planned, and overall quality monitored and ensured. Without them, resource needs and financing are too often inappropriately estimated and allocated. The specific elements that should be added are outlined in the Technical Note at the end of this chapter.

FOCUSED INTERVENTIONS CAN BE PARTICULARLY EFFECTIVE IN ASIA

As Figure 3.3 shows, a focused and expanded HIV intervention package could be expected to achieve the following between 2007 and 2020:

- reduce cumulative new infections by 5 million;
- reduce number of people living with HIV in 2020 by 3.1 million; and
- reduce the number of deaths by 40 per cent.

¹⁵J.H. Herbst, *et al.* (2005), 'A Meta-Analytic Review of HIV Behavioral Interventions for Reducing Sexual Risk Behaviour of Men Who Have Sex With Men', *Journal of Acquired Immune Deficiency Syndrome*, 1 June, 39 (2), pp. 228–41.

¹⁶*Waria* is a Bahasa-Indonesia term, which refers to transgenders.

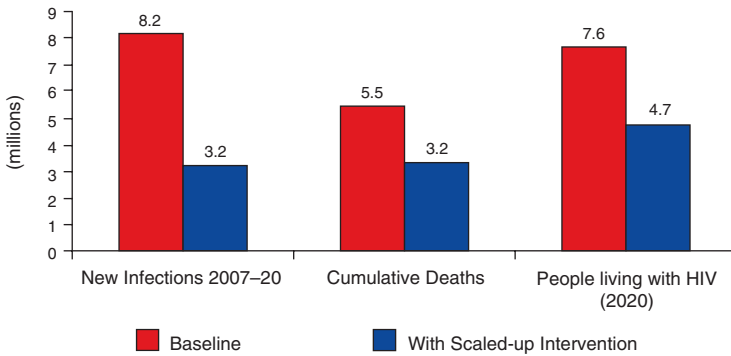


Figure 3.3: The projected impact of AIDS in Asia—with and without a comprehensive HIV response, 2007–2020

Source: Based on the Commission’s projections for the region, using the Asian Epidemic Model.

Note: The ‘baseline’ scenario in this projection assumes that current HIV programming and effectiveness continue (for example, 30–50 per cent consistent use of condom among sex workers and their clients, while about 25 per cent of people who need antiretroviral treatment receive it). In the ‘full intervention’ scenario, 80 per cent consistent condom use is achieved among sex workers and clients, there are similarly high levels of risk reduction among men who have sex with men and injecting drug users, and 80 per cent of people in need of antiretroviral treatment receive it.

The argument for investing adequately in the HIV response is compelling.

IMPACT OF AIDS IN ASIA IS LARGELY FELT AT THE HOUSEHOLD LEVEL

The epidemic’s impact will register at many levels, most dramatically within affected households and communities. The annual economic cost of AIDS borne by Asian households is estimated to be around USD 2 billion. Introducing a comprehensive intervention package immediately could reduce this cost by 50 per cent over the next decade.¹⁷

¹⁷The simulation model used by the Commission shows that foregone income at the household level (due to loss of earnings of both patients and caregivers due to illness, healthcare-related expenses, loss of income due to premature death, funeral costs, etc.) totals about USD 2 billion annually. A full and comprehensive intervention programme starting in 2007, could halve that to about USD 1 billion by 2020. In contrast to earlier

Although AIDS is the single-largest cause of death from disease among people in their productive prime, the epidemic's impact at the macro-level appears to be negligible. Because national adult HIV prevalence is comparatively low in Asia, AIDS is unlikely to shorten average life expectancy significantly at the national level. Against a backdrop of strong economic growth, the epidemic is unlikely to affect national economic output noticeably or to affect labour productivity in key sectors.¹⁸ Even where HIV prevalence is concentrated in certain localities, local economic output probably will not be dramatically affected.

But given the large populations in many Asian countries, 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. That impact is most harsh in poor households; they lack the income and assets that can help cushion the consequences of AIDS-related illness and death.

A great deal of the damage done by AIDS therefore is concentrated in and around the homes and lives of the poor who, in the absence of formal social protection systems, somehow have to fend for themselves. Such a situation is at variance with the rapid pace of economic growth in Asian countries and the commitments of Asian Governments to ensure a better standard of life for all its citizens.

AIDS has already reduced life expectancy in several Asian countries, albeit by relatively small margins.¹⁹ As Figure 3.4 shows, it is estimated that life expectancy in Cambodia in 2005 was three years lower than it would have been in the absence of an AIDS epidemic, while it was 1.7 years lower in Myanmar and 1 year lower in India and Thailand.

studies in the region, loss of income due to premature death has been calculated for only five years, in line with similar assumptions made in recent studies in Africa. The methodology and detailed findings are available in the background study on socio-economic impact for the Commission, in the Technical Annex.

¹⁸A comparison of life expectancy, Gross Domestic Product, Gross National Product, and workforce losses, is provided in the Technical Annex.

¹⁹Life expectancy at birth measures the average number of years that a new-born child would live if mortality rates remained constant throughout his or her lifetime.

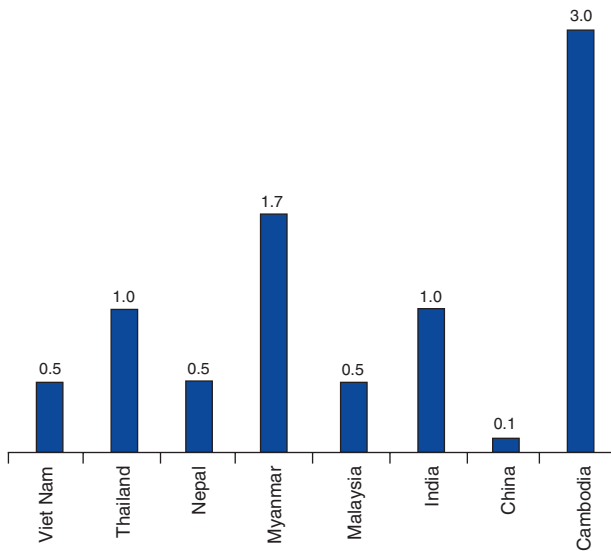


Figure 3.4: Reduced life expectancy due to AIDS (in years) for various countries in Asia, 2005

Source: Background study on socioeconomic impact for the Commission, available in the Technical Annex.

THE HUMAN FACE OF AIDS—LOSSES, FOREGONE OPPORTUNITIES, AND SOCIETAL REJECTION

It is difficult to quantify the impact of HIV when children must forego schooling in order to care for parents or kin, when wives caring for HIV-infected husbands are ostracized by their families and communities or when surviving widows are forced to abandon their homes and land.

For example, according to a United Nations Development Programme study in India (2006),²⁰ an estimated 40 per cent of widows leave their in-laws' homes after their husbands' deaths due to AIDS, and 80 per cent of those women are deprived of their property and inheritance rights.

Often, the AIDS stigma cloaks these experiences in silence and secrecy, with families afraid to divulge their plight to neighbours, colleagues, or even relatives. Moreover, because such hardship tends not to be revealed by standard socio-economic and demographic indicators,

²⁰B.K. Pradhan and R. Sundar (2006), *Gender impact of HIV and AIDS in India*, New Delhi: UNDP.

it often goes unnoticed by policymakers. This will change. Over the course of the next two decades, AIDS is forecast to remain one of the biggest killers of adults in Asia.

Box 3.2: A Sense of Scale—Like a SARS Epidemic every 5 Years

In recent years, the optimism fostered by strong economic growth across the region has been overshadowed by the threat of emerging infectious diseases. The resurgence of avian influenza in 2003 was preceded by fears of a severe acute respiratory syndrome (SARS) pandemic. The Asian Development Bank has estimated that Asian Governments spent approximately USD 28 billion fighting SARS over a six-month period in 2003. This sum represents only one-fifth of the expected cumulative economic costs of AIDS over the next 20 years. Put differently, the economic cost associated with AIDS over the next two decades will be equivalent to fighting a SARS epidemic every five years.

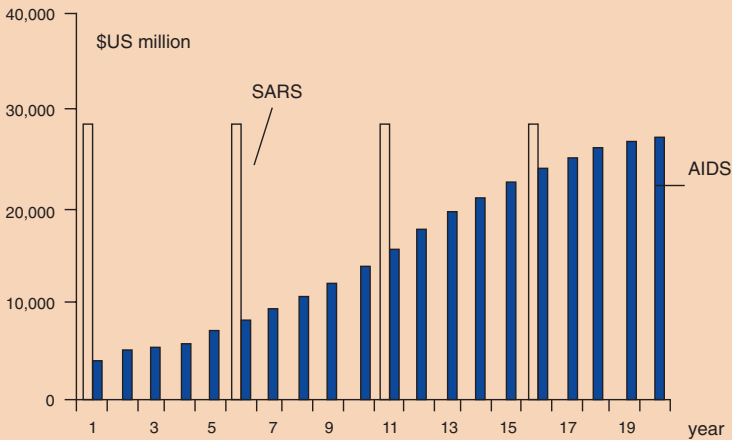


Figure 3.5: AIDS and SARS: A comparison of costs

Source: Asian Development Bank (2003), Economic impact of SARS in Asia, Bangkok; Asian Development Bank & UNAIDS (2007); Background paper on the socio-economic impact of AIDS in Asia, Bangkok. The complete paper is available in the technical annex. This particular calculation is based on the Spectrum model, not on the Asian Epidemic Model.

Note: Economic impact due to AIDS is measured mainly in terms of the economic losses incurred due to foregone household income at household level and public sector expenditures on prevention and treatment programmes. The economic losses in the case of SARS were based on lost income due to reduced international travel, sales, lost revenues, and more.

Box 3.3: What Can we Hope to Accomplish?

Effective HIV prevention interventions (see Box 3.1) can:

- raise condom use between sex workers and clients to over 80 per cent on a national scale;
- cut STIs among sex workers and clients in half or better;
- cut needle sharing among IDUs in half and cut the percentage of actual injections they share in half as well;
- raise MSM condom use to 80 per cent or above.

One of the reasons these projections were done was to explore the impact of possible policies and programmes that produce behavioural change. This chapter concludes with a presentation of what will happen if the levels of behavioural change outlined above are achieved. Figures 3.6 and 3.7 show the future course of the epidemic and the trend in new infections on the assumption that the prevention programmes known to work are applied on a region-wide basis between 2007 and 2012. This is an achievable and realistic target—both richer and poorer countries in Asia have achieved it on this time scale.

Figure 3.6 shows what will happen to the *regional epidemic* if these programmes are implemented. New infections will fall steadily, and regional

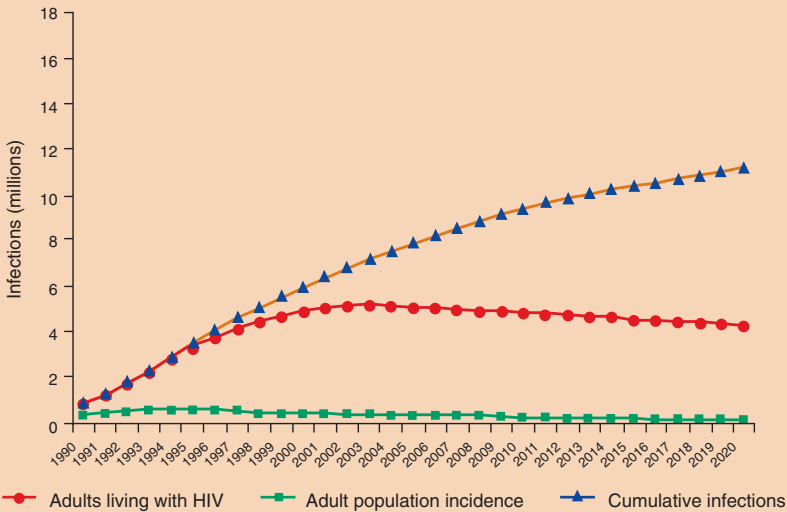


Figure 3.6: Impact of focused prevention package recommended by the Commission on the regional epidemic (compared with Figure 2.14 in Chapter 2)

Source: Based on the Commission's estimates and projections for the region, using the Asian Epidemic Model; complete details are available in the Technical Annex.

HIV prevalence will begin to fall slowly. The fall would be very much steeper were it not that ART will be saving many lives. Cumulative infections from the beginning of the epidemic through 2020 will fall from over 16 million to 11 million, over 5 million infections averted. HIV prevalence in the region will never rise again, but will begin a steady decline.²¹

The impact of such a programme on new infections is even more dramatic, as Figure 3.7 shows. New infections will fall in every group, and for the region as a whole, new infections will drop to one-third of their peak level by 2012. Asia has the resources and ability to make this a reality; the only question is whether Asia has the political will to become the first global success story in reversing a regional pandemic.

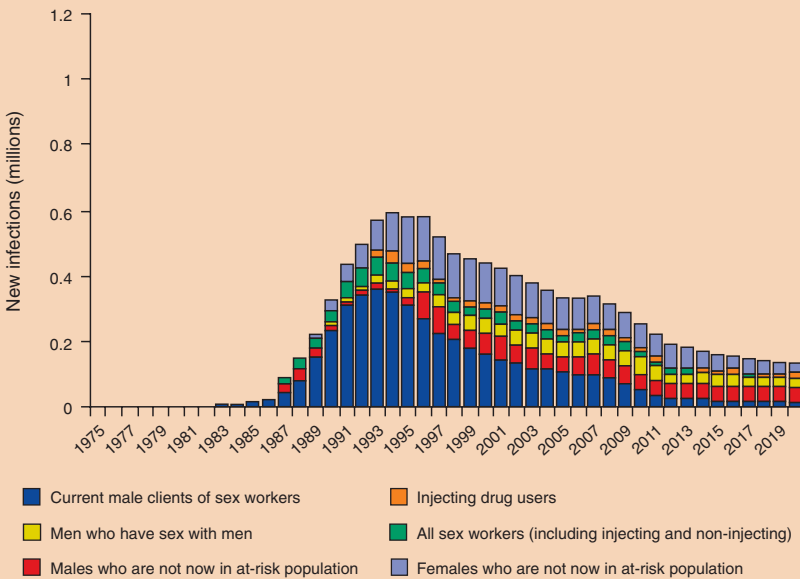


Figure 3.7: New infections if we implement best practice intervention packages for sex workers and clients, MSM, and IDUs on a regional basis (compared with Figure 2.15 in Chapter 2)

Source: Based on the Commission's estimates and projections for the region, using the Asian Epidemic Model; complete details are available in the Technical Annex.

²¹These estimate figures differ from the numbers quoted earlier in this chapter, because this estimate is inclusive of several additional countries and has different assumptions about treatment scale-up.

AIDS PUSHES MANY INTO POVERTY

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 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 USD 5000—the equivalent of nearly 14 years of income for people earning USD 1 per day at current prices.

In light of the above, there is a compelling argument for providing antiretroviral treatment for all households as a public good. Thailand has shown this can be done within the ambit of a national social insurance system, where more than 80 per cent of people in need of antiretroviral therapy could be provided treatment. At current levels of antiretroviral need, public provision of HIV treatment and care lies within the financial means of all Asian Governments.

Overall, preventing HIV infections is the most effective way to curb the HIV epidemic, to avoid the burgeoning costs of treating AIDS-related illnesses and to reduce their impact on individuals and households.

THE EPIDEMIC HAS A WIDER IMPACT

While the epidemic patterns of HIV spread in Asia demand *prevention* efforts that focus to a large extent on most-at-risk populations (as discussed in Chapter 2), the epidemic's *impact* is much more diffuse. The bulk of the economic and social costs of AIDS is borne by members of the general public, particularly women and children.

As HIV epidemics spread from networks of injecting drug users to sex workers and their clients, the economic characteristics of the people infected also change.²² As already noted, drug injectors tend to belong to lower income groups (often as a consequence of their drug-taking habits), whereas commercial sex clients tend to belong to relatively wealthier segments of society. For example, in Viet Nam, men belonging

²²About 70 per cent of all people living with HIV in Asia are in countries where the epidemics are driven mainly by sex work.

to the top income quintile were nine times more likely to have paid for sex in the previous 12 months than were men in the lowest quintile. A similar, though less pronounced, correlation was found in India, where HIV prevalence was highest in the second-top income quintile, at 0.5 per cent among adult men.

A similar pattern is evident in Cambodia, where the most recent Demographic and Health Survey (2005) found that 1.3 per cent of men in the lowest household income quintile had paid for sex in the previous year, compared with 12.7 per cent of men in the highest quintile. Simulations done for the Commission indicate that in countries where national adult HIV prevalence is below 0.4 per cent, most people with HIV tend to belong to the lower income groups. As prevalence rises and more clients become infected, the distribution of HIV cases shifts towards wealthier segments of society in the medium-term.

Until now, most people dying of AIDS in Asia have been men, almost all of whom will have acquired HIV when buying sex, having sex with other men, or when sharing contaminated injecting equipment. Only a small percentage of men and women dying from AIDS will have been infected when selling sex. It follows, therefore, that the majority of surviving spouses to date have been female, many of whom will have been unaware of their husbands' HIV status or how their husbands became infected. Their only 'risk' was to have had unprotected sex with their husbands.

Much of the physical and psychological burden of HIV, the associated loss in household income and other costs associated with AIDS illness and death, is borne by people who do not belong to socially marginalized most-at-risk groups, as shown in Figure 3.6. The majority of people living with HIV are male clients of sex workers. Clients, by definition, are a most-at-risk population. But they are not a marginalized group; for the most part, they are indistinguishable from the 'general' population.

While HIV *prevention* efforts will be most effective where they focus on such most-at-risk groups, treatment and impact mitigation programmes need to reach all affected men and women. For the same reasons, programmes for preventing the mother-to-child transmission of HIV and voluntary counselling and testing should focus not only on those groups most at risk of infection. This principle has important implications for how services are targeted, financed, and delivered.

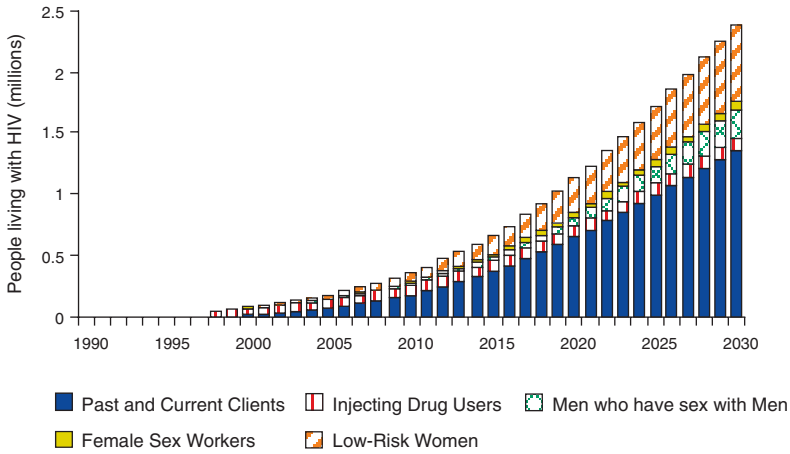


Figure 3.8: Estimated number of people living with HIV, by risk group, in 100 million population, 1990–2020

Source: The graph is based on the Asian Epidemic Model, and uses standard assumptions regarding the size of most-at-risk groups, HIV transmission dynamics, and the extent of preventive behaviours.

CURBING HIV IN ASIA IS BOTH AFFORDABLE AND ACHIEVABLE

In 2004, UNAIDS estimated that a comprehensive HIV response in Asia would have required an annual investment of USD 5.1 billion in 2007. The package recommended in this Report includes a total of 19 prevention, treatment and impact mitigation interventions, as well as surveillance and programme management activities. 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.²³ Further details of the inputs, assumptions and methodology of these calculations are provided in the Technical Annex.

²³Except for impact mitigation, in which case the Commission has set its own target of 80 per cent coverage for all affected households, as shown in Table 3.1.

Table 3.1: Resource needs estimates for 2007 for Asia, by intervention category

Intervention	Estimated resource need for comprehensive HIV interventions in Asia	
	UNAIDS estimate for 2007* (000s)	Commission estimate for 2007 (000s)
Interventions focussed on sex workers and their clients	\$376,000	\$293,000
Harm reduction programmes	\$192,000	\$376,000
Interventions focussed on men who have sex with men	\$329,000	\$340,000
Voluntary counselling and testing	\$261,000	\$319,000
Prevention of mother-to-child transmission of HIV	\$92,000	\$10,000
Post-exposure prophylaxis	\$2,000	\$2,000
Public and commercial condoms	\$525,000	\$525,000
Universal precautions	\$908,000	\$908,000
Safe injection	\$700,000	\$700,000
Youth (out-of-school)	\$280,000	\$280,000
Sexually transmitted infections management	\$263,000	\$263,000
Workplace prevention	\$224,000	\$224,000
Special populations	\$12,000	\$12,000
Condom social marketing	\$104,000	\$104,000
Blood safety	\$69,000	\$69,000
Prevention for people living with HIV	\$4,000	\$4,000
Mass media	\$9,000	\$9,000
Youth in school	\$25,000	\$25,000
Community mobilization	\$500	\$500
Prevention	\$4,376,000	\$4,463,000
Adult antiretroviral treatment	\$827,000	\$754,000
Pediatric antiretroviral treatment	—	\$7,000
Treatment	\$827,000	\$761,000
Impact mitigation	\$73,000	\$321,000
Programme management	\$215,000	\$832,000
Total	\$5,491,000	\$6,378,000

Source: Adopted from (1) *Resource needs for an expanded response to AIDS in low- and middle-income countries* (2005), Geneva, UNAIDS; (2) *Funding Required to Confront the HIV/AIDS Epidemic in the Asia and the Pacific Region* (2004), ADB/UNAIDS Study Series Paper 1, Manila/Geneva: ADB-UNAIDS; (3) Background paper for the Commission on Costing resource needs for Asia, available in the Technical Annex.

PRIORITIZATION IS ESSENTIAL TO DESIGN A COST-EFFECTIVE PROGRAMME

The Commission then assessed the various components of such a response in terms of their likely impact on the epidemic and in mitigating its effects. This was done by matching the relative costs of interventions against the numbers of HIV infections prevented, the numbers of AIDS deaths averted, and the scale of income losses avoided. The Asian Epidemic Model was used to estimate the outcomes of the proposed interventions based on experiences observed in various best practice cases in Asia.

With regard to prevention, the Commission’s analysis indicates that the costlier interventions (such as ensuring blood safety and safe injection) would prevent only about 1 per cent of new HIV infections. But such interventions would absorb more than 25 per cent (USD 1.7 billion of USD 6.4 billion) of the estimated total HIV response budget. On the other hand, the kind of focused response recommended in this Report could prevent 80 per cent of new infections with just 15 per cent of the total HIV response budget (USD 1 billion of USD 6.4 billion).

As Figure 3.9 illustrates, several of the interventions currently regarded as integral to a comprehensive prevention strategy under the global framework are best classified as high-cost/low-impact activities, described later in the chapter.

For example, life-skills education for young people tends to be promoted to prevent HIV transmission between young people who do not visit sex workers. Therefore, it would prevent a small percentage of new infections. The Commission’s analysis finds that if such interventions

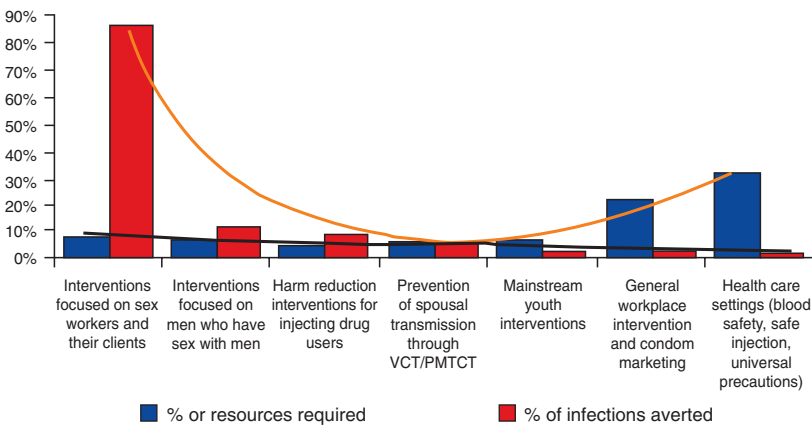


Figure 3.9: Comparison of prevention interventions, according to distribution of resources and percentage of new infections averted, 2007–2020

reached a large number of young people, they would cost at least 10 per cent of the total HIV response budget, but would prevent fewer than 1 per cent of new infections.

Nonetheless, the effects on the sexual and reproductive health of young people can be positive and substantial. Therefore, the Commission recommends that AIDS programmes advocate, catalyse, and leverage further 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.

Fund-raising efforts should not be relaxed. A projection of current resource availability for Asia shows that only USD 1.2 billion of the USD 6.4 billion needed annually for an effective overall HIV response would be available in 2007.²⁴ Resources are constrained. In light of this, it is wise 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.

Bearing that in mind, the Commission then used the Asia Epidemic Model to estimate the cost-effectiveness of various interventions. Its findings highlight the cost-effectiveness of interventions that focus on preventing infections in sex workers and clients. These require as little as USD 3.23 per disability-adjusted life year (DALY); in expanding epidemics, every USD 1 invested in appropriate prevention would save up to USD 8 in averted treatment costs over the next 20 years.

CLASSIFYING INTERVENTIONS BY COST AND IMPACT

Based on the analysis reported above, the Commission has classified HIV interventions into four categories, according to their effectiveness and cost:

- High-cost/High-impact
- Low-cost/High-impact
- Lost-cost/Low-impact
- High-cost/Low-impact

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. Indeed,

²⁴UNAIDS Global Resource Tracking Consortium (2004), 'Financing the expanded response to AIDS', UNAIDS, Prepublication Draft.

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.

Figure 3.10 shows their cost to be approximately USD 3.23 per disability-adjusted life year saved. In most of Asia's epidemics, these interventions could prevent up to 70 per cent of future HIV infections and save a correspondingly large number of DALYs. They therefore fit in the *Low-cost/High-impact* category.

Antiretroviral treatment, on the other hand, tends to be quite costly (approximately USD 2,000 or more per DALY saved), but the effectiveness of that intervention is high. Access to a continuum of antiretroviral therapy can save several years of life per person receiving the treatment. This intervention would fit in the *High-cost/High-impact* category.

The Commission proposes 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 fit into this category.²⁵

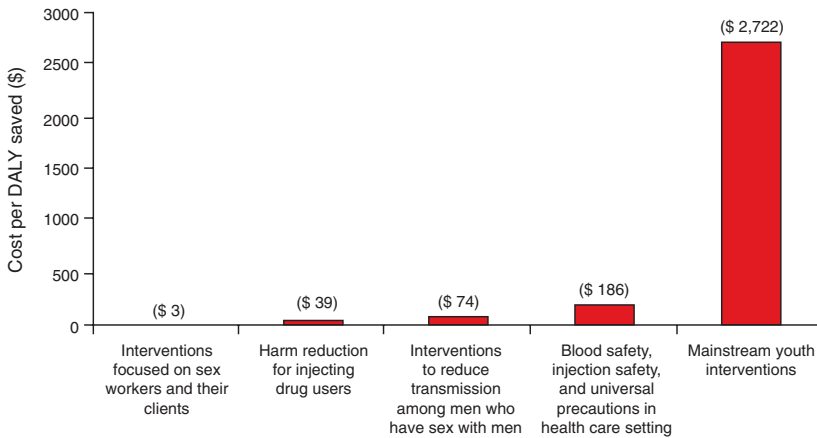


Figure 3.10: Prevention interventions: Cost per disability-adjusted life year (DALY) saved

²⁵Although most of the funds for antiretroviral drugs should be borne by the AIDS budget, other infrastructure and human resource costs should be absorbed by the general health budget. This would serve the larger purpose of integrating these interventions into the general health delivery system.

Table 3.2: Classifying HIV interventions according to cost and impact

		Costs per disability-adjusted life year (DALY) saved	
		Low cost	High cost
Effectiveness	High number of disability-adjusted life years (DALY) saved	Interventions that can prevent large numbers of new HIV infections quickly and at relatively low cost. <i>Examples include interventions focused on sex workers and clients, harm reduction programmes and prevention programmes for men who have sex with men.</i>	Interventions that are highly effective in preventing infections or averting deaths, but that are relatively costly. <i>Examples include antiretroviral treatment and programmes to prevent mother-to-child transmission</i>
	Low number of disability-adjusted life years (DALY) saved	Interventions where the impact is either low, long-term or difficult to quantify, but costs are also low. <i>Examples include mass media, AIDS awareness programmes, securing property and inheritance rights of women, improving girls' access to education, etc.</i>	Interventions that are costly and that have long-term or low impact on HIV infection or AIDS deaths. <i>Examples include health systems strengthening, such as blood safety and universal precaution measures.</i>

Source: Background paper for the Commission on Costing resource needs for Asia, available in the Technical Annex.

Note: Generally, interventions categorized under primary prevention (such as reducing poverty, eliminating gender inequality and life-skills education) are not included here because of their lack of documented impact on the HIV epidemic. It is also often difficult to estimate the cost per DALY saved or to estimate the total number of DALYs saved that can be attributed to such interventions. Generally, such interventions probably would fit in the Low-cost/Low-impact category.

Table 3.3 summarizes a budget for prioritized interventions, which would include:

- High-impact prevention activities: Interventions for sex workers and clients, drug users, and men who have sex with men, as well as focused programmes to prevent mother-to-child transmission and transmission within marriages and relationships;
- Treatment: Comprehensive package of first and second-line antiretroviral therapy, including all laboratory testing and subsidies for transportation;
- Impact mitigation: Livelihood security programmes for AIDS-affected women, and social protection for children orphaned by AIDS;
- Strategic information, surveillance, and monitoring and evaluation;
- Programme management.

Such a priority package 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.

As shown in Table 3.3, such an intervention package would cost about *USD 3 billion*, and 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 1 million families. Overall, the cost of such a HIV response would amount to less than USD 1 per capita per year.

An expanded response that also includes other long-term, low-impact interventions (along the lines of the resource needs estimates done at global level and adopted by the Commission to local costs) would cost around USD 6.4 billion annually in Asia.

The Commission believes that stronger global resource mobilization efforts should make additional resources available for mounting a full-scale, long-term, and sustained response. However, in the short-term the Commission recommends that part of the available resources be used to catalyse such long-term programmes, which are essential for ensuring sustainability and creating a supportive environment for AIDS programmes.

Table 3.3: Priority interventions, programme and related costs (USD millions) across the Asia region

	Total cost (millions USD)	% of total	Regional average per capita (range) (USD)
High-impact prevention	1,338	43%	0.39 (0.29–0.41)
Treatment	761	24%	0.21 (0.00–0.81)
Impact mitigation	321	10%	0.09 (0.03–0.18)
Programme management	363	12%	0.21 (0.005–0.21)
Policy and enabling environments	359	11%	0.11
Total	3,143	100%	1 (0.5–1.7)

Source: Background paper for the Commission on costing resource needs for Asia, available in the Technical Annex.

Note: Costs related to the creation of ‘enabling environments’ at the project level (see Chapter 4) have been additionally incorporated into the various line items of prevention, treatment, and impact mitigation.



WITH THE RIGHT CHOICES, HIV EPIDEMICS IN ASIA CAN BE EFFECTIVELY CONTAINED

If the countries of Asia adopt the approaches and programmes recommended in this Report, the benefits would be immense, in terms of lives spared, hardship averted, and resources saved. Such a response is affordable for most countries in Asia.

Efforts to combat a particular public health threat typically also yield other wider benefits. For example, the drive to combat cholera helped to improve sanitation systems in Europe, while the response to tuberculosis has helped improve hygiene practices and strengthen community health facilities, and response to avian influenza has promoted improvements in disease surveillance. Effectively addressing HIV brings a range of wider public health benefits, and serves as a platform for strengthening social development in Asia. Scaling-up national HIV programmes can help to improve health care delivery systems for marginal and poor populations, especially in countries with weak health systems. An HIV response of the kind recommended in this Report can also engender more productive relationships between the authorities and communities, and between various ministries and agencies themselves.

TECHNICAL NOTE

How Much will it Cost to Halt and Reverse the Epidemic? An Estimation of Priority Resource Needs for AIDS in Asia

The need to estimate the resources required for an effective AIDS response is a vital part of financing as well as mobilizing donor funding that properly addresses and reflects the appropriate national priorities in the region. In the past, global resource needs estimates have been calculated based on a broad spectrum of interventions, without necessarily reflecting the specific components involved or their relative priority and impact in addressing the epidemic.

The typical nature of the AIDS epidemic in Asia and the scenarios presented in Chapter 2 of this Report form a basis for prioritization of the interventions which will have the maximum impact in Asia. Through a review of best practices in HIV prevention and their expected levels of behaviour change, the Commission has suggested a standardization of the elements of intervention packages for important populations in Asia, the necessary coverage needed, the unit costs and the expected behavioral and epidemiological outcomes of these interventions, including their cost effectiveness. The results of this analysis have been presented in this chapter. This note explains the methodology used to generate the Commission's estimated priority resource needs for a high impact and effective AIDS response in the region.

It is important to note that the resource needs estimates presented here are based on regional averages and should be adapted by each country according to their own national and sub-national epidemic situation, local costs, and other local data.

The main steps involved in the estimation of resource needed for this Report are as follows:

- Characterizing the current phase of the epidemic for each country;
- Defining the package of interventions with maximum effectiveness for these countries in terms of population groups to be reached by prevention, treatment, care, and impact mitigation;
- Specifying the activities required for each intervention;
- Assessing the unit cost of such interventions on a regional basis;
- Estimating the resource needs for population-specific services by multiplying the average unit cost of services to one person by the size of the population to be reached;

- Summing the total costs and gains due to these interventions to get a regional average;
- Recommending a resource allocation norm for the region based on the calculation of the per capita resource need arrived above.

Phase of the epidemic

Following the four scenarios described at the end of Chapter 2, each country in this region has been classified as latent, expanding, maturing or declining. Based on the current epidemiological situation, no countries were classified into the maturing phase. The populations of the countries classified into each scenario were then summed to find the total population in each. This gave population sizes of 439 million in the latent phase, 2.87 billion in the expanding phase, and 79 million in the declining phase. Sub-national variations within countries were not taken into account for this rough estimation at regional level.

Most effective intervention package

The package of population-specific interventions that will produce a maximum prevention effect was presented in the technical note for Chapter 2 based on an Asian Epidemic Model for each of the four scenarios. In summary, all countries required interventions among IDUs, sex workers, and clients, and the MSM population except that in latent countries the MSM intervention was not factored in because prevalence among these men is assumed to be extremely low. If national MSM prevalence is already growing significantly, then this should be added even in the latent countries. Effective prevention strategies to target and reduce spousal transmission have yet to be developed in Asia despite the urgent need for them, but for the purposes of this estimation, the necessary costs of voluntary counselling and testing, and prevention of mother-to-child transmission services are added to all country scenarios. Voluntary counselling and testing will be an important component of any interventions to prevent transmission within married couples.

Treatment needs are estimated from the Asian Epidemic Model for each scenario. The need for first line and second line ART has been calculated based on an eight year average period between acquiring

HIV infection and need for treatment, with an average survival of 3 years after this if no treatment is provided.²⁶ After initiating first line antiretroviral therapy, it is assumed that 15 per cent will fail in the first year and 5 per cent every year thereafter creating a need to move them onto second line ART. Thus, in 2007, fewer than 1,000 people in the latent scenario countries, 955,000 in expanding, and 84,000 in declining scenario countries required first line ART. Second-line therapy was estimated to be required just over 55,000 and 5,000 persons in the expanding and the declining scenario countries, respectively.

A comprehensive impact mitigation programme in addition to ART for positive men and women was targeted at families of positive men with affected women and children being recruited through community organizations and the women being linked with income generating programmes. Cash transfers were assumed to be provided for foster families supporting children who were orphaned by AIDS. A recent estimate using weighted averages from several countries in the region, estimated that approximately 1 million orphans in the region are in need of such familial support.²⁷

Activities required for each intervention

Based on an analysis of existing best practices in the region, the standard minimum elements of interventions were extracted and their approximate cost was calculated, based on local knowledge and evidence. All three programme areas, that is, prevention, treatment, and impact mitigation, have common elements of peer education, management and capacity building for non-governmental and community-based organizations at project level, and creation of an enabling environment at local level along with commodities and supplies for prevention and treatment. These elements, as they pertain to the most effective intervention packages outlined above, and the costs of each element, are outlined in Tables 3.4 and 3.5 below.

Unit cost: The unit costs for each of the intervention packages were then calculated based on a review of local best practices in these

²⁶This is consistent with the current recommendation for estimating ART need set by UNAIDS Reference Group.

²⁷Background paper for the Commission on children vulnerable to and orphaned by AIDS; complete paper is available in the Technical Annex.

Table 3.4: Cost and elements of prevention interventions for high-risk populations

Activity	Periodicity
Peer education	<ul style="list-style-type: none"> Once in a fortnight
Prevention tools	<ul style="list-style-type: none"> Condoms to cover all sex acts for sex workers, MSM and IDU Clean needles for 80 per cent of all injections and 70 per cent of injectors
Prevention-related Treatment	<ul style="list-style-type: none"> STI care for sex workers and men who have sex with men (at least 2 visits/year) Methadone/buprenorphine treatment for at least 30 per cent of injectors
Enabling Environment	<ul style="list-style-type: none"> Local advocacy with power structures, promoting self-organization of community groups and affected people
Referral and NGO management	<ul style="list-style-type: none"> One-time cost to support capacity building and infrastructure development for NGOs. Also, to provide recurrent cost for staff time, management, monitoring and referral for ART and livelihood programmes

Source: *UNAIDS-ADB (2004), *Costing Guidelines for HIV/AIDS Intervention Strategy*, Bangkok–Manila.

Note: Buprenorphine cost is still high and unit cost is not available for a large-scale programme through Government-funded outlets.

Table 3.5: Cost and elements of spousal transmission

Activity	Periodicity	Estimated unit cost (per beneficiary)
Voluntary counselling and testing for male clients and their partners	<ul style="list-style-type: none"> At least once a year, outreach to recruit these groups, led by community-based organizations and NGOs 	US\$ 17
Prevention of mother-to-child transmission for women	<ul style="list-style-type: none"> At least once a year, led by community-based organizations of affected women and in collaboration with health care providers, to be carried out in 'hot spot' zones 	US\$ 129 (including screening costs)

Source: *UNAIDS-ADB (2004), *Costing Guidelines for HIV/AIDS Intervention Strategy*, Bangkok–Manila.

programmes, which include the essential elements of prevention, treatment, and impact mitigation programmes (described further in Chapter 5 and outlined in Tables 3.4–3.6).²⁸

²⁸A review of unit costs and cost-effectiveness analyses in the region is presented in the Technical Annex.

Table 3.6: Unit costs of prevention, treatment and impact mitigation, and programme management needed for an effective response

Intervention	Unit cost
Interventions for most-at-risk populations, including elements as outlined above.	100 USD
Treatment for adults including cost of transport and lab testing	450 (first-line) and 5000 (second-line) USD annual
Treatment for children	130 USD
Impact mitigation for affected women and children (in addition to ART cost estimated separately as above)	1000 USD per affected woman life time 100 USD per orphan per year
Surveillance and Programme Management	15 per cent of total programme cost
Enabling Environment at state and national level involves media and interventions required across all sectors	(10 per cent of the total cost of prevention and awareness interventions targeted for general population as presented in Table 3.1, excluding the costs of such prevention programmes as captured above)

Source: Background paper for the Commission on costing resource needs for Asia, available in the Technical Annex.

Coverage

Modelling and empirical evidence have demonstrated that if interventions reach at least 80 per cent of the target population of most-at-risk populations, the programme induces behaviour change in at least 60 per cent of the population—leading to the levels of behaviour change documented in a box earlier in this chapter and exceeding the minimum level needed to reverse the epidemic’s upward trend. By the same reasoning, then, prevention of mother-to-child transmission, antiretroviral therapy, and impact mitigation programmes are all targeted to reach at least 80 per cent of the targeted population to ensure a lasting impact on the epidemic.²⁹

²⁹Coverage for voluntary counselling and testing is targeted for those male clients who can be approached in clusters (for example mobile, migrant worker, sailors) or through existing testing networks like client initiated voluntary counselling and testing programmes or programmes for prevention of mother-to-child transmission. This will mean reaching approximately 1 per cent of adult male population and their female partners. The number of pregnant women who are positive is estimated based on the newly revised number of people living with HIV in the region.

Total and average cost

Using the steps described, then, the total annual cost of each component of an effective response in Asia was calculated in each of the scenarios (Latent, Expanding, Maturing and Declining) by multiplying the size of the target population for that component by the unit cost of the respective interventions. After the total prevention, care and impact mitigation costs were derived, a per capita cost was calculated for each of the areas (prevention, treatment, impact mitigation) in each of the scenarios by summing across all programme components.

In addition to these essential components for an effective response in Asia, there are several additional prevention interventions targeted at the general population like those for lower-risk young people, blood safety, etc. which may have little direct impact in reducing new infections or deaths, but which are important to the creation of an enabling environment. These components were itemized in the estimation of resource needs according to the global estimation procedures and calculated to cost USD 3.6 billion annually. Ten per cent of the costs of these less effective interventions was included in the priority response to ensure actions are catalysed and to enlist the collaboration and cooperation of relevant ministries and sectors that must deliver these services. The other 90 per cent is assumed to be additionally mobilized as more resources become available.

Programme management, including surveillance and strategic information, monitoring and evaluation, and administrative management was calculated as an additional 15 per cent on the cost of the programme.

Instead of country specific models, a regional AEM for a standard 100 million population was run for each of the four scenarios described, and the per capita costs calculated in that scenario. These per capita costs were then multiplied by the size of the total population in the countries classified into that scenario and summed across scenarios to get the total regional response cost.

Table 3.7 presents the per capita costs and relevant population sizes in each scenario, providing an overview of the calculation of the overall annual priority resource need of USD 3.1 billion.

The result shows that the average cost of prevention for most-at-risk populations varies between USD 0.2 to USD 0.3 per capita, ART cost USD 0.1 to USD 0.8 per capita and impact mitigation between USD 0.03 and USD 0.2 per capita with overall per capita response cost varying between USD 0.5 in the latent scenario countries to USD 1.7 in the declining epidemic countries with a regional average of USD 1. Although

Table 3.7: Estimation of priority resource needs in the region, according to scenario

Scenarios	Latent	Expanding	Declining	Total
No. of countries [†]	8	7	2	17
Total Population (millions)	439	2,873	79	3,391
Interventions	Average resource needs in USD (per capita)			Est. Resource Needs in millions USD (total = \$3,145)
Prevention of most-at-risk population	\$0.20	\$0.31	\$0.31	\$1,008
Reducing Spousal Transmission	\$0.09	\$0.09	\$0.10	\$330
Treatment by ART	\$0.001	\$0.24	\$0.81	\$761
Impact mitigation	\$0.03	\$0.10	\$0.18	\$321
Programme Management	\$0.05	\$0.11	\$0.21	\$363
Creation of Enabling Environment	\$0.11	\$0.11	\$0.11	\$359
Average total cost (per capita)*	\$0.48	\$0.97	\$1.72	\$0.93

Source: Background paper for the Commission on costing resource needs for Asia, available in the Technical Annex.

Notes: *Refers to the average cost per person (and not per adult).

[†]No country is currently in the Mature scenario.

this figure offers a regional estimate, cost for every country, state, province, and district will vary depending on the environment, the nature of the local epidemic, and the understanding of the need for a comprehensive but focused response.

It is estimated that successful implementation of a package funded at this level will reach 80 per cent of the most at-risk populations for prevention, provide ART for 80 per cent of those in need, and mitigate the impacts of HIV on 80 per cent of families, women, and children affected by AIDS. It will achieve a reduction in new infections of 60 per cent and reduce deaths by 40 per cent. This will reverse the regional epidemic as seen earlier in this chapter and will provide the essential ART and impact mitigation programmes needed to keep people living with HIV healthy and productive.

4

Towards a More Effective HIV Response

CHAPTER SUMMARY

- Risk behaviours among men and women do not occur in a social, economic, or cultural vacuum.
- The epidemics—and countries' efforts to control them—are shaped by two sets of overlapping factors: underlying factors that generate HIV vulnerability, and those that undermine or improve the provision and use of HIV services. HIV interventions cannot be effective and sustained without addressing these factors.
- The debate that pits a 'public health' approach against a 'development' approach is sterile and misleading. More useful is a pragmatic approach based on a solid understanding of the epidemics' dynamics, and the factors that drive HIV transmission and affect the effectiveness of HIV programmes.
- HIV-related stigma and discrimination continue to undermine Asia's response to the epidemic, and prevent people from accessing a range of important services. They must be addressed as an integral part of the HIV response.
- Governments should remove or relax legislation that supports the arrest and harassment of most-at-risk populations and service providers that seek to assist them.
- Often, what appears to be intractable resistance to respecting the basic rights of most-at-risk populations yields to thoughtful advocacy and bridge-building with local authorities and powerbrokers.
- In many Asian countries, especially in South Asia, laws and customs prevent women from inheriting or controlling property and other

assets. Such gender inequalities badly compromise women's economic security and reduce their abilities to avoid behaviour that involves high risks of HIV infection.

- Existing insurance and social security schemes should be extended in order to provide protection to AIDS-affected households.
- Skewed national sex ratios and increased migration among men and women are among the driving factors in several of Asia's HIV epidemics. But not all migrants are at higher risk of HIV infection.
- Creating an enabling environment by combating discrimination against sex work, homosexuality, and use of needles and syringes for drug use is a 'sine qua non' for effective prevention and treatment programmes among marginalized populations. Costs towards the creation of such an enabling environment at the local level should also be worked out and integrated into effective prevention programmes.
- The underlying societal factors must also be tackled if a focused public health approach is to achieve maximum effectiveness. But the responsibilities for addressing these social and developmental issues should be spread appropriately across the system.



THE COMPLEXITY OF THE UNDERLYING LINKS BETWEEN SOCIETAL FACTORS, ENVIRONMENT, AND HIV

Focused interventions that have proved successful in preventing the spread of HIV among most-at-risk populations are well-documented, and should form the core of HIV prevention programmes.¹

Free provision of treatment can help sustain the livelihoods of affected families. Impact mitigation, by way of social protection packages, will also reduce the adverse consequences of AIDS deaths at household, community, and national levels. Such interventions should be part of the core business of the HIV response.

But the challenge should not be oversimplified. 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 social dynamics, 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.

The dynamics that shape behaviour and affect people's vulnerability to HIV are sometimes referred to as 'social drivers' of the epidemics. They may include socio-economic and gender inequality, migration and mobility, trafficking of women, lack of information and education (especially ignorance about sex and HIV), discriminatory legal and policy barriers, and more. It is this multifaceted nature of the epidemic that calls into play the need for a multisectoral response to HIV.

Although relatively easy to describe at the conceptual level, it can be difficult to discern in practice the causal links that may exist between some of these factors and HIV. For example, it is often argued that poor women who lack access to education and social support may resort to sex work to earn livelihoods. Following this logic, poverty-reduction schemes that especially favour women would seem to help prevent HIV infections. The evidence indicates, however, that the links between poverty and HIV risk are highly complex, difficult to quantify,² and require sophisticated, long-term study.

¹See Chapters 2 and 3 for detailed discussion.

²S. Gillespie, S. Kadilyala and R. Greener (2007), 'Is poverty or wealth driving HIV transmission?', *AIDS*, 21 (supplement 7), pp. S5–S16.

‘AN ENABLING ENVIRONMENT’ CAN QUICKLY REDUCE MANY BARRIERS TO PREVENTION AND CARE

Many of the factors that deepen susceptibility to HIV infection also affect the extent to which people obtain access to HIV-related services. This aspect of risk reduction is often neglected both in the HIV literature and programme design, although it is occasionally captured in the concept of ‘enabling environments’. At the programmatic level, it is vital to identify and address factors that impede the scope, reach, operation, and use of HIV services.

For example, since large-scale poverty reduction schemes can require 20 years or more to yield tangible results, their impact on HIV transmission is even more difficult to quantify. Yet it is clear that people living in poverty are considerably less likely to gain access to healthcare services (even when provided free of charge), often because of the additional costs they entail (including transport expenses, opportunity costs such as loss of income, and more). Those barriers *can* be removed—for example, by providing subsidized transportation to clinics or by ensuring that clinics operate after-hours on some days of the week.

Such interventions will not eradicate poverty, but they can, in a short space of time, render important healthcare services more accessible to poor people. These kinds of initiatives are especially important when it comes to providing services to most-at-risk populations.

The successful implementation of HIV interventions therefore demands, first of all, that local-level barriers be addressed and that an ‘enabling environment’ must be created. This is not difficult to achieve. Often, what appears to be intractable resistance to respecting the basic rights of most-at-risk groups yields to thoughtful advocacy and bridge-building with local authorities and powerbrokers.

The epidemics and the efforts to control them are shaped by two sets of overlapping factors: the underlying dynamics that generate HIV vulnerability (or ‘social drivers’), and the factors that undermine or boost the provision and use of HIV services (the ‘enabling environment’). Progress is required on both fronts if an HIV response is to have a realistic chance of achieving lasting success. The question is how to achieve this, the subject to which we now turn.



INFORMATION AND KNOWLEDGE ENABLES PEOPLE TO MAKE BETTER INFORMED CHOICES ABOUT THEIR SEXUAL BEHAVIOUR

It is commonly believed that better knowledge about sexual and reproductive health can enable people to make better-informed choices about their sexual behaviour, and to guard their health with greater success. High levels of ignorance about HIV (and about sex in general) persist in much of Asia, largely because sex education is either poor or non-existent. Such ignorance is linked to societal norms and mores that associate sexual ignorance and inexperience in women with virtue.

Studies carried out in India and Viet Nam, for example, have shown that young women often know little about their bodies, pregnancy, contraception, or sexually transmitted infections, and that many avoid seeking information about sex for fear of being labeled promiscuous. A study among young brides in the Indian state of Uttar Pradesh found that 71 per cent of the women (some of whom had been in their early teens when they married) knew nothing about how sex occurs, and 83 per cent did not know how women become pregnant.³ In Viet Nam, more than two-thirds of young women (aged 15–24 years) did not know the three main methods for preventing HIV transmission.^{4,5}

Ironically, although notions of innocence, purity, and virginity are not imposed on men, many of them are also unschooled about sexual matters largely because they too have received little or no sex education. In a recent review of the Millennium Development Goal indicators for young people from nine countries in Asia, no country reported more than a 50 per cent level of sexual knowledge among boys, with some countries reporting as low as 3 per cent.⁶ In several Asian societies,

³M.E. Khan, *et al.* (2004), *Sexual violence within marriage*, Vadodara: Centre for Operations Research and Training.

⁴The three main methods for preventing the sexual transmission of HIV are: avoid penetrative sex, use condoms when having sex, or have sex only with one, uninfected partner.

⁵Committee for Population, Family and Children and ORC Macro (2003), *Vietnam Demographic and Health Survey 2002*, Calverton: Committee for Population, Family and Children and ORC Macro.

⁶Bergenstrom, A. and P. Isarabhakdi (forthcoming), 'Comparative analysis of sexual and drug use behaviour and HIV knowledge of young people in Asia and the Pacific', in A. Chamratrithirong and S. Kittisuksathit (eds), *HIV Epidemic among the General Population of Thailand: National Sexual Behavior Survey of Thailand*, volume 2, 2008, 2nd Report.

this aversion to sex education is rooted in taboos about the public discussion of sex.

Such ignorance includes even those people most at risk of HIV. More than half of the sex workers surveyed in the Indian state of Haryana did not know that condoms can prevent HIV transmission,⁷ while in Karachi (Pakistan) one in five female sex workers surveyed could not recognize a condom, and three-quarters did not know that condoms prevent HIV (indeed, one-third had never heard of AIDS). Not surprisingly, only 2 per cent of the women said they had used condoms with all their clients in the previous week.⁸

It is possible to overcome such ignorance among most-at-risk populations in ways that are non-judgemental and that do not fuel wider social prejudice and taboos. Thailand achieved this goal in the early 1990s. A recent study has confirmed the impact of the mass media campaign that was a central part of its 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 judgement. The study concluded that a well-designed mass media campaign is a prerequisite for a potentially successful HIV response.⁹

Knowledge of HIV was shown to be poor among surveyed groups of men who have sex with men. For example, in Bangalore (India) three in four men who have sex with men did not know how the virus is transmitted, and a large proportion of them reported not using condoms during sex.¹⁰ Basic HIV knowledge is also lacking among injecting drug users. A study among injectors in China's Yunnan province, for example, found that one in five did not know that needle-sharing carries a high risk of HIV transmission.¹¹

⁷MAP (2004), *AIDS in Asia: Face the facts*, Bangkok: Monitoring the AIDS Pandemic Network, available at http://www.mapnetwork.org/docs/MAP_AIDSinAsia2004.pdf.

⁸MAP (2005), *Sex work and HIV/AIDS in Asia—MAP Report*, July, Geneva: Monitoring the AIDS Pandemic Network.

⁹M. Sarkar (2007), 'HIV prevention mass media advertisements and impact on sexual behavior—A study of the 1990's mass media campaign in Thailand', Background paper for the Commission on AIDS in Asia; Full paper is available in the Technical Annex.

¹⁰J. Anthony, *et al.* (2006), 'Men who have sex with men in southern India: Typologies, behaviour and implications for preventive interventions', Abstract CDD0331, XVI International AIDS Conference, 13–18 August, Toronto.

¹¹J. Christian, *et al.* (2006), 'Risk behaviour among intravenous drug users and improved programming in Yunnan province, China', Abstract MOPE0479, XVI International AIDS Conference, 13–18 August, Toronto.



POVERTY AND INEQUALITY LIMIT ACCESS TO ESSENTIAL HIV SERVICES

Poverty greatly affects the risks people take. When basic needs such as food, clothing, and shelter are not met, individuals, particularly women, may find themselves drawn into sex work, for example. Poverty also diminishes the abilities of individuals, households, and families to deal with the effects of HIV infection. Often, the failure to manage an infection will lead to further impoverishment.

Nevertheless, income poverty appears *not* to be a significant risk factor driving Asia's HIV epidemics. Many (but by no means all)¹² drug injectors are poor, although often as a consequence of their addictions. While some clients of sex workers might be classified as poor, it is not their poverty that impels them to buy sex or not to use condoms. By definition, clients need disposable income in order to buy sex, and some are even willing to pay extra in order to have unprotected sex. At the macro level too, no clear relationship exists between income inequality (as measured by Gini coefficient)¹³ and HIV prevalence, as shown in Figure 4.1.

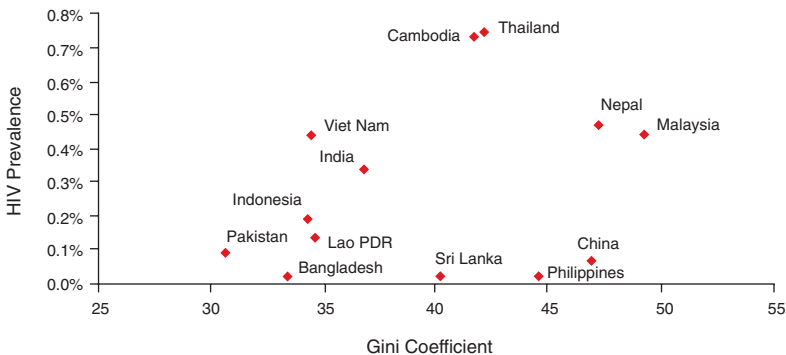


Figure 4.1: Association between HIV and income inequality is unclear

Source: Data on the Gini coefficient is extracted from the World Development Indicators, available at <http://www.worldbank.org/data>; HIV prevalence extracted from Commission's estimates using Asian Epidemic Model.

¹²Research in Indonesia, for example, found that a significant proportion of drug injectors were from middle-class backgrounds, and a large proportion of them were (at least *initially*) not socially marginalized: more than 4 out of 5 injecting drug users in three cities lived with their parents or family members, and had at least a high-school education (MAP 2004).

¹³Gini coefficient is a measure of inequality of income distribution, ranging from 0

Poverty in the context of HIV seems best addressed by removing factors that block access to prevention services and antiretroviral treatment. With respect to treatment, this goal can be achieved by the use of subsidies (including subsidies for transport and laboratory expenses) as well as by involving community groups and non-governmental organizations in the early recruitment of poor households into treatment networks and by ensuring that impact mitigation programmes reach them.¹⁴

GENDER INEQUALITY ENHANCES THE RISK OF HIV FOR WOMEN

Women and girls face a range of HIV-related risk factors and vulnerabilities that men and boys do not—many of which are embedded in the social relations and economic realities of Asian societies.

Women generally have more difficulty than men in gaining access to education, accessing credit and support services, and finding formal employment that matches their skills. In many countries, laws and customs prevent them from controlling property and other assets (especially in South Asia). These gender inequalities compromise women's economic security and reduce their ability to avoid behaviour that involve high risks of HIV infection.¹⁵ For that reason (and many others), such material inequalities must be addressed. However, removing or even significantly reducing them can take decades, even generations.

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. In a society dominated by patriarchal values, where men dominate decision-making in the household and society, women are not usually free to decide when and with whom to have sex, and whether or not to use a condom when doing so. 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.

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

(perfect equality, where everyone has equal income) to 100 (perfect inequality, where one person has all the income).

¹⁴Further details of components of impact mitigation programme, provided in the Technical Annex.

¹⁵UNAIDS/WHO (2004), *AIDS Epidemic Update—December 2004*, Geneva: UNAIDS.



persons living with HIV) and are more likely to take in orphans, cultivate crops, and seek other forms of income to sustain households.¹⁶ Gender inequalities tend to aggravate the vulnerability of such households, especially where women are denied equitable access to livelihood opportunities. Indeed, improved social protection policies for women are feasible in the area of impact mitigation, and some of these measures also offer opportunities for HIV prevention for women.

Economic assets, such as land and housing, provide women with a source of livelihood and shelter, thereby protecting them when a husband or father's disability or death places the family at risk of poverty. Control over such assets can give women greater bargaining power within households and can act as a protective factor in domestic violence. Research in the Indian state of Kerala found that 49 per cent of women with no property reported physical violence compared to only 7 per cent of women who owned property.¹⁷ Moreover, land and housing provide a secure place to live, serve as collateral for loans during financial crisis, and are symbols of status in most societies—all of which can benefit women who are contending with a health crisis in the household.

In many countries, laws and customs prevent women from owning or inheriting property and other assets. This is particularly true of South Asia where gender inequalities in women's rights to property significantly compromise women's economic security and reduce their ability to avoid situations that involve a high risk of HIV infection.¹⁸ Even where the law is not gender biased, women whose husbands or fathers fall sick and die of AIDS, or women who are sick themselves, often lose their homes, inheritance, possessions, and livelihoods either because of 'property grabbing' by relatives and community members or because they have no access to legal redress to regain ownership of property.

Legal and other obstacles that prevent women (including those widowed by AIDS) from inheriting assets must be removed. Special support (including cash transfers or subsidies for education, transport, and food expenses) should be available to families fostering children orphaned by AIDS. More generally, income support should be available to women in AIDS-affected households, irrespective of whether the women are infected with HIV. Also valuable would be the extension of

¹⁶J. Ogden and S. Esim (2003), *Reconceptualizing the care continuum for HIV/AIDS: Bringing carers into focus*, Desk review draft, Washington DC: International Center for Research on Women.

¹⁷S. Panda, *et al.* (2002), 'Drug use among the urban poor in Kolkata: Behaviour and environment correlates of low HIV infection', *The National Medical Journal of India*, 15 (3), pp. 128–34.

¹⁸UNAIDS/WHO (2004), *AIDS Epidemic Update—December 2004*, Geneva: UNAIDS.

existing insurance and social security schemes to ensure they provide protection to AIDS-affected households.

The potential benefits of such interventions extend far beyond AIDS-affected individuals and households. The HIV epidemic, in other words, provides countries with a valuable opportunity to strengthen social protection programmes for meeting catastrophic health expenditures. Such impact mitigation efforts fit best within existing or nascent social development programmes; they should not be set up as stand-alone programmes. The best approach is to integrate them into existing or future national social security programmes.

Where such programmes do not exist, AIDS budgets could be used to catalyse 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 actions for women.

IN SOME PLACES, MIGRATION CONTRIBUTES TO THE DEMAND FOR SEX WORK

Economic inequality in the midst of rapid development also tends to lead to large-scale migration, which may be associated with sexual risk-taking (mainly the buying or selling of sex).

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,¹⁹ and several studies have highlighted sexual risk-taking behaviour among some groups of migrants.^{20,21} A 2003 survey in the southwest of China found that temporary female migrants were 80 times more likely than non-migrants to sell sex.²² In Viet Nam, high levels of injecting drug use and sex work among young male migrant workers (16–26 years of age) underline the need for prevention programmes that reach migrants.²³

¹⁹J.D. Tucker, *et al.* (2005), 'Surplus men, sex work and the spread of HIV in China', *AIDS*, 19, pp. 539–47.

²⁰B. Wang, *et al.* (2006), 'HIV-related risk behaviors and history of sexually transmitted diseases among male migrants who patronise commercial sex in China', Abstract MOAC0305, XVI International AIDS Conference, 13–18 August, Toronto.

²¹C.J. Smith and X. Yang (2005), 'Examining the connection between temporary migration and the spread of STDs and HIV/AIDS in China', *The China Review*, 5 (1), pp. 109–37.

²²X. Yang and G. Xia (2006), 'Gender, migration, risky sex and HIV infection in China', *Studies in Family Planning*, 37 (4), pp. 241–50.

²³L.M. Giang, *et al.* (2006), 'HIV risks among young male migrants using heroin in Hanoi, Viet Nam', Abstract WEAD0204, XVI International AIDS Conference, 13–18 August, Toronto.



In Nepal, it is estimated that almost half of all people living with HIV have worked as migrant labourers.²⁴ 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.²⁵ There are also concerns about the potential role of migrant labour in Pakistan's epidemic. In Lahore, for example, one in ten (11 per cent) unmarried male migrant workers reported having had unprotected paid sex in the previous year.²⁶

Generalizations, however, 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.²⁷ It is therefore *not* the case that *all* migrants are necessarily at higher risk of HIV infection.

STIGMA AND DISCRIMINATION FUELS HIV EPIDEMICS

HIV-related stigma and discrimination continue to undermine Asia's response to the epidemic, and prevent people from accessing a range of important services. The take-up of HIV testing and counselling services is low and probably will remain so unless stigma and discrimination are reduced, and integrated prevention, treatment, and care programmes are more widely available. Equally, discrimination against people infected with or affected by HIV continues to affect their access to employment, housing, insurance, social services, education, and health care.

In several countries, studies in healthcare settings, for example, have documented disturbing levels of ignorance about HIV and strong prejudice against people living with HIV.²⁸ Stigma is a problem in the healthcare

²⁴WHO, UNICEF, UNAIDS (2006), 'Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections: Nepal', December, Geneva: World Health Organization, available at http://www.who.int/GlobalAtlas/predefinedReports/EFS2006/EFS_PDFs/EFS2006_NP.pdf.

²⁵J.G. Silverman, *et al.* (2007), 'HIV prevalence and predictors of infection in sex-trafficked Nepalese girls and women', *Journal of the American Medical Association*, 298 (5), pp. 536–42.

²⁶A. Faisel and J. Cleland (2006), 'Migrant men: A priority for HIV control in Pakistan?', *Sexually Transmitted Infections*, 82 (4), pp. 307–10.

²⁷T. Hesketh, *et al.* (2006), 'HIV and syphilis in migrant workers in eastern China', *Sexually Transmitted Infections*, 82 (1), pp. 11–4.

²⁸Asia Pacific Network of People Living with HIV/AIDS (2004), 'AIDS Discrimination in Asia, Bangkok', available at <http://www.gnpplus.net/regions/files/AIDS-asia.pdf>.

systems of both India²⁹ and China, among others. In a 2005 survey of almost 4,000 nurses in China's Guangxi, Sichuan and Yunnan provinces, for example, almost one in five (18 per cent) said patients with HIV should be isolated,³⁰ while in another study in Yunnan Province almost one in three (30 per cent) health professionals participating said they would not treat an HIV-positive person.³¹

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. In many ways, these groups are already marginalized and/or criminalized by the penal code, which makes it all the more important that their rights be protected. Sex work, drug injecting and sex between men is illegal throughout much of Asia. Licensed sex work is allowed only in the Philippines and Singapore. The possession of certain narcotics, meanwhile, can carry the death sentence in four Asian countries (China, Malaysia, Singapore, and Thailand). Sex between men is not illegal in only five Asian countries.

Irrespective of the legal status of such behaviours and the nominal rights of people engaging in them, the typical experiences of those people most-at-risk include harassment, and the (sometimes violent) violation of their basic human rights. Indeed, the experience of men who have sex with men 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.³²

The criminalization of those groups which are most-at-risk tends to drive them underground and fosters distrust of state officials and projects. Harassment not only makes it difficult to supply these groups with HIV services, as documented in Thailand (see Box 4.1), 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.

²⁹V.S. Mahendra, *et al.* (2006), 'How prevalent is AIDS-related stigma among health care workers? Developing and testing a stigma index in Indian hospitals', Abstract TUPE0729, XVI International AIDS Conference, 13–18 August, Toronto.

³⁰S. Sun, *et al.* (2006), 'Health providers' attitudes towards mandatory HIV testing in China', Abstract TUPE0782, XVI International AIDS Conference, 13–18 August, Toronto.

³¹T. Hesketh, *et al.* (2005), 'Attitudes to HIV and HIV testing in high prevalence areas of China: Informing the introduction of voluntary counselling and testing programmes', *Sexually Transmitted Infections*, 81, pp. 108–12.

³²K. Sovannara and C. Ward (2004), 'Men who have sex with men in Cambodia: HIV/AIDS Vulnerability, Stigma and Discrimination', Policy Project, available at <http://www.policyproject.com/pubs.cfm>.



Partly as a result of such heavy-handedness, ignorance about HIV and other health risks can be surprisingly widespread among the groups that are most-at-risk. Harassment discourages people from carrying condoms or clean syringes (to avoid giving the police a pretext for arresting them). The fact that injectors can buy needles in pharmacies is of little consequence if they risk arrest for being in possession of the needles; this is the reason most commonly cited by injectors in Indonesia and Nepal for not using clean equipment.³³

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.

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 design 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, healthcare providers, Government, and other civil society organizations. Indeed, people living with HIV often have led the way in forcing HIV into the public realm and by 'putting a face' to the epidemic. These issues have been discussed extensively in Chapter 6.

Stigma in healthcare 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 healthcare 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 been developed and tested and need to be used more widely.

HIV-related discrimination can be tackled in more 'literal' ways. A range of remedies is available. 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

³³MAP (2004), *AIDS in Asia: Face the facts*, Bangkok: Monitoring the AIDS Pandemic Network, available at http://www.mapnetwork.org/docs/MAP_AIDSinAsia2004.pdf.

forms of insurance, healthcare and social services and inheritance rights (particularly of women). More generally, HIV-related discrimination needs to be systematically monitored and publicized by 'AIDS Watch' bodies.

A few countries (notably China and Viet Nam) have altered their laws to grant drug users a legal right to needle and syringe exchange and drug substitution programmes. But 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 (an example of such a proposed legislation found in the Technical Annex).

Box 4.1: Harm Reduction—Learning from Successes and Failures

Although controversial, the scientific evidence regarding the effectiveness of harm reduction programmes is clear. Promoting safe and consistent access to sterile injecting equipment can cut the transmission of HIV. But the provision of clean syringes is not in itself sufficient. Those services must be provided in appropriate conditions, as the experiences of India and Thailand illustrate.

In Thailand, harm reduction was initially left out of the HIV prevention programme, with Government opting instead to detain and/or rehabilitate drug users. When harm reduction was finally introduced in 2005, the Government avoided needle- and syringe-exchange programmes, providing instead only methadone substitution treatment (analogous to despatching sex workers to sexually transmitted infection clinics but not providing them with condoms). By many accounts, the methadone clinics were less than welcoming, with patients complaining of abuse and stigmatization. And this occurred against the backdrop of a high-profile and highly aggressive 'war on drugs' which coincided with a 50 per cent drop in attendance at methadone clinics.³⁴

In Manipur in India, harm reduction interventions for injecting drug users in the early 1990s were also opposed by the police and Government authorities (who deemed it illegal), as well as by underground political groups (who only supported HIV projects involving total abstinence from drug use, and who reportedly threatened injectors and anyone helping them with violence). In such circumstances, launching a harm reduction programme seemed futile, but recognition of the rapidly growing epidemic among drug

³⁴UNAIDS (2006), 'From advocacy to implementation: Challenges and Responses to Injecting Drug Use and HIV', Speech delivered at XVII International Harm Reduction Conference, Vancouver, Canada.

users led to efforts to gradually put in place steps for the introduction of harm reduction.

The first step was to arrange meetings with representatives of the Government and various political movements, as well as intellectuals and journalists believed to be associated with underground political organizations. Intensive advocacy work was carried out, and politicians from the ruling party and opposition were briefed about the envisaged programme and its benefits. Eventually, elected assembly members at state level unanimously agreed to endorse the harm reduction proposal as policy, and support followed from other quarters, including the underground political groups.

Source: K. Singh (2000), 'Translating knowledge and experience into policy change and action—success stories from Manipur, India', Paper presented at the Global Research Network Meeting, 5 June, Durban, South Africa.

CREATE AN ENVIRONMENT TO FACILITATE SERVICES FOR MOST-AT-RISK GROUPS

Efforts to provide or use HIV services aimed at most-at-risk groups can encounter serious obstacles; but most of those obstacles can be removed by creating appropriate 'enabling environments'. Below is a checklist of relevant measures:

- the affected community must be involved in designing, implementing, and assessing delivery of the services;
- local power relations (involving the police, religious, and other social leaders, politicians, and local goons) and other factors that could affect the project need to be understood;
- interventions should incorporate elements that also address some of the other pressing, subjective needs of beneficiaries (such as child care for sex workers, legal support for dealing with police harassment, safe spaces that offer shelter against violence, or toilet and resting facilities for street-based sex workers);
- negotiations should be held with local power brokers and service providers;
- support is necessary for setting up and running local community organizations; and,
- budgets must include funding for these activities.

Avoiding HIV infection is seldom the main concern of sex workers or drug injectors, mainly because of the need to deal with daily hardships like police harassment, the threat of violence, and the need for safe shelter and income. Exhortations to practise safe sex or only to use clean needles

ring hollow. This is why it is so important that HIV interventions occur in ways that also address other, subjective priorities of those groups most at risk.

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 (whether HIV testing and counselling, treatment for sexually transmitted infections or finding a room to rent).

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 thugs are valuable elements of an HIV intervention. Providing a crèche for sex workers' children, facilitating the creation of retirement plans with bank-based savings, or offering a voluntary detoxification service for injecting drug users not only build trust but permit people to think beyond their immediate survival needs.

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.³⁵ Standard guidelines for costing such programmes have also been published.³⁶

In addition to addressing the stigma and discrimination experienced by people living with HIV and their relatives, special attention needs to be paid 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 them with livelihood security.

STRIKING THE RIGHT BALANCE—ADDRESS IMMEDIATE PRIORITIES AND CATALYSE LONG-TERM ACTIONS

Factors that hinder access to, as well as delivery and utilization of, HIV services have a direct bearing on the outcomes of HIV programmes.

³⁵NACO and UNAIDS (2002), *Costing of focused interventions among different sub-populations in India: A case study in South Asia, Delhi*, available at <http://www.nacoonline.org>; NACO (2004), *Costing guidelines for targeted interventions*, Delhi, available at <http://www.nacoonline.org>.

³⁶*Costing Guidelines for HIV/AIDS Intervention Strategies* (2004), Bangkok–Manila, UNAIDS-ADB.



Similarly, certain factors render some people particularly vulnerable to the impact of the epidemic. Although all such factors must be addressed as part of a comprehensive multisectoral response, they cannot be tackled in the same timeframe, or by the same institutions and with the same strategies. Some yield to short-term interventions, others require pervasive social changes that can take decades to achieve.

Balancing the short- and long-term approaches within AIDS programmes often poses a dilemma; finding the right balance is not always easy. As early as 1997, UNAIDS raised the concern that a focus on underlying factors that seemed to drive HIV epidemics might lead to the neglect of other urgent interventions that were more likely to bring short-term results. It also raised the important question of whether such manifold activities might compromise the focus, and drain the resources, of HIV programmes.³⁷

To varying degrees, these questions have been reflected in the planning and resource allocation decisions of countries over the past decade. Recognizing this, the Commission reviewed countries' practical experiences in dealing with these issues.

It is now recognized that there has been a relative failure to protect those people who are at immediate and high risk of HIV infection, and those who are especially vulnerable to the effects of AIDS illness and death. This is true despite the fact that the positive impact of practical, short-term interventions—of the kinds outlined above—is well-documented. In a similar vein, remedial measures are available for increasing access to and use of services that have been shown to reduce the risk of HIV infection. These more immediate actions are generally recognized, but they are seldom costed and integrated into countries' HIV strategies.

Take, for example, the relationship between sex work and HIV. The evidence shows clearly that reducing the number of men who buy sex and increasing condom use during paid sex are the two most important steps needed to stop the spread of HIV in Asia. But there is also a view that programmes that might help women avoid becoming sex workers should be given priority even when such programmes are unlikely to have a short-term impact on the HIV epidemic.

Similarly, many Governments seem to shun harm reduction programmes in favour of efforts to prevent young people from using drugs. While both those interventions are important, harm reduction

³⁷UNAIDS (1998), 'Expanding the global response to HIV/AIDS through focused action: Reducing risk and vulnerability: definitions, rationale and pathways', Geneva: UNAIDS.

should be given priority in designing the HIV response; the evidence shows that it leads to an immediate reduction in new HIV infections.

In light of this, the Commission recommends that:

1. Programmes that prevent new infections and that reduce the epidemic's impact by providing treatment, care and support services must remain at the top of the agenda in Asia, and countries should ensure that sufficient resources are made available to achieve this. The core business of HIV programmes should be clearly delineated and should focus on interventions that promise maximum effectiveness. At the same time, for an HIV response to achieve widespread and lasting success, the contextual factors that affect HIV interventions must be addressed—without sacrificing the focused approach advocated in this Report. The creation of an 'enabling environment', especially at the local level, is an essential contextual factor, which needs to be integrated into all components of HIV programmes.
2. The underlying dynamics that shape behaviours and affect people's vulnerability to HIV need to be properly understood and addressed to achieve maximum and long-term effectiveness of programmes. The responsibilities for addressing the long-term developmental goals need to be spread appropriately across the system, including civil society. In so far as they potentially relate to the HIV response, they can be supported from within the national HIV programme. HIV programmes can catalyse or provide seed funding for some initiatives, provide technical and other guidance for the design, implementation and monitoring of programmes that are vested with various sectors of social and economic development. National AIDS Commissions (rather than the national HIV programmes) should be responsible for advocacy and mobilizing resources from these sectors in order to mount a more comprehensive and multisectoral response to HIV in Asia.

These two items appear in Chapter 7 as Prevention Recommendation 1.3 and Policy Recommendation 7.3, respectively.

5

National HIV Responses in Asia

CHAPTER SUMMARY

- Many countries in Asia have been taking important steps toward strengthening their HIV responses. Unfortunately, these positive steps do not always fit into comprehensive and coherent HIV strategies—at least not yet.
- Even within countries, the quality of responses varies, depending on the kinds of interventions that are undertaken. Political engagement and support for HIV programmes have improved in several countries in the past 10 years. But in only two countries in Asia has a Head of State provided leadership to the national AIDS programme as its chair.
- The Commission found that national strategic AIDS plans vary significantly in quality. In some cases, resource allocations do not match the priorities highlighted in the national AIDS plans. Some national strategic plans fail to prioritize most-at-risk populations for prevention, or lack comprehensive antiretroviral treatment plans and impact mitigation programmes, particularly for women and children in high prevalence areas. Only six countries in Asia have costed their national AIDS plans.
- The magnitude of external funding for HIV made available to Asian countries in recent years has grown significantly, but domestic investment has not increased at the same pace. In fact, the percentage of total HIV expenditure funded out of national budgets has *decreased* in the 14 surveyed countries—from 60 per cent in 1996 to 40 per cent in 2004. Based on the normative standard of USD 0.50 to

USD 1.00 per capita, applicable to most countries in Asia, each country seems to be spending less than this requirement in the region.

- The coverage levels of prevention and treatment programmes are also inadequate, as are participation of affected communities in programme design and implementation, and the creation of policy and legal environments to support them.
- Only four of the 11 countries in Asia with HIV epidemics among injecting drug users are providing both needle exchange and drug substitution services from Government-funded outlets and only two of those involve peer outreach programmes.
- Among countries with sex worker interventions in place, only five have introduced large-scale peer education programmes, and two have launched nationwide information and education campaigns that target clients of sex workers.
- There is hardly any country which devotes significant resources to interventions for men who have sex with men.
- The current coverage to treatment programmes is also low, reaching one in four people in need.
- Impact mitigation programmes are not part of most national responses. Good governance and the creation of efficient and sustainable programme management structures (at various levels of service delivery) have had a profound impact on the effectiveness of HIV programmes in Asia.
- The emergence of broad-based, multisectoral responses, coupled with the growth in external funding (and partners), underlines a need for effective national coordination.
- Although they exist in most countries, National AIDS Commissions are not coordinating the HIV responses effectively enough. In many cases, National AIDS Commissions lack sufficient mandates, support, and direction from the countries' top political tiers.
- The Country Coordinating Mechanisms (CCMs) of the Global Fund have not always been successful as representative bodies of important stakeholders, especially the affected communities. The representation of the communities has been mostly tokenistic, and their participation in decision-making, ineffective.
- The Joint UN Programme on HIV/AIDS (UNAIDS) has succeeded in creating an impact on political advocacy and mobilization of resources for AIDS control. However, the Joint UN Programme has had less success in delivering coherent and coordinated technical support to Governments and communities for a scaled-up response.

CURRENT RESPONSES FALL SHORT IN MAKING A MAJOR IMPACT

The Asian experience has much to tell us—both good and not so good—about national HIV responses.

In a few instances, strong and focused efforts have brought striking results on a large scale, as the examples of Cambodia, Thailand, and the Indian state of Tamil Nadu reveal. 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 (see Box 5.1), but the degree of urgency, coherence, and scale needed to curb the epidemics is not yet evident.

All these experiences offer lessons for improving HIV responses in Asia to the point where the epidemics can be subdued and eventually halted. While there is no blueprint for the ‘ideal’ HIV response, Asia’s experiences to date reveal a series of prerequisites and pitfalls that can guide countries in their bid to strengthen the response to HIV.

Box 5.1: Signs of Progress, but Much Remains to be Done

In recent years, many countries in Asia have taken important steps toward strengthening their HIV responses.

- In Indonesia, HIV surveillance and data collection at district level now document behavioural risks and disease burdens; this allows planners to identify and zero in on geographic ‘hot-spots’ and anticipate new outbreaks of HIV infection.
- By including civil society in its HIV policies, and making safer sex work a priority, the Philippines has paved the way for a more focused HIV programme.
- China is fostering collaboration between its health authorities and law enforcement agencies in order to introduce harm reduction programmes for injecting drug users.
- Despite its rudimentary public health system, the Lao People’s Democratic Republic (Lao PDR) has expanded its antiretroviral therapy programme to the point where it now reaches more than 40 per cent of people in need of treatment.¹

These are important signs of progress. Unfortunately, these positive elements are not always embedded in a comprehensive and coherent HIV strategy—at least not yet!

¹WHO, UNAIDS, UNICEF (2007), *Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector, Progress Report*, Geneva: WHO.

It can take several years before the effects of a 'successful' national response become evident in the form of a decline in the national level of HIV prevalence. A drop in prevalence, therefore, is an imperfect indicator of the impact of an intervention. More useful indicators are the ones that allow for the assessment of the following aspects of HIV responses:

- political engagement and support;
- HIV programmes and strategic plans;
- resource mobilization and making the money work;
- civil society and community participation;
- the creation of a better policy and legal environment (especially in relation to HIV-positive persons and most-at-risk populations);
- institutional structures and governance;
- the external response and the role of international partners.

Box 5.2: National Responses in Asia are Evolving Unevenly

The Commission's analysis indicates that the HIV responses in Asia fit a predictable pattern:

- initially, responses are based on fear or denial. Countries try to halt the epidemic using laws and punitive measures;
- usually this is followed by an 'ad-hoc' response, as countries introduce more HIV interventions. Unfortunately, those efforts are often not informed by solid evidence;
- eventually the response improves and is shaped by scientific evidence, although problems of coverage prioritization remain;
- ultimately, a mature response is achieved, and Governments deploy the necessary financial, human, and institutional resources to achieve a sustainable and comprehensive HIV response.

In order to assess the status and evolution of country responses, the Commission conducted in-depth interviews with specialists and key informants from the public sector and civil society (including AIDS activists, programme managers, political figures, and community leaders). The Commission asked them to rank countries in relation to these four response stages. The findings are shown in Figure 5.1 below (The matrix used in this analysis is available in Technical Note at the end of the chapter).

While countries in Asia have made significant progress in their overall response during 1996–2006, their responses varied considerable when assessed in terms of the desired levels of quality and scale with respect to policies, strategies, programmes, and implementation.

In Figure 5.1, the square icon represents the Commission's assessment of the overall status of current responses, based on the assessments of specialists and key informants. However, the range and quality of the response varies, as depicted by the black lines.

Even within countries, the quality of response varies, depending on the type of intervention. For example, taken as a whole, Thailand's response has been quite advanced and has reflected strong leadership and resolute execution. Focused prevention in sex-work settings, which were based on

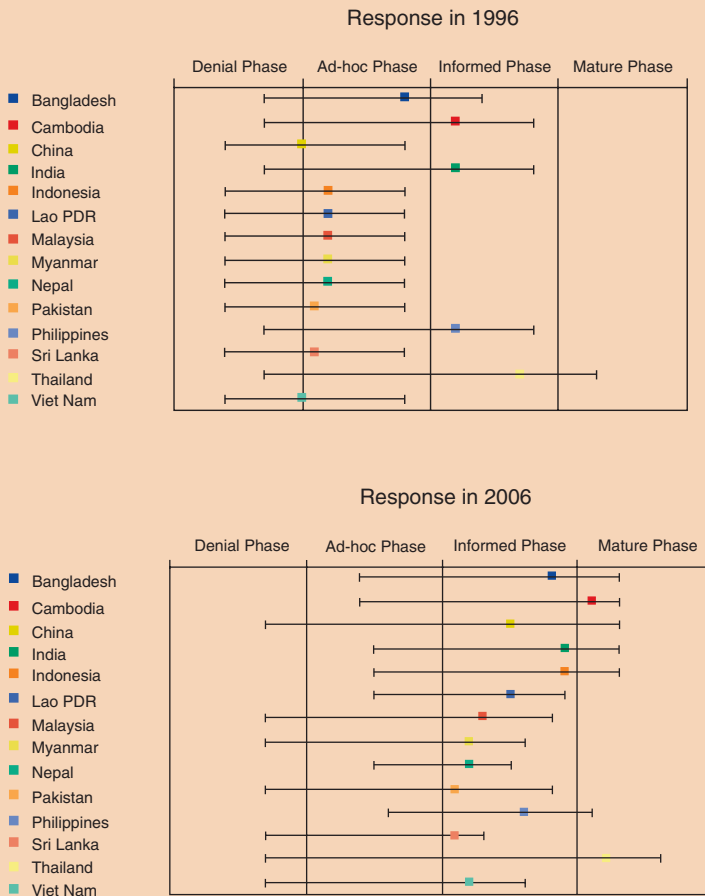



Figure 5.1: Review of national HIV responses in 14 Asian countries, 1996–2006

Source: Background Study on National Response for the Commission, available in the Technical Annex (2007).

strategic information and solid scientific evidence, placed Thailand's response in the 'informed' phase as early as 1996. The integration of treatment programmes into the national health care and social security systems² has helped ensure long-term sustainability of the antiretroviral therapy programme. However, prevention strategies did not reflect the need for harm reduction programmes, even when HIV prevalence among injecting drug users stayed at a level of 30 per cent for one decade.³

Consequently, Thailand's response matches more than one of the stages outlined above. The relative neglect of the epidemic among drug injectors corresponds to the ad-hoc or even the denial stage, while in its treatment programme and sustainable funding elements, Thailand is in the mature stage.⁴

China has surpassed most other countries in the region in terms of allocating domestic resources, and it has made impressive progress in providing harm reduction services. Its response also reflects growing leadership and commitment at the highest levels. On the other hand, it continues to try and 'rehabilitate' sex workers, and civil society organizations complain of a lack of co-operation from (and even harassment by) some provincial authorities. Thus, China's overall response fits in the advanced informed phase, while some elements lag behind in the denial or ad-hoc phase.



POLITICAL ENGAGEMENT NEEDS TO BE STRONG

Strong political commitment and leadership have proved to be prerequisites for setting the agenda and driving a potentially effective response. It was decisive in Thailand's response in the early-to-mid 1990s, and it provided vital impetus to the HIV programmes that have unfolded subsequently 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 their countries' HIV responses. Parliamentary committees on HIV have been set up in a few countries, and they have also given rise to regional networks that focus on HIV and sexual and reproductive health.

²The Thai 'health security scheme' provides universal coverage of health care services; for more information, please see National Health Security Office (<http://www.nhso.gov.th>).

³National surveillance data published by Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health, Thailand, *HIV Serosurveillance in Thailand*, December 2007, Bangkok.

⁴In Figure 5.1, the black lines depict this variability, while the small blocks reflect the Commission's overall assessment of the country's response—in this case 'Mature'.



When it comes to dealing with issues of stigma and discrimination, and overcoming taboos on the public discussion of sex and sexuality, the role of leadership cannot be underestimated. This is particularly true in Asia, because the epidemic is driven by stigmatized behaviours such as drug use, sex work, and sex between men. 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. Political commitment is also important for instilling a sense of urgency.

Much has been made of the need for explicit support from political leaders. Indeed, leaders of all the countries in the region signed the UN General Assembly Special Session (UNGASS) Declaration,⁵ and later committed their countries to the Universal Access initiative.⁶ Unfortunately, in many cases those official commitments have not yet translated into sufficient and tangible actions at national level.

In only two countries in Asia has a Head of State, for example, provided leadership to the national AIDS programme as its chair. Other elements of demonstrable leadership would include championing practical policies, ensuring adequate resources, and establishing a strong management structure (such as a National AIDS Commission), and involving civil society in the response.

As Figure 5.2 shows, political commitment changes over time. The information used to compile this graph was drawn from a leadership mapping study conducted by the Asia Pacific Leadership Forum (APLF). It found that most countries in the region strengthened their political commitment to the HIV response, although some lost ground after having achieved initial success in controlling their epidemics.

In the Philippines and Thailand, political leadership appears to have lost momentum over the period surveyed, while in Cambodia, China, India, Indonesia, and Malaysia, it has increased considerably. It is important to understand what prompts political leaders to embrace and then remain committed to HIV advocacy and action. In some cases, strong advocacy and activism have spurred leaders into action, but generally,

⁵The UNGASS Declaration, signed at the UN General Assembly Special Session on HIV/AIDS in 2001, was a commitment to prevention, treatment and care, and accelerated research to achieve the Millennium Development Goals of halting and reversing the spread of HIV by 2015.

⁶The Universal Access initiative arise from the UN General Assembly's 2005 High Level Meeting on AIDS, where the Political Declaration commits to set ambitious national targets for prevention, treatment, and care by 2010.

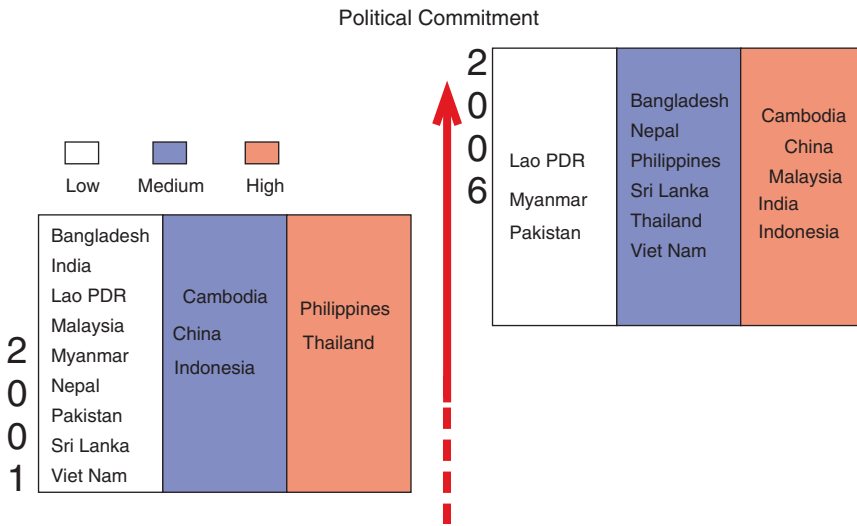


Figure 5.2: Shifts in political leadership on AIDS

Source: Asia-Pacific Leadership Forum (2006), ‘Background Study on Leadership in the Region’ (unpublished), presented at the Asia-Pacific Leadership Forum Steering Committee Meeting, April 2007.

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 (for example, the Philippines).

What is clear currently is that political leadership on HIV needs to be strengthened in Asia as well as sustained. The process of building impetus tends to originate within the community of AIDS activists—as has been evident in countries as diverse as Brazil, South Africa, and the United States of America.

HIV PROGRAMMES AND STRATEGIC PLANS STILL LACK KEY PLANNING COMPONENTS

The Commission’s review of HIV responses in 14 Asian countries⁷ revealed that all of them have national strategic plans, but the quality of those plans varies significantly. Some countries lack the necessary

⁷The 14-country review includes: Bangladesh, Cambodia, China, India, Indonesia, the Lao People’s Democratic Republic, Malaysia, Myanmar, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand, and Viet Nam; the detailed review is available in the Technical Annex.



strategic information to create an informed response, while others are premised on incomplete interpretations of the data. In some national plans, resource allocation does not match the priorities highlighted. A few plans seem to be based on misinterpretations of international best practices. Overall, most of the plans still lack key planning components for the operation, management, and financing of the response.

Better use of strategic information is required in the preparation of national plans

In the initial stages of HIV epidemics in Asia, incomplete or unreliable HIV and behavioural data made it difficult to identify the most effective interventions, pinpoint areas where interventions should be concentrated, and deploy resources efficiently. As a result, programming priorities and spending decisions have not always matched the epidemiological realities in countries. In some places, a patchwork of interventions has emerged. In other cases, although apparently comprehensive strategies were devised that sought to address every facet of the epidemic, these stretched resources and capacity so much that the results were disappointing.

Used effectively, strategic information can have a powerful impact on the epidemic. In Thailand, for example, following the analysis of high-quality information on HIV transmission patterns and trends, the identification of epidemic 'hotspots' and their associated risk behaviours laid the basis for a focused and highly effective response.⁸

HIV data collection has improved in several Asian countries over the past decade, and eight countries now have second-generation surveillance⁹ (Bangladesh, Cambodia, India, Indonesia, Nepal, the Philippines, Thailand, and Viet Nam). Unfortunately, the push for such surveillance still tends to come more from external donors than national agencies. While several international agencies provide country level HIV projections, only five countries (Cambodia, Indonesia, Myanmar, Thailand, and Viet Nam) generate their own projections, and only three countries (Bangladesh, India, and Indonesia) have information that makes it possible to prioritize and focus interventions at the sub-national level.

Once collected, high-quality HIV information needs to be analysed before it becomes useful for policymaking and programme design. The

⁸UNDP (2004), *Thailand's Response to HIV/AIDS: Progress and Challenges*, Bangkok: UNDP.

⁹Second-generation surveillance systems refer to the collection of biological (such as HIV and STI prevalence) and behavioural (such as frequency of condom use and safe injecting behaviours) data.

systems and capacity to analyse the information and channel those findings into policymaking still pose a challenge in many countries, although Bangladesh, Cambodia, China, India, Indonesia, Nepal, and Viet Nam are among the countries that have strengthened their capacity to meet the challenge.

Some national strategic plans are skewed towards treatment provision. Others fail to give priority to those groups most at risk of infection; still others lack comprehensive plans for antiretroviral treatment and impact mitigation programmes in high prevalence areas.

The right focus and a supportive environment are essential for effective programmes

Even when those groups most at risk are identified as a priority for prevention, Governments must ensure that an effective approach is adopted. In many cases, efforts to mobilize strong leadership and resources are later undermined if the interventions fail to reduce HIV risk and transmission in the targeted groups.

For example, in the first reporting phase on progress in reaching the UNGASS targets, one country reported that 80 per cent of injecting drug users were being reached with HIV interventions. In reality, these so-called HIV interventions entailed massive arrests of drug users, partly in the hope that confinement in correctional institutions would force them to abandon their risky behaviour. There is no evidence anywhere that such tactics have such an effect. By contrast, there is ample evidence that access to clean needles and drug substitution programmes do reduce risky behaviour.

Box 5.3: Programmes That are Effective have Several Components

Once the elements of a comprehensive programme for prevention, treatment, and impact mitigation have been defined, country responses can be assessed in terms of their implementation of such programmes. After reviewing the HIV literature, the Commission concluded the following elements are essential:

- **Community engagement:** Peer education should be led by communities—either most-at-risk groups themselves, or networks of HIV-positive people or affected communities and women. Such education and outreach

should include provision of accurate information as well as recruitment and facilitating access to services;

- **Access to commodities:** Programmes must ensure the availability and accessibility of commodities, including condoms and lubricants for all most-at-risk populations; clean needles and syringes for injecting drug users; and both first- and second-line antiretroviral drugs for treatment;
- **Care and treatment services:** These include treatment for sexually transmitted infections, voluntary counselling and testing, drug substitution programmes (methadone, buprenorphine and others), laboratory testing (CD4, CD8 and viral load), home-based care, and women-friendly microfinance or other income generating services; and
- **An enabling environment:** Finally, successful interventions must be implemented in the context of an 'enabling' environment. This includes policies and regulations that are supportive and allow groups most at risk to access services and practise safe behaviour without threat of arrest or harassment. It also means protecting HIV-positive people against discrimination when accessing treatment, and creating a supportive environment for affected family members (especially women).

These elements specified above are necessary but not sufficient to an effective response. Four additional prerequisite conditions are needed for the successful implementation of an effective response: (1) supportive legal and policy environment; (2) political support and leadership action; (3) sufficient operational, long-term investment, and human resource plan; and (4) management of implementation.

A review of country programmes reveals considerable room for improving services for most-at-risk populations.

Currently, only four of the 11 countries in Asia with HIV epidemics among injecting drug users are providing *both* needle exchange and drug substitution services through Government-funded outlets—and only two of those involve peer outreach programmes. Among countries with HIV threats in the sex trade, only five have introduced peer education programmes, and only two have launched nationwide information and education campaigns that target sex work clients. Few countries are devoting significant resources to interventions for men who have sex with men.

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 four of those plans address all three groups that are most at risk, and none contains all of the effective intervention elements

described above. In particular, the element of 'enabling environment' is currently missing from almost all focused interventions for most-at-risk groups.

Implementing strategic plan calls for strong management and adequate resources

Even the best-designed programmes are difficult to implement if they lack supporting operational, management, and financing plans. In this respect, there is much room for improvement.

Among countries that have designed plans for effective interventions, for example, only six have costed those plans. Consequently, most countries in Asia cannot currently guarantee sufficient programme coverage, adequate financial and human resources, or reliable procurement processes for the various drugs and prevention commodities that are needed.

A case study from China illustrates the problem. 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.

Cambodia, on the other hand, has shown that adequate operational planning and finance can enable a rapid scale-up. Despite both economic and infrastructural obstacles, the Cambodian Government has been able to effect a significant improvement of its testing and treatment services.

Monitoring coverage of HIV programmes is important to highlight gaps

Coverage ranks high among the several yardsticks for measuring the effectiveness of HIV programmes. In the kinds of HIV epidemics that predominate in Asia, substantial coverage is particularly required in four areas:

- HIV prevention information and services for most-at-risk populations;
- provision of antiretroviral treatment including to HIV-positive pregnant women for prevention of mother-to-child transmission; and

- impact mitigation activities for poor and vulnerable people and households (including widows and orphans).

Since the late nineties, even though resources available for HIV interventions have grown dramatically, coverage of HIV services for groups most at risk has remained more or less stagnant in Asia. Despite the growing recognition of the need to reach high-risk groups, coverage of prevention services for such people remains low (see Figures 5.3 and 5.4).

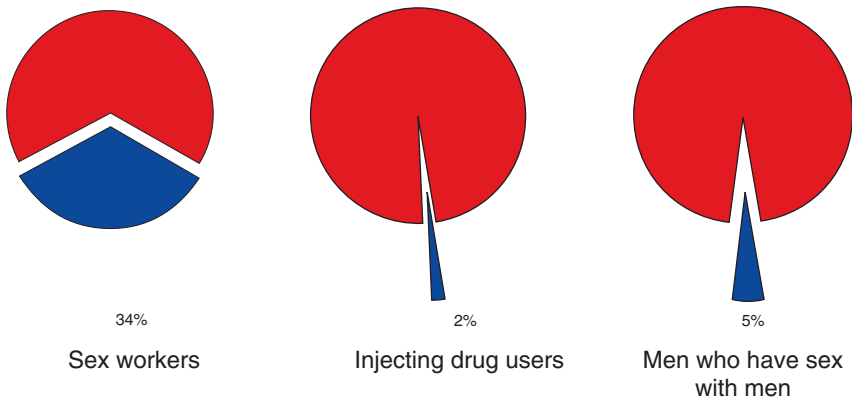


Figure 5.3: Coverage of most-at-risk populations by HIV prevention services in Asia, 2005

Source: J. Stover and M. Fahnstock (2006), *Coverage of Selected Services for HIV/AIDS Prevention, Care and Treatment in Low- and Middle-Income Countries in 2005*, Washington, DC: Constella Futures, POLICY Project.



Figure 5.4: Coverage of HIV treatment services in Asia, 2005

Source: WHO/UNAIDS/UNICEF (2007), *Towards Universal Access: Scaling-up priority HIV/AIDS Interventions in the Health Sector, Progress Report*, April 2007, Geneva.

To reverse the epidemic, it is necessary that effective prevention services reach a critical mass of people who are most-at-risk of HIV infection. That threshold of coverage is estimated to be in the region of 80 per cent as shown in Figure 5.5.¹⁰ Yet, coverage levels are still a long way short of that target.

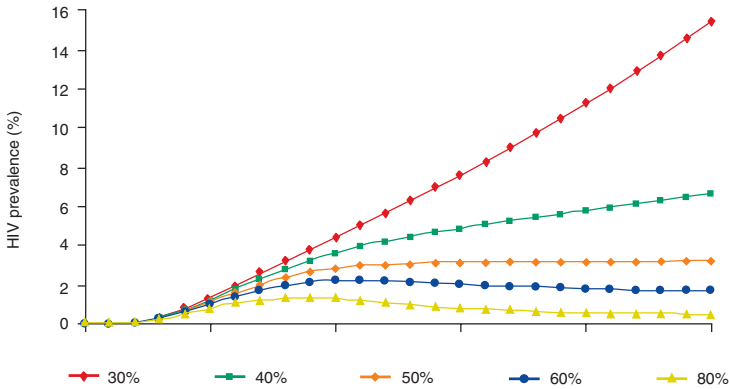


Figure 5.5: Coverage must reach 80 per cent to initiate the 60 per cent behaviour change needed to reverse the epidemic

Source: Commission’s estimates using Asian Epidemic Model, based on regional averages.

As discussed in Chapter 4, the availability, accessibility, and use of HIV services by groups most at risk of infection depends on a range of factors, including the levels of stigma and discrimination in a society, law enforcement policies and practices, and the extent to which organizations or representatives of those populations participate in the response.

With regard to commercial sex, in addition to progress made at the national level in Cambodia and Thailand, significant local-level progress has been made in other places (for example, Sonagachi in Kolkata, India, and the SHAKTI project in Dhaka, Bangladesh). But these successes are yet to be replicated successfully on a national scale.

Across Asia as a whole, only about one in three sex workers were being reached by HIV prevention services in 2005, while only one in 50

¹⁰Modelling (using AEM and HIV Toolkit) indicates that about 60 per cent of most-at-risk populations need to adopt safer behaviours if HIV epidemics among them are to be reversed, and service coverage has to reach about 80 per cent for that level of behaviour change to occur.



injecting drug users and about one in 20 men who have sex with men had access to prevention services. Indeed, successful programmes for men who have sex with men are scarce in Asia.¹¹ Yet the exceptions, such as the AKSI Stop AIDS project in Jakarta (Indonesia), have shown how effective such interventions can be.¹²

Meanwhile, about nine out of ten pregnant women in the region are not being reached by the prevention of mother-to-child transmission services. In some countries, this is partly attributable to the lack of institutional services for pregnant women generally. 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.¹³ In addition, countries where most deliveries occur outside the formal health system (such as Cambodia, India, the Lao People's Democratic Republic, and Nepal), service provision remains poor.

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. A few countries, notably Cambodia, have used these opportunities to expand HIV testing, treatment, and care provision. But despite the comparatively small numbers of people in need of antiretroviral treatment in Asia overall, few other countries have followed suit. As a result, only about one-fourth of the people in need of antiretroviral treatment in Asia are receiving it.

URGENT NEED: MORE RESOURCES AND MAKING THE MONEY WORK

One of the major changes in the past decade has been the vast increase in financial resources now available to countries for fighting their HIV

¹¹J. Stover and M. Fahnstock (2006), *Coverage of Selected Services for HIV/AIDS Prevention, Care and Treatment in Low- and Middle-Income Countries in 2005*, Washington, DC: Constella Futures, POLICY Project.

¹²UNAIDS (2007), 'Men who have sex with men: the missing piece in national responses to AIDS in Asia and the Pacific', Bangkok: UNAIDS RST-AP.

¹³WHO, UNAIDS, UNICEF (2007), *Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector: Progress Report*, Geneva: WHO.

epidemics; much of it available via the Global Fund to fight AIDS, TB, and Malaria, and the World Bank, as well as bilateral funding agencies.

Nevertheless, domestic investment has not increased at the same pace. The Global Fund, for example, has approved more than USD 600 million for 18 Asian and Pacific countries, with the bulk of the funds earmarked for AIDS programmes. The Gates Foundation is investing more than USD 200 million in India, while in the UK, the Department for International Development (DfID) has committed an additional USD 45 million to aid Indonesia’s HIV response. At the same time, domestic spending on HIV-related programmes in Asia has increased at a slower rate than in other regions.

Box 5.4: Challenges of Resource Mobilization and the Role of the Global Fund (GFATM)

Funding for HIV has increased dramatically over the past decade and in particular with the establishment of the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM). Multi- and bilateral donors have played an increasingly important role in the AIDS response, but the need for a substantial increase in resources remains. The Global Fund, with annual disbursement of nearly USD 190 million, is emerging as the largest donor in Asia, with grants increasing more than ten times in the last five years. The World Bank’s funding during these years has remained stable (around USD 100 million per year) with its main focus on South Asia. Funds need to increase from the current availability of USD1.2 billion

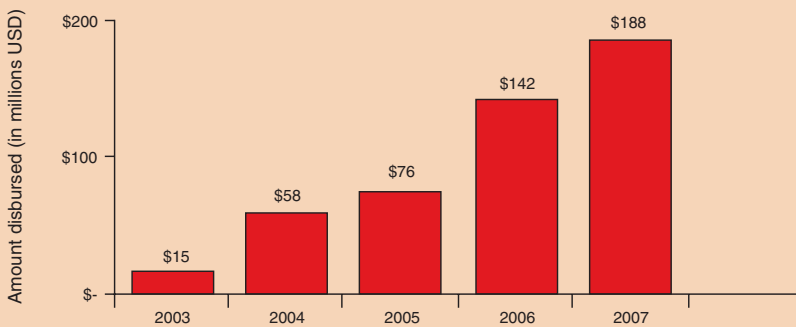


Figure 5.6: Global fund disbursements for AIDS in the Asian region, 2003–7

Source: Global Fund for AIDS, TB and Malaria, Geneva, courtesy Suman Jain, personal communication (2008).

annually (including both public and private resources) to at least USD 3 billion to produce a direct impact and to USD 6 billion for a comprehensive response.

The large burden of resources therefore falls upon the national Governments and families, the latter covering more than three-quarters of overall health expenditure in the region through out-of-pocket expenditure. Indeed, Asia has the lowest per capita public expenditure on health in the world and even in the future, it seems that a large proportion of spending may still need to be covered by the private sector and out-of-pocket spending. Strategic planning has so far given little attention to public–private sharing that might enhance efficiency and successful priority setting in mounting a comprehensive AIDS response.

It is noted that even a full expansion of the programme for AIDS care and support to a comprehensive response 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. Even despite this fact, 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, but resources alone are not enough. They must be accompanied by staff training, introduction of testing equipment, increased skills in policy and advocacy for behavioral changes, and a host of related infrastructure improvements for the health sector as a whole. Increased funding can enable an effective response, but many organizational and operational changes must also take place to ensure effective implementation.

In light of earlier discussions in this chapter, it is time that donors—particularly the Global Fund—shift away from project-based funding, towards funding AIDS programmes, and that bilateral donors fund high impact activities and remove such conditionalities, which are hampering the flow of resources to these priority programmes. UNAIDS must play a larger role in assisting countries in identifying priorities and estimating resource needs, and encourage donors to fund these priorities.

Source: Background Paper for the Commission on the Socioeconomic Impact of AIDS in Asia; ADB/UNAIDS (2004), 'Background Research Paper 1: Funding Required to Confront the HIV/AIDS Epidemic in Asia and the Pacific Region', Manila/Geneva.

Figure 5.7 shows how current public expenditures on AIDS compare with the normative resource needs for an HIV response, as defined in Chapter 3. The resources required differ depending on national HIV prevalence and must cover five essential programme elements: prevention, treatment, impact mitigation, policy and programme management (including the creation of an ‘enabling environment’), and monitoring and evaluation. Even in countries such as Cambodia and Thailand, HIV expenditure still falls short of the estimated amounts needed to fund full prevention, treatment, and impact mitigation services that can curb the epidemic and its impact.

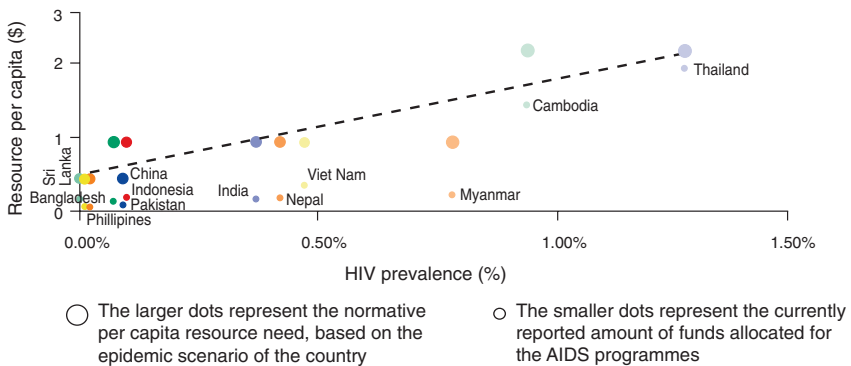


Figure 5.7: Resource commitments from countries compared with normative estimates of resource needs

Source: Background paper for the Commission on Costing resource needs for Asia, available in the Technical Annex.

As available resources for funding HIV programmes have increased, the percentage of total HIV expenditure funded out of national budgets has *decreased* in the 14 surveyed countries—from 60 per cent in 1996 to 40 per cent in 2004. There are two notable exceptions to this trend: China, where domestic funding now accounts for almost 60 per cent of total AIDS expenditure, and India, where domestic funding has reached almost 50 per cent in 2005 (up from 10 per cent in 2004 as shown in Figure 5.8).¹⁴ In the other surveyed countries, the ratio of domestic to external funding has remained the same or decreased, as Figure 5.4 shows.

The increase in external funds available for HIV programmes makes it easier for countries to fund their HIV responses. But it can pose other difficulties. Medium- to long-term sustainability of some programmes may

¹⁴Although the 2004 data given represents AIDS expenditures, the references to India and China are based on resource allocation estimates after 2004.

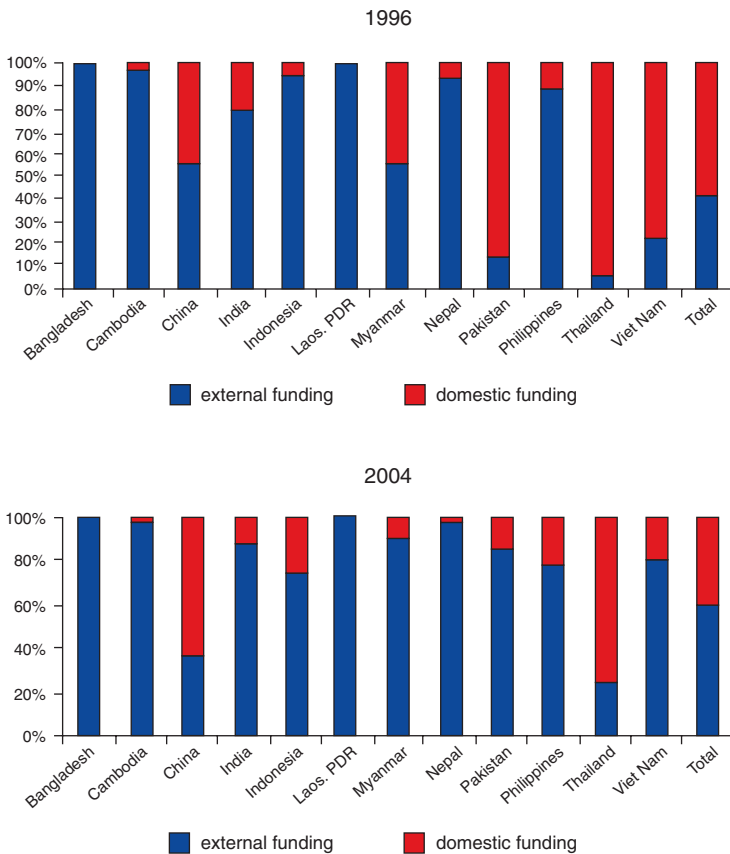


Figure 5.8: National budgets as a proportion of total AIDS funding in 12 Asian countries, 1996 and 2004

Source: UNAIDS-Harvard School of Public Health (1999), *Level and flow of national and international resources for the response to HIV/AIDS, 1996–1997*, Geneva: UNAIDS. Background study for the Commission on the socioeconomic impact of AIDS in Asia (2007).

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, and even muddled; governments' 'ownership' and sense of responsibility for their HIV responses might suffer.

Besides the need to mobilize additional national resources for HIV programmes, it is necessary to ensure that available resources (external and domestic) are used to maximize effect. At the very least, this

requires that funding priorities match the patterns and trends of the epidemic. Here, too, countries in Asia have an opportunity to improve their performance.

Donor funding sometimes does not reflect or fit well with the national (or sub-national) priorities laid out in countries' national strategic plans. Donors sometimes select and fund projects in ways that lead to disjointed and duplicated interventions. A Global Fund (Round 6) grant to Bangladesh, for example, provides USD 40 million for awareness education for young people, while peer educators for sex workers (who could prevent a much larger proportion of new infections) have been left without funds due to lack of donor interest.¹⁵

Donors should align their funding strategies to an empirically sound understanding of what interventions are most likely to have the greatest impact in preventing HIV infections, treating people living with HIV, and mitigating the epidemic's impact. Guidelines for assigning relative priority of interventions, according to epidemiological and other local evidence, are provided in Chapter 2.

Note, though, that it is not only donors who mismatch resources against strategic priorities. For example, in Thailand, where the Government funds almost 80 per cent of the HIV budget, there is a marked bias toward treatment, as shown in Figure 5.9. More recently, Thailand

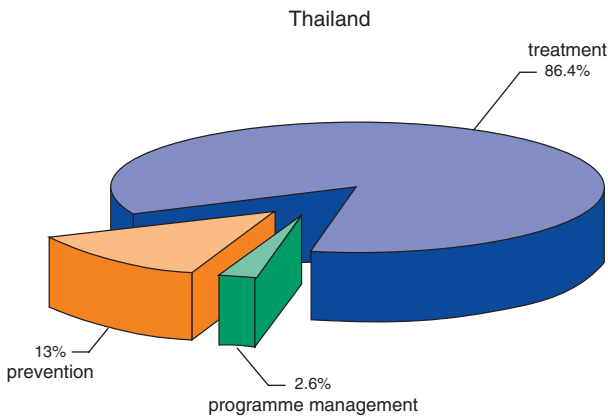


Figure 5.9: Spending priorities in Thailand are strongly biased toward treatment

Source: Commission Background Paper on National AIDS Spending Assessment (NASA) in Asia, 2007.

¹⁵Based on the Commission's findings, which are discussed in detail in Chapter 6.



has been working to revitalize its prevention efforts and mobilize additional prevention funding.

CIVIL SOCIETY AND COMMUNITY INVOLVEMENT IS CRITICAL

It is widely accepted that national HIV responses tend to be strengthened when community-based and non-governmental organizations are able to participate in policy development, programme planning, and implementation. Cambodia, India, and the Philippines are among the countries that offer tangible evidence for this proposition. But the opportunities for genuine community participation in HIV responses in Asia remain mixed. Occasionally, communities are able to exert some influence on the response, but often their participation is nominal. The importance of community involvement and examples of their successes in the region are discussed in more detail in Chapter 6.

POLICY AND LEGAL ENVIRONMENTS FOR HIV-POSITIVE PERSONS AND GROUPS MOST AT RISK NEED TO BE MORE SUPPORTIVE

Malaysia's decision in 2005 to support harm reduction was in keeping with a trend in Asia toward adopting HIV strategies that are informed by the specific characteristics of their own countries' HIV epidemics—even when such choices might seem politically difficult. China, Nepal, and Indonesia are also part of this trend, and now make harm reduction services available to injecting drug users. This shift is welcome, though not yet ideal. In China, needle exchange and methadone substitution are not available in the same locality; substitution in Nepal is very limited; and Viet Nam's programme is still in the initial phases.

But prejudice remains against groups most at risk and is embedded in laws, policies, and the operational guidelines of law enforcement agencies. Reports of harassment of men who have sex with men, sex workers, and drug users are common across the region¹⁶ and in many countries, these populations experience a corresponding lack of access to appropriate HIV prevention, treatment and care services. Indeed, in most Asian countries, sex work, drug use, and sex between men remain criminalized activities.

¹⁶C. Jenkins and S. Sarkar (2007), *Creating environments that care: interventions for HIV prevention and support for vulnerable populations: focus on Asia and the Pacific*, Bangkok: Alternate Visions.

Sodomy laws for male–male sex remain on the statute books in twelve countries in the region (Bangladesh, Bhutan, India, the Lao People's Democratic Republic, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Singapore, and Sri Lanka).¹⁷ Sex work is licensed only in limited settings within Singapore and the Philippines. Advocacy to amend or relax such laws remains weak, as does the appetite of political leaders for taking up these issues. This poses a problem. The criminalization of these risk behaviours can effectively neutralize otherwise supportive HIV policies—unless the cooperation of law enforcement agencies and the judiciary can be achieved. Such a feat requires methodical and patient liaison work and bridge-building, and is more likely to be achieved if underwritten by strong support from the highest levels of Government.

In addition, only three countries (Cambodia, Philippines and Viet Nam) in Asia have introduced laws that specifically seek to protect the rights of people living with HIV and guard them against HIV-related discrimination. Another five (Bangladesh, China, India, the Lao People's Democratic Republic, and Singapore) have announced policies that explicitly protect the rights of HIV-positive people.

INSTITUTIONAL STRUCTURES AND GOVERNANCE ARE STRONG DETERMINANTS OF AN EFFECTIVE RESPONSE

National HIV responses in Asia have evolved amid shifting Government priorities, changing perceptions of the epidemic, and the emergence of a range of HIV stakeholders and partners. As a result, unity of purpose, policy clarity, and harmonized action have suffered. Too often the various actors involved are not operating in a harmonious fashion. The 'Three Ones' principle arose in response to this problem and is aimed at achieving the most effective and efficient use of resources and to ensure 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 multisectoral mandate; and
- one agreed country-level Monitoring and Evaluation System.

At the core of this approach is the recognition of how important coherent national leadership and ownership is for sustainable and effective national HIV responses.

¹⁷Douglas Sanders (2006), 'Health and rights: human rights and interventions for males who have sex with males', available at: <http://www.risksandresponsibilities.org/>

In Asia, as elsewhere, Governments have tried to improve their ability to manage HIV programmes that have become increasingly complex (partly because of the involvement of so many national and international partners). While Ministries of Health continue to play a central role in the health sector response (partly in keeping with the importance of antiretroviral treatment programmes and associated prevention opportunities), other sectors have moved centre-stage, as well. This emergence of broad-based, multisectoral responses, coupled with the growth of external funding (and partners), underlines the need for effective national coordination.

In theory, National AIDS Commissions are the preferred candidates for that role—and many countries in Asia have established such bodies. But a brief overview of the 10 Reports by UNAIDS Country Offices shows that their political status, authority, capacity, and responsibilities vary greatly, as seen in Tables 5.1 and 5.2 below.

Such variation raises important questions about the role and responsibilities of national coordinating bodies in Asia's HIV responses. Does one model of national coordination and oversight fit all the different political and administrative structures in various countries? Are National AIDS Commissions always the ideal coordinating structure, or are there

Table 5.1: Status of National AIDS Commissions

Recognized in law or political decree	All 10 countries
Recognized as the only national coordinating body	6 out of 10
Chaired by a higher office than a minister	4 out of 10
Led by the Health Minister	4 out of 10
Led by the Head of Government	2 out of 10
Civil society represented	8 out of 10

Table 5.2: Capacity of National AIDS Commissions

Overall coordination	7 out of 10 with some capacity
Authority to allocate budgetary resources	4 out of 10
Monitoring and Evaluation	6 out of 10
Strategic Information	4 out of 10 with some capacity
Reporting on inputs of all sectors	3 out of 10
Plays a leading role in the Country Coordinating Mechanism and other donor mechanisms	4 out of 10

Note: The 10 countries with National AIDS Commissions are Bangladesh, Cambodia, China, India, Indonesia, Myanmar, Nepal, Philippines, Thailand, and Viet Nam.

alternatives that may be better suited? What should be the primary role of National AIDS Commissions? Who should lead such a coordinating body, and what are the (dis)advantages of placing the Ministry of Health rather than, say, the Planning Ministry or Office of the Head of Government at its helm?

It does seem clear that the role of National AIDS Commissions should be limited to policymaking, coordination and monitoring and evaluation of the response, and that they should not be directly involved in direct implementation or service delivery.

But there is no one-size-fits-all answer to these questions. Countries need to face up to these problems and to devise options that best suit their respective political framework and priorities. In other words, what is needed is an in-depth assessment of existing National AIDS Commissions in the context of the differing epidemiological, social, and political contexts.

A review of experiences to date suggests that, as a provisional rule-of-thumb:

- the Health Ministry should be 'first among equals' in the National AIDS Commission;
- the National AIDS Commission needs to decide which entity should act as its Secretariat. Often the Health Ministry would be well-suited for that task;
- only ministries with direct involvement in the HIV response (for example, Ministries of Education, Police, Justice, Social Welfare) should sit on the National AIDS Commission;
- these ministries should allocate some of their own funds and incorporate HIV components into their programmes to ensure their involvement in and commitment to the response; and
- strong coordination is essential.

Who should head this structure? The Commission has compared the potential effectiveness of National AIDS Commissions in three different hypothetical scenarios: National AIDS Commissions are led by the Ministry of Health, by another Ministry outside of Health (such as Finance or Planning), or by a Head of Government.

The findings (shown in Table 5.3) highlight the advantages of ensuring that overall responsibility for managing the HIV response is vested with a strong National AIDS Commission that is led by the Head of Government. But such an arrangement appears to be effective only when the Head of Government is strongly committed to the HIV response.

Table 5.3: Comparison of three leadership scenarios for National AIDS Commissions

	Ministry of Health leads HIV response	Other Ministry (e.g., Ministry of Planning) leads HIV	National AIDS response Commission led by Head of Government leads response
Leadership & political commitment	Low	Low	High
Allocation of resources	Low	High	High
Coordination	Low	Medium	High
Flow of resources	Low	Medium	High
Most-at-risk groups prioritised	High	Low	High

The Commission also reviewed the programme implementation mechanisms at the national level. It found that many of them are headed by technical personnel from Health Ministries who are not always well-positioned at the decision making level. In some countries, programme managers have to pass through three or four levels of administrative hierarchy to reach a decision making level. Frequent personnel changes also undermine the continuity of programme leadership and hamper the effectiveness of programmes.

Currently, only India has been successful in assigning leadership of the programmes to a senior level functionary in the Government; where this has been done, it has proved to be highly successful.

An important governance structure which has evolved over the past five years is the Country Coordinating Mechanism of the Global Fund for AIDS, TB, and Malaria. While Country Coordinating Mechanisms in Asia have been fairly successful in compiling strong funding proposals, the implementation of the programmes has been poorly monitored.

Although the Country Coordinating Mechanisms are meant to act as multisectoral bodies with strong civil society representation, most of them are dominated by Health Ministries. Civil society representatives in many countries feel left out and complain about the lack of scope for meaningful participation. Even non-health Government structures appear not to participate effectively in the Country Coordinating Mechanisms.

The Commission is strongly of the view that the establishment of good governance structures for policy, planning, implementation, and coordination of AIDS programmes is a prerequisite for an effective response. Weak governance structures lead to skewed priorities and

lopsided allocation of resources, in turn leading to ineffective service delivery and an accountability vacuum.

FOR TECHNICAL SUPPORT, THE UNITED NATIONS SYSTEM SHOULD DELIVER AS ONE

The HIV responses in Asia have evolved in the context of several important global developments.

One was the emergence of highly-active antiretroviral therapy, and the success of efforts to lower the prices of those drugs, which made HIV treatment an increasingly affordable component of national HIV responses. The second was the dramatic increase in donor funding for HIV programmes, principally via the Global Fund (to fight AIDS, TB, and Malaria), the World Bank, and the Department for International Development, the US President's Emergency Plan for AIDS Relief,¹⁸ and several large private foundations.

Thirdly, several other initiatives have served as the backdrop for countries' attempts to enhance and consolidate their HIV responses. These have included the UN General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment in mid-2001 and its follow-up processes, the ongoing Millennium Development Goals campaign, the '3 by 5' treatment initiative, and the push to achieve Universal Access to prevention, treatment and care services.

These developments have spurred greater efforts (especially on the part of United Nations agencies) to craft, cost, and implement comprehensive national HIV strategic plans based on quality HIV data and analysis.

The strong global advocacy of UNAIDS has had a positive impact in Asia, by spurring a significant increase in resources for HIV and in strengthening the political commitment of Asian leaders for their respective HIV responses.

However, the Commission is concerned that UNAIDS has not always been effective in facilitating well-integrated support to countries—largely due to the duplication of effort and at times disjointed activities on the part of the UN agencies (see Box 5.5). Because some programmes reflect the corporate priorities of respective UN agencies (rather than those of UNAIDS or the affected countries), the HIV support programmes often lack coherence. It is still unclear whether the division of labour

¹⁸In Asia, PEPFAR funds have benefited mainly one country (Viet Nam).

between the UNAIDS cosponsors agreed to as part of the Global Task Team recommendations¹⁹ can be realized effectively.

Bearing in mind those concerns, the UN should continue to press for greater financial and political commitment from member countries. It should also help develop and provide cohesive support for a strategy that reflects the dynamics of Asia's HIV epidemics, and that suits the environments in which they occur. Equally, UN agencies must provide coherent technical and managerial support to realize that strategy at regional and country levels.

Box 5.5: Reaching Young People Who are Most at Risk

There is a growing need to address the causes and consequences of risky behaviour of young people—especially of those adolescents most at risk such as injecting drug users, young men who have sex with men, and young women who sell sex and their young male clients.

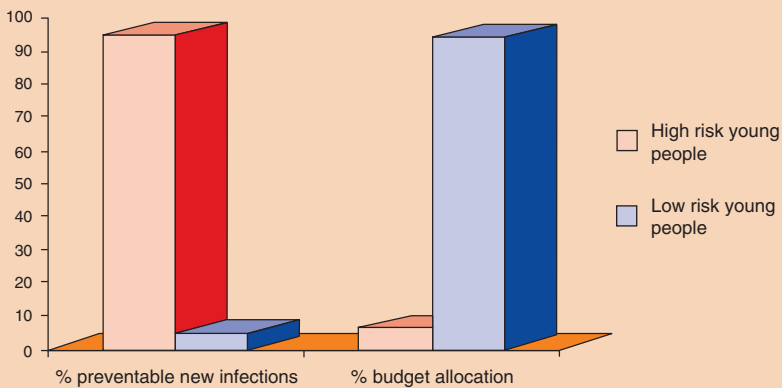



Figure 5.10: Percentage of new HIV infections in young people, and allocation of resources for young people by UNICEF, UNFPA, and UNESCO

Source: Background Commission Paper Asia Epidemic Model (AEM)¹⁹; Unified Budget and Work plans (UBW, 2004–2005).

¹⁹The Global Task Team was formed to improve coordination among multilateral institutions and international donors to further strengthen the AIDS response. More information on the Global Task Team and its recommendations are available at [http://www.unaids.org/en/CountryResponses/MakingThe MoneyWork/GTT/default.asp](http://www.unaids.org/en/CountryResponses/MakingTheMoneyWork/GTT/default.asp)

The analysis carried out by the Commission shows that over 95 per cent of all new HIV infections among young people occur among most-at-risk adolescents. However, 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. As Figure 5.10 shows, 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.



Finally, Asia's regional intergovernmental bodies—particularly the Association of Southeast Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation (SAARC)—will continue to offer strategic platforms for political advocacy. It may also be timely, given the many actors and agendas and the resultant complexity of responses, for a regional political body such as ASEAN to assume a more prominent role (besides its continued engagement on AIDS) as a 'watchdog' that tracks and assesses Member States' HIV responses.

TECHNICAL NOTE: STAGES OF NATIONAL RESPONSE

Based on the most effective package, according to the scenario of the epidemic defined in Chapter 2, elements of interventions described in Chapters 3, 4, and 5, the following matrix has been used to describe the typical evolution of national responses to AIDS in Asia (as shown in Figure 5.1).

	Denial Stage	Ad-hoc Stage	Informed Stage	Mature Stage
Main Characteristics	Response based on fear or denial	Recognition of the problem, however responses are not informed by evidence	Responses are mature, informed by evidence, but neither comprehensive nor to-scale	Response is comprehensive with all necessary elements, and appropriate integration into institutional mechanisms
Political engagement and support	Leaders deny existence of high risk behaviours and blame foreigners, or believes in protection by religion or heritage	Statements and appearances are made by leaders without necessary resource allocation or effective action	Inconsistent involvement of senior leaders or Head of State, without necessary policy adjustment, allocation of adequate resources, and guidance on controversial issues	Head of State provides visibility to the programme—particularly on sensitive issues. Involvement can be used to leverage resource, commitment from other sectors, and policy adjustment
HIV programmes and strategic plans (including management)	Absence of a national strategic plan	National strategic plans are non-strategic and without prioritization or operational plan	National strategic plan is prioritized but is not backed by resources, operational, human resource, or management plan	Prioritization is scientific and explicit in national strategic plan, and matched by operational, human resource, and management plan with measurable annual targets

	Denial Stage	Ad-hoc Stage	Informed Stage	Mature Stage
Strategic information	Strategic information limited to records of HIV-positive people from mandatory testing	Surveillance is restricted to sentinel sites for antenatal women; rudimentary data often generated to address global and external needs	Information on the following elements (surveillance, size estimation and coverage, projection on PLWH, infection, death, ART needs, data on most new source of infection) and geographic prioritization) are often incomplete or generated by international agencies or not owned by the Governments	Strategic information is internally generated and owned by the Government, and has the following elements: surveillance, size estimation and coverage, projection on PLWH, infection, death, ART needs, data on most new source of infection, and geographic prioritization
Prevention	Mainly punitive or legal measures (for example, closure of brothels, arrest of drug users, sex workers, and gay people, and deportation of HIV-positive people).	Main programme elements are awareness (without provision of prevention tools), mass media, education in schools (often abstinence-based), rehabilitation programmes for sex workers and drug users, tracing of contacts of positive people	Programmes are still not comprehensive, in terms of four essential elements. Programmes, mainly project-centred, yield poor coverage	Periodic mass campaign for general population (once every few years, for example), comprehensive prevention package with necessary elements for all most-at-risk populations with supportive legal and policy environment; general health and population interventions are embedded into different sectors, like education, social welfare, and health
Treatment	Denial of treatment services to HIV-positive people	Testing without consent, lack of public sector investment on treatment, or treatment without prevention programmes in place	ART is in place, but not universal and mainly externally funded. No active outreach to enroll people with special needs or hard-to-reach, second generation drugs are often absent	Balance of prevention and care, with the treatment programme integrated into the long-term health care system

	Denial Stage	Ad-hoc Stage	Informed Stage	Mature Stage
Impact mitigation	Absence of impact mitigation programme; discriminatory measures for sick and positive people	Impact mitigation is restricted to religious counselling, VCT, and palliative treatment	No systematic programmes on livelihood security, income generation, especially for women and orphans and limited role of community organizations. Treatment is not seen as impact mitigation strategy	Treatment programmes are seen as an essential component of impact mitigation. Women- and child-centred programmes for livelihood security are in place as a part of the social security system, with necessary legal and policy support, and with the involvement of community organizations
Resources	Resources mainly deployed to mandatory testing, arrest of high-risk populations, or other punitive legal measures	Resources are minimal and mainly allocated for training, blood safety programmes, and mass media campaigns promoting abstinence	Resources may be prioritized for most-at-risk population programmes and antiretroviral treatment, but are mainly external, insufficient, and do not fund all necessary interventions	Resources, primarily from domestic sources, are at least adequate for priority programmes
Policy and legal environment	Prohibition measures and arrest or quarantine of HIV-positive people or most-at-risk populations are considered effective prevention strategies	Still no appropriate law or policy: some awareness programmes may be set up to educate police and local law enforcement officials but there is little emphasis on discrimination or mobilizing support for high-risk group programmes	Poor implementation of available policy or legal measures-related to prevention services, discrimination in health care settings, workplaces, and educational institutions. Mechanisms are absent at the local level to ensure or monitor policy implementation for an enabling environment	Policy and legal measures are in place and implemented at local level in health care settings, education, prevention services, with necessary support from law enforcement, official and local leaders

	Denial Stage	Ad-hoc Stage	Informed Stage	Mature Stage
Community and civil society involvement	Absence or lack of involvement of community organizations and NGOs	Ad-hoc small-scale projects conducted by community organizations and NGOs without any link to Government policy or national priorities, and civil society has limited role in planning and implementation of national strategic plans.	The role of community organizations and NGOs to participate in planning, policy, and service-delivery are recognized but representations may be tokenistic	Community organizations and NGOs are able to participate in policy dialogue, planning, service delivery and outreach for difficult-to-reach populations in prevention, treatment, care and impact mitigation programmes, and continue to play a 'watchdog' role
Institutional structures and governance	Giving additional portfolio of AIDS to an official in health ministry	Special AIDS cell in health, no coordination or involvement of other ministries	The need for coordination with other ministries is recognized, but the non-health programmes are tokenistic	Led by supra-departmental (for example, led by Head of State), mechanism with priority for health, direct service delivery for most-at-risk populations, treatment and integrated in existing health care system, impact mitigation programme is a part of social security measures

6

The Need for Meaningful Community Engagement¹

CHAPTER SUMMARY

- The Commission reviewed community involvement in Asia's HIV programmes through key informant interviews with more than 600 community-based non-governmental organizations.
- Community participation is essential for reaching people involved in risky behaviour with information and services they are likely to trust. Community participation is also the key to understand and influence the contexts in which risk occurs, and to help create supportive environments for risk reduction.
- The Commission found that community involvement is vital for reaching at-risk populations and people living with HIV, for understanding the issues that affect these populations, for building trust between Governments and communities, and for achieving overall transparency and accountability in the HIV response.
- The genuine involvement of affected communities in planning and implementing, HIV programmes is one of the best ways of tackling

¹The ideas and discussions presented in this Chapter were initiated and developed through an on-line consultation, collecting the perspectives of civil society throughout the region to strengthen the quality of the Commission's recommendations. The 'Asia regional stakeholder perception and priority survey' took in the views of over 600 participants from the community of people living with HIV (PLHIV); local and national NGOs, international NGOs, community-based organizations (CBOs), media and journalist groups, academic and education institutions, and private sector companies, through an online survey and key informant interviews. This open and independent civil society online consultation was one of the first of its kind in Asia, and it has provided valuable inputs to inform this chapter and the recommendations of this Report.

stigma and discrimination. Unfortunately, community involvement in planning, implementing and monitoring HIV interventions tends to be tokenistic in most countries of Asia.

- Communities' participation in HIV responses is also being held back by a lack of capacity development. Governments and large non-governmental organizations involved in HIV programmes need to invest more in support community organizations.
- But representation on national bodies like National AIDS Commissions or Country Coordinating Mechanisms should involve a process in which communities nominate their representatives. *Ad hoc* representation by individuals 'cherry-picked' by Governments should be done away with.
- A public-private partnership should be set with equal representation between Government and civil society to channel funds for community-based programmes.
- The creation of AIDSWATCH bodies at national and regional levels could improve accountability of various actors, from Government ministries and civil society organizations, to external donors and United Nations agencies.
- Community-based and other civil society organizations should adhere to the 2005 *Code of Good Practice for NGOs responding to HIV/AIDS* of the International Federation of the Red Cross.

Communities comprise the glue that holds people together. The key to achieving health in the community is based not only on getting services to the community, but also engaging and empowering them to be the catalysts of change and bearers of success.

—The Global Health Council

Who decides about HIV priorities and who sets the agenda? This question was among the main concerns of the ‘new’ health promotion principles embodied in the 1996 Ottawa Charter on Health Promotion, and the subsequent Jakarta Declaration. Rather than regarding communities as passive beneficiaries of services, these principles recognise that ‘people are able to think and act constructively in identifying and solving their own problems’.²

RESPONSES OFTEN BEGIN AT THE COMMUNITY LEVEL

In many countries, organized responses to AIDS have begun at the community level, and have been driven by the efforts of people living with AIDS, their loved ones and caregivers, and activists. This has also been true in Asia. Crusading journalists in southern India challenged mandatory HIV testing and the detention of sex workers. In Manila, gay men began early peer education and condom distribution projects. Families in China demanded care services for people infected by transfusions of contaminated blood products.

It is now generally accepted that community engagement is an essential part of HIV programme implementation and service delivery. This reflects more than merely a demonstration of an ethical commitment to involve communities in decisions that affect them. This approach acknowledges that the experiences of individuals and communities, especially people living with HIV, are essential in crafting, implementing, and evaluating an effective response.

Box 6.1: The Meaning of Community

Like many social constructs, the meaning of ‘community’ is not fixed. At least two definitions have emerged in the context of the HIV epidemic:

²WHO (1983), *New approaches to health education in primary health care: Technical Report Series*, 690, World Health Organization.

Community as a sense of place

This notion constitutes the most basic interpretation of a community. In this case, community refers to a group of people who are linked together by virtue of being in the same location. Although their personal circumstances and needs may differ, members of the community share certain characteristics, such as traditions and values. They usually share a language, dialect, or even a set of religious beliefs. Membership is relatively easily defined, since it is based on physical location. For the purpose of this Report, community in this sense will be referred to as 'local community'.

Community as a form of identity and belonging

Here, the notion of community refers to a group of people who are linked through a sense of common circumstances and experiences—such as people living with HIV, or people who share certain behavioural traits. The sense of community is strengthened by people's awareness of their common experiences; often this sense emerges gradually, but it can be fomented and supported by the actions of external actors. This notion of community is based on a subjective sense of identity; it is defined as much by a sense of who does not belong as it is by who does belong.

In the context of Asia's HIV epidemics, the word 'community' usually refers to those people who are infected or affected by HIV, rather than to people living in specific places. This is the usage adopted in this Report. Such communities would include people living with HIV, sex workers, injecting drug users, transgendered people, and men who have sex with men.

In discussing how to involve and support communities, it is important to recognize that not all these people necessarily regard themselves as belonging to a particular 'community'. Some, such as brothel-based sex workers or men who have sex with men, may readily self-identify as sex workers or as gay. But others, such as rural women who occasionally exchange sex for money or food, or men who have sex with men while imprisoned, are unlikely to see themselves as part of such 'communities'.

COMMUNITIES AND COMMUNITY ORGANIZATIONS: HOW THEY DIFFER

In some parts of Asia, the word 'community' is used inter-changeably with community-based organizations and/or non-governmental



organizations. It is also used to refer to members of mass organizations (such as national women's leagues) or activists in social movements (such as HIV treatment activists, or participants in social renewal efforts such as Sri Lanka's Sarvodya Shramadana Movement). In India, the most decentralized governmental structures (the Panchayati Raj Institutions) were explicitly designed to serve the interests of 'communities'.

Although there is no single 'correct' typology of community organizations, it is useful to differentiate people or community members from community-oriented entities. Some institutions are set up and led by a particular community, and they can range from small self-help groups to large trade unions. Others are organized by 'outsiders' to serve, mobilize or even foster a community. They may include community-oriented local Government structures or professional non-governmental organizations involved in public health or development work.

ENGAGING COMMUNITIES IS ESSENTIAL TO STRONG RESPONSES

By signing onto the UN General Assembly Special Session (UNGASS) Declaration on HIV/AIDS, Governments declared a commitment to the participation of civil society in their response to HIV. Unfortunately, involvement of key populations in national HIV responses in Asia remains uneven and in many places is merely tokenistic. Yet the benefits of strong community participation are well-documented.

Community leaders foster trust: Given that HIV is usually transmitted by risky sex or drug injecting practices, it is not surprising that most successful HIV prevention interventions feature strong participation by community members. At its most basic, community participation in the context of HIV programmes is essential for reaching people involved in risky behaviour with information they are likely to trust. Studies in Asia have shown that more than 80 per cent of drug users could be reached within six months with cleaning kits and condoms through the involvement of peer outreach workers. Approaches relying on other types of interventions, such as police, local community leaders, social workers, and medical staff, reached only about one quarter of the drug users.³

³C. Hangzo, *et al.* (1997), 'Reaching out beyond the hills: HIV prevention among injecting drug users in Manipur, India', *Addiction* 92 (7), pp. 813–20.

Changes in community norms are critical to sustained behaviour change: Community participation is also crucial to understanding and influencing the norms of groups at risk in order to encourage safer practices. Examples include sex workers' efforts to enforce safe sex norms in commercial settings. Community participation of people living with HIV is also important for the provision and use of care and support programmes, reducing stigma, promoting adequate nutrition and palliative care and supporting continuity of treatment.

There is a growing body of empirical evidence showing the benefits of community participation. In a study of over 6,000 female sex workers in the Indian state of Andhra Pradesh, it was found that 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 colleagues who did belong to such groups. Women who were less able to count on the social support of peers for financial and medical emergencies had a two to three times higher risk of being infected with HIV. Similar, though less dramatic, patterns were observed in the same state in a linked study of over 6,000 men who had sex with men.⁴

It is important to note that stigma, discrimination, gender inequality, violence against sexual minorities, and other social inequities that undermine HIV programmes are also very localized. This underlines the need to engage local communities directly through advocacy, and indirectly through influential institutions such as religious organizations.

Community involvement can open space for discussion about controversial issues: Thereby helping to promote greater understanding of HIV among political and social leaders. Although sex (especially paid sex and sex between men) and drug use are typically treated as taboo subjects, non-governmental and community-based organizations are often willing to broach these sensitive issues publicly. An excellent example has been the advocacy work of the Sonagachi Project of Kolkata, India, which has been important in persuading elected representatives, ministers and party officials to acknowledge the rights of sex workers and to support efforts to improve their working conditions.

⁴Frontier Prevention Project: Participatory Site Assessments: Cambodia, Ecuador, Andhra Pradesh State in India (2003). International AIDS Alliance, available at http://www.aidsalliance.org/custom.asp/publications/view.asp?publication_id=87

Community engagement helps build more realistic and sustainable programmes:

Partnerships and community engagement can foster a sense of 'ownership' of the response that is typically absent when projects are externally run. This kind of trust can help ensure that the interventions are more viable, acceptable, and suited to the needs of communities.

Community knowledge can accelerate effective responses:

Communities can also contribute to research into HIV risk behaviour and transmission trends. For example, if a narcotic suddenly becomes more expensive due to a reduction in supply, drug users may switch from smoking to injecting the drug, thus increasing the risk of HIV transmission. This information will be known immediately at the community level, but may take time to reach researchers and planners. A study in Southeast Asia cites an example where molecular epidemiology studies and satellite imaging were used by researchers to plot the spread of HIV among injecting drugs users. The same evidence was also available from the drug users themselves who had already described the geographical patterns of drug routes and resultant HIV spread between Myanmar and India.^{5,6} The sooner new information can be gathered, the sooner programmes can be developed or adapted to address new trends and the more cost-effective they are likely to be.

**Box 6.2: 100 Per Cent Condom Use Programmes:
The Need for Sex Worker Involvement**

The 100 per cent condom use programmes introduced in Asia have underscored the importance of involving affected communities in HIV prevention activities.

Such programmes have been shown to increase condom use among sex workers and to reduce new HIV infections. In Thailand, where the Government introduced a 100 per cent condom use programme in sex establishments in 1989, HIV prevalence declined significantly during the 1990s. In Cambodia, where a similar policy was applied in brothels in the late 1990s, HIV prevalence also fell. Similar programmes are underway or

⁵C. Beyrer, *et al.* (2000), 'Overland heroin trafficking routes and HIV-1 spread in south and Southeast Asia', *AIDS* 14, pp. 75–83.

⁶K. Sarkar, *et al.* (1997), 'Relationship of national highway with injecting drug abuse and HIV in rural Manipur, India', *Indian Journal of Public Health*, 41(2), pp. 49–51.

are planned in Lao People's Democratic Republic, Mongolia, the Philippines, Myanmar, and Viet Nam, as well as in several provinces of China.

However, research by the POLICY Project⁷ has contrasted the 100 per cent condom use programme in Cambodia with sex worker-driven initiatives in other countries. It found that the programme has involved significant violations of sex workers' human rights, including persistent harassment, thus reducing the programme's potential effectiveness. There was little evidence of encouraging the involvement of sex workers in the programme, apart from a requirement for passive compliance.

Communities and their organizations can quickly adopt new approaches and advocate for them:

Community-based organizations are often less bureaucratic than their Government counterparts. Being smaller can give them the flexibility to respond quickly to new situations and adopt new lessons. They can identify important issues that require swift action, and help muster the activism that might be needed to achieve the desired results. In this way, the AIDS ACCESS Foundation of Thailand, worked with other partners to increase the availability of an important HIV drug, 'ddI'.⁸ To do so, they formed alliances, built networks, and drew together a range of expertise in the non-governmental sector.

Communities can help Governments respond effectively:

When programmes piloted by community-based organizations prove successful at the local level, Governments can consider scaling them up to the national level. For example, in China, gay and other men who have sex with men set up community hotlines to provide support and information on HIV and other issues. By 2007, the Government had recognized the importance of working with men who have sex with men and was funding programmes aimed at supporting them.

Community-based organizations are often more efficient in service delivery:

The involvement of community-based organizations also increases operational efficiency in the delivery of services, since it is in the community's interest to ensure that work is carried out responsibly

⁷David Lowe (2003), *Documenting the experiences of sex workers*, unpublished draft report to the Policy Project, David Lowe Consulting, Asia.

⁸N. Ford, *et al.* (2004), 'The role of civil society in protecting public health over commercial interests: lessons from Thailand', *Lancet*, 363, pp. 560–3.

and effectively. This could be one of the reasons why, according to some studies, Global Fund projects in which the Principal Recipient was *not* a Government organization tend to show better results than Government-led projects. 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.⁹ These findings are supported by evaluations of World Bank HIV programmes, where the efficiency of governmental and non-governmental sub-grant programmes have been compared.¹⁰

By involving the affected communities, both Governments and the communities benefit. However, for such involvement to occur, Governments must recognize that effective, sustainable, and appropriate responses to HIV are a shared responsibility. This can only happen if communities are involved in the design of policy, development of strategic and operational plans, and mid-course correction.

Box 6.3: The Importance of Involving People Living with HIV

People living with HIV are crucial to the HIV response. Involving them in national HIV responses is not just a question of moral responsibility. It is a highly effective way to improve national policies, strengthen HIV prevention, and support the scale-up of treatment and care programmes. It was in recognition of these benefits that leaders of 42 nations endorsed the principle of the Greater Involvement of People with HIV/AIDS (GIPA) at the Paris AIDS Summit in 1994, thus acknowledging the central role of people living with HIV in AIDS education and care, and in the design and implementation of HIV policies and programmes. They also acknowledged that people living with HIV require increased support if they are to have a stronger role in the response.


One way to give practical expression to the GIPA commitment would be for HIV decision-making bodies to formalize the participation of people living with HIV, preferably in designated seats. The Commission urges all

⁹S. Radelet (2004), 'The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Progress, Potential and Challenges for the Future', report available at: <http://www.cgdev.org/content/opinion/detail/2992/>

¹⁰Martha Ainsworth, *et al.* (2005), 'Committing to results: improving the effectiveness of HIV/AIDS assistance: an OED evaluation of the World Bank's assistance for HIV/AIDS control', full report and supporting documents available at <http://go.worldbank.org/X59Z9LKYO0>

Asian Governments to adopt the principles of GIPA for securing community involvement in programmes.

A study by Horizons and the International HIV/AIDS Alliance¹¹ has found that the involvement of people living 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 healthcare 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.



Throughout the world, treatment centres collaborate with community-based organizations to enlist people living with HIV as outreach workers, counsellors, adherence support workers, and home-based care providers. In many cases, people living with HIV fill a gap in health care delivery where there are shortages of 'professional' workers. However, it is not unusual for people living with HIV who perform essential services either to work for nothing or to receive a nominal stipend in acknowledgement of their work. Community organizations typically receive minimal funding when they participate in these partnerships. This state of affairs is unsustainable. Formal programmes that actively recruit people living with HIV as employees in relevant areas should be established, and wages reflect the nature of the work performed.

ACCOUNTABILITY IS ESSENTIAL FOR BOTH GOVERNMENT AND COMMUNITIES

Accountability and transparency can be improved by involving community organizations in monitoring and evaluating HIV programmes. Skills training and resources should be available to community organizations in order to facilitate these tasks. Monitoring and evaluation should also gauge the extent and quality of civil society participation and community engagement in national HIV responses. The Coalition of Asia-Pacific Regional HIV/AIDS Networks (The Seven Sisters) has produced a toolkit for carrying out such an evaluation in relation to

¹¹See 'Meaningful involvement of people living with HIV/AIDS' at www.aidsalliance.org under 'documents'.

Universal Access processes, known as ‘The Minimum Standards of Participation of Civil Society in Universal Access’¹²

Regional monitoring of national responses can be useful for tracking countries’ progress in meeting their various commitments. For example, the International Treatment Preparedness Coalition has released its 4th *Missing the Target* Report, a donor-funded exercise in which community organizations and representatives researched and identified gaps in the provision of treatment at country level.

Accountability is vital; even when priority areas are funded, the programmes need to be effective and well-monitored. The Commission, therefore, sees a need for impartial ‘AIDSWATCH’ bodies to monitor and objectively assess HIV responses. Such bodies should exist at both regional and national levels to ensure accountability for monitoring all actors in the AIDS response: Governments, communities, and donors.

One option would be for people living with HIV and representatives of key populations to Report to regional community HIV networks, which in turn would Report to UNAIDS with the aim of integrating findings into UNGASS and Universal Access reporting processes. But accountability should be a two-way process. However important it is for communities to monitor Governments, it is civil society and community organizations that are responsible for a growing share of HIV programmes. These organizations should also be accountable—both to their constituencies and to Government—for the commitments they make and the responsibilities they assume.

Three factors should be taken into account in assessing the contributions from various community groups and representatives:

- their accountability to people who are affected by the deliberations;
- their relevant experience; and,
- their knowledge of the issues at hand.

A good point of departure is for civil society and non-governmental organizations to adhere to the principles contained in the *Code of Good Practice for Nongovernmental Organisations Responding to HIV/AIDS*,¹³ which identifies guiding, organizational, and programming principles that have been endorsed by over 160 international and national

¹²The Seven Sisters: The Coalition of Asia-Pacific Regional Networks on HIV/AIDS (2007), *Minimum Standards for Civil Society Participation in the Universal Access Initiative* available at: <http://www.hivpolicy.org/Library/HPP001335.pdf>.

¹³International Federation of Red Cross (2005), available at: <http://www.ifrc.org/what/health/hiv/aids/code/>.

organizations. Regional and national networks have the responsibility to ensure this happens.

More broadly, Governments and community-based organizations should recognize the importance of mutual accountability, especially with respect to:

- transparency of information;
- open and equitable governance (structures and processes); and
- authentic consultation (planning and execution of advocacy and programmes).

There is much room for improvement in these areas. Many Governments and inter-governmental agencies are reluctant to share information or to involve community-based organizations in decision-making processes. At the same time, some community-based organizations are inclined to be more accountable to their funders than to their constituencies.

STRONGER PARTNERSHIPS BETWEEN GOVERNMENT AND COMMUNITIES CAN BUILD COMMITMENT AND MUTUAL TRUST

Gaining the confidence and co-operation of the groups who are most at risk is critical to the success of HIV responses. Government staff may be uncomfortable working with community-based organizations, which sometimes are seen as being donor-driven, opportunistic, unaccountable or representing narrow interests rather than the wider public. Governments may feel that community groups are unduly negative, exaggerate social problems, and promote the interests or concerns of marginal communities.

For their part, community-based organizations may be frustrated by what they perceive as the inflexibility of Government bureaucracy. They may fear that Governments want to maintain control over decision-making processes and avoid sharing resources and power and strategic information, or else their previous experiences of working with Governments may have been disempowering and demoralizing.

Creating more effective collaboration between Governments and communities depends on the degree to which Governments are open to input from the communities, and what communities gain in working more closely with Governments. In Indonesia, for example, the Working Group on AIDS of the Faculty of Medicine of the University of Indonesia has successfully worked with people living with HIV, and built partnerships with the Government and the local pharmaceutical manufacturing industry to provide over 1,000 people with antiretroviral therapy since 1999.



A tangible way to build commitment and trust is to institutionalize community involvement, rather than to rely on good will alone. Stronger partnership would address complaints by Governments about a lack of genuine community engagement. Institutionalizing community involvement means creating formal, salaried positions in relevant Government and other structures (National AIDS Commissions, HIV research bodies, decision-making or consultation bodies, etc.); such a step would greatly strengthen the relationship between Governments and communities.

The regional coordinating mechanism of the Global Fund to Fight AIDS, TB, and Malaria for the Pacific Islands provides an example of how to ensure meaningful community representation and involvement. Many of the Fund's Country Coordinating Mechanisms have been struggling to ensure community involvement. But the Pacific Islands Country Coordinating Mechanism is exceptional; it has achieved equal participation of Government and community representatives. Each of the 11 participating countries nominates a Government *and* a civil society representative, and the Country Coordinating Mechanism also includes room for representation from a regional organization of people living with HIV.

STIGMA AND DISCRIMINATION BLOCK COMMUNITY PARTICIPATION IN POLICYMAKING

The stigma attached to sex work, drug use or sex between men is reflected in many countries by national legislation that makes such behaviour illegal. In certain countries, community activists have helped overcome some of these barriers, even where there is little likelihood in the short term of effecting legal reforms or changes in social attitudes. Often, progress has been achieved through participation in national AIDS governance structures such as Global Fund Country Coordinating Mechanisms and National AIDS Commissions. There are also many local-level examples where communities have managed fruitful negotiations with local police to allow outreach, participation and harm reduction activities to occur unimpeded.¹⁴

Meanwhile, stronger efforts are needed to reduce discrimination by means of effecting legal reform and strengthening the human rights

¹⁴C. Jenkins and S. Sarkar (2007), *Creating environments that care: interventions for HIV prevention and support for vulnerable populations: focus on Asia and the Pacific*, Bangkok: Alternate Visions.

frameworks, as well as by supporting community organizations in monitoring discrimination and developing advocacy strategies. Legal working parties could be established to review current legislation and laws, in order to recommend concrete actions for Governments.

At a more basic level, it may also be necessary to help to mobilize and to organize affected communities. This implies, among other things, providing training in skills and network-building. It is not that communities lack skills and assets, but rather that those attributes may need to be adapted so that communities can engage more effectively with Governments.

BUILD A TRADITION OF COMMUNITY INVOLVEMENT IN COUNTRIES WITH LIMITED CIVIL SOCIETY PRESENCE

What about countries where civil society hardly exists? While some countries in Asia have well-developed civil society sectors that include non-governmental and community organizations, others lack a tradition of civil society mobilization and organization. Indeed, some Governments seem to be uncomfortable with the mere notion of autonomous community mobilization and engagement, and a few openly discourage or proscribe such activities. In some places, support groups of people with AIDS are classified as self-help groups rather than non-governmental organizations or community organizations, and independent local organizations do not exist. In a few countries, civil society engagement is currently impossible.

In such situations, rather than recite mantras about the importance of community partnerships, practical strategies must be devised to support the emergence of independent community organizations, and to encourage a more tolerant attitude on the part of Governments. The Global Fund and UNAIDS, including UNDP with its focus on governance and human rights, should take the lead in supporting and ensuring that community organizations have the space and capacity to be involved in the AIDS response.

PUBLIC-PRIVATE PARTNERSHIPS ENSURE FAST DISBURSEMENT OF FUNDS FOR COMMUNITY PROGRAMMES

Community organizations cannot participate in national processes if they lack human resources, finance, information, and preparation time.



Often, they are expected to take part in processes or provide services on a volunteer basis, while covering their own transport and opportunity costs. This is unfair and ultimately counterproductive. Resources for community engagement need to be a part of overall budgets for even the simplest HIV projects.

In Asia, such organizations of people living with HIV that do exist tend to be fragile, under-resourced and reliant on a small number of dedicated individuals. It is important to devise ways of supporting these organizations and enhancing their work, so that they can strengthen community engagement. One way of doing this is to make sure that resources are allocated in national AIDS plans and budgets to support capacity building for community organizations.

When drawing up budgets, adequate funds should be earmarked for building capacity and for management infrastructure of community-based organizations. Funding agencies should also help to fund the core activities of community-based organizations. The responsibility for disbursing funds efficiently could be assigned to designated structures in Government. Another option would be to set up a small grants fund that specifically addresses these resource needs.

The Commission proposes the creation of public–private partnership structures that would be responsible for the funding and oversight of community-run HIV projects and programmes. Government and non-governmental entities would be equally represented in these structures, which should include strong representation from community groups. Funding would come from national AIDS budgets, as well as from bilateral donors. The same structure could serve as ‘principal recipient’ of Global Fund grants. Funds would then be disbursed to those projects or organizations that provide services to most-at-risk populations, people living with HIV and their families. The Commission recommends that the World Bank and the Global Fund should take the initiative to develop a quality model of public–private partnerships along these lines.

GOVERNMENT HAS THE PRINCIPAL RESPONSIBILITY TO MAKE COMMUNITY INVOLVEMENT ‘MEANINGFUL’

Governments may engage with communities, but often the process is formalistic and lacks substance. Consultation outcomes are not reflected in Government decisions, or community representatives do not have the power to negotiate issues, or they are coerced into adopting or supporting particular positions. Governments sometimes ‘cherry-

pick' those community representatives who are most compliant and sideline others.

Governments should promote the authentic involvement of community organizations. Building direct relationships with key individuals and organizations may assist in this process. It may also be useful to support interest-based coalitions that can consult with their constituencies, develop a consensus, and coordinate their inputs with those of Government.¹⁵ Many such entities exist in Asia, ranging from networks of people living with HIV, sex worker organizations, women's coalitions, national bodies such as the Malaysian AIDS Council, regional networks (such as the Coalition of Asia Pacific Regional HIV/AIDS Networks), and international networks that work in Asia (such as the International Treatment Preparedness Coalition).

Strengthening community engagement presupposes knowing where they are located and what work they do. An assessment or mapping of community organizations and representatives is needed to identify who is working on HIV. Further assessments can then identify which of those actors is most appropriate to work with, and what their skills, experiences, resources, and needs are.

A further step in strengthening community involvement is to develop a broad action plan with a time-frame for implementation and measurable indicators. Such a plan will include the terms of reference for involving communities in national plans, monitoring and evaluation, and programme implementation. It could also include analysis of the support and resources that are needed in order to facilitate stronger community involvement.

While community representatives can play a role in advocating in favour of community engagement, and advising on how to best to do this, it is ultimately national Governments who are responsible for making it happen.

But representation on national bodies like National AIDS Commissions or Country Coordinating Mechanisms should involve a process in which communities nominate their representatives. *Ad hoc* representation by individuals 'cherry-picked' by Governments should be done away with.

¹⁵In general, it is desirable for Governments to work with organizations rather than individuals. National HIV/AIDS non-Government organizations such as the Malaysian AIDS Council, the HIV/AIDS Coordinating Council (Cambodia) or the Thai National Coalition of AIDS organizations have legitimacy and accountability based on their representation of many groups, and would likely have built up strong organizational experience.

COMMUNITY ORGANIZATIONS NEED SUPPORT TO BUILD THEIR CAPACITY FOR ENGAGEMENT

Although community organizations have a vital role to play in building an effective and sustainable HIV response, many are disorganized and lack capacity. In much of Asia, they lack the administrative and managerial capacity to organize, manage, and implement interventions without technical and financial support. They often lack legal status, are not registered, and therefore are ineligible to receive donor funds, and are unable to act as representatives in official forums and structures. It is important that they receive the support they require to meet these logistical requirements.

Community-based organizations often require partnerships with established non-governmental organizations and academic bodies to earn credibility, develop capacity, and articulate their needs. In this sense, there is a clear scope for other non-governmental organizations and academic institutions to become involved in the community-level response by strengthening community-based organizations.

Many mainstream non-governmental organizations in Asia do not participate in the HIV response because it involves dealing with unfamiliar groups of people. Without an understanding of the lifestyles and hardships faced by people affected by the epidemic, it is difficult to implement effective interventions.

Some international non-governmental organizations act as AIDS service providers, mainly by disbursing funds to local non-governmental organizations, with or without community involvement. Sometimes successful implementation occurs, but communities are treated as passive beneficiaries. Devolution of power to the community organization is seen as an optional feature, rather than an intrinsic aspect of the project. Once funding dries up, some of these organizations move onto other work, leaving their community 'partners' with little or no support. The involvement of non-governmental organizations as intermediary actors therefore must address the issue of sustainability of the programme (see Box 6.4).

Box 6.4: Funding Often Bypasses Community Organizations: A Case of Sex Workers' Organization in Bangladesh


Bangladesh is one of the few countries with a countrywide programme for sex workers. This has been made possible by government's support and donor funding from international non-governmental organizations.

The programme, run by CARE Bangladesh, has been documented by UNAIDS as a best practice. Gradually, with the help of CARE Bangladesh, sex workers' organizations have acquired the capacity to set up, design, implement, and monitor their own programmes.

However, measures introduced by the US Government have made it difficult for many international non-governmental to support sex workers' organizations. USAID will no longer fund such programmes, while DfID (a funder of the CARE Bangladesh project) stopped funding non-governmental groups when it transferred its contribution to the national Government by means of a Sector-Wide Approach' grant recommended by the World Bank.

Meanwhile, the Global Fund donated some USD 40 million to Bangladesh for sex workers' interventions, but those funds were allocated to many governmental rather than community organizations. Consequently, the sex workers' organizations, a powerful vehicle for peer education, were bankrupted. Many of their leaders, who had been working full-time for the organization for several years and were no longer earning money from sex work, suddenly found themselves penniless.

Source: Deposition to the commission by the sex worker organization, Dhaka, Bangladesh, May 2007.



Non-governmental initiatives can be more costly than community-run programmes. A comparison of Thai and Cambodian responses illustrates this. The latter programme was mainly funded by donors and cost four to five times more than the Thai response, which was almost exclusively nationally funded. This may be justifiable where an emergency response is required to an epidemic such as HIV. However, there is no excuse for ignoring the need to strengthen the human and organizational capacity of community groups.

Large international or national non-governmental organizations can play a valuable role in providing services where community organizations have not yet developed the necessary technical and management capacity to do so. But the ultimate objective must be to hand the programme over to the community. Ideally, the role of such NGOs should be temporary, laying the groundwork for community-led programmes.

A few organizations (HOPE in the Philippines and KHANA in Cambodia) have been very successful in building capacity and supporting community initiatives. AVAHAN, a Bill and Melinda Gates Foundation initiative for India, which has received the largest grant of its kind for most-at-risk groups, has committed itself to transferring ownership to the community in its programme statement.

7

Findings and Recommendations

I. KEY FINDINGS

1. Too few Governments in Asia have given AIDS the priority it deserves

The HIV epidemics in Asia have already affected millions of people, and they continue to grow. The Commission's projections show that an estimated 9 million Asians have been infected with HIV since the start of the epidemic, and almost 4 million of them have died of AIDS-related causes. In 2007 alone, some 375 000 Asians were infected with HIV (a significant proportion of them women) and 420 000 died of AIDS.

AIDS is the leading cause of disease-related deaths among working-age adults in Asia. AIDS has emerged as the single-largest cause of disease-related deaths and work days lost among 15–44 year-old adults in Asia. In the absence of a major expansion of well-designed HIV responses, this will remain true for the foreseeable future.

Nevertheless, HIV responses in many Asian countries do not reflect the urgency of the situation.

2. Stronger leadership and political commitment on AIDS is urgently needed in Asia

Globally, successful HIV responses have been driven by strong commitment and leadership from political leaders. Without high levels of political support, it is impossible to overcome

the obstacles that block effective programmes for controlling the pandemic.

Effective leadership tackles difficult issues and mobilizes productive action. Addressing AIDS brings to the fore controversial issues which mainstream society prefers to avoid—like sex work, drug use and homosexuality. Social taboos go hand-in-hand with the stigma and discrimination which people infected with HIV experience and which sabotage HIV responses. In a few places, courageous leadership from political and social leaders has challenged these taboos, defused stigma and mobilized the public into supporting successful HIV programmes.

Asian countries with strong leadership have reversed the growth of their HIV epidemics. Asian leaders in places such as Thailand, Hong Kong SAR, Cambodia and Tamil Nadu in India had the foresight to recognize the threat of AIDS early on; they provided leadership that proves vital for reversing their epidemics. But such cases are the exception to what has been until quite recently a generalized lack of high-level commitment and leadership with respect to AIDS programmes in Asia.

More Asian leaders are now acting on HIV, but much more is needed. Evidence gathered by the Commission shows that more political leaders in Asia are taking up the AIDS agenda. Many national leaders have begun to provide some leadership support to AIDS programmes. This is evident in the larger commitment of resources, the creation of stronger governance structures for programme delivery, and the more meaningful involvement of affected communities in some places. At the same time, current responses in most countries are still too limited to reverse the epidemics. Leaders should—and can—do more.

There are still serious gaps in addressing AIDS as an emergency issue and recognizing its serious impact on individuals, families, and societies. Few leaders in Asia have made AIDS a genuine national priority. Efforts to create a supportive environment for HIV interventions remain scarce. In the past five years, hardly any country in Asia has brought its laws in line with the urgent need to provide those people most at risk of infection with HIV-related services. In many countries, the rights of people living with HIV are not yet explicitly safeguarded. Where top-



level commitment does exist, resources often do not reach the provincial and local levels, leading to uneven, unpredictable and inefficient HIV programmes. Moreover, few Government bureaucrats recognize the importance of the active involvement of communities. Resource commitments still fall short of the levels needed to halt and reverse the epidemic.

Politicians have key roles to play. The Commission acknowledges the important role of parliamentarians in AIDS advocacy in Asia. Some politicians have made valuable efforts to build awareness among their constituencies, lobby for HIV-related legislation, ensure that intellectual property laws support equitable access to medicines, press for more HIV resources, and hold their Governments accountable for their countries' HIV responses. Parliamentary committees on HIV have been set up in a number of countries. Increasingly, regional networks of Parliamentarians are also focusing on issues related to HIV and sexual and reproductive health.

Leadership and political commitment are the most important prerequisites for an effective HIV response. Asia's countries have the opportunity to reverse the HIV epidemics and undo the damage being done. Seizing that opportunity requires stronger leadership across the board. Leaders should begin by clearly demonstrating their support for HIV strategies that are pragmatic and of proven effectiveness.

3. Prevention still does not have an urgent enough priority—even though effective prevention is both feasible and affordable in Asia

The vast majority of HIV infections in Asia occur during three high-risk behaviours (unprotected commercial sex, the sharing of contaminated injecting equipment, and unprotected sex between men) and one ostensibly 'low-risk' behaviour (sex between wives and their HIV-infected husbands). The Commission's country-specific analyses show that this conclusion applies across the region. The epidemics thrive where sex work is common, needle-sharing is widespread and men are having unprotected sex with other men. Casual sex outside of the sex trade is not yet a significant factor in Asia's HIV epidemics. HIV

risk is highest among men. Male clients outnumber sex workers by 10 to 1; most injecting drug users in the region are men, and anal sex is extremely effective in transmitting HIV between men. Thus, most infections to date have been among men. The majority of women living with HIV in Asia were infected during sex with husbands with high-risk behaviour. The epidemics follow a common pattern in which HIV prevalence initially rises among injecting drug users, then increases among female sex workers and their male clients, and eventually grows among those clients' wives and children. Parallel epidemics among men who have sex with men have also reached high levels in many Asian countries.

A focus on these risk behaviours is essential for effective prevention in Asia. The extent and intensity of these risk behaviours in different countries ultimately shape the evolution and scale of their HIV epidemics. Differences in HIV prevalence between countries are largely the result of variations in these behaviours, especially the prevalence of sex work. Therefore, in order to achieve maximum effectiveness, national HIV responses need to focus on preventing HIV infections in those sections of the local population that are most at risk for HIV, and on providing them with treatment and care services and impact mitigating support.

Asia's epidemics are best-classified according to an analysis of which risk behaviours are responsible for most new infections. In light of their basic commonalities, Asia's HIV epidemics should be classified not according to national HIV prevalence, but rather according to the behaviours that drive transmission. Such analysis enables one to pinpoint the current status and likely evolution of the epidemic, and makes it possible to implement those HIV interventions which have maximum impact.

National programme decisions should be based on their effectiveness in preventing new infections. Not all prevention programmes are equally effective. As a general rule in Asia, those programmes should focus on reducing HIV risk and removing those social factors that generate the largest number of new HIV infections. Such relatively low-cost but high-return interventions should form the core of HIV prevention efforts.



Currently, this essential focus is missing in many Asian countries. Few countries currently focus their prevention efforts on those population groups that are most at risk of becoming infected with HIV. Even when this focus is sought, the resulting programmes generally do not achieve adequate coverage.

In many countries, prevention efforts are not adequate to contain the epidemics. Except in Cambodia, Hong Kong, SAR, Thailand, and some states in India, prevention programmes are not demonstrably affecting the growth of HIV epidemics in Asia. Because programmes are heavily dependent on external funding, few Governments in Asia have taken full responsibility for, and ownership of, their HIV responses. Even in countries with documented successes, little has been attempted or achieved in preventing HIV transmission among men who have sex with men and injecting drug users, and between husbands and wives.

Asia's growing economies can finance stronger HIV programmes. Curbing HIV spread and transforming AIDS into a manageable, chronic disease is entirely feasible in a region that includes some of the most dynamic economies in the world. Given Asia's comparatively low prevalence and its rapidly-growing economies, the programmes required to contain the epidemic and provide care for those affected are well within the means of most Asian countries.

Efforts to combat a public health threat like AIDS often yield other, wider benefits. For example, the drive to combat cholera helped to improve sanitation systems in Europe, while the response to tuberculosis has helped improve hygiene practices and strengthen community health facilities, and avian influenza has promoted improvements in disease surveillance. Effectively addressing HIV brings a range of wider public health benefits, and serves as a platform for strengthening social development in Asia.

4. Sustainable success requires also addressing key social factors

HIV risk, decisions on HIV responses and the responses themselves are shaped by the contexts in which they occur. HIV-related risks do not occur in a social, economic or cultural vacuum. Numerous factors facilitate, aggravate or reduce HIV risk-

taking. Many of these can be addressed successfully. Similarly, decisions on where to focus HIV interventions often are influenced by social, cultural, religious, political or institutional factors. Particularly important in this respect are stigma and discrimination, two factors which often undermine the implementation of effective prevention, treatment and impact mitigation responses. Finally, poor policies, weak governance and legal or operational barriers often also block effective action. HIV responses work best when such hindrances are removed.

Steps for addressing the factors that influence risk and affect programme effectiveness must be incorporated into the HIV response. Those factors must be addressed as an integral part of the overall HIV response. But the responsibilities for doing so should be spread appropriately across the system. Leaders should ensure that an 'enabling environment' for prevention, care and impact mitigation is established. Legislatures and institutions must address legal or institutional restrictions that undermine effective programmes. Non-governmental and community organizations, working with Government entities, need to develop strategies to convince the public to support appropriate efforts. Some of those interventions form an intrinsic part of the HIV response and should be funded accordingly. Some are best integrated into existing programmes and systems, with AIDS funds used as catalysts. Others are relatively low cost (for example, legal reforms) but need to become concrete, well-defined components of the overall response.

Women and poor households bear a disproportionate part of the epidemics' impact. Although the strong growth rates of Asian economies are helping to reduce poverty, rapid economic development is also widening economic disparities in the region. In many places, economic growth is also outstripping the pace of social development and the protective effects of social safety nets. Those trends could have significant consequences for the HIV epidemic and its impact, especially among women, who often are already socially and economically disadvantaged. Asian leaders need to recognize the importance of equity and social development as elements of an effective HIV response. Effectively addressing HIV brings a wider range of benefits and serves as a platform for social sector reforms in Asia.



5. *Treatment and care pose important challenges, but if prevention keeps HIV prevalence low, universal access to treatment becomes feasible*

Identifying people in need of treatment and care is a challenge.

While most HIV infections occur in people with specific risk behaviours, the illnesses associated with AIDS often occur long after they have changed those behaviours. Identifying those individuals can be a challenge, since they may no longer belong to the communities that are usually targeted for HIV testing. Stigma and discrimination against people living with HIV pose further difficulties, by reducing their willingness to access testing and other HIV services. Stigma and discrimination may also undermine efforts of affected families to raise the resources needed for antiretroviral treatment. Given the predominant patterns of HIV transmission in Asia, the challenge is to achieve wider access to a continuum of affordable treatment and care services to all those in need.

Financial sustainability of care and treatment programmes needs more attention.

In countries where the provision of free or subsidized antiretroviral treatment relies heavily on external funding, the financial sustainability of those services is a concern. More research is needed to determine the best combinations of Government subsidies, insurance coverage, work-based health care, and private sector resources for ensuring sustainable access to antiretroviral treatment and care services.

Regional mechanisms that can help countries expand access to treatment and care are not being used fully.

It is within the means of most Asian countries to deal with many of the financial, technical and logistical factors that currently limit treatment coverage. Collective and regional mechanisms can be used more fruitfully to negotiate favourable pricing, make bulk purchases, reduce costs and expand access to life-saving medications.

Prevention programmes must be expanded to make treatment and impact mitigation programmes affordable and sustainable.

Even in Thailand, where prevention programmes kept HIV prevalence below 2 per cent, the recurring costs of antiretroviral treatment will soon be more than USD 200 million a year. National HIV prevalence is lower than 2 per cent in all other countries in Asia. If other countries can keep infection levels

low, treatment and impact mitigation costs can also be kept down. Effective prevention is the first line of defence against rising treatment costs and growing impact mitigation duties.

6. *Impact mitigation in Asia is needed primarily at the household level.* The impact of Asia's HIV epidemics is most evident at the household level, where women, as caregivers, workers and surviving spouses, generally bear the brunt of the consequences. Women-centred impact mitigation needs to be at the core of a country's HIV response. Yet mitigation programmes for HIV and other catastrophic health conditions do not exist in most Asian countries. Ultimately, treatment is the most effective way to reduce the epidemic's impact. Treatment can keep families together, stop women from being widowed, prevent children from being orphaned by AIDS, and enable families to continue supporting themselves.
7. *Programmes are not currently large enough to reverse the epidemics, provide care for those living with and affected by HIV, and mitigate the impacts of the epidemic.* Despite the notable successes achieved by Thailand and Cambodia in reducing new infections, Asia overall has not yet put in place HIV responses that match the scale and patterns of its HIV epidemics. Instead, most countries in the region are in danger of losing ground to an epidemic that has proved resilient, particularly when presented with new opportunities for its spread. Currently, HIV prevention and treatment services in Asia reach fewer than one-third of the people who need them most. Despite the relatively low numbers of people in Asia who currently need antiretroviral therapy, only one in four (26 per cent) people are receiving it.
8. *Addressing social exclusion and involving communities is critical to an effective response*

HIV-related stigma and discrimination continue to undermine Asia's response to the epidemic—whether by sanctioning inaction or encouraging the harassment and maltreatment of people affected by the epidemic. Leaders must show greater resolve in challenging the ignorance and prejudice that surround the epidemic, and in supporting legislative and other changes that can reduce stigma and discrimination.

**Activism is underdeveloped in many countries of Asia.**

Activism, advocacy and the active participation of people living with or threatened by HIV have been key elements in mobilizing and sustaining enhanced responses elsewhere in the world. Governments should be open to these vital elements of the overall response, and United Nations agencies and other development partners need to do more to foster partnerships and dialogue between Government and civil society.

Engagement of affected communities in planning, implementing and assessing HIV responses is weak.

Because of the marginalization of people most at risk and the stigma experienced by people living with HIV, AIDS policies and programmes need to be informed by engagements with the affected communities. At present in Asia, the involvement of such key populations in national HIV responses is weak and, in many places, tokenistic.

9. Asia has the resources for an effective HIV response. Investing them sensibly will yield substantial returns**The countries of Asia can decide the future course of their HIV epidemics.**

The future of Asia's HIV epidemics will depend largely on whether sufficient resources are effectively deployed in HIV responses that achieve wide coverage among people most at risk. If the right choices are made, the entire region could soon be experiencing the same decline in the epidemic observed in Cambodia, Thailand, and Tamil Nadu.

Less than USD 1 per capita is needed for effective responses.

The Commission estimates in most countries in Asia, an average annual investment ranging from USD 0.50 to less than USD 1 per capita, depending upon the level of HIV prevalence, if focused along the lines recommended in this Report, can halt and eventually reverse the epidemics.

The benefits of appropriate prevention, treatment and care programmes outweigh their costs.

The Commission's research shows clearly that the advantages of appropriate action far outweigh the costs, and would bring benefits that reach beyond the HIV epidemic and the public health system.

II. POLICY RECOMMENDATIONS

1. *Leaders of Governments in Asia should clearly demonstrate their resolve and commitments to halt the spread of HIV in the region in time to achieve the Millennium Development Goal of reversing it by 2015. This cannot be done in one swift move. It requires a concerted plan of action—from policy to strategy to implementation.*

Having reviewed the national HIV responses in Asia, the Commission has found that they follow predictable patterns, starting with either denial or panic before gradually evolving into better-informed but often uneven responses. The Commission is pleased to note that in many countries there is a commitment among top-level political leaders to speak out about AIDS. Mostly, though, this is confined to policy statements—a necessary but insufficient ingredient for a comprehensive and full-scale response.

- 1.1. The time has come to translate political resolve into effective action.** Action means setting out policies, designing programmes, committing sufficient resources and putting into place strong governance structures for managing those programmes. Effective action also involves creating a supportive legal, political and institutional environment in which people most at risk can be reached with interventions.
- 1.2. Political leaders need to acquire a deeper understanding of the dynamics of the epidemic and its impact on individuals and families.** Low national HIV prevalence means that the impact of the epidemic is not yet obvious nationally in many parts of Asia. But in affected households and communities, the impact is severe. Leaders should be more alert and responsive to those realities.
- 1.3. Given the important role that politicians can play in supporting the HIV responses, the Commission strongly recommends that they set up HIV committees in their parties and parliaments.** Where such committees already exist, they and their regional counterparts (such as the ASEAN Parliamentary Assembly) should be further encouraged to monitor the progress Governments make towards achieving Universal Access to HIV prevention, treatment, care, and

support (as agreed to in the 2006 High Level Meeting on AIDS at the UN General Assembly) and expressed in Millennium Development Goal Six (halting and reversing the HIV epidemics). The capacity of these structures should also be strengthened in order to combat HIV-related discrimination, protect human rights, ensure adequate funding for HIV programmes and in order to remove legal, regulatory and other barriers that block access to treatment, prevention, care and support.

- 1.4. Generating quality evidence and using it effectively is vital, needs to be given higher priority.** The Commission's Report partly addresses this need, although it does so largely at a regional level. Similar work is needed at country level. Evidence of the epidemic's impact at various levels of society should be collected and collated regularly. The Commission's call for a biennial HIV Impact Assessment and Analysis, carried out by an independent agency (see Recommendation 3 in this chapter), is important in this context. Regional-level bodies, like the Association of South East Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation (SAARC), as well as UN agencies such as the UN Economic and Social Commission for Asia and the Pacific (UNESCAP) can also produce evidence-based reports on progress against AIDS, and use them as advocacy tools for scaling-up responses at country-level.

- 1.5. Besides Governments, business leaders need to assume a more proactive role in the HIV response.** Even though the epidemic's impact on their businesses may not be as damaging as in some African countries, failing prevention programmes will affect them in the form of rising medical expenditures, insurance payments, staff retraining costs and productivity losses. On the other hand, they are well-placed to build AIDS awareness and to mount prevention and treatment programmes among workers and their families. Leaders of industries involved in infrastructure delivery (and especially those employing large numbers of migrants) have a particular responsibility for dealing with HIV in their workplace policies and programmes. Except for isolated commitments by some business leaders, the Commission

has not yet witnessed organized efforts by the business community to meet these responsibilities.

2. AIDS programmes should be implemented through well-defined and efficient governance structures that are backed by strong political leadership and meaningful community involvement

The experiences of various HIV governance structures in Asia are discussed in Chapter 5. The Commission wishes to underline the need to improve arrangements in three aspects of programme management: National AIDS Commissions; national programme management structures; and the Country Coordinating Mechanisms of the Global Fund for AIDS, Tuberculosis, and Malaria.

2.1. Focus the mandate and membership of National AIDS Commissions on policy-making, coordination, monitoring and evaluation

Many countries have established National AIDS Commissions to spearhead and coordinate their HIV responses. Unfortunately, these structures are often large, unwieldy and, as a consequence, ineffective. The roles and responsibilities entrusted to these structures often have been poorly-defined and inappropriate. This has resulted in inaction, inefficiency, duplication, and confusion. On occasion, even the most basic elements of the HIV response have suffered.

The National AIDS Commission should be headed by the highest political authority if there is sufficient commitment to the HIV response at that level. Its mandate should centre on policymaking, coordination, monitoring and evaluation; it should *not* be responsible for implementing HIV programmes. Within those bounds, its roles and responsibilities—especially those that involve collaboration with health ministries—must be clearly defined. The National AIDS Commission should be compact in structure and membership. It should include only those key ministries that have key roles in implementing HIV programmes (the Health Ministry and, as appropriate, Ministries of Education, Social Welfare, the Interior, Police, Justice, by way of example). Each of these ministries should have their own HIV budgets, and retain primary responsibility for implementing the respective programmes and projects



that fall within their ambit. Membership should also include civil society, through elected and appointed community representatives (see Chapter 6), networks of people living with HIV and non-governmental organizations. National AIDS Commissions should have equal membership of both Government and non-governmental members and should feature a strong Secretariat to support their coordination functions.

2.2. Strengthen national programme management

The Commission is concerned about the weakness of management structures at programme delivery level in many countries (see Chapter 5), which undermines the effectiveness of national programmes and causes a waste of resources.

The Commission recommends that countries place senior and experienced managers at the helm of national programmes, individuals who also have a positive attitude about working with communities. These people should be selected in an open and competitive process. The managers should have the necessary financial and administrative authority to run programmes and access funds. A strong technical team should provide support. Once appointed, that team's tenure should be of a fixed duration in order to avoid the inefficiency arising from frequent rotation and transfers. The UN system and other development partners should also invest in building the capacity of the national programme manager's team to ensure its ability to manage a sustainable response.

Governance structures should be simple and the decision making process should be speeded up in such organizations. It would be wise to develop broad guidelines for a proper programme management structure based on best practices available within and outside the region. UNAIDS should be able to take up this role in consultation with Governments.

2.3. Improve the functioning of Country Coordination Mechanisms (CCMs)

The Global Fund to fight AIDS, Tuberculosis and Malaria will continue to play a central role in providing resources to national AIDS programmes. The Fund has established several governance

structures for managing and monitoring the implementation of funded programmes. Thus, the Country Coordinating Mechanisms play a crucial role in recommending programmes for funding, and in monitoring the progress of their implementation. Those structures have an important hand in the performance of prevention and treatment programmes undertaken by Government and civil society organizations.

2.3.1. Make Country Coordination Mechanisms (CCMs) more transparent and responsive.

The Commission recommends that the reform of the Country Coordinating Mechanism process be made a priority by country leaderships. Country Coordinating Mechanisms need to operate in a more democratic and transparent manner, and should encourage more meaningful involvement by civil society partners (especially community representatives). The Commission took note of several complaints from community leaders about the lack of transparency in Country Coordinating Mechanism activities, and the token involvement of communities. UN agencies and other development partners involved in the Country Coordinating Mechanisms have a special responsibility for ensuring genuine and meaningful participation of community representatives in those structures.

2.3.2. Let decisions be guided by the local epidemiological situation.

The Commission emphasizes that Global Fund funding decisions should be solidly grounded in the epidemiological realities of countries.

2.3.3. Clarify relationship with National AIDS Commissions.

In many countries the relationship between the National AIDS Commissions and Country Coordinating Mechanisms is not clearly-defined. While the Country Coordinating Mechanisms are usually under the administrative control of Health Ministries, National AIDS Commissions tend to be organized as multisectoral bodies for coordination purposes. The overall accountability of Country

Coordinating Mechanisms to coordinating bodies such as National AIDS Commissions is often unclear. The Commission urges UNAIDS and the Global Fund to develop guidelines for fostering stronger and more effective links between these two important organs for coordinating AIDS programmes at country-level.

3. *Understand the epidemic*

As discussed in Chapter 2, the HIV epidemics in Asia share several basic features. In all countries, most new HIV infections occur during unprotected paid sex, the sharing of contaminated drug injecting equipment, unprotected sex between men, and when persons infected in that manner (mostly men) then have unprotected sex with their spouses and other sex partners. The extent and intensity of such risk behaviours ultimately shape the scale of the various epidemics. On current evidence, it is highly unlikely that Asia's HIV epidemics will grow independently of the commercial sex trade, drug injecting and sex between men. This makes it more appropriate to classify Asia's HIV epidemics according to their stages of evolution, rather than according to the disease burden they represent. What is needed is a classification system that distinguishes between the various stages of evolving epidemics: 'latent', 'expanding', 'maturing' and 'declining'.

Beyond the basic common features, certain differences in patterns and trends of HIV transmission (and risk behaviours) are evident between and within countries. These should be identified and properly understood—at both national and sub-national levels. HIV epidemics often are concentrated in 'hot-spots' that can be targeted with intensive prevention and treatment efforts. But risk behaviours and patterns of transmission change, making it vital to stay abreast of new developments in the epidemic, as well as to monitor and assess the impact of the HIV response on the epidemic.

3.1. Evaluate and strengthen strategic information systems.

Each country has to strengthen its epidemiological and behavioural information systems (including the analysis of data generated by those systems) in order to achieve the best-possible, up-to-date understanding of its epidemic.

While HIV information systems have improved in most Asian countries in the recent past, there is still considerable room for improving data collection systems. In particular, national data collection systems and their analytical capacity must be strengthened. The transparency of those processes and access to the HIV data should be improved as well.

- 3.2. Make better use of existing data to estimate the magnitude of the problems.** The methodologies used to achieve such understanding should be regularly re-assessed (including through peer review) with a view to constant improvement.

In order to improve the accuracy of HIV estimates, country estimates should be based on pertinent survey data, including those collected in sentinel surveillance, HIV household and sectoral surveys.

- 3.3. Create a Regional Reference Group to support the countries' efforts.** The Commission proposes the establishment of a Regional Reference Group for Asia to support, review and validate country estimates and projections on HIV infections and resource needs. This would help refine the quality and effective use of HIV-related data and to set appropriate standards to guide programmes and policies.
- 3.4. Use in-country analyses to guide responses.** HIV policies and programmes must be guided by country-owned HIV and AIDS estimations and projections, and by the sound analysis of evidence relevant to successful prevention, treatment, care and impact mitigation programmes.
- 3.5. Expand information systems to include data on responses.** The coverage, quality and efficacy of prevention, treatment, care and impact mitigation efforts should be included within the ambit of information and analysis systems.
- 3.6. Conduct a biennial HIV Impact Assessment and Analysis.** Each country should conduct a biennial HIV Impact Assessment and Analysis that would guide HIV policies and programmes. Such an Assessment would review the latest epidemiological evidence, identify new HIV 'hot-spots', analyse factors (including rapid economic and social changes)



that can increase HIV transmission and hinder effective responses, assess the current HIV response (across various sectors), and project the impact of the epidemic (from the household level onward).

- 3.6.1.** Conducting the HIV Impact Assessment and Analysis should be the responsibility of a high-level Government body, one which should include civil society representation (including representatives of people most at risk).
- 3.6.2.** Each Assessment and Analysis should be compiled into a Report that is widely publicized and disseminated.
- 3.6.3.** Countries must ensure that their HIV responses are tailored and adapted in accordance with the assessments and analyses emerging from this process.

4. Combat stigma and adopt measures to remove discrimination

Myths and misconceptions about HIV persist in every Asian country. Whether these myths are the product of ignorance or prejudice, they help fuel the stigma and discrimination that plague HIV responses. This is evident even in the healthcare systems of several countries, where studies have documented disturbing levels of ignorance about HIV and prejudice towards people living with HIV.

HIV-related stigma and discrimination are distinct (although mutually reinforcing) concepts, and they are best tackled in ways that reflect those differences. Stigma and discrimination against people infected or affected by HIV continue to affect their access to employment, housing, insurance, social services, education and health care. Consciously or not, the reluctance of many social and political leaders to arm themselves with the facts and to speak out on these issues helps keep in circulation false claims about 'AIDS cures', myths about how HIV is transmitted, and the chauvinism that stigmatizes people living with HIV. But there is ample evidence, too, that legislative interventions can reduce HIV-related discrimination and empower people living with HIV or groups at high risk of infection to organize themselves and participate actively in HIV responses.

- 4.1. Leaders should speak out against stigma and discrimination.** Leaders in all walks of life, and at all levels in

society, have a responsibility to stay well-informed about HIV and to speak out against ignorance, prejudice and deception.

4.2. Correct or remove laws that support discrimination.

Governments should repeal or amend laws or regulations that enshrine HIV-related discrimination, especially those that regulate the labour market, the workplace, access to medical and other forms of insurance, healthcare, educational and social services and inheritance rights (particularly of women). They should also ensure that laws and regulations aimed at safeguarding the rights of affected communities and persons living with HIV are introduced and enforced.

4.3. Create AIDSWATCH bodies to monitor and highlight discrimination.

In order to help counteract HIV-related discrimination, the Commission recommends the creation of 'AIDS monitoring bodies'. These would monitor and address HIV-related discrimination in healthcare settings, in workplaces and educational institutions and in the wider society. AIDS funds should be used to support the establishment of these AIDS monitoring bodies. Countries with existing Human Rights Commissions should ensure that these additional roles are integrated into their responsibilities.

4.4. Support the active involvement of people living with HIV.

One proven way of reducing stigma against people living with HIV is by enabling and supporting their efforts to organize themselves as HIV advocates, educators and activists—and to forge partnerships with the media, healthcare providers, governmental and other civil society organizations. Funding, technical and logistical support can help them achieve this goal—equally, a more tolerant and facilitating approach from the authorities is necessary.

5. *Adopt a human-centred approach and speak out on controversial issues*

The criminalization of people most at risk undermines efforts to prevent new infections and provide treatment and care to people who are already infected. Research shows that where sex workers and drug injectors are targeted for arrest and prosecution, condom use tends to

be lower and needle-sharing tends to be higher. Such policies drive people most at risk deeper underground, which makes the provision of outreach services not only more labour- and cost-intensive, but also less effective. In some countries, outreach workers and service providers are harassed and arrested. The Commission believes such policies are counter-productive and dangerous.

- 5.1. Address legal barriers to effective prevention in most-at-risk populations.** Sex work, the use of narcotics, and sex between men is illegal in many countries. In Asia, where these behaviours are at the centre of the HIV epidemics, such legal provisions should not be allowed to hinder potentially effective efforts to control HIV. Countries should repeal punitive laws that criminalize sex between men.
- 5.2. Enhance services and protections for those most-at-risk of HIV.** Governments are advised to shift their focus from punitive legislation towards policies providing protection for vulnerable people who are at high-risk of HIV infection, as well as for service providers and their beneficiaries. Rather than try to address HIV risk and transmission among groups most at risk as a legal issue, health-enhancing services should be made available or improved—such as sexual health services for sex workers and their clients, and men who have sex with men and harm reduction programmes for injecting drug users.
- 5.3. Remove barriers that prevent sex workers from organizing.** Governments should remove legislative, policing and other barriers that prevent sex workers from organizing collectives, and to strengthen their access to services. Donors must remove conditionality or policies that prevent their partners from supporting organizations that work with sex worker organizations.
- 5.4. Bring public security people into the response.** Governments should issue legislative and/or administrative directives to the police, correctional and judicial services to facilitate the provision of HIV-related services to people most at risk (including those who are imprisoned or interned).
- 5.5. Implement prison-based HIV programmes.** Given the high imprisonment rates of people most at risk, Governments

are advised to ensure that prisons and other correctional service institutions provide prisoners with HIV information and essential prevention services.

- 5.6. **When controversy arises, speak out boldly.** In order for these steps to be taken, opinion leaders must be bold enough to speak out on these issues and the controversies that surround them.

6. *Promote and support AIDS activism and civil society advocacy*

Despite the increase in funding available for combating the HIV epidemics, HIV has been slipping down the list of priorities in many Asian countries. This is partly because the epidemic is slow-moving and often 'hidden'. It lacks the sudden and explicit drama of other epidemics, such as SARS. Activism and advocacy is therefore essential to keep HIV constantly on the agenda. Civil society organizations, the media, opinion leaders, United Nations agencies and external donors all need to support such activism and advocacy in order to help build an effective and sustainable response. At the global level during the last five years, such advocacy and activism has helped increase resources devoted to HIV, reduce antiretroviral drug prices, and ensure greater involvement of civil society networks in the planning, programming and monitoring of HIV responses.

- 6.1. **Expand the base of HIV champions to raise HIV's public profile.** The Commission's analysis of national responses reveals a paucity of HIV champions among social and religious leaders, and media, entertainment and sports celebrities. In most countries, little sustained pressure exists from civil society groups and voters for dealing with HIV issues, the very groups that have proved so vital in HIV responses elsewhere. Societal leaders must encourage such people to become actively engaged and help in raising public awareness.
- 6.2. **Encourage advocacy partnerships and activism around HIV issues.** Governments should be open to these important dimensions of the overall response, while United Nations agencies and other development partners have a special responsibility to foster partnerships and activism at various levels.



7. *Focus resources to achieve maximum impact*

The Commission's review of national and international HIV responses shows that, of the estimated USD 6.4 billion required annually for a scaled-up response in Asia, only around USD 1.2 billion was available in 2007. These funds are not always used for programmes that are focused enough to have the maximum impact on the epidemic. HIV programmes in Asia currently span too many activities. This state of affairs stretches resources, complicates the task of programme managers and reduces the effectiveness of interventions. Current spending patterns also reveal a mismatch between resource allocation and strategic priorities. Multiple funding, political and other pressures have led to programming decisions that are not fully formed and developed and inappropriate funding allocation. In addition, current domestic investment in HIV is low across most of Asia. As a result, much of the HIV response is externally-funded and -driven.

- 7.1. Prioritize the interventions that are most effective.** The Commission emphasizes that interventions that can have the quickest, largest and most sustainable effect on reducing HIV transmission and the impact of the epidemic must be given priority in allocating HIV resources.
- 7.2. Focus on the high-impact interventions to reverse the epidemic and lessen its impacts.** Based on its research, the Commission has classified current HIV programmes into four categories: Low-cost/High-impact, High-cost/High-impact, High-cost/Low-impact, and Low-cost/Low-impact. Prevention activities that focus on populations that are at risk and on creating a supportive environment are examples of Low-cost/High-impact activities. Antiretroviral treatment would be an example of a High-cost/High-impact intervention. Together, with women-friendly livelihood support and orphan programmes, these high-impact interventions should constitute the core of the HIV response. If countries committed resources to the response of the order of USD 0.50–USD 1.00 *per capita* range as proposed in Chapter 3, HIV epidemics in Asia could be reversed, 40 per cent of AIDS-related deaths could be averted (through the provision of antiretroviral therapy), and 80 per cent of women and orphans could be provided with social security protection and livelihood support.

7.3. Leverage additional resources to address other drivers of the epidemic and impediments to effective responses.

A variety of other programmes and policies are available to address some of the underlying drivers of the HIV epidemics, the factors that aggravate their impact and that block or undermine the provision and use of HIV services. When successful, such programmes bring long-term sustainability to the HIV response and link with wider social development objectives. The Commission therefore recommends that additional resources be mobilized to leverage and support activities such as the prevention and treatment of sexually transmitted infections (aimed at the general population, as opposed to most-at-risk groups), condom promotion and provision for the general population, health systems strengthening measures, such as blood safety and universal precaution systems, sex education for school students, as well as strengthening social and health sector infrastructure and women's empowerment programmes.

7.4. Increase local investments in HIV responses. Governments should reduce their dependency on external financial support and invest more in their national HIV response. This can increase local ownership, and improve the coordination of HIV activities. An essential step along that path is the development of a normative guideline for resource needs, based on the kind of high-impact, focused approach the Commission proposes in this Report.

8. *Take proven prevention activities to scale*

At present, HIV interventions that focus on most-at-risk groups in Asia are very limited in their coverage. In a few countries, including Cambodia, Thailand and parts of south India, programmes for reducing HIV transmission during commercial sex have been introduced on an adequate scale. But such examples are exceptional. Most responses still favour small, local projects whose combined impact on the overall epidemic is marginal. The Commission is disappointed to report that in no country in Asia are prevention and treatment services for people most at risk currently available on anything like the scale needed to alter the course of the epidemic. Based on data collected from countries

in 2005, prevention programmes reached only about one third of sex workers, only 2 per cent of injecting drug users and less than 5 per cent of men who have sex with men. The situation might have improved marginally since then, but it is highly improbable that service coverage has reached the desired levels. Epidemiological modelling suggests that if 60 per cent of people engaging in high-risk behaviours adopt safe behaviours (for example, consistent condom use with sex workers, use of sterile injecting equipment, etc.) the HIV epidemics can be reversed.

Unfortunately, most countries in Asia have not standardized the preventative measures required for the different groups most at risk. For example, needle exchange and drug substitution programmes are often treated as optional rather than essential HIV services for injecting drug users. Indeed, only four countries in Asia offer comprehensive risk reduction programmes for drug injectors, and none has a comprehensive prevention programmes for men who have sex with men. Peer education—a powerful component of interventions targeting sex workers, injecting drug users, and men who have sex with men—hardly exists, in several countries like Cambodia, China, Thailand and Viet Nam. These shortcomings stem partly from a lack of standardization in the programmes, which allows donors to fund programmes of variable appropriateness and effectiveness.

- 8.1. Ensure that prevention efforts are at a scale that makes an impact.** Proven interventions should be scaled-up to reach the critical coverage thresholds that are needed to achieve a significant impact on the epidemic. It is primarily the responsibility of Governments to ensure that this happens. The Commission calls for some standardization of effective programme elements, which could be initiated and validated by the United Nations and other international partners.
- 8.2. Focus on geographic 'hot-spots'.** HIV 'hot-spots' and high disease burden localities must be given priority when expanding coverage. The expansion of services should occur simultaneously in those places, and should comprise a set of clearly-defined activities and standards.
- 8.3. Define and implement the elements of a full prevention package for each at-risk population.** The essential elements

of prevention interventions for sex workers, injecting drug users and men who have sex with men should be defined for the Asian context both on a regional and national basis. Governments—supported by United Nations agencies, regional bodies and external donors—need to revise and/or endorse the standard elements of a comprehensive HIV prevention package for Asia, as proposed by the Commission later in this chapter (as described in Prevention Recommendation 1, below).

9. Ensure universal access to HIV treatment and care

Antiretroviral therapy is the mainstay of treatment for people who are infected with HIV. In addition to successful prevention programmes, antiretroviral treatment is the most effective way to reduce the impact of the epidemic, especially in poor households, by prolonging productive lives and enabling persons to continue to earn livelihoods. Affordability problems should not deny the poor these benefits. The Commission therefore recommends that provision of antiretroviral drugs, along with support services (such as CD4, CD8 and viral load tests) be fully subsidized. In order to secure better access for the poor, women, and children, a subsidy element also needs to be added for meeting transportation and other 'hidden' costs associated with accessing treatment services. The numbers of people in need of antiretroviral therapy in most of Asia are relatively low, and only four countries (China, India, Myanmar, and Thailand) account for about 90 per cent of that need. Yet, only one quarter (26 per cent) of people in need of antiretroviral treatment in Asia currently receive it.

The Commission believes that universal antiretroviral therapy coverage is well within the means of most Asian countries—and must therefore be achieved in the near future.

- 9.1. Delivery of quality antiretroviral therapy is a Government responsibility.** Governments have a duty to ensure that a comprehensive package and continuation of effective treatment services (that is, first- and second-line antiretroviral drugs) is accessible to those who need it.
- 9.2. Integrate HIV treatment services into existing health systems and ensure equitable access.** The Commission recommends that antiretroviral treatment programmes

should be integrated into the general healthcare systems of countries. However, a comprehensive set of services which include expanding access to free voluntary testing and counselling, CD4 and CD8 testing, viral load monitoring when needed and the treatment of opportunistic infections should be funded out of the AIDS budget. In the case of poor people, transportation costs to reach treatment centres should be funded from programmes to ensure treatment compliance. Social insurance schemes should include antiretroviral treatment.

- 9.3. Engage affected communities to expand treatment access.** Governments must assume responsibility for ensuring that free antiretroviral therapy is available and accessible to all who need it. Community organizations, including those representing most-at-risk groups and people living with HIV, should be involved in designing, implementing and monitoring this undertaking.

10. *Make impact mitigation an integral part of the national response*

Much of the impact of HIV occurs at the individual and household levels. The evidence shows that poor, affected households bear a disproportionate burden associated with HIV illness and death. This is not surprising, given the fact that social security systems in most of Asia are either weak or absent. The stigma experienced by AIDS-affected people (especially widows and orphans) means that gaining access to social welfare is often difficult. The low social status accorded to women, limitations on their access to employment and the denial of their property and inheritance rights in some countries (notably in South Asia) cause considerable insecurity—especially for women affected by AIDS. Indeed, most countries in Asia lack practical mechanisms to protect women against such consequences. However, studies suggest that a dedicated, AIDS-specific mechanism probably would be unviable in the predominantly low-prevalence settings in Asia. Strengthening livelihood security and income generation programmes—with special focus on AIDS-affected women—would seem a more prudent approach. For similar reasons, support for children orphaned by AIDS is best channelled through cash transfer programmes for vulnerable children.

10.1. Fund impact mitigation programmes through the national AIDS budget. The Commission urges Governments to include impact mitigation as an integral part of their national HIV responses, and to devote sufficient resources from the AIDS budgets to that end.

10.2. Ensure impact mitigation programmes should have the following components, at a minimum:

- income support should be available to women in AIDS-affected households, regardless of whether the women are infected with HIV;
- special support (including cash transfers or subsidies for education, transport and food expenses) should be available to families fostering children orphaned by AIDS;
- existing insurance and social security schemes must be reviewed and, if necessary, revised to ensure that they provide protection to AIDS-affected people; and
- laws are needed to guarantee equal inheritance rights for women and men.

10.3. Integrate into existing social security programmes wherever feasible. To the maximum extent possible, impact mitigation should be integrated into existing national social security programmes, while being funded out of the AIDS budgets. In countries where the social security programmes are weak or non-existent, AIDS impact mitigation programmes should be organized independently and fully funded. Indeed, the HIV epidemic provides countries with a valuable opportunity to strengthen their social protection programmes for catastrophic health and other expenditures. These programmes are not very expensive: the Commission estimates that for the whole of Asia, the total cost would be of the order of USD 300 million per year.

11. *Ensure community and civil society involvement in all stages of policy, programme design, implementation, monitoring and evaluation*

Civil society involvement has been shown to be a vital aspect of successful HIV responses around the world. In settings where groups

most-at-risk also tend to be marginalized and vulnerable to discrimination, community and civil society involvement becomes even more important.

Organizations of people living with HIV, and groups representing or supporting people most at risk, must be actively involved in designing, implementing and monitoring HIV programmes. They should be represented on the key bodies entrusted with fighting the epidemic, including National AIDS Commissions and Country Coordinating Mechanisms of the Global Fund. These representatives should be selected in a transparent and fair manner. While Governments need to facilitate such involvement, additional donor support is needed to ensure that sufficient financial, technical and human resources are available to enable civil society organizations to participate effectively. Donors should consider including genuine civil society involvement among their criteria for funding national HIV programmes.

12. Increase community accountability through greater transparency, democratic governance and improved preparedness. *The International Federation of the Red Cross Code of Conduct for non-governmental organizations is a useful guide for improving accountability and governance. The better-prepared, better organized and more accountable community organizations become, the more fruitful their collaboration with Governments is likely to be.*

12.1. Community organizations must become more accountable for their conduct and performance. To that end, they should establish systems and structures that support their effective participation in the HIV response (including the selection of their representatives to participate in HIV structures).

12.2. Bring communities together to strengthen their ability to participate at the national level. The Commission recommends that community organizations form national alliances, which can in turn assign representatives to national bodies such as Country Coordinating Mechanisms and National AIDS Commissions on the basis of an open and transparent selection process.

12.3. Community organizations involved in national HIV responses need to collaborate with each other. They need to develop procedures and policies to inform such collaboration, including the selection of representatives and accountability procedures.

13. *Use regional organizations to strengthen coordinated responses across the region*

Dialogue, cooperation and the sharing of HIV programming experiences at regional level can help strengthen and extend Asia's HIV responses. Regional intergovernmental organizations have been involved in Asia's HIV response for some time, and groupings such as the Association of South East Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation (SAARC) have made high-level commitments to fighting the epidemic. However, those commitments are yet to translate into activities that capitalize on the strengths and advantages that such regional bodies offer.

13.1. Regional intergovernmental organizations, like ASEAN and SAARC, should take leadership in enhancing HIV responses and as platforms for promoting new understandings and approaches across the region.

13.2. Regional organizations should assume a stronger role in negotiations on antiretroviral drug prices, and regular monitoring of the AIDS response in member countries in high-level political forums.

14. *Strengthen and sharpen the roles of United Nations agencies*

The Commission did not undertake an extensive review of the functioning of the United Nations system in support of the AIDS response in the region. But it did conduct a strategic overview of the role of UNAIDS and its cosponsor organizations in supporting Asian countries' HIV responses. It found that the strong global advocacy for resources and political support for AIDS programmes mounted by UNAIDS has had a positive impact in Asia. UNAIDS should be commended for its achievement in substantially scaling-up resources available to AIDS and in strengthening the political



commitment of Asian leaders to improving HIV responses in their respective countries.

However, the Commission is concerned that UNAIDS is not yet effective in providing truly integrated technical support to countries, partly because of the numerous UN agencies that are involved in the Joint Programme. UN support programmes often lack coherence. One reason appears to be that the programmes sometimes reflect the corporate priorities of the respective agencies, rather than the national priorities of the affected countries. It is yet to be seen whether the division of labour among UNAIDS cosponsor agencies outlined in the Global Task Team recommendations will be put into practice.

14.1. The UN should continue to advocate for greater financial and political commitment from countries, based on its comparative advantage in this area.

14.2. UNAIDS should develop and support a coordinated regionally specific strategy for Asia. The Commission recognizes the unique role of UNAIDS in monitoring and evaluating national commitments and responses to the epidemic with respect to achieving the Goals set in UN Declarations on Universal Access and in the Millennium Development Goals. UNAIDS should develop and support a strategy that pertains specifically to Asia's HIV epidemics and responses. It needs to ensure that UN agencies provide coherent technical and managerial support to realize such a strategy at country and regional levels.

III. STRATEGIES AND PROGRAMME IMPLEMENTATION

The policy priorities identified above have to be translated into effective strategies and programmes for implementation. Successful strategies and programmes require the following basic elements:

- *establishing linked behavioural and epidemiological surveillance systems for tracking patterns and trends in the epidemics, and for gauging the coverage and impact of interventions;*
- *prioritizing the most effective interventions functionally and geographically, and investing accordingly;*

- *providing universal access to treatment (with a special emphasis on reaching poor households and geographic locations with a high burden of disease), and linking this to outreach programmes for marginalized populations;*
- *institutionalizing impact mitigation programmes to reduce the burden of the epidemic at household level, focusing efforts in high prevalence settings and giving priority to affected women and children;*
- *creating a supportive legal and political environment to facilitate and foster the active participation of most-at-risk and affected communities and people living with HIV while expanding prevention, treatment and impact mitigation efforts to an adequate scale.*
- *establishing efficient governance structures to secure appropriate involvement of all relevant ministries and sectors in programme formulation and implementation.*

Irrespective of the roles assumed by other stakeholders and actors, the primary responsibility for an effective HIV response rests with the Governments of Asian countries.

The next section groups specific programmatic recommendations under four broad headings: prevention, treatment and care, impact mitigation; and programmatic issues for implementing those components. Because the components are inter-related, some recommendations cut across several categories.

A. Prevention

Effective and timely prevention efforts are the cornerstone of a successful HIV response. As stated in Chapter 3, in countries with expanding epidemics, every USD 1 spent on appropriate prevention programmes can save USD 8 in averted treatment costs.

The Commission's review of epidemiological evidence and country experiences in Asia highlights the fact that effective prevention which focuses on the behaviours that carry the highest risk of HIV infection can reverse the epidemic. Strong political commitment to give such programmes priority and to create an enabling environment for them is essential. Effective prevention interventions can keep the costs of operation, treatment and care manageably low.

The payoff would be considerably fewer people infected with HIV, and higher quality treatment and care for those living with HIV—thus sparing millions of lives, protecting livelihoods and saving resources that can be directed to meeting other development priorities.



1. Focus prevention programmes on interventions that have been shown to work and that can reduce the maximum numbers of new HIV infections

1.1. Focus on most-at-risk populations: *Most new HIV infections in Asia are directly or indirectly attributable to unprotected paid sex, the sharing of contaminated, injecting equipment, and unprotected sex between men.*

Focused programmes that have proved successful in preventing the spread of HIV among those groups most at risk of infection are well-documented, and should form the core of HIV prevention programmes. These groups include sex workers, injecting drug users, men who have sex with men, male clients of sex workers, and regular partners of these men. Effective prevention services for these groups can avert over 80 per cent of new HIV infections.

1.1.1. Introduce comprehensive harm reduction programmes

The Commission's review of research evidence from Asia and elsewhere confirms that harm reduction programmes are effective in reducing the sharing of contaminated drug injecting equipment, increasing condom use among drug injectors and reducing HIV infection levels among them. The Commission acknowledges that these measures are not always politically popular, but their effectiveness is beyond dispute. If introduced on a large-enough scale, they can contribute significantly to reducing the HIV epidemics in countries where injecting drug use is common.

Of the 11 countries in Asia with drug-related HIV epidemics, no country currently offers a comprehensive harm reduction programme that includes both drug substitution and needle (and syringe) exchange services on the required scale. Most of these countries offer one or the other of those services, which is inadequate and less effective. When large proportions of drug injectors are infected with HIV, substitution treatment becomes especially important. If successful, such treatment removes those infected persons from injecting networks, thereby reducing the chances of HIV transmission. Although

WHO has included substitution drugs on its Essential Drugs List, legal barriers blocking the therapeutic use of such drugs remain in place in many countries.

- Governments must facilitate and support the introduction of integrated, comprehensive harm-reduction programmes that provide a full range of services to reduce HIV transmission in drug injectors.
- The harm reduction package should include needle-exchange, drug substitution and condom use components, as well as referral services (for HIV testing and antiretroviral treatment). The evidence shows that the overall effectiveness of such programmes suffers when such components do not form an integrated package.
- Legal obstacles blocking the implementation of comprehensive harm-reduction programmes (including the procurement of drugs for substitution treatment like methadone and buprenorphine) should be lifted in the broader interests of public health.
- The overlap of HIV and Hepatitis C infections is also a matter of growing concern. Significant numbers of people infected with both viruses are dying of Hepatitis C complications, even when they receive and adhere to antiretroviral treatment. A successful needle and syringe exchange programme would also prevent Hepatitis C infections, thus reducing the very costly treatment of that disease.
- The Commission recommends that United Nations agencies negotiate price reductions for substitution drugs such as methadone and buprenorphine, as well as facilitate the streamlined and sustainable procurement of these drugs by Governments that introduce harm reduction programmes.

1.1.2. Increase the consistent use of condoms during paid sex

The consistent and correct use of condoms is the most effective method for preventing the sexual transmission of HIV during commercial sex. Indeed, the 100 per cent condom use programmes introduced in Cambodia and Thailand were crucial in increasing condom use during paid sex in brothels



in those countries. However, the subsequent implementation of similar programmes has brought complaints about human rights violations from sex workers. In addition, the past decade has seen significant shifts in several Asian countries from brothel-based sex work to other settings (such as massage parlours, bars, streets, and parks). While the principle of 100 per cent condom use still holds, the reach and effectiveness of programmes modelled on the Thai experience is open to question. At the very least, sex worker involvement through peer education and protection of their human rights must be essential components of such programmes.

- More sex work interventions based on peer education should be introduced and scaled up. The Bill and Melinda Gates Foundation experience in India confirms that the scale of such programmes can be increased, but only when their various components (including the creation of an enabling environment) are well-defined and appropriately packaged, and when clear indicators are set and adequate funding is secured.
- Government has a key responsibility to ensure that condoms are available, accessible and affordable to sex worker and their clients.
- The Commission recommends that the use of female condoms (especially in paid sex) should be encouraged as an empowering measure for women and should be introduced where the operational feasibility of so doing has been demonstrated.
- Political and social leaders should be involved in mass information campaigns to educate the public about the numerous public health benefits of condom use. There should not be any restrictions on the use of the mass media to promote condom use.

1.1.3. Reduce HIV transmission among men who buy sex

Men who buy sex are the most important source of new HIV infections in most Asian countries. Many of them go on to infect their wives and girlfriends, women whose only risk behaviour is to have unprotected sex with their husbands or boyfriends. Interventions focused on these groups should be a key component of all Asian HIV prevention

programmes. Focusing prevention efforts on sex work clients (who are mostly young and almost exclusively male) can bring considerable benefits as most of them participate actively in mainstream social and economic life.

- The Commission underlines the need to make commercial sex clients a central focus of HIV prevention programmes in Asia.
- Attempts to reduce HIV transmission in paid sex usually target sex workers. Several such programmes have been partially successful. But when interventions also target the clients of sex workers, the outcomes tend to be more impressive—as is the case in Cambodia and Thailand, where powerful mass media campaigns directed at clients played an important role in helping instil a virtual norm of condom use during paid sex. These media campaigns also have a long-lasting effect, as has been the case in Thailand.
- Other than media-driven campaigns, other programmes focusing on clients are in general poorly developed. There is an urgent need for innovative operational research and creative programming to reach these (mainly male) clients with effective interventions.
- One such approach would be to introduce HIV education and provide HIV services (such as treatment for sexually transmitted infections, and condom promotion) in work settings that tend to be associated with demand for sex work—such as men working in the military, the police, the merchant navy, and in long-haul transport, construction, and infrastructure projects.
- The Commission's review of evidence also indicates that programmes targeting commercial sex clients should not be morally judgmental. They should be pragmatic and must provide clients with the necessary information and services to protect them and others against HIV infection.

1.1.4. Reduce HIV transmission during sex between men

HIV transmission among men who have sex with men does not necessarily lead to a large-scale epidemic in the wider population. However, a serious epidemic among men who

have sex with men can potentially account for between 10 per cent and 30 per cent of new HIV infections, making it a significant factor in the overall HIV epidemic.

- A comprehensive programme to prevent infections among men who have sex with men includes intensive HIV education (especially peer education), provision of condoms and water-based lubricants, access to services for managing sexually transmitted infections, as well as support for local advocacy and self-organization.
- Legal and policy barriers that hinder the delivery of HIV services to men who have sex with men should be removed or, at least, relaxed. For example, anti-sodomy laws could be repealed or legislation to provide beneficiaries and service providers with immunity from prosecution could be introduced.

1.1.5. Protect the wives of men who buy sex, inject drugs or have sex with other men

Studies from South and South-East Asia have shown that 75–90 per cent of women infected with HIV are monogamous and were infected during sex with their husbands or boyfriends. Preventing HIV infections in sex work clients can therefore significantly reduce HIV infections in the wider population. Prevention of mother-to-child transmission is important and offers additional opportunities to reduce HIV infections among infants.

- No intervention aimed at protecting 'low-risk' women has yet proved effective on a large scale. The Commission recommends that high-quality research be undertaken to improve HIV interventions aimed at reaching those women who are likely to be exposed to HIV by their husbands.
- HIV counselling and testing for (male and female) patients seeking treatment for sexually transmitted infections and other indicative settings should be expanded.
- The Commission recommends that access to programmes for preventing mother-to-child transmission of HIV be expanded (especially in HIV

'hot-spot' areas) by integrating them into the existing healthcare system. Reproductive health services should be used as an entry point to increase women's access to HIV prevention, testing and referral services.

- The Commission notes, however, that in several Asian countries the majority of deliveries of new-born babies do not occur in medical institutions. Consequently, improvements in the accessibility and quality of antenatal care and institutional delivery are needed, the benefits of which transcend the HIV response and will help reduce the high rates of infant and maternal mortality in many Asian countries.

1.2. Target specific geographic regions

The epidemics in Asia show considerable variation at sub-national level. Early and effective interventions among injecting drug users in a handful of urban areas could still avert a large-scale epidemic in, for example, Pakistan. In Viet Nam, injecting drug use is driving most of the HIV epidemic in the north, while paid sex is a more important factor in the south. Prioritizing prevention interventions according to the sub-national characteristics of the epidemic can save significant human resources and funds.

Most national HIV surveillance systems currently do not provide a detailed enough picture of the HIV transmission and behavioural patterns and trends at sub-national levels. These systems should be adapted to generate data and analysis in order to identify geographic 'hot-spots' of high-risk behaviour and/or high HIV incidence so that HIV programmes can respond more quickly and appropriately to changes in the epidemic. Local-level capacity should be strengthened or built so that these data and analyses inform HIV plans and programmes.

1.3. Create an enabling environment for HIV interventions

'Enabling environments' are essential for delivering HIV services to most-at-risk populations. The environment in which risk behaviour and risk reduction occur has a major bearing on how HIV epidemics evolve and how effective HIV responses become. Some contextual factors shape the potential effectiveness of HIV interventions—by preventing at-risk persons from understanding the HIV risks they face, accessing information and services that can reduce those risks,



or being able to maintain safer behaviours. Such inhibiting factors often are linked to the conduct and practices of local law enforcement personnel, religious and other community leaders, and local powerbrokers. Even where national laws enshrine rights that should shield those groups most at risk against harassment and persecution, these laws are often ignored at the local level.

1.3.1. Engage local partners in building an enabling environment.

At the *local level*, solving this problem requires delicate advocacy (and education) efforts directed at opinion leaders and law enforcement authorities so that the importance of HIV interventions are understood and supported. The networking of sex workers, drug injectors and men who have sex with men must make up an integral part of the enabling environment, as explained in Chapter 4. Harassment and violence against most-at-risk populations must be avoided, by involving police and other law enforcement agencies in education and communication programmes, and through supportive media campaigns.

1.3.2. Improve the legal and policy environment.

At the national level, this requires supportive laws and policies—which may entail removing, altering or relaxing the enforcement of certain laws and regulations.

1.3.3. Build trust by addressing community needs.

At the level of individuals, finding a solution requires recognizing and addressing some of the immediate needs of those groups most-at-risk, in order to foster the trust and rapport that is needed to deliver effective HIV services to them. This would include improving access to male and female condoms and lubricants, needle syringes, substitution drugs, sexually transmitted infection clinics, and to other basic health services (for diagnosing and treating TB, for example, or treating abscesses and sores).

1.3.4. Cost enabling environment activities and support.

Activities related to creating an ‘enabling environment’ must be costed for HIV interventions, particularly at the project level; such ‘enabling’ activities need to be factored into intervention costs.

2. Avoid programmes that accentuate AIDS-related stigma

It is important to recognize that not all interventions aimed at most-at-risk groups are effective, and to note which have been proven to be ineffective, or even counter-productive. In their enthusiasm to initiate large-scale prevention programmes, Governments are seen to adopt certain programmes which accentuate stigma and violate the human rights of most-at-risk groups. These include 'crack-downs' on red-light areas and arrest of sex workers, large-scale arrests of young drug users under the 'war on drugs' programmes, mandatory testing in healthcare settings without the consent of the person concerned and releasing confidential information on people who are HIV positive through the media.

These initiatives can be counterproductive and can keep large numbers of at-risk groups and people living with HIV from accessing even the limited services being provided by the countries.

3. Take interventions to scale

The Commission's research, using the Asian Epidemic Model, shows that a behaviour change among 60% of the high-risk populations can effectively halt the epidemic's growth.

Research and empirical evidence has shown that the reach and uptake of prevention services for most-at-risk groups needs to reach at least 80 per cent if the levels of protective behaviour needed to reverse the epidemic (at least 60 per cent) are to be achieved.

The scaling-up of efforts needs to occur simultaneously in the various, high priority geographic areas, and should include the necessary service elements and quality specifications. The involvement of civil society organizations and community groups is vital for achieving these goals.

4. Catalyse other prevention programmes with longer-term benefits

Even though their relative contribution to reduction of infection rates in the short-term is low, these programmes provide sustainability to AIDS control efforts because of the involvement of mainstream society and non-HIV programmes run by Government agencies. Efforts should be made to integrate them as much as possible into existing health, education and welfare programmes of Governments. AIDS funds can be used to highlight these often-neglected issues at policy level and catalyse the response in the appropriate sectors, Given the long-term benefits of

such programmes, Governments should consider investing resources from relevant sectoral programmes in order to ensure their long-term sustainability.

4.1. Provide sex education in schools and colleges

Although only a small minority of young people (mostly young men) engage in activities that carry a high risk of HIV infection, sex education can strengthen the overall impact of the HIV response. Research confirms that levels of HIV knowledge among young people remain low throughout Asia. In many countries, sex education in schools is a highly contentious matter, and it is often alleged that it encourages sexual 'experimentation' and promiscuity. Yet, the Commission has found that there is no evidence—in Asia or anywhere else in the world—that sex education increases promiscuity. Instead, the Commission's research underscores the value of education in promoting responsible sexual behaviour based on greater knowledge and understanding of sexual and reproductive health issues.

The Commission urges Governments to introduce high-quality HIV and sex education programmes as part of curricula in all education establishments to equip young people with the information that can help them avoid or reduce risky behaviours.

4.2. Ensure that HIV media campaigns are forthright and accurate

Regular and frequent HIV publicity in the media provided important impetus to Cambodia and Thailand's HIV responses. Media publicity promoted awareness and improved understanding of how HIV is spread and how infection can be prevented and treated. Publicity also helped reduce stigma. At the height of its HIV response in the early 1990s, the Thai Government, for example, required television and radio stations to broadcast one-minute AIDS education spots every hour, highlighting the importance of behaviour change and consistent condom use in preventing HIV infections.

Governments should ensure that adequate resources, including media time, are devoted to addressing HIV-related issues, through public information broadcasts, public-private media partnerships and the creative use of entertainment media. Those efforts can be led by ministries of public information, under the guidance of public health authorities, and should be coordinated at various levels.

The responsibility for developing these public information campaigns should rest with advertising and media professionals (rather than Health Ministry officials).

4.3. Protect healthcare workers who are exposed to HIV infection

Physicians, nurses and other healthcare workers are at risk of HIV infection, particularly because of needle-stick injuries or during surgical procedures. The Commission believes that those perceived risks contribute to the stigma and discrimination which HIV patients sometimes experience at the hands of healthcare workers.

Healthcare providers who may be exposed to HIV infection in the course of their work must have guaranteed access to post-exposure prophylaxis. They must also be provided with the information and resources that can best enable them to protect themselves against accidental infection. AIDS funds should be used for training health care workers on the indication and use of post-exposure prophylaxis.

B. Treatment and Care

Steep declines in the costs of antiretroviral drugs, coupled with the increased quality and availability of generics and the relatively low numbers of people currently requiring treatment in Asia, make universal access to treatment a realistic target in most Asian countries. However, apart from a few exceptions such as Cambodia, Indonesia and Thailand, very few Asian countries appear to be on-track to reach their 2010 universal access targets (which require that 80 per cent of people in need of antiretroviral treatment receive it). Access to other forms of care and treatment are also inadequate, and access to basic nutrition, sanitation and prophylaxis to reduce opportunistic infections remain out of the reach for many of Asia's HIV-infected poor. Ensuring universal access to affordable or free treatment and care must be a priority of Asian Governments.

1. Establish a comprehensive treatment programme

The provision of antiretroviral drugs is a central but not the only element of an HIV treatment programme.

Governments must ensure comprehensive, continuous and sustainable antiretroviral treatment programmes, coupled with access to HIV testing and counselling, HIV diagnostics (including CD4 and CD8



counts, as appropriate), diagnosis of and treatment for opportunistic infections, guidance on and assistance in sourcing adequate nutrition, and the provision of subsidies for transport to reach treatment centres.

2. In HIV testing and counselling, strike a balance between individuals' rights to privacy, confidentiality and choice on the one hand, and the public health need for strategic information about infected populations on the other

Voluntary counselling and testing is appropriate in all settings. However, the Commission is concerned that the HIV testing of groups most-at-risk and people living with HIV, particularly in healthcare settings, must not be allowed to be used in a punitive or harassing fashion.

Routine testing by service providers should not be the guiding principle in general health care settings. Routine testing is recommended only in highly-indicative healthcare settings, such as sexually transmitted infection clinics and tuberculosis clinics. Testing must adhere to the principles of consent, confidentiality and counselling, and persons who test HIV-positive must have access to affordable treatment and care services.

3. Establish and maintain systems that ensure affordable, continuous and sustainable access to antiretroviral therapy for all who need it

Antiretroviral therapy is the main treatment for people who are infected with HIV. The life-prolonging and health-enhancing effects of the treatment are well-established in diverse settings around the world, including in Asia. However, the Commission is concerned that, in some Asian countries, cost barriers are hindering access to first- and second-line antiretroviral drugs. Patent barriers remain a significant obstacle blocking the provision of treatment to all who need it. In addition, procurement, distribution and other logistical systems do not always operate smoothly enough to ensure continuous access to antiretroviral drugs. This can result in discontinuity of treatment and the emergence of drug resistant strains of HIV.

An effective and appropriate antiretroviral therapy programme must ensure:

3.1. Affordability

3.1.1. Find mechanisms to reduce the cost of drugs.

Governments should explore other methods for reducing the cost of antiretroviral drugs, including pooled

procurement, joint negotiations, and tiered or differential pricing. Risk-pooling mechanisms, such as insurance and social security programmes, should also be explored.

3.1.2. Use all legal options necessary to ensure equitable access to antiretrovirals. The price of antiretroviral drugs (especially second-line drugs) must be reduced to affordable levels. Governments must step up their efforts to ensure that the cost of first- and second-line antiretroviral drugs does not block equitable and sustained access to antiretroviral treatment. To that end, countries in Asia should be more resolute in using all legal measures available to them to reduce these costs—including invoking compulsory licensing for second-line drugs and using parallel importation.

3.1.3. Adopt regional approaches to support countries exercising their legal rights. In addition, the Commission emphasizes that countries have the right to pursue such actions under internationally-agreed mechanisms, and believes that collective, regional approaches could strengthen such efforts. Governments must also establish mechanisms to ensure smooth and uninterrupted transition from first-line to second-line drugs.

3.2. Availability and quality

Maintain the quality of antiretroviral drugs and ensure both first and second-line access. Governments must ensure that both first-line and second-line antiretroviral drugs are available in sufficient quantities to meet national needs and avoid stock-outs. They also have to ensure that imported and locally produced antiretroviral drugs meet international quality standards. When Governments initiate provision of first-line antiretroviral drugs, there should be a guarantee that second-line antiretroviral therapy will be available for those who require it.

3.3. Accessibility

3.3.1. Use subsidies to reduce barriers to antiretroviral access for the poor. As mentioned in the Policy Recommendations (Recommendation 9), transport costs and loss in wages should not be allowed to prevent poor



people from benefiting from antiretroviral treatment. Antiretroviral programmes need to subsidize transport and other essential costs to ensure that the poor enjoy equitable access. In some countries, existing health equity funds or community-based health insurance can be adapted to cover such costs.

3.3.2. Integrate outreach providers into treatment programmes. Official, state-run health programmes are sometimes shunned by marginalized people who fear harassment or victimization. The fact that a significant proportion of HIV infections in most Asian countries are among people belonging to marginalized groups highlights the need to integrate outreach providers from communities into antiretroviral programmes, and to create an enabling environment for access to services.

3.4. Adherence

Use community support to promote adherence. Adherence to treatment regimens is critical for maintaining the effectiveness of antiretroviral therapy and limiting the emergence of drug resistance. Antiretroviral programmes must ensure that there is sufficient social support for people to adhere to their regimens, especially during the early phases of therapy. In this respect, communities and people living with HIV have a valuable role, especially where health systems are too burdened to provide this kind of support.

4. Strengthen the linkages between HIV and tuberculosis diagnosis and treatment to boost service delivery under both programmes

In several parts of the world, including in some Asian countries, the HIV and tuberculosis epidemics intersect. However, in most places, HIV and tuberculosis diagnosis and treatment services operate separately, and cross-referral systems are either absent or weak.

Public health systems must develop integrated service mechanisms that focus on the needs of the infected person. It is not sufficient merely to bring together two, separate vertical disease programmes. Practical procedures must be adopted to achieve more effective integration of HIV and tuberculosis diagnosis, treatment provision and treatment monitoring.

C. Impact Mitigation

Impact mitigation programmes are needed to protect the livelihoods of HIV-infected and -affected households and families who bear the heaviest burden of illness and death, largely because most countries of Asia lack social security systems that can protect them. The Commission has found that this aspect of the HIV response remains particularly underdeveloped and poorly-resourced. As a result, the household-level impact of the epidemic is especially severe for poor families. Gender discrimination aggravates this situation. In many countries, women's access to and control over economic assets such as land and housing are highly restricted. Inheritance and property rights for women often are limited or absent, putting widows at risk of losing their homes, productive assets and other possessions. In addition, the possibility of adapting existing insurance schemes and other social protection mechanisms (both formal, state-run schemes, and informal ones) to assist in impact mitigation has not yet been adequately explored in Asia.

Impact mitigation programmes are cost-effective and affordable. It is estimated that impact mitigation programmes in Asia would cost approximately USD 300 million per year (as discussed in Policy Recommendations 10). A big challenge is to ensure that community organizations have the capacity and ability to deliver such interventions on a large, programmatic scale (and not as isolated projects).

1. Link affected families into HIV testing and treatment systems.

Treatment *per se* is a very important impact mitigating intervention. Non-governmental and community organizations involved in prevention and impact mitigation activities should conduct outreach to recruit affected men, women and children into HIV testing and antiretroviral treatment services. Antiretroviral therapy enables infected people to live healthy, productive lives and to sustain their livelihoods.

2. Make impact mitigation programmes an essential component of national HIV responses.

Impact mitigation programmes must be based on a strategic mix of livelihood sustainability, income-generation and access to HIV testing, counselling and treatment, with particular emphasis on supporting poor families and affected women and children, as well as using community-based organizations as the main vehicles of programme delivery.



- 3. Ensure impact mitigation programmes reach and serve the needs of affected households with widows or children.** Overall, these programmes should be *women-centred* (not only to counter gender discrimination but because the majority of surviving spouses in Asia are women) and should include support for income-generation and other forms of livelihood security. Programmes for children should include two key components: cash transfers to single parents, foster parents or other families who take responsibility for raising orphans, and subsidies for books, school materials, uniforms, as well as school and related fees to ensure that orphans and vulnerable children receive quality education. Additional measures which are important include protecting the rights of children through birth registration and inheritance protection, and ensuring that they have access to essential services. Steps are needed to ensure microfinance and credit support is available to affected households.
- 4. Review and, if necessary, amend insurance regulations so that people infected with HIV have equitable access to insurance coverage.**

In many countries, people infected with HIV often are either prevented from taking out life and health insurance, or insurance schemes rule out or minimize cover for persons with HIV-related diseases. Governments must amend insurance regulatory laws in a manner that gives people living with HIV equitable access to life and health insurance.

D. Organizational Issues

A complex mix of factors drives HIV epidemics in Asia and conditions the potential effectiveness of HIV responses. Because HIV strategies extend beyond the sphere of public health, such strategies require mobilizing and harmonizing the activities of a range of Government departments and civil society actors. The past 25 years have seen various attempts to achieve this, although not all have been successful or even appropriate. Having reviewed the experiences to date, the Commission believes that the following programmatic approaches can greatly enhance HIV responses in Asia.

- 1. Establish a policy and programme analysis unit to make maximum use of available data to guide, monitor and evaluate responses**

An effective response has to be focused on populations and in places where most new infections occur. It also has to mobilize sufficient financial

and human resources to scale-up programmes, evaluate their coverage and assess treatment and impact mitigation needs. In order to do this, high quality data must be collected and carefully analysed. Good data provides the evidence-based guidance that national AIDS bodies, programme management, Government financing and budgeting structures, and community, non-governmental and donor organizations need in order to plan and act effectively. In short, all these actors have to act on the basis of a common, shared understanding of the epidemic situation wherever it occurs.

- 1.1. Locate the analysis unit in an appropriate national institution or agency.** A policy and programme analysis unit should be set up and appropriately located within the national AIDS infrastructure. The location of the unit may vary from country to country—it could be in the national HIV programme itself, or within the epidemiology unit of the Ministry of Health, or in an independent policy research unit associated with the Ministry of Health, for example.
- 1.2. Assign the unit the responsibility to bring all types of HIV relevant data together.** The unit should collate existing sources of data (epidemiological, behavioural, response indicator, financial, etc.), assess their quality, build country-specific epidemiological models, and use the data and models to determine the effectiveness of various strategic options. It should also cost those options.
- 1.3. Staff the unit with people with the right skills and provide expert support.** The unit should be adequately staffed with people capable of working in a multi-disciplinary setting, and should have access to support from outside experts in pertinent fields (such as epidemiology, modeling, demography, programme design, monitoring and evaluation, and more).
- 1.4. Make the unit work closely with decision makers in deciding what options to explore and to disseminate results.** The unit should conduct its programme and policy analyses in consultation with key stakeholders and decision-makers. It should function in a transparent manner and should disseminate its findings to all interested parties.
- 1.5. External agencies should provide countries tools and guidelines to streamline this process.** International agencies and donors should develop tools and guidelines for using data



sources to guide and evaluate policies and programmes and policies. They should also provide technical assistance and training to assist countries in setting up these units, and they may wish to review the outputs of the units periodically.

2. Strengthen partnerships with civil society for service delivery

Government systems often are not ideal for delivering HIV services to most-at-risk groups. Government-led HIV interventions tend to achieve greater coverage and effectiveness when carried out in partnership with civil society organizations (especially community groups). Existing links between Government and civil society organizations should be strengthened and made an integral part of the HIV response.

2.1. Streamline funding flows to community projects

Funds destined for community organizations that provide outreach and other HIV services are often slow to reach their intended recipients. This can delay or even disrupt important HIV activities (especially community outreach efforts).

Encourage and develop public-private partnerships for smooth fund flow. The Commission proposes the creation of public-private partnership structures that would be responsible for the funding and oversight of community-run HIV projects and programmes. Government and non-governmental entities would be equally represented in these structures, which should include representatives from community groups. Funding would come from national AIDS budgets, as well as from bilateral donors. The same structure could serve as 'principal recipient' of Global Fund grants. Funds would then be disbursed to those projects or organizations that provide services to most-at-risk groups, people living with HIV and their families. The Commission recommends that the World Bank and the Global Fund should take the initiative to develop a quality model of public-private partnerships along these lines.

2.2. Support and build the capacity of organizations that represent most-at-risk populations and people living with HIV.

The scaling-up of programmes for most-at-risk groups and people living with HIV requires the participation of community organizations in their design and implementation.

2.2.1. Make involvement of communities the main criteria for programme funding.

Donors and Governments

must ensure that community organizations receive adequate technical and financial support to assist in programme design and implementation. Donors should include the involvement of these communities among the main criteria for programme funding.

- 2.2.2. Allocate budget specifically for community capacity building.** Governments should identify and channel finances and resources to support capacity-building and coordination in community organizations. In each country, a minimum annual amount should be allocated for these purposes.

3. Address appropriate service delivery mechanisms to ensure a suitable mix of focused and integrated approach

Prevention, treatment, and impact mitigation are three distinct programmes, each focusing on specific population groups. No single service delivery formula applies to all of them.

- 3.1. Prevention services for most-at-risk populations should not be left to Government agencies and should be entrusted to public-private partnerships.**

In most countries in Asia, organized basic services provided by Governments are not accessible for most-at-risk groups. Stigma and discrimination experienced in state-run facilities discourages such groups from utilizing Government-run HIV services. The Commission recommends that prevention programmes for most-at-risk populations should be implemented through community-based and other civil society organizations. At the same time, it notes that community organizations often are weak and highly reliant on small numbers of dedicated individuals (many of whom volunteer their labour). Many struggle to secure adequate resources to do their work, and the lack of sustainable funding, human resources, information and preparation time often prevents them from participating in national processes. Supporting and strengthening such organizations is therefore an important facet of the HIV response.

- 3.1.1. Prevention programmes for most-at-risk populations should be directly implemented through community-based and other civil society organizations.**

3.1.2. Earmark resources in national programme budgets for community engagement. In order to strengthen effective community engagement, national HIV programmes and budgets should earmark resources to support implementation activities (such as peer outreach), and should build the capacity of community organizations.

3.1.3. Consider establishing an independent AIDS trust. Set up a separate, autonomous board or trust, under the stewardship of Government and community representatives. Such a trust would be responsible for collecting funds from Government and donors, and for disbursing those funds to community groups for implementing programmes. This could mimic the process by which Government disburses funds to various ministries. Such an approach would make it easier to channel funding to organizations which some Governments have difficulty in providing direct funding for (such as organizations working with and/or including sex workers and drug injectors).

3.2. Integrate programmes for preventing mother-to-child transmission of HIV, HIV counselling and testing, and treatment and care into healthcare systems.

Antiretroviral treatment programmes and services for preventing mother-to-child HIV transmission should be made integral to existing healthcare services. Antenatal clinics, sexual and reproductive health services, and family-planning clinics should be used as vital entry points for these services. Outreach programmes that involve civil society and people living with HIV can link marginalized groups, as well as women and children in affected families, with antiretroviral therapy service delivery facilities.

3.3. There should be a mix of direct and integrated programme delivery structure for HIV interventions.

The Commission recommends that all programmes for prevention, treatment and impact mitigation should have a focused delivery component, directly supervised by the AIDS programme, but other components should be embedded in the

existing programmes in different sectors. Following from this Recommendation, a suggested mix of programmes, with direct and integrated components, is illustrated in Table 7.1.

Table 7.1: Illustrative programme structure for HIV interventions

	Direct	Integrated
Prevention	<i>Activities focused on sex workers and their clients, injecting drug users, men who have sex with men, and their respective partners, including enabling environment and focused media campaigns</i>	<i>Prevention of mother-to-child transmission, school education, blood safety, universal precautions, prevention and treatment of sexually transmitted infections (for general population)</i>
Treatment and care	<i>Community outreach, targeted antiretroviral treatment for vulnerable populations and community-based care, including counselling and testing</i>	<i>Institution-based treatment and care programmes, HIV counselling and testing</i>
Impact mitigation	<i>Outreach and community-based services for women and children</i>	<i>Social insurance, livelihood programmes, and programmes for orphans</i>

Governments must fulfil the commitment they have made via international political instruments such as the Declaration on Universal Access for prevention, treatment, care and support by 2010 as well as Millennium Development Goal 6 to halt and reverse the epidemic by 2015.

The Millennium Development Goals: Progress in Asia and the Pacific 2007 Report, published by the United Nations Economic and Social Commission for Asia and the Pacific, takes the view that, barring a few exceptions, most Asian countries are on track to achieve Millennium Development Goal 6.

The Commission shares this optimism and believes that Governments in Asia have the information, the institutions and the means to achieve huge reductions in new HIV infections. If they deploy their money, staff and partnerships effectively, they will be able to meet these optimistic targets.

The most important ingredient is political will. If the Governments of Asia choose to meet the challenge and take the handful of steps set out in this Report, then the battle against HIV in Asia can be won.

8

The Way Forward

The Report of the Commission rests on a solid foundation of evidence, and it presents clear findings and firm recommendations for reversing the spread of HIV in Asia.

It outlines an approach for making maximum use of resources and capacities, and it sketches the details of a response that can curb and eventually halt Asia's AIDS epidemics.

The Report is therefore addressed to everyone with a stake and interest in vanquishing the AIDS pandemic in Asia.

The next step of this challenge is to disseminate and engage with these findings, and to translate the recommendations into practice. The Commission cannot achieve that on its own.

It is essential to provide a strategy for taking these insights and proposals forward on different fronts and with various stakeholders—Governments, donors, multilateral agencies, civil society organizations, United Nations agencies, activist groups, public health practitioners, and more.

To start with, people from all walks of life who care about a healthy and disease-free Asia should have access to this Report, in a language they feel comfortable with. Key findings and recommendations of the Commission should therefore be available in the major languages of the region.

What Governments can do

It is vital that Governments in the region adopt this Report and act on its recommendations.

A great deal of effort is needed to remove the dangerous complacency about AIDS that still exists in Asia. These epidemics may pivot on certain high-risk behaviours, but they are not limited to the persons who

practice those behaviours. The evidence shows clearly that HIV does not obey the boundaries people try to erect between themselves and stigmatized groups.

Understanding this, though, is not enough. Asia's leaders must act against AIDS. This Report highlights the approaches and methods that have been shown to work—and that are affordable.

The Commission urges the Governments of Asia to use the Report as a strategic resource and high-level advocacy tool for galvanizing commitment and sketching an implementation strategy that can take the recommendations forward.

We appeal to Heads of Governments to lead the way in that regard.

National AIDS Commissions could be charged with conducting a detailed review of the Report, and with developing an implementation plan that can be synthesized with their national strategies in order to fulfil global commitments like Universal Access by 2010 and achievement of the Millennium Development Goals by 2015. Such a plan would assign responsibilities across various sectors and departments, and clearly pinpoint accountability.

What regional organizations can do

The Report presents several recommendations which have transnational implications.

The regional intergovernmental bodies such as the Association of South East Asian Nations (ASEAN) and the South Asian Association of Regional Cooperation (SAARC) have key roles in mobilizing political commitment for a coordinated and long-term AIDS response in the region.

These bodies are uniquely placed to translate those recommendations into regional action programmes. Summits and other gatherings can serve as platforms for monitoring their implementation.

What civil society and community organizations can do

The Report has great relevance for the meaningful participation of community-based organizations and other civil society groupings in national AIDS responses.

The Commission suggests that national and regional networks of affected communities should not wait on Government to act on the Recommendations of this Report, but need to step forward themselves.

They should review, disseminate and debate the findings and recommendations of this Report among their members. And they should



use the Report to press Governments and other stakeholders into action—especially on matters that relate to community and civil society involvement in the AIDS response.

What donors and UN agencies working in Asia can do

The Report presents a pragmatic assessment of the resource needs for a comprehensive and sustainable HIV response. It also reviews the current mix of funding (domestic versus external) and proposes ways to achieve a more effective funding balance.

The Commission appeals to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), and other important donors to examine the resource needs provided in the Report in relation to their medium- and long-term funding decisions for AIDS programmes in Asia.

Policymaking bodies such as the Boards of the Global Fund, World Bank, and Asian Development Bank can serve as important platforms for engaging with some of the key recommendations of the Report.

The UN Economic and Social Commission for Asia and Pacific Commission (UNESCAP) should consider adopting this Report as part of its AIDS agenda, and can monitor the implementation of key recommendations.

What UNAIDS can do

UNAIDS has a major stake—and responsibility—in taking the Report's recommendations further. In addition to the Programme Coordination Board of UNAIDS, the various management boards of UNAIDS co-sponsors have the opportunity to discuss the Commission's findings and recommendations, and identify roles for their agencies in their implementation.

The Commission believes that UNAIDS in Asia should assume a coordinating and monitoring role in relation to the Report's recommendations, and that it should provide regular feedback to all stakeholders on progress in implementing them.

The UNAIDS Secretariat could prepare a more detailed dissemination and implementation strategy which would map opportunities in the region—including events, media channels and key opinion leaders—for publicizing the Report.

An implementation strategy should slot into national planning procedures, and should translate the recommendations into components of national AIDS plans.

The UNAIDS secretariat and co-sponsors would need to work closely with Governments, communities and donors to achieve all this.

The Commission believes that this Report can mark a watershed in Asia's battle against AIDS—if the opportunities and recommendations highlighted in it are used to the full.

That challenge now rests in the hands of everyone who wishes to see an Asia free of AIDS.

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Annex 1: List of Countries Covered by this Report

1. Bangladesh
2. Bhutan
3. Brunei Darussalam
4. Cambodia
5. China
6. Democratic People's Republic of Korea
7. India
8. Indonesia
9. Japan
10. Lao People's Democratic Republic
11. Malaysia
12. Maldives
13. Mongolia
14. Myanmar
15. Nepal
16. Pakistan
17. Philippines
18. Republic of Korea
19. Singapore
20. Sri Lanka
21. Thailand
22. Timor-Leste
23. Viet Nam

Annex 2: Terms of Reference of the Commission on AIDS in Asia (June 2006)

The Asia-Pacific region is home to 56 per cent of world's population and its 44 countries represent an enormous socio-cultural diversity. In the present era, they also represent a very broad development spectrum with varying degrees of socio-economic development. In the twenty-first century, this region is also turning out to be the economic powerhouse of the world with some of the economies growing at 8 per cent of GDP and above annually. In contrast, there are also many countries with a fragile financial base and weak economies resulting in weak delivery systems in social sectors. Poverty, unemployment, and traditional dependence on the primary sector for growth are some of the inhibiting factors towards rapid economic development of the region.

However, in recent years, no other problem has impacted on the economies of these countries as the epidemic of HIV and AIDS. HIV entered this region around 1986 about 5 to 6 years after its first appearance in US and later in Africa. In the last two decades, it has spread rapidly across the region with varying degrees of prevalence. Even though the percentage of population infected with the virus is still low, Asia today is home to over 5 million infected persons and the numbers are growing rapidly. At the current level of inadequate response, it is expected this number will rise to about 20 million in the next 5 years. The number of deaths is averaging around 300 thousand and the estimated financial loss to the countries is put at \$ 5 billion every year.



The reasons for the sub-optimal response to the epidemic in this region are manifold. They range from low level of awareness and understanding of its long term impact among policy makers and administrators to weak health care delivery systems, inadequate budgets, and poor community involvement. Part of the reason for the low level support and commitment among policy makers and opinion leaders is on account of the methodological and empirical difficulties in predicting the dynamics of disease progression and the lack of awareness about the deep impact an uncontrolled epidemic can cause on the socio-economic development of countries. It is predicted that the economic costs could rise to as high as \$ 15 billion per year by the year 2015 if the epidemic is not controlled. In spite of these projections, investments on HIV control in the region remained extremely low at 10 per cent of the required \$ 5 billion per year.

The HIV and AIDS pandemic have also raised some basic questions on societal norms that form the basic fabric of societies. Sex and sexuality remained high taboo, with very little encouragement for sex and family life education for young people and adolescents. As the epidemic is mainly driven by multi-partner sex and injecting drug use which are criminal acts in the eyes of the law and are socially unacceptable, the Governments are often at a loss on defining priorities for implementation of control programmes including access to care and treatment to infected population. As a result, the infected populations remain highly stigmatized and deprived of even the limited health care services available in the countries.

With the possibility of a cure or a preventive vaccine emerging on the international scene appearing very remote in the near future, the problem of HIV will continue to challenge Governments and civil societies for the next decade and beyond. It would be necessary for countries in the region to be sensitive to the short- and medium-term implications of the presence of a large HIV infected population and members of their families who are affected. The problem needs to be understood not just at the macro economic level but at the individual, family, and community level also where the impact will be maximum in Asian countries. Governments need to adopt policies which will minimize the impact of HIV at all levels while attempting to halt and reverse the spread of the epidemic.

UNAIDS, the Joint UN Programme for HIV/AIDS, is vitally interested in getting an objective and independent analysis conducted to address these issues and provide various policy options to member countries in the region for an active engagement in their fight against the pandemic.

UNAIDS therefore proposes to constitute an Independent Commission on AIDS in Asia with the following Terms of Reference:

- To objectively assess the state of the AIDS epidemic in Asia and the Pacific region in terms of incidence, awareness, prevention, and treatment and its progression at existing and scaled up levels of national and international efforts;
- To analyse the socio-economic composition of the infected and affected populations and the impact of the epidemic on them at household, community, workplace, and societal levels;
- To analyse the medium- and long-term implications of the presence of a large HIV infected population in Asian societies and its impact on the socio-economic environment in the affected countries. Special focus needs to be given on human resources, labour productivity, poverty reduction, social stability, and household savings;
- To assess the impact of the epidemic on Governments, with regard to allocation of limited resources to health budgets, strain on existing health systems, diversion of resources from priority areas of social and economic development, issues of national security, and the ability to stay competitive in the emerging global economic scenario; and
- To provide specific recommendations on the nature of institutional reforms and policies that need to be adopted to minimize the adverse impact of HIV and AIDS on households, community, society, and the economy.

The findings of the Commission will be summarized in a Report to be completed by the end of 2007. The findings will also be widely disseminated to the UNAIDS Cosponsors and the Secretariat, National Governments of the Region, bilateral and multilateral donors, and prominent leaders of civil society.

The duration of the Commission will be of 18 months and financial support for the functioning of the Commission will be provided by the UNAIDS Secretariat. Given the short time frame, maximum use will be made of available data and information, and operational research will be undertaken only for filling critical gaps. For commissioning such studies, putting together the evidence in the form of a Report and providing secretarial assistance to the Commission in its day-to-day work, a leading Research/Academic Institution will be engaged from the region.

The Commission, during its first sitting, will determine the plan of work and develop operational guidelines for conduct of business and preparation of the Report.

Annex 3: List of Commission Members

1. Chakravarthi Rangarajan	Chairman, Economic Advisory Council to the Prime Minister of India	Chairman
2. Nerissa Corazon Soon-Ruiz	Congress Representative, 6th District—Cebu, Philippines	Member
3. Rajat Kumar Gupta	Senior Partner Worldwide, McKinsey & Company	Member
4. Tim Brown	Epidemiologist and senior research fellow, East-West Centre, Hawaii	Member
5. Tadashi Yamamoto	President, Japan Center for International Exchange (JCIE)	Member
6. Wu Zunyou	Director of the National Center for AIDS/STD Control and Prevention, Chinese Center for Disease Control and Prevention	Member

7. Mahmuda Islam	Professor of Sociology, Dhaka University	Member
8. Frika Chia Iskandar	Coordinator, women's working group of Asia Pacific Network of People Living with HIV and AIDS (APN+)	Member
9. J.V.R. Prasada Rao	Director, UNAIDS Regional Support Team for Asia and the Pacific	Member Secretary

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The Commission wishes to thank the following for their contributions to the Report.

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