SPEECH 09

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Good morning. Selamat datang. Welcome to ICAAP 2009. I want to thank the organizing committee for this opportunity to review progress in our region since our meeting 2 years ago in Colombo and to identify challenges.

The release of the report by the Commission on AIDS in Asia was a significant milestone for our region. The report has catalyzed a more evidence informed and appropriate response in the region. Greater recognition is now possible , of the specificity of the HIV dynamics in Asia , of the risk factors and the underlying social determinants of the HIV epidemic in this region that are totally different to those in other parts of the world. There is now more guidance available on the successful best practices in the region among at risk populations in terms of policy reform, cost effectiveness, and programming tools.

In India, the first steps were taken towards decriminalization of same sex sexual relations through a landmark judicial pronouncement. In Nepal, there is increased recognition of the rights of homosexuals and transgender.

Harm reduction programs, including methadone maintenance programs, are being implemented at larger scale in some countries such as China, Malaysia, Bangladesh and Nepal. Across 13 countries in our region, the number of Oral Substitution Therapy sites increased from approximately 341 in 2006 to 852 in 2008. The number of Needle Syringe Programs sites increased from approximately 238 in 2006 to 1469 in the same period.

Countries are re-orienting their national plans and financial resources to focus more on the at risk populations. The increased attention for prevention among these populations has translated into more effective resource use. In a workshop in September 2008, 7 out of 18 of countries already prioritized at-risk populations in their strategic plans and others are in the process of doing so.
For instance, between 2006 and 2008, the proportion of Global Fund grants focusing on prevention among at-risk populations increased from 24% to almost 59%.

We see increased political commitment and an increase in national spending on HIV in some countries, especially China and Thailand where more than 80 percent of total spending on AIDS is coming from national resources. We also notice positive trends in India, Cambodia and the Philippines.

But all this progress is not meaningful if we do not simultaneously address the serious issues of stigma and discrimination and human rights abuses constantly taking place in this region. We are seeing the displacement of entire families to what can only be described as AIDS camps without access to the basic services and health care they need to survive. Young children affected by HIV are being evicted from schools and young drug users are still being locked up in so-called treatment centers. Even at this conference, some AIDS activists have

been denied permission to travel. This must change! UNAIDS is committed to work with other partners in addressing these issues squarely.

Despite our progress, we still have a long way to go. Last year, the number of new infections matched the number of deaths, 380,000 each . Our prevention and treatment efforts are still not keeping up. This disease is still outpacing us.

You will notice an interesting feature of the AIDS epidemic in this region. 91% of all infections in Asia are in just 6 countries India, China, Thailand, Indonesia, Viet Nam and Myanmar, and 96% of infections in the Pacific are in only 1 country, Papua New Guinea. This points out the need for prioritization.

The AIDS Commission has projected that without a scaled up response we will see increasing numbers of new infections among MSM, and clients of sex workers and their regular partners in the years ahead.
Based on the 2008 country reports, we still witness very high rates of HIV prevalence among IDUs in the region. The highest national prevalence among IDU is in Indonesia ~ 50 %. In many countries, national figures hide severe epidemics in some of their cities. Reports further show that Afghanistan, the newest member to our region, has over 1 million drug users of whom 120,000 inject the drug.

We are particularly alarmed by rapidly rising HIV prevalence rates among Men who have Sex with Men in several countries in the region. The highest prevalence is in Thailand ~25 %. Here too we see much higher HIV prevalence rates in urban centers. There is also an evident increase in the Asian high income countries.
In the case of sex workers, there is clear evidence of successful interventions over the last ten years. Despite this, we still see high rates of HIV prevalence among female sex workers in many countries.

In all three populations, the high level of HIV prevalence also demonstrates the fact that they suffer from continuing harassment and violence from law enforcement agencies, which denies them access to services. Without a stable enabling environment nothing will change!

Let us now talk about what we have achieved since the time we met last.

On the treatment side, we have made some solid progress. By the end of 2008, about 565,000 people have been put on treatment - with 220,000 additional people on ART since Colombo. There is clear evidence of a decline in mortality in countries like Thailand where treatment coverage is high enough.

Treatment coverage in Asia has an interesting pattern. In 2007, the AIDS Commission estimated that almost 90% of treatment load is in just 4 countries China, India, Thailand and Myanmar. For all the other countries meeting treatment coverage goals should pose no problem at all. Even among these four countries you have the three fast growing economies China, India and Thailand. This clearly shows that Universal Access to treatment is an achievable goal in most of Asia. If China and India can do – Asia must be able to do it too.

But our children are less fortunate! The coverage of PMTCT services, which is not any more complex than ART is rather dismal. It is less than 20% in most countries except Thailand and probably China. This is unacceptable – particularly when some of the sub-Saharan African countries with much higher prevalence levels have been able to achieve impressive levels of ART and PMTCT coverage.

It is time that we resolve that in our region we achieve the target of 80% treatment and zero vertical transmission by 2015.

While I would have liked to give an equally clear picture of prevention coverage, I'm sorry to say that the figures we have are not credible enough.

The median progress in coverage of prevention interventions and in behavior change among high risk groups as reported by countries in 2006 and 2008 may indicate a rising trend, but it is not possible to draw a clear picture of where we stand on prevention in the region because of major issues with the quality of data in many countries.

The next global reporting round in March 2010, provides countries with another chance to collect and use more reliable information on prevention coverage of at-risk populations. We should start preparing for that now.Countries should take this opportunity to get the denominators right!

Twenty years on, we still have critical gaps in our response to the epidemic. The rapid economic growth and societal changes in this region increase the vulnerability of children, youth and migrants. In many countries these groups are not covered in the national AIDS response.

However, the most glaring gap is the lack of attention to the estimated 50 million women in Asia who are put at risk by their regular male partners.

At the national level, we are seeing a steady increase in the proportion of these otherwise low-risk women among infected adults. UNAIDS and its partners are launching an important report on ‘Intimate Partner Transmission of HIV in Asian countries ’ during this conference outlining the strategy to address this very important population.

In addition to the issues discussed above, I want to highlight three important factors that strongly influence the AIDS response.

First, meaningful involvement of our civil society partners at all levels remains essential. A 2007 survey shows that this region is lagging behind the rest of the world in the levels of involvement of civil society organizations in national planning, budgeting and implementation.

Secondly, since Colombo we see more countries affected by conflict and natural disasters, leading to displacement of populations.

Thirdly, the AIDS response is in permanent competition with other emerging crises. The most recent one is the global economic downturn, which has the most potential impact on AIDS funding.

A 2009 UNAIDS/World Bank survey has shown that in Asia and the Pacific, funding for prevention programs is at risk of being cut down. While not to be ignored, the impact on treatment is expected to be less pronounced.

With such challenges, it is more important than ever to prioritize. So what should we focus on in the coming years?

Decriminalize risk behaviors by repealing/amending outdated laws, including relating to sex work, male-to-male sex and drug use
Phase out compulsory drug detention and treatment centers and introduce Methadone in substitution programmes
Provide treatment access to all those who need it: reach 1 million by 2011
Increase coverage levels of PMTCT: no transmission from mothers to children by 2015
Scale up high-impact prevention coverage to match Universal Access commitments

In addition to our immediate next steps, we must also change the way we think about AIDS. In doing so we must recognize and seize the opportunities that AIDS presents to us. The

siloed approach we adopted until now is not a sustainable model. The time has come to link it to the broader social development agenda like the MDGs.

The decriminalization of risk behavior and vulnerable populations, and changing the gender norms are some of the social sector reforms that can be triggered by the AIDS response.

The history of the AIDS response in Asia shows that without sustained activism AIDS will fall off the agenda. So maintain it!

We should view accountability through a new lens - moving beyond financial accountability towards holding each other accountable for real results.

I would like to call it ‘the new politics of AIDS ‘.Somehow I like these words!

Thank you.