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CHECK AGAINST DELIVERY

Overview of Epidemic and Response in Asia and the Pacific -

Outline

Distinguished guests, colleagues and friends, good morning. I thank the local organizing committee of the 8th ICAAP for this opportunity to stand before you once again and to look at how we are progressing after the Kobe ICAAP.Meeting two years after the Kobe Conference presents a good opportunity to take stock of the situation and to look ahead at the enormous challenges we are facing in the region in combating the AIDS epidemic. So I will begin by giving you a brief overview of developments in the epidemic and in the national and regional responses to it. I'll then critically examine the debates that have arisen over strategies, their implementation and even over basic data in our region, before summing up the challenges we face and the rays of hope that inspire us to do better in the future.

So let us first look at how far we have travelled since we last met at Kobe.

From Kobe to Colombo: State of the Epidemic in the Region

The last two years have produced good and bad news on the progression of the epidemic. You will see, first of all a new figure of 5.4 million for the total number of people living with HIV in the region. We cannot take comfort from the fact that this is considerably less than the earlier figure of 8.3 million, as nearly a million new infections have occurred in the last two years - 50% of which are among young people who are our most productive asset. In addition, 640,000 people died despite the efforts of scaling up treatment services by countries in the region. The harsh reality is that the grim march of the epidemic in our region continues unabated.

State of the Epidemic - Asia

There are plenty of reasons to worry about AIDS in this region. This is starkly underlined by the rising number of new infections in countries like China, Vietnam, Indonesia, Nepal, Bangladesh and Pakistan.

State of the Epidemic - Pacific Islands and Papua New Guinea

The recent household level survey in Papua province of Indonesia shows an adult prevalence of more than 2%. This confirms our previous warnings that in the absence of intervention, Papua New Guinea, Papua province of Indonesia and possibly Pacific Islands can face a high-prevalence epidemic driven by concurrent multi partner sex among both males and females. In Papua New Guinea, revised estimates based on better data collection now put national prevalence at 1.3%, but there is evidence from last year's surveillance that the epidemic is spreading fast in areas outside the capital and several sites are reporting prevalence of HIV higher than 2% among adult population.

Turning the Tide

There is of course some good news. Thailand and Cambodia are no longer the only countries where we can take heart from a progressive decline in the incidence of HIV. The epidemic has not shown any sharp increase in either Philippines or Sri Lanka and it appears there has been some decline in HIV in Myanmar, although this needs to be confirmed.

But the most exciting news is in India, the country with the largest number of infections in Asia, where there is strong evidence that prevalence in the most affected regions in the South and West of the country have either stabilized or come down. With India mounting a large new programme supported by US$ 2.4 billion in funding, we should see significant change in the state of the epidemic in that country and the region in the years to come.

An expanding epidemic in the region

But this is a snapshot of where the numbers are going up, down and where they are remaining stable. And as you can clearly see, it is not a reassuring picture.

The Numbers Debate

What is it? What are the implications?

So this is a good point to look at the issue of numbers and to consider what conclusions we ought to draw from it.

The current estimate of 5.4 million infections in the Asia-Pacific region as I mentioned a short while ago is a significant reduction from the earlier number of 8.3 million and I want to take a few minutes to explain the reasons and the need for such a revision.

The globally accepted methodology for estimating the number of people living with HIV has always been to use the prevalence levels among ante-natal mothers as a surrogate for the general population.

With an increase in the number of sentinel surveillance sites in many countries, especially in rural areas, and with improvements in methods of data collection as well as quality control of data, there was no doubt that revision of estimates was bound to happen. But we are also getting increasing access to alternative sources like household surveys which provide more accurate data on prevalence in general population. And this is a good thing too. UNAIDS definitely welcomes such survey. Clearly, the accuracy of numbers is absolutely important for ' knowing its own epidemic' by each country to focus on policy, prioritising budgets and mobilising public opinion.

New evidence from household surveys

But what the household based surveys completed in Cambodia, India, Vietnam and Thailand (in the late 1990s) show us is that a downward revision of our estimates is required only in some countries, not all of them.

Revision of adult population prevalence estimates in Cambodia, India

The Indian estimate for 2005 was earlier considered to be 0.9% among the adult population (translating into 3.4 million – 9. 4 million people living with HIV).

However, with household survey data coming in for the first time, the 2006 estimate showed the figure was closer to 0.4% adult prevalence (translating into 2.0 – 3.1 million people living with HIV). Similarly Cambodia's prevalence has been readjusted down to 0.9 % in 2006 from 1.6% in 2005 because of higher estimates of rural prevalence in the past.

In countries like Thailand and Vietnam, however, household survey data has not required any adjustment to the estimate of prevalence among adults.

Look at Trends – not numbers...

But the unfortunate upshot of these revisions has been the renewed debate on the accuracy of estimates and, worst of all, on the intentions of UNAIDS in supporting them year after year. As a joint UN programme, UNAIDS has been in the forefront over the last 10 years cautioning countries about the impending risk of an unchecked AIDS epidemic and exhorting them to mount an adequately resourced response. To do this, UNAIDS has been constantly advocating with the countries to generate strategic information to guide their response, An independent expert group constituted by UNAIDS has been in place to validate country numbers and guide the organization both on methodologies and numbers I therefore regard it as an uncharitable accusation that UNAIDS has been deliberately inflating the numbers to mobilize more funds for AIDS programmes.

Worse, however, it's also dangerous. Because if one looks at the data carefully, despite the downward revision in some cases, what they essentially tell us is that the overall trend of

infection has remained the same. It's extremely important to understand this point, because it tells us the key factors that underpin our battle against the AIDS epidemic have not significantly changed. The numbers of people infected by this disease and needing care and treatment are ***still*** too large and the trends are ***still*** too alarming to allow for any complacency.

No change in programme needs

Just consider, ladies and gentlemen, that even in the revised estimates, nearly 6 million people in the Asia-Pacific region are likely on present trends to be infected with HIV by 2010. Half a million people could still be becoming infected every year and more than 300,000 people could still be dying every year, more than the number of people killed by the Asian Tsunami of 2004.

And quite regardless of the numbers infected, the overall number of sex workers, IDUs, MSM, women and, young people who need to be protected from becoming infected has not changed at all. What this means is that the intensity of prevention efforts and the resources for prevention need to remain the same. Even for treatment, with existing levels of coverage still being very low, the level of commitment needed will remain the same despite the revised numbers.

Need for better strategic information

The issue most clearly brought to light by this debate is not, then, one of exaggeration in past estimates but of the need to understand the epidemic properly. This is important both for Government and non-governmental sectors alike. Yet few countries in this region are investing in creating the databases that can act as baselines for planning, executing and monitoring activities for scaled up interventions.

The total number of countries in the region with their own HIV projections is just 4. The total number of countries in the region with regular second-generation surveillance is 6. Too few countries have any good data on adult male or female sexual behavior. The time has come for carrying out systematic behavioral surveys at national level in the region to collect data on such indicators as age at first sex, exposure to commercial sex and the extent of casual sex.

It is also clear that the emphasis needs to be on developing nationally-owned data collection for reasons that are easy to explain. Quite simply, whenever evidence is country-generated, policy makers seem to pay closer attention and frame policies accordingly.

Newly emerging threats

Having looked at the state of the epidemic in the region, I'd like now to turn your attention to what is new in the response.

Political instability and conflict

One of the most disturbing developments in recent years of course is the increase in number of countries in this region engulfed in political instability and civil conflict. At the time of the Kobe Conference two years ago it was mainly Nepal that was severely affected by lack of services, but today at least 8 more countries in the region have slipped into unstable political situations or intensified conflict which have the potential to affect national AIDS programmes. Conflict not only causes loss of human life, it exacerbates existing problems of poverty and displaces thousands making them more vulnerable to health-related problems.

Two other results of conflict or political instability that directly affects the battle against the HIV are that:

a) large populations living in conflict zones do not get access to prevention and

b) programmes face a shortage of funds and treatment services

Skirting debate, courting disaster

More disturbing is the continued onslaught by opponents of prevention programmes like condom promotion and sex education for youth, to name a few.

There is no doubt any more that condoms continue to be the *only* effective prevention tool available for protection against HIV, yet opposition to its promotion continues in many countries. Inaccessibility to condoms continues to afflict prevention programmes aimed at most-at-risk populations in many countries which still lack a proper condom promotion strategy, including social marketing.

School-based education programmes for young people exist in some countries, although their level of coverage remains low. These programmes are also coming under pressure for withdrawal from school curricula. In India as many as 11 state governments have either banned or are in the process of forcing sex education for adolescents out of schools. This is a highly retrograde step. What surprises me more than the silence of the Government of India is the lack of a strong response from civil society in India to this organised campaign. Except for a few assertions made on email and IT networks, hardly any voice of protest has been raised against these moves. Why? Very baffling indeed!

Stigma continues

Although access to treatment and testing is increasing, stigma continues. In health care settings, people are tested without consent and pre-marital testing continues to be "a popular solution" with some policy-makers. HIV-positive people and civil society organizations are still ignored or at best, are involved in a tokenistic fashion. A few countries have legislation to protect the rights of infected people before and during employment, but of course, these do not necessarily stop discrimination.

In fact, in some countries, positive people and their networks continue to face denial of basic human rights like free association, holding of meetings and accessing legal services for protection against harassment. National policies often do not get reflected at provincial and local level where authorities continue to remain hostile to positive people's organisations.

It is also a hard reality that the divisions between civil society organizations' voices perpetuate their exclusion and the exclusion of marginalized groups.

Minor Victories

Still, ladies and gentlemen, for all the obstacles we encounter, we must make progress. We need to develop strong movements for the fight against AIDS and the modest successes of the last two years give us something to build on.

Universal Access

In June 2006, countries across the regions called for Universal Access to prevention and treatment for all those who need it by 2010. The political resolution adopted in UN General Assembly unleashed a process of grass roots planning not witnessed before in AIDS programmes. The Asia-Pacific region led the world in these efforts.

Countries of the region embarked on a process of setting ambitious targets for Universal Access, prepared National Strategic Plans and tried to identify resources for funding them. Nine countries now have ambitious NSPs set through a bottom-up process. Others are in the process of drawing them up and expect to complete the task by December 2007.

Better Political commitment

Political leaders in most countries of the region have expressed their commitment to tackling AIDS. A survey by the Asia-Pacific Leadership Forum on HIV/AIDS and Development or APLF found that an increasing number of countries are moving from low to higher degree of commitment.

Most recently, Thailand made a strong statement by invoking a compulsory license for the production of second-line antiretroviral drugs. At the regional level, inter-governmental organisations are showing more commitment to AIDS responses. The ASEAN special session on AIDS in Cebu earlier this year is an example of regional-level advocacy that enhances the commitment of national leaders.

Major Scale-up of Resources

There are also promising developments on the resource front. The availability of funding for programmes has increased tremendously, thanks to the availability of Global Fund grants and increased World Bank financing of AIDS programmes in South Asia. There is a strong chance that PEPFAR, which has doubled its commitment to AIDS programmes, will provide assistance to a few more Asian countries in the next few years. Meanwhile, bilateral donors like DFID and AUSAID are providing more resources at the regional level, making funds accessible to focused prevention programmes.

ART coverage increases

Increased resources have helped to scale up treatment programmes, particularly increasing the provision of ARTs, which has increased by three times during the last few years.

Emerging networks of marginalized groups

UNAIDS along with its co-sponsors has taken the initiative to facilitate regional level networks of most-at-risk populations in the region. The first regional meeting of Governments, Communities, Donors, and media was held in September last year to set up a regional network on MSMs. The community body Asia-Pacific Coalition on Male Sexual Health (APCOM) will be launched during this conference.

UNFPA and UNAIDS have also jointly worked to set up the first regional forum of sex workers' organizations, which will also be discussed during this conference. These partnerships of community organizations of two most-at-risk groups of populattion is a great step forward that will help to redefine civil society relations with governments.

Critical Gaps in the Response

This is the bright side of the picture, Ladies and Gentlemen, but there are several serious gaps and challenges which continue to affect the national efforts.

Overdependence on external funding

Resources for AIDS programmes have increased substantially, but the lion's share has come from external sources. This graph shows AIDS expenditures in 2004, but little has changed since then. In all but a few countries, external providers account for more than 80% of the available resources. In a recent 12-country study, only three countries were found to invest domestic resources of more than 25%, whereas 5 countries are contributing less than 10% of the resources for AIDS response. This can't last indefinitely. In order for countries to address their national priorities and ensure long term sustainability of their programmes, they need to commit more of their own resources.

Mismatch between Strategy and Resource Allocation

Even where resources are secured, the way countries allocate them is often skewed. Most countries direct the resources they have available for prevention towards the interventions on behalf of the general population, not to focussed prevention programmes.

Programme implementation and service delivery also often reveal the same skewed prioritization in planning as in resource allocation. Interventions like universal precaution can avert less than 1% percent of new infections in this region, while promotion of condom or interventions reaching the most vulnerable young people can reduce transmission by 90 % or more, yet resources are not allocated accordingly.

Both external agencies and national governments suffer from this problem of balancing between effective strategies and matching the allocation of resources accordingly. Global data on PEPFAR, for example, shows that more resources are spent on universal precautions and blood safety than on condom promotion. I am not saying that universal precautions or blood and injection safety are not important. But governments should spend a larger share of their general health budget on these programs, which are not entirely HIV-focused, and release scarce AIDS resources for focused prevention programmes. Even in a much-acclaimed national program like Thailand's, little is spent on prevention and there is insufficient focus on prevention among its MSM or IDU population. Without stronger focus and commitment to prevention among most-at-risk populations, we will not achieve the impact on the epidemic that we are looking for.

Human face of Economic growth

The Asia-Pacific region is one of the most economically dynamic in the world, which has its obvious advantages but in the context of AIDS also has a downside. The displacement, mobility and extra income available through economic growth also brings with it greater vulnerability to HIV amidst the population, particularly the young. HIV in Asia is closely associated with people who are the beneficiaries of progress – the Mobile Men with Money. Their monogamous wives are the unfortunate recipients of HIV infection from their husbands and suffer the most serious AIDS-related stigma at home and in society. As nations in this region enjoy the fruits of economic progress, they must be alive to this emerging challenge, which concerns the most productive sections of their populations.

Agenda for Future

These concerns, Ladies and Gentlemen, beg the question of what we can do to strengthen performance. And I shall end my address by highlighting eight major challenges we need to address in Asia and the Pacific in the coming years.

Fighting denial and complacency:

Ever since it emerged nearly three decades ago, AIDS has faced skeptics- people who believe either that it is not a disease at all or does not pose much threat to human societies. That kind of response has already been countered with very obvious and dramatic evidence - just ask the families of the millions who have died in its wake. And yet the peculiar phenomenon of denying HIV persists. Moreover, the downward revision of HIV estimates in Asia has fuelled this trend, and has been twisted out of context to say there is no threat from the epidemic. Such arguments are confined to a few, but it is a dangerous trend that can cost a lot of lives due to negligence.

The counterpart to denial is complacency, that's to say the tendency in some countries that have achieved much in their battle against AIDS to rest on their laurels as if nothing more needs to be done. But there can be no let up in the effort against the epidemic which does

not respect past glories but ruthlessly spreads on depending on what you do in the present and how well you have prepared for the future.

Promoting and sustaining continued AIDS activism:

Activism by individuals and lobby groups has all along played a key role in putting AIDS on the agenda of policy makers, forced drug companies to lower cost of treatment and empowered those affected by the epidemic. An important characteristic of countries that have done well in containing and even reversing the epidemic has always been the strong participation of civil society as well as popular 'champions' of HIV-related causes. There is an important lesson to be learnt from this for nations that are still struggling to cope with the epidemic: it shows they need to nurture and actively encourage such activism instead of mistakenly seeing it as a threat or 'troublesome' to those in authority.

Prioritizing resources for reducing new infections:

Although the resources available for dealing with AIDS in the Asia-Pacific region has gone up considerably in recent years , they are still not enough to be spent without considering priorities. From the experience of countries that have tackled the epidemic successfully we know that money needs to be spent on areas where it will have maximum impact, such as on prevention work among most-at-risk populations. Allocating scarce resources in a targeted way will produce better results instead of spreading these resources thinly over a wide area with little impact.

Universalising coverage of ART services

Countries in Asia have struggled to provide ART to their affected populations and to meet the WHO's 3 by 5 targets for some time Barring a few Asian countries like India and Thailand, China and Myanmar which have a large number of infected populations, most countries have a manageable number of people requiring ART, for whom they can easily provide universal coverage..

.Poor coverage to ART is partly attributed to the lack of investment of these countries in health care delivery itself. Asia ranks lower than Africa and Latin America in per capita investment in health.

The fact is Asian countries today have enough resources to provide universal coverage. They should learn from Thailand, a middle-income country which, as a result of its high per capita investment on health, has managed to reach its care targets. Another factor behind Thailand's success is that it has made the ART a part of general health services, as in developed countries and in line with the recommendation of health economists that countries should 'pool' risk of such high cost investment through cost sharing and integration with the health sector.

Promoting educational programmes on sex for young men and women

Matters of sex and sexuality have always been taboo in many Asian societies that hardly debate these matters in private let alone in public. More than anything else ignorance of such matters remains the biggest threat to the health of our populations. Those who claim sex education is against their national culture are in some ways claiming that learning and knowledge are against their traditions. The choice is ours—what form of education do we want for our children on the process of growing up? Is it through a carefully researched adolescent education programme, or through pornographic movies and internet sites? Trying to shut off knowledge and information is like blocking the sunrise with your palm–it can't be done.

Orphans and vulnerable children as the hidden face of the Asian epidemic:

While a lot of attention has been rightly paid to the plight of those living with HIV, we are increasingly confronted in the region today by the tragic phenomenon of children losing one or more parents to the AIDS epidemic. These orphaned children need care, social support and also protection lest they too become vulnerable to the ravages of the epidemic. In the coming years we will need to focus a lot of effort on this growing population of AIDS orphans.

Married monogamous women- most silent sufferer

The typical Asian epidemic follows a general progression from injecting drug users to sex workers; then to the clients of sex workers, who then transmit the virus to their wives, and finally to the children born of HIV-positive women. In this entire chain married housewives- who should normally be under little threat from HIV/AIDS- are the most silent sufferer . They are estimated to constitute nearly 25-40% of the total number of people infected, yet they are faceless. The time has come to give them a face, a voice, and to address their needs. According to one UNDP study in South Asia, 40% of women leave their in-laws house after their husbands' death due to AIDS, and 80% of these women, mostly infected by their husbands, are denied of property rights.

SCALE UP your interventions

As far as our region is concerned the phase when countries were still tentatively trying out strategies and experimenting with what could be the best approach to AIDS is clearly over. Now it's time to bite the bullet and take the challenge of fighting the epidemic head on by scaling up interventions to appropriate levels. Such scaling up will require resources, technical support and, above all, political will at all levels of governance.

The global battle against AIDS has to be won in Asia

I'd like to finish, Ladies and Gentlemen, by saying that what we do in this region has implications for people far beyond its borders. Asia and the Pacific account for 60% of the world's population. The battle against AIDS therefore has to be won here and our response holds the key to the future.

Our response holds the key…

Thank you.