"Accelerating the Momentum in the Fight Against HIV/AIDS"

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Issues Paper 1

Accelerating the Momentum in the Fight Against HIV/AIDS in South Asia

Overview Paper

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"As the world enters the third decade of AIDS, it is becoming clearer than ever that this is the most devastating disease humanity has ever faced. Driven by stigma and inequality the global epidemic makes ever deeper inroads into human security".

–Peter Piot

"The future course of the HIV/AIDS pandemic lies in the hands of young people. It is absolutely vital that we do everything possible to arm them with the knowledge they need to protect themselves and their communities".

–Carol Bellamy

"The proper strategy has also become clear: Prevention of new infection, above all by teaching young people how to avoid it and by providing the medicines that can prevent transmission from mother to child".

–Kofi Annan

Accelerating the Momentum in the Fight Against HIV/AIDS in South Asia

Introduction

It is estimated that at the end of 2001 there were 4.2 million people living with HIV/AIDS in South Asia – Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. Much is now known about the disease in South Asia. A number of commitments have been made, meetings, conferences, marches, and mobilisation drives held. This paper lays out some of the issues in 'accelerating' the momentum in the fight against HIV/AIDS in South Asia.

What happens in the future is in the hands of today's leaders and those to come. It is equally in the hands of society at large particularly young people and families. Mothers and fathers have a primary duty to educate children and protect them from HIV/AIDS. Children have a right to be protected. Governments and today's leaders play the most critical role – the accountability and responsibility is universal and collective but the starting point is in leadership. What today's leaders will do to fight HIV/AIDS will impact on what happens to its growth and spread in South Asia in the future.

This overview paper, prepared for the South Asia High-Level Conference – "Accelerating the Momentum in the Fight Against HIV/AIDS in South Asia" – jointly sponsored by UNICEF and UNAIDS - is meant to further galvanise action and add to the monitoring and results report card of South Asia. The Conference is a follow-up to the United Nations Special Sessions on HIV/AIDS, June 2001 and on Children, May 2002. The participants include government delegations comprising of senior Ministers and other government officials, NGOs, parliamentarians, media, children and young people representing key partners needed to accelerate the fight against HIV/AIDS in South Asia. In preparation for the Conference, a South Asia Regional Forum for Young People on HIV/AIDS was organised by Save the Children and UNICEF in Kathmandu, December 2002.

The objective of the Conference is to arrive at a South Asia consensus on how to bring about greater accountability for the prevention of a large-scale epidemic in South Asia and how to monitor results in the fight against HIV/AIDS as a follow-up to the goals and targets set at the UN General Assembly Special Session in June 2001 for HIV/AIDS prevention and care and in the outcome document of the UN General Assembly Special Session on Children, May 2002 – A World Fit for Children.

The paper is focused on actions for the prevention and mitigation of the impact of the epidemic of HIV/AIDS in the future and its reversal with particular focus on children and young people. The actions must be looked at in the context of the overall situation of HIV/AIDS in the region. Assessing the situation and learning lessons from within the region and other countries, the paper calls for accelerated results in the fight against HIV/AIDS. It suggests that there is a need for greater accountability for achieving results and monitoring progress to fulfil the commitments that have been made by the leaders of South Asia. It is structured around results that need to be achieved which are also some of the critical challenges faced in South Asia in the fight against HIV/AIDS.

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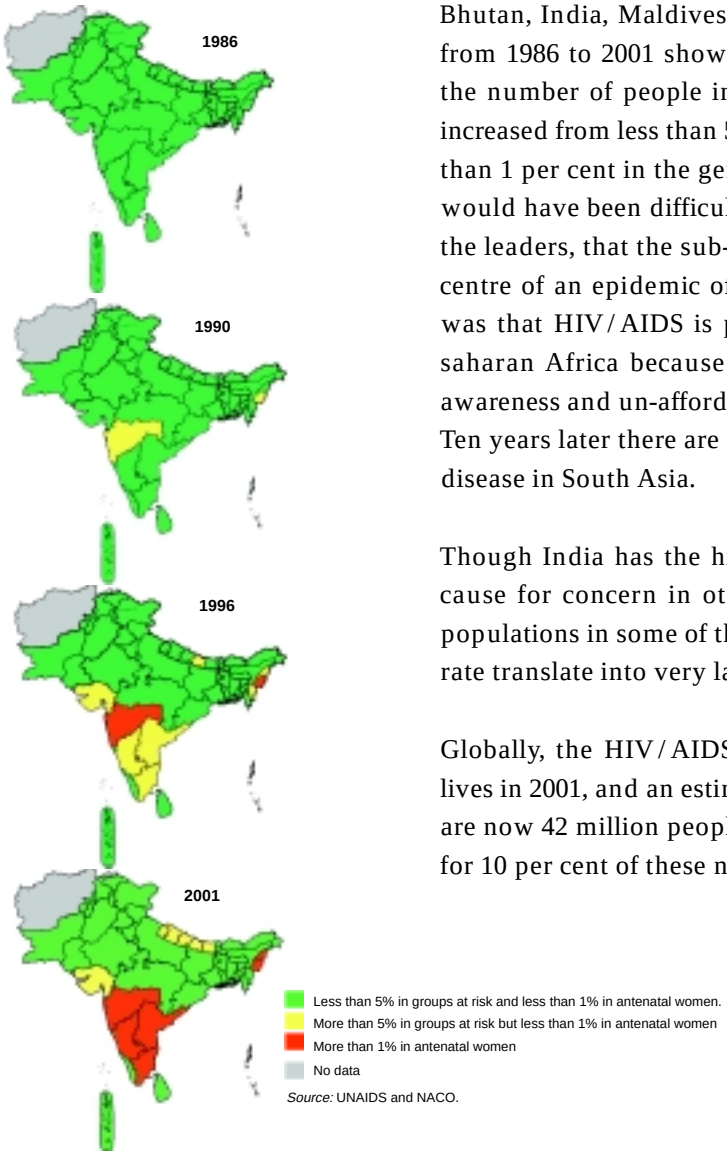
HIV/AIDS in South Asia:
A looming threat

FIGURE 1:
Evolution of HIV/AIDS epidemic in South Asia



Source: UNAIDS and NACO.

Note: The boundaries and names shown and the designations used on these maps do not imply official endorsement or acceptance by the United Nations. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan.

It is estimated that at the end of 2001 there were 4.2 million people living with HIV/AIDS in South Asia – Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. Trend data from 1986 to 2001 show that there has been a significant increase in the number of people infected. In some regions the prevalance has increased from less than 5 per cent in population groups at risk to more than 1 per cent in the general population (Figure 1). In early 1990's it would have been difficult to convince people in South Asia, including the leaders, that the sub-continent had the potential for becoming the centre of an epidemic of HIV/AIDS. The familiar belief at the time was that HIV/AIDS is prevalent on an epidemic scale only in Sub-saharan Africa because of factors such as sexual practices, lack of awareness and un-affordability of the costs for reducing its prevalence. Ten years later there are more than four million people living with the disease in South Asia.

Though India has the highest prevalence rate in the region, there is cause for concern in other countries also (Table 1). With the large populations in some of the countries, small increases in the prevalence rate translate into very large numbers.

Globally, the HIV/AIDS epidemic claimed more than three million lives in 2001, and an estimated five million newly acquired HIV. There are now 42 million people living with the virus - South Asia accounts for 10 per cent of these numbers.

TABLE 1:
HIV/AIDS prevalence in South Asia, end 2001

	Adult prevalence rate (15-49 years)	Number of adults & children living with HIV/AIDS	Number of women living with HIV/AIDS (15-49)	Number of Children living with HIV/AIDS (0-14 years)	Number of children orphaned by HIV/AIDS (0-14 years)
Afghanistan	-	-	-	-	-
Bangladesh	<0.1%	13,000	3,100	310	2,100
Bhutan	<0.1%	<100	-	-	-
India	0.8%	3,970,000	1,500,000	170,000	-
Maldives	0.1%	<100	-	-	-
Nepal	0.5%	58,000	14,000	1,500	13,000
Pakistan	0.1	78,000	16,000	2,200	25,000
Sri Lanka	<0.1%	4,800	1,400	<100	2,000

Source: UNAIDS, *Report on the Global HIV/AIDS Epidemic,* 2002.

What is happening among young people and adults - 15-49 years old - is relevant to children since the number of children infected closely follows the number of adult infections given the possibility of transmission from mother to child. There were estimated to be less than 100 children in Sri Lanka living with the virus, around 310 in Bangladesh, 1500 in Nepal and 170, 000 in India in 2001. The number of children orphaned by AIDS is much higher testifying to the dual risks that children face in this epidemic – one through mother-to-child transmission even before they are born and the other through the death of both the father and mother. Figures on children orphaned by HIV / AIDS are even more difficult to collect with estimates available only for Sri Lanka of 2,000; Bangladesh of 2,100, and Nepal 13,000.

The number of children living with HIV / AIDS in South Asia is small today. The lesson is that it is not the smallness of the number of children (and relatively also adults) living with HIV / AIDS today that is the relevant and operative criterion to focus upon but rather its "potential growth" because the epidemic in these countries is still in the early stages, given the time lag between HIV infection and the onset of illness and infections among children. Data for the ten highest prevalance countries in Sub-saharan Africa show a large number of children living with the disease (Table 2).

The question for South Asia is both about fighting the epidemic of today and about avoiding an even larger epidemic in the future. One of the major lessons learned globally as well as in South Asia is that national responses should not wait for HIV / AIDS cases to soar. Another lesson learned is that it is possible to reverse the growth of the epidemic as seen from the success of Thailand and Uganda (Figures 2 & 3). Also countries starting from the same position can fundamentally change the trajectory of their epidemics (Figure 3). However, the further lesson from Thailand is that even where substantial success has been achieved, there is a need for renewal and extension beyond what seemed the obvious targets - young people might know about condoms for commercial sex, but need to use them with boyfriends and girlfriends too.

TABLE 2: **Estimated number of children living with HIV/AIDS in selected countries (top ten adult prevalance countries) in Sub-saharan Africa, end 2001**

	Children (0-14)
Botswana	28,000
Swaziland	14,000
Zimbabwe	240,000
Lesotho	27,000
Zambia	150,000
South Africa	250,000
Namibia	30,000
Malawi	65,000
Kenya	220,000
Central African Republic	25,000

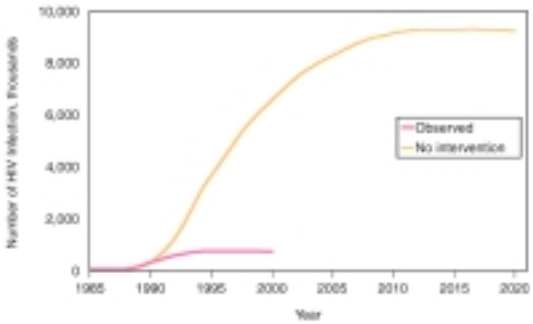
Source: UNAIDS, *Report on the Global HIV/AIDS Epidemic,* 2002.

How many children will be living with HIV/AIDS in South Asia in 2005, 2015?

Of the 42 million people living with the virus in the world in 2001, South Asia accounts for 10% of this number.

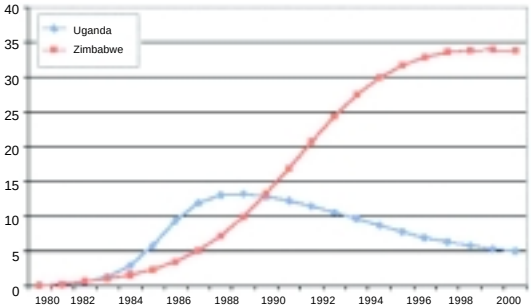
FIGURE 2: **HIV/AIDS trends in Thailand: Lesson for South Asia?**

Scenario of the epidemic in Thailand, had there been no intervention through 2020, and observed epidemic curve



Source: Division for AIDS, Ministry of Public Health in Thailand; Thai Working Group on HIV/AIDS Projection (2001). HIV.AIDS Projection for Thailand: 2000-2020, for UNAIDS, Report on the global HIV/AIDS epidemic, 2002, Geneva, 2002 *in UNAIDS, Report on the Global HIV/AIDS Epidemic, 2002.*

FIGURE 3: **Adult HIV prevalence in Uganda and Zimbabwe**



Source: Seth Berkley, Peter Piot, Alan Whiteside, *SCENARIOS The Global HIV/AIDS Crisis,* 2003.

A major lesson learned globally is that national responses should not wait for HIV/AIDS cases to soar. South Asia cannot afford to wait to find out the scale of the epidemic.

Commitments to fight HIV/AIDS in South Asia exist.

What is needed is commitment to 'accelerate' the fight, ccountability, consensus on reporting echanisms and results.

Millennium Development Goals

By 2015 all 189 members of the United Nations have pledged to:

Combat HIV/AIDS, malaria and other diseases

- halt and begin to reverse the spread of HIV/AIDS
- provide special assistance to children orphaned by HIV/AIDS

Source: United Nations, Millennium Development Goals.

"Declaration of Commitment on HIV/AIDS"

called on follow-up action at the regional level:

- Inclusion of HIV/AIDS and related public health concerns, as appropriate, on the agenda of regional meetings at the ministerial and Head of State and Government level;
- Support data collection and processing and wide dissemination of results of reviews;
- Encourage exchange between countries of information and experiences in implementing the measures and commitments.

Source: Full text of the 'Declaration of Commitment on HIV/AIDS, UN General Assembly, July 2001.

A World Fit for Children

We hereby call on all members of society to join us in a global movement that will help build a world fit for children through upholding our commitments to …..

Combat HIV/AIDS. Children and their families must be protected from the devastating impact of human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/AIDS)

Source: United Nations, *A World Fit for Children,* 2002.

The governments of South Asia have, in a number of forums, made commitments to fight HIV / AIDS which is one of the Millennium Development Goals. The most extensive and comprehensive among these is the "Declaration of Commitment on HIV / AIDS" adopted by the UN General Assembly Special Session on HIV / AIDS, June 2001. It called for maintaining the momentum and monitoring progress at the national, regional and global levels.

Recently at the United Nations Special Session on Children, May 2002 Governments have renewed the commitment to fight HIV / AIDS. At the Special Session, the children who participated made their own statement through delegates representing the Children's Forum.

Commitments have also been made in regional and national forums in South Asia. At the South Asia High Level Meeting in Kathmandu in May 2001, convened in prepartion for the Special Session of the UN General Assembly on Children, the participants and delegations of the Governments of SAARC countries in the "Kathmandu Understanding" committed that: "We recognise the urgent need to protect adolescents and young people from HIV / AIDS". The Eleventh SAARC Summit in Kathamandu in January 2002 noted with appreciation the "Kathmandu Understanding" and agreed to mobilize the necessary resources and intensify broad based actions to achieve a set of priority goals related to improving the status of children, including protection from mother-to-child transmission of HIV / AIDS within a time-bound period. The South Asia Strategy against Commercial Sexual Exploitation of Children and Child Sexual Abuse adopted in Dhaka in November 2001 noted that "with increasing rates of HIV infection in the region, sexual abuse of children places them at increased risk of sexually transmitted infections such as HIV / AIDS".

In their own parliaments and national assemblies, policies and legislations, the Governments of South Asia have committed themselves to fight and protect children from HIV / AIDS. National leaders have made statements recognising that HIV / AIDS is a serious problem faced by their countries and called for urgent actions, including breaking the silence surrounding it.

TABLE 3: **Overview of the National Response to HIV/AIDS in South Asia**

■ Afghanistan

Framework for assessment and response yet to be developed.

■ Bangladesh

National Policies:

- Comprehensive national AIDS and STD programme 1997
- Legislation on safe blood 2002
- Legislation on bio-medical waste in process

Actions:

- National AIDS Committee (NAC) and Technical committee established 1985. NAC is the national advisory body.
- National Strategic Intergrated Workplan for 2002-2006 developed.
- Ministry of Health and Family Welfare is the supreme executive body.
- DGHS implementing agency for health-related activities.
- Activities (2002-06):
  - Comprehensive interventions to reach high-risk groups.
  - Advocacy and communications, with special focus on young people, migrants and mobile populations, and uniformed services.
  - Biomedical issues including blood safety.
  - Project support and institutional strengthening, including surveillance and research.
  - Care support and greater involvement of People living with HIV/AIDS (PLWHA).

Sources: UNAIDS, National response briefs; National Aids Policy.

■ Bhutan

Objectives:

- Prevent transmission through blood
- Prevent vertical transmission
- Care and social support
- Reduce social and economic impacts

Policies:

No independent policy on HIV/AIDS - part of 8th Five-year Plan, 1997-2002.

Actions:

- National STD/AIDS programme set up in 1988.
- National AIDS committee established in 1994.
- A multi-sectoral task force and a working committee established at Dzongkhag level in all 20 districts.

Sources: Bhutan National STD/AIDS Programme.

■ Maldives

Objectives:

- Awareness raising throught media campaigns, inclusion in school-based health education component for primary schools, lectures to so-called risk groups such as seamen, resort workers resulting in high levels of knowledge of modes of transmission of HIV/AIDS
- Surveillance based on case detection
- Ensuring blood safety

Actions:

- 10 year health Master Plan 1996-2005.
- National strategy for prevention and control of HIV/AIDS/STI 2002 - 2004.

Sources: National Strategic Plan - 2002-2004.

■ Nepal

Objectives:

- Prevention of STIs and HIV infection among vulnerable groups
- Prevention of new infections among young people
- ensuring care and support services are available and accessible for all people infected
- and affected by HIV/AIDS
- Expansion of monitoring and evaluation frame through evidence based effective
- Surveillance and research.
- Establishment of an effective and efficient management system for an expanded response

Policies: In 1995, HMG/Nepal adopted a national policy for AIDS prevention, with key policy statements.

Actions:

- In 1988, HMG/Nepal launched the first National AIDS Prevention and Control Programme.
- Nepal's National HIV/AIDS Strategy 2002-2006, was adopted in Oct. 2002
- Structure:
  - The MoH formed the National AIDS Coordination Committee (NACC) and related sub-committees. The Minister of Health chairs the NACC and its membership is composed of the secretaries of various ministries, the UN as well as representatives of NGOs working in the sector.
  - Recently Nepal established a "National AIDS Council" chaired by the Prime Minister.

Sources: National HIV/AIDS Strategy, 2002-2004.

■ India

Objectives: Four specific objectives by end 2004:

- To keep HIV prevalence rate below 3% of adult population in states with 1% prevalence and below 1% in all other states by end of National Aids Control Programme (NACP) II
- To attain awareness level of not less than 90% among young people and others in reproductive age
- To reduce blood borne transmission of HIV to less than 1%
- To achieve condom use of not less than 90% among high risk categories like sex workers.

Policies:

- National AIDS Prevention and Control Policy (1999 and 2002)
- National Blood Policy
- Related Policies:
  - National population policy 2000
  - National Health Policy 2001

Actions:

- NACP I launched in 1992
- NACP II, 1999-2004 developed through a participatory process, with the Government of India, State governments, UNAIDS and bi-laterals working in partnership with community members, PLWAs, NGOs industry and labour organizations, and other sectors of civil society.
- The national response to the AIDS epidemic in India is managed by three bodies:
  - National AIDS Control Board, chair: Secretary (health), Ministry of Health and Welfare
  - National AIDS Control Organization (NACO), an autonomous body within the Ministry of Health and Family Welfare, which reports to the National AIDS Control Board.
  - Multisectoral National AIDS Committee, chaired by the Union Minister of Health and Family Welfare.
- Responsibiltity for implementation transferred to:
  - Independent State AIDS Control Societies in each of the 35 States and Union territories.
  - Municipal AIDS Control Society in Mumbai, Chennai and Ahmedabad to implement the AIDS programme in their city.
- Project activities:
  - Targeted interventions for communities at highest risk
  - Prevention of HIV transmission among the general population
  - Provision of low cost care
  - Strengthening institutional capacities (at national, state and municipal levels)
  - Intersectoral collaboration.

Sources: National Aids Control Organization

■ Pakistan

Policies:

- Constitution of Pakistan guarantees certain fundamental right to the citizens of Pakistan, and further provides that laws inconsistent with or in derogation of fundamental rights shall be void.
- Article 9 of the Chapter of Fundamental Rights guarantees security of person
- Article 14 provides for the inviolability of the dignity of man
- Item 35 of the principles of the state policy provides protection for the family, marriage, the mother and child. These rights are translated into guiding principles in the context of protection of the health and well being of the nation's citizens from HIV/AIDS.

Actions:

- Federal Committee on AIDS (FCA)established in 1987
- National AIDS Control Programme established in 1990.
- National Strategic HIV/AIDS Framework with nine priorities developed in 2000
- Enhanced HIV/AIDS Prevention Programme 2003-2007:
  - Expansion of intervention for vulnerable populations
  - Improved HIV prevention by the general public
  - Prevention of transmission through transfusion of blood and blood products
  - Capacity building and program management (public and private sectors)

Sources: National HIV/AIDS Strategy Framework 2001-2006.

■ Sri Lanka

Policies:

- Draft National AIDS Policy
- National Blood Policy adopted (2002)

Actions:

- The NAC is the apex body that co-ordinates national level activities. Chair: Secretary, Ministry of Health with 21 members and a number of observers. Main tasks is to make policy decisions.
- With support from UNAIDS, the government has developed its National Strategic Framework for the prevention and control of HIV/AIDS:
  - Maintain low prevalence rates in populations with high partner exchange rates
  - Information and educational activities aimed at youth and programmes to affect behavioural change in other vulnerable populations
  - Creating an enabling environment
  - Maintaining a safe supply of blood and blood products
  - Addressing the human rights implications of HIV
  - Provision of care and support

Sources: National HIV&STD Prevention Campaign.

The Children's Statement

Address at the Opening of the UN General Assembly's Special Session on Children

We the world's children.

We are the victims and orphans of HIV/AIDS

In this world,

We see the eradication of HIV/AIDS:

- educational systems that include HIV prevention programmes,
- free testing and counselling centres,
- information about HIV/AIDS freely available to the public,
- orphans of AIDS and children living with HIV/AIDS cared for and enjoying the same opportunities as all other children.

Source: The Children's Statement at the UN General Assembly's Special Session on Children, 8 May 2002.

Commitments are important, but lessons from previous commitments made in other areas is that more than this is needed. The focus must also shift from statements of what actions are being taken to what results are being achieved. The fight against HIV / AIDS, like all fights and battles, is ultimately to be seen on the basis of the results achieved. To achieve results the 'right' set of strategies and above all the 'will' to succeed is necessary.

This paper assumes that there are enough commitments by the governments of South Asia. There also exist national policies in most of the South Asian countries and actions are being taken by individual governments in South Asia (Table 3). These are pre-requisites for an effective response but policies and strategies have to be implemented and results achieved.

While it is useful to reaffirm commitments and obligations, what is really needed is accelerated results. This paper calls for some key results that need to be achieved and monitored. They are not new. The challenge is to accelerate actions to achieve the desired outcome of protection of all from HIV / AIDs, particularly children and young people from HIV / AIDS-sooner rather than later.

Words are not enough.
Commitments are not enough.
Actions are not enough.
Accelerated results are needed.

HIV/AIDS and Poverty -
a deadly mixture for South Asia

Poverty - human and income - conspires with HIV / AIDS to constitute a double blow to people in developing countries. Countries, which have experienced a generalised epidemic in the midst of human and income poverty, have substantially added to their burden in overcoming poverty. The set-backs have to be measured not only in terms of the deaths due to HIV / AIDS but in terms of the impact on all indicators of poverty – income and human - the costs and drain of national resources – human and financial – the reduced rates of economic growth, and the reduced resources available for human and national security. The toll of HIV / AIDS on the family, society and economy is well documented, particularly in Sub-saharan Africa.

No country can afford the costs of an HIV / AIDS epidemic. It would be a mistake to consider that these costs are borne only by individuals – those who have contracted HIV / AIDS from whatever source. The costs are ultimately borne by the nation and society as a whole. In economic parlance, HIV / AIDS is a 'public bad' and actions to fight it are part of 'public goods' since the whole society benefits from it.

The consequences of an epidemic on social development in South Asia can be quite dire. The lesson from Africa has been that HIV / AIDS and poverty are a deadly mixture – draining national and human resources right down to the community and family level. The prevalence rates and the estimated number of adults and children living with HIV / AIDS in Sub-saharan Africa, where it has been prevalent for a number of years, surpass those in South Asia (Table 4). However, compared to some of these countries some South Asian countries are at an even lower starting point for some of the critical social indicators. Their social indicators are also worse off than some of the countries which have been success stories such as Thailand and Uganda. For example in the case of malnutrition (Figure 4), girls enrolment in primary school (Figure 5), gross national product per capita (Figure 6), access to health services (Figure 7), and income poverty (Figure 8) some countries in South Asia are worse-off than some of the epidemic countries in Africa and Thailand.

These data do not suggest causality of the social indicators considered with the prevalence of HIV / AIDS but low levels of social indicators will clearly hamper the ability of countries to fight the disease and affect the speed of their response. Different instruments are being used

Economic Impact

The effects of the epidemic radiate from the household across society. In Cote d'Ivoire, urban households that have lost at least one family member to AIDS have seen their income drop by 52-67 per cent, while their expenditures have soared four fold. To cope they have had to cut their food consumption by about 41 per cent. Rural households facing similar predicaments in Thailand are seeing their agricultural outputs shrinking by half. In 15 per cent of cases children are removed from schools to take care of family members who are ill and to regain lost income.

Some companies in Africa have already felt the impact of HIV on their bottom line. Managers in one sugar estate in Kenya said they could count the cost of HIV infection in a number of ways: absenteeism, lower productivity (50 per cent drop between 1993 and 1997) and higher overtime costs as a result of workers being obliged to work more hours to compensate for their sick colleagues.

Source: UNAIDS.

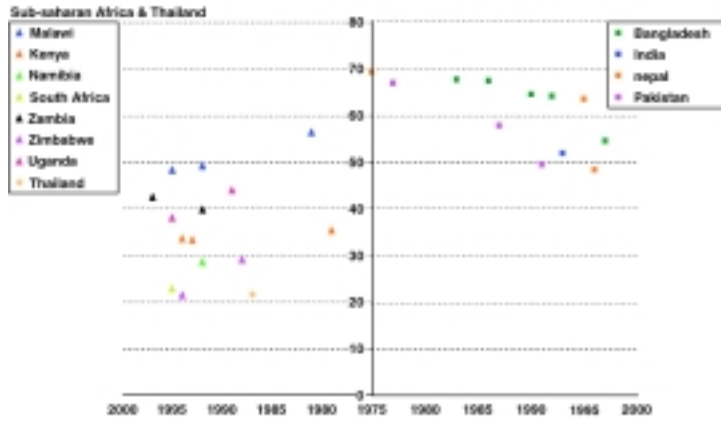
TABLE 4: **Estimated number of people living with HIV/AIDS in selected countries (top ten highest adult prevalence rate) in Sub-saharan Africa, end 2001**

	Adults (15-49 years) prevalence rate (%) end 2001	Number of adults (15-49 years) end 2001
Botswana	39	300,000
Swaziland	33	150,000
Zimbabwe	34	2,000,000
Lesotho	31	330,000
Zambia	22	1,000 000
South Africa	20	4,700,000
Namibia	23	200,000
Malawi	15	780,000
Kenya	15	2,300,000
Central African Republic	13	220,000

Source: UNAIDS, *Report on the Global HIV/AIDS Epidemic*, 2002.

in South Asia to address the many social issues affecting children and the nation as a whole – each of which carries its own financial cost. Clearly an upturn in the epidemic in South Asia will be an added burden. With the potential of a HIV / AIDS epidemic for eroding many of the achievements so far in social development, South Asia cannot afford to add a large-scale HIV / AIDS epidemic to the many challenges it already faces, such as in malnutrition and access to basic social services. It is best to nip the HIV / AIDS epidemic in the bud or even as a sapling, as it already is, in some of the regions within the countries of South Asia.

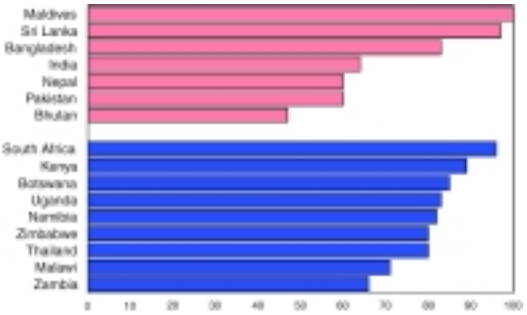
FIGURE 4: **Malnutrition Prevalence**
Selected Countries: South Asia and Sub-saharan Africa; and Thailand 1975-1997
Height for Age (% of Children under 5)



Source: World Bank, World Development Indicators, CD-ROM,1999, and http://www.worldbank.org

With the potential of a large-scale HIV/AIDS epidemic eroding many of the achievements so far in social development, South Asia cannot afford to add this disease to the many challenges it already faces such as malnutrition and access to basic social services.

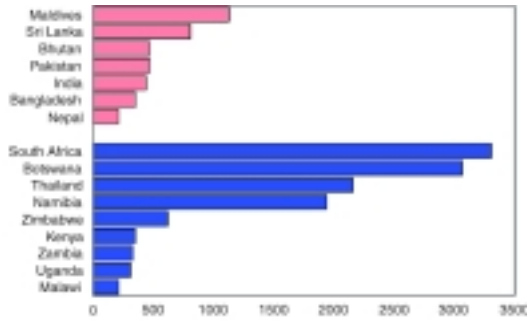
FIGURE 5: **Girls: Primary school net enrolment ratio**
Selected Countries: South Asia and Sub-saharan Africa;
and Thailand, 1995-99



Source: United Nations Children's Fund, The State of The World's Children 2003, UNICEF, New York, 2002.

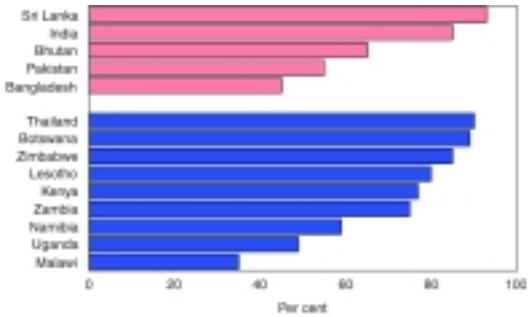
Some South Asian countries are worse off in many social indicators than many of the HIV/ AIDS epidemic countries in Sub-saharan Africa.

FIGURE 6: **GNP per capita (US$)**
Selected Countries: South Asia and Sub-saharan Africa; and Thailand, 1998



Source: United Nations Development Programme, Human Development Report 2000, Oxford University Press, UNDP, 2000.

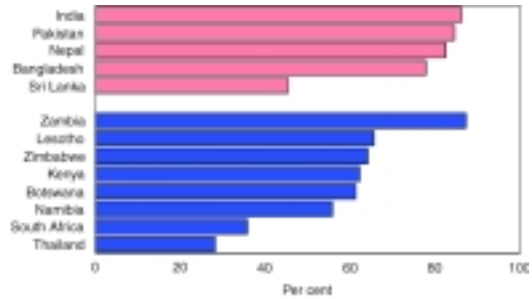
FIGURE 7: **Population with access to health services**
Selected Countries: South Asia and Sub-saharan Africa; and Thailand, 1990-95



Note: *Data refer to the most recent year available during the period specified.

Source: United Nations Development Programme, Human Development Report 1998, Oxford University Press, UNDP, 1998.

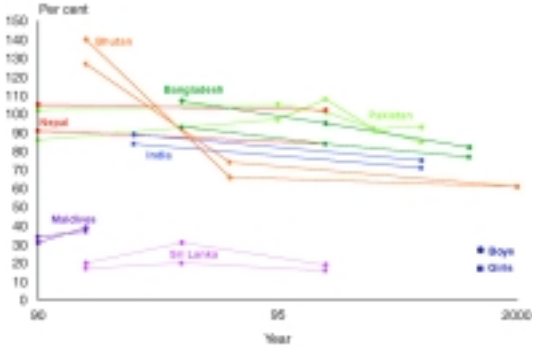
FIGURE 8: **Population below income poverty line $2 a day**
Selected Countries: South Asia and Sub-saharan Africa; and Thailand, 1983-2000



Source: United Nations Development Programme, Human Development Report 2002, Oxford University Press, UNDP, 2002.

FIGURE 9: **IMR: Progress in South Asia**

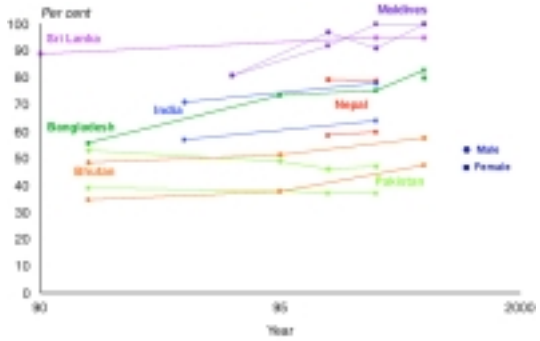
Infant Mortality Rate per 1,000 live birth by sex.



Source: UNICEF Regional Office for South Asia, *Children of South Asia Our Future, Our Legacy, Investing in Children, Fulfilling Commitments,* Prepared for The Eleventh SAARC Summit Kathmandu, Nepal, 4-6 January 2002.

FIGURE 10: **Primary Education: Progress in South Asia**

Trends in net enrolment ratio (boys and girls)



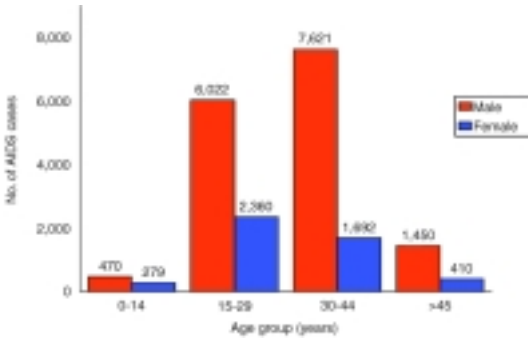
Source: UNICEF Regional Office for South Asia, *Children of South Asia Our Future, Our Legacy, Investing in Children, Fulfilling Commitments,* Prepared for The Eleventh SAARC Summit Kathmandu, Nepal, 4-6 January 2002.

Social indicators, such as net primary school enrolment, education, immunisation, malnutrition, access to improved water supply and sanitation, and poverty for South Asian countries show that there has been progress in the 1990s, for example in the reduction of infant mortality and primary school net enrolment for boys and girls (Figures 9 & 10)**.** They also show that many of the commitments made in these areas in the 1990s and reinforced in various forums have not been achieved by many of the South Asian countries. The glass is only half full in the terms of success in meeting targets. While there is progress in South Asia in economic and social development over the last 10-15 years and there is potential and capacity among the governments and populations to take actions and achieve results, progress is slow. What is important is the pace of progress. Slow result is a 'killer' in the fight against HIV / AIDS.

A lesson from South Asia's economic and social development is that there is potential and capacity to take actions and achieve results but progress is slow. Slow result is a 'killer' in the case of HIV/AIDS.

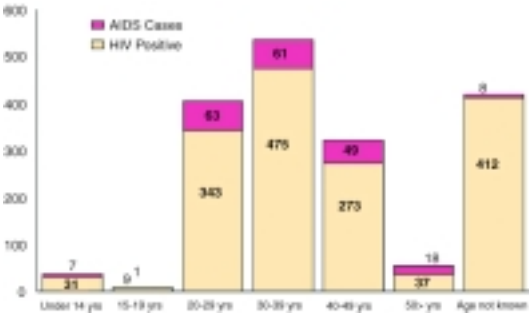
Is enough known about the epidemic in South Asia?

FIGURE 11: **Age & Sex distribution of reported AIDS Cases in India** (n=20,304) May1986-March 2001



Source: NACO, Combating HIV/AIDS in INDIA 2000-2001, http://naco.nic.in/indianscene/country.htm

FIGURE 12: **Pakistan, Age-wise Distribution of HIV/AIDS Cases 1986-2001** (Total HIV/AIDS Positive 1,787 out of total 2.586 million cases tested)



Source: Pakistan, National AIDS Prevention & Control Programme, July 2001.

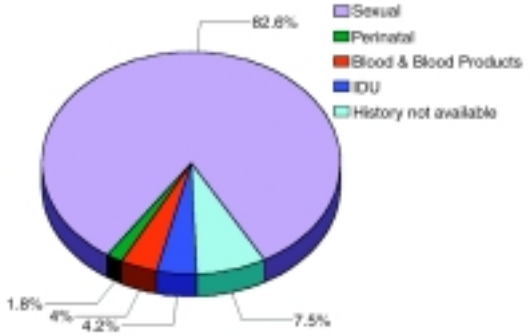
Although data and information on the nature and growth of the epidemic in South Asia has been difficult and slow to gather, much is now known. Surveliance data provide indications of the transmission mechanism of the disease in some of the countries and the age and sex distribution. A disaggregated picture by states and provinces is also developing.

In India, even with the limited data on reported AIDS cases young people between the ages of 15-29 years account for a large proportion of cases (Figure 11). A similar age pattern is seen in Pakistan (Figure 12). Among young people, girls are highly vulnerable.

In India, of the 25 million live births each year an estimated 16 per cent (4 million or one in five) are to those in the teenage years of 15-19 years. Although, data for other South Asian countries on percentage of births to teenagers are not available, early marriage and teenage pregnancies are common in most of the countries of the region, despite declines in recent years. In Bangladesh, more than half of women 19 year olds are mothers or pregnant with first child. In Nepal, the figure stands at 40 per cent (Table 5). Given these realities, in the event of a large-scale epidemic with transmission of the virus to young girls, the unborn child is highly vulnerable. This highlights the need to focus on young girls for achieving a direct impact on reducing mother-to-child transmissions. In a widespread hetrosexual epidemic mother-to-child transmission becomes a much larger proportion of infections.

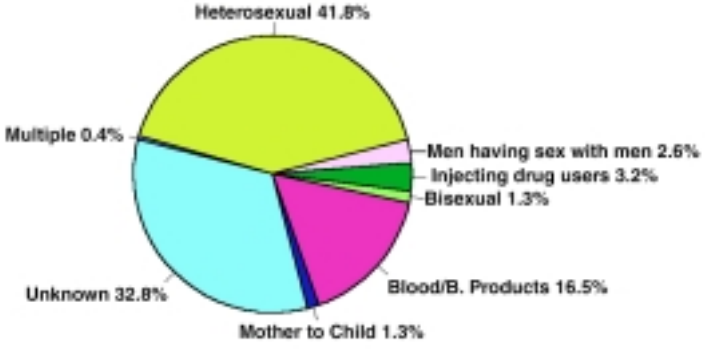
The probable sources of infection of reported AIDS cases around the world is also known. Available data for India and Pakistan show the predominat source of transmission is sexual (Figure 13 & 14). Other

FIGURE 13: **Probable source of infection of reported AIDS cases in India** (n=20304) May 1986-March 2001



Source: NACO, Combating HIV/AIDS in INDIA 2000-2001, http://naco.nic.in/indianscene/country.htm

FIGURE 14: **Pakistan, Mode of HIV/AIDS transmission** (n=1,787)



Source: Pakistan, National AIDS Prevention & Control Programme, July 2001.

modes such as injecting drug use and unsafe blood can potentially fuel the rates of transmission in South Asia. In Kathmandu, Nepal, the HIV prevalence rate among intravenous drug users (IDUs) has shot up significantly in the 1990s (Figure 15). Needle-sharing was rife in the 1990s, yet HIV infections among IDUs stayed negligible for six or seven years before rising sharply to the point where, by 1997, nearly half the users were infected. Similarly, HIV seroprevalence among IDUs in Manipur, India has shown sharp increases with saturation at high levels (Figure 16). Data from Central Bangladesh show the potential spread of HIV from high risk groups to the general population (Figure 17). It is also known that labour migration and mobility in search of employment from economically backward to more advanced regions, low literacy levels leading to low awareness among the potential high risk groups, gender disparity, sexually transmitted infections and reproductive tract infections both among men and women are factors in the rapid spread of the disease.

TABLE 5: **Percentage of 15-19 year old women who are mothers or pregnant with first child**

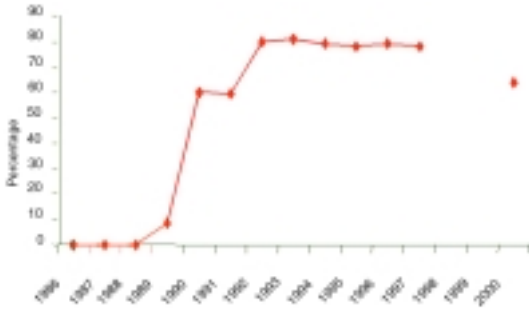
Age	Bangladesh	Nepal
15	15.9	1.5
16	26.0	9.3
17	36.5	17.5
18	45.0	34.0
19	57.3	40.5

Source: Bangladesh Demographic and Health Survey 1999-2000, Table 3.12: Nepal Demogprhic and Health Survey 2001, Table 4.10.

FIGURE 15: **HIV prevalence among injecting drug users in Kathmandu, Nepal: 1991-1999**

Source: Peak A et al. (1995); AIDS. Gurubacharya RL et al. (1998); 12th World AIDS Conference, Abstract 23246. Oelrichs RB et al. (2000) *J. Virol. in UNAIDS, Report on the Global HIV/AIDS Epidemic*, 2002.

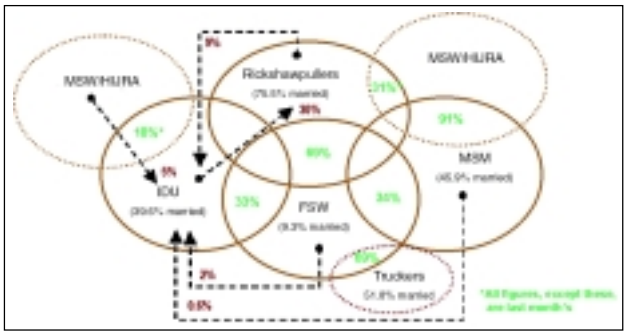
FIGURE 16: **HIV Seroprevalence among IDUs in Manipur, India**



Source: NACO, INDIA

Lessons from other parts of the world also show the implications of epidemic on life expectancy, economic growth, gross national income, foreign direct investment, and overall confidence in countries with a widespread epidemic. Life expectancy in epidemic countries in Africa has declined significantly compared to the 'no AIDS' scenario. The declines range from around 34 years for Botswana, 17 years for South Africa and 7 years for Burkina Faso (Figure 18). Even Thailand with its successes in fighting the diseases has seen declines, albiet of only a few years.

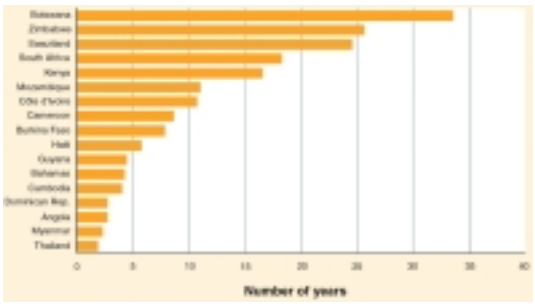
FIGURE 17: **Potential spread of HIV from high risk groups to the general population in central Bangladesh**



Note: MSW - male sex worker; MSM - men having sex with men; FSW - female sex worker; IDU - intravenous drug users.

Sources: Second Generation Surveillance for HIV in Bangladesh, AIDS and STD Control Programme, Directorate General of Health Services, Ministry of Health and Family Welfare & Govt. of the People's Republic of Bangladesh.

FIGURE 18: **Reduction in life expectancy compared to the "no AIDS" scenario in selected countries: 2000-2005**



Source: UN Department of Economic and Social Affairs (2002), *World Population Prospects, the 2000 Revision in* UNAIDS, *Report on the Global HIV/AIDS Epidemic, 2002.*

Accelerating the momentum in the fight against HIV/AIDS in South Asia – What results are needed?

Governments committed themselves to the following targets for prevention at the United Nations Special Sesson on HIV/AIDS, June 2001

- By 2003, establish targets to reduce HIV prevalance among young people (aged 15 to 24) by 25% in the most affected countries by 2005; and to reduce it globally by 2010; challenge gender inequalities in relation to HIV/AIDS; and encourage the involvement of men and boys in HIV-prevention programmes
- By 2005, ensure that 90%, and, by 2010, 95% of youth aged 15-24 have information, education, services and life-skills that enable them to reduce their vulnerability to HIV infection
- BY 2005, reduce by 20% and, by 2010, by 50% the number of babies infected by HIV by ensuring that: 80% of pregnant women in antenatal care recieve HIV information, counselling, and other prevention services; HIV-infected women receive voluntary and confidential testing and counselling, treatment, including antiretroviral drugs, and, if needed, breast-milk substitutes.

Sources: UNAIDS, *Summary of the Declaration of Commitment on HIV/AIDS.*

Small scale successes in the fight against HIV/AIDS in South Asia exist. Results on a large scale are needed.

Overarching Outcome: The HIV/AIDS epidemic is reversed in South Asia.

Preventing the further spread of HIV, reversing its prevalence and mitigating the epidemic's impact in South Asia is the ultimate desired outcome. In some of the countries in South Asia, the aim is to maintain prevalence of HIV infections below 5 per cent in vulnerable populations. Other smaller countries would like to count the numbers in less than a hundred or thousands as they currently stand. Country specific targets need to be set to guide actions. The achievement of the overarching outcome of prevention of an epidemic in South Asia requires a number of results in specific areas. Some of them are discussed in this section.

The greatest threat to fighting HIV / AIDS in South Asia is a belief that a large scale epidemic cannot or will not happen here. This must be treated as a myth if South Asia is to accelerate its fight against the disease.

There are successful countries that have avoided such a scenario, prominent among which are Thailand and Uganda. Within a matter of five to seven years, Thailand has managed to reverse the upward trend. However, the Thailand experience also shows that constant vigilence is needed. Youth is now the priority in Thailand. Transmission from sex workers is now under 20 per cent of new infections, and sex between hetrosexaul (non-commercial) partners is now 50 per cent. Experience suggests that it may be difficult to make accurate projections on the growth of the epidemic in any country because of a number of non-measurable factors and emergence of new ones.

Although any projection is subject to a number of assumptions, South Asian countries should look into the future consequences of a large-scale epidemic as part of the policy dialogue and action agenda. This is indeed one of the lessons from Thailand, where such an approach was part of their advocacy with leaders and an effective strategy for accelerating actions. It is arguable that in the case of HIV / AIDS there is value in using a sledge hammer, even if it does not turn out to be a large-scale epidemic in the end. Given the 'right' breeding condition, prime among which are denial, neglect, lack of education, stigma and discrimination, violence, sexual abuse and exploitation of young girls

and boys and above all slow achievement of results, the possibility of a more widespread epidemic in South Asia exists.

Another lesson is that it takes time to reverse the upward trend of the epidemic. If the prevalence rate reaches more than one per cent in the generalised population then the task becomes much harder and the reversal will take much more time with greater implications on mortality and costs. In Thailand, it took less than four years for the epidemic to shift from groups at risk such as sex workers and injecting drug users to the general population. In Indonesia, after a decade of low prevalence, HIV prevalence has shot up first among injecting drug users and sex workers and then moved to the population at large. It now stands at 0.1% adult prevalence rate (15-49 years) with 120,000 adults and children living with the virus at the end of 2001.

At a time when South Asia is competing with other regions to be the destination for foreign direct investments and chalk up higher rates of economic growth as a route out of poverty, a HIV / AIDS epidemic can result in a major setback from which the region will take years to recover.

The governments of South Asia have realised the possibility of an epidemic and its dire consequences. A number of actions are being taken and there are many small scale successes. The elements of an expanded response have also been outlined (Table 6). They can be made country specific. However, what is needed are successes on a large enough scale.

All countries in South Asia have established national AIDS bodies or committees as part of their prevention and control programme. Policies are in place and the national objectives have been stated. A co-ordination mechanism has been put in place in most countries. Information on HIV / AIDS, access to services and commodities and the creation of an enabling environment have been accepted as a major tools for reaching the high-risk groups and the general population. These are all healthy and welcome actions. Yet past actions have not managed to stem the increase in the number of cases and reduce prevalence rates. A lot more needs to be done and done fast. This is what needs to occupy the minds of policy makers and implementers. It is important that the fight is accelerated so that the national, community and individual costs are minimised.

Denial, neglect, lack of education, stigma and discrimination, violence, sexual abuse and exploitation of young girls and boys and above all slow achievement of results are some of the "breeding" conditions for an HIV/AIDS epidemic in South Asia.

TABLE 6: **Prevention Interventions and care and support activities of an expanded response programme**

Prevention interventions:
School-based AIDS education
Peer education for out-of-school youth
Outreach programme for commercial sex workers and their clients
Public sector condom promotion and distribution
Condom social marketing
Treatment for sexually transmitted infections
Voluntary counselling and testing
Workplace prevention programmes
Prevention of mother-to-child transmission
Mass media campaigns
Harm reduction programmes
Outreach programmes for homosexual men
Care and support activities:
Palliative care
Treatment of opportunistic infections
Diagnostic HIV-1 testing
Prophylaxis for opportunistic infections
Highly active antiretroviral treatment, treatment with three antiretroviral drugs
Laboratory testing to monitor effect of highly active antiretroviral treatment monitoring
Orphanage care
Community support for orphans
School fee support for orphans

Source: John Stover et. al. (July 6, 2002) " Can we reverse the HIV/ AIDS pandemic with an expanded response?" The Lancet, Vol. 360.

RESULT 1:

Talking about sex and HIV/AIDS in South Asian society is not taboo - it is culturally appropriate, sensitive and essential.

What is Stigma?

Stigma has been defined in various ways and has its own cultural specificity. It is a quality that 'significantly discredits' an individual in the eyes of others. In the case of HIV/AIDS it is often the feeling of 'guilt' or 'wrongdoing' that it tends to inculcate in the minds of those infected, 'shame' or 'loss of izzat (honour)' in the minds of the families and individuals, which can result in 'discrimination' and 'outcasting' of the individual and/or his/her family by members of society. This is exactly what needs to be avoided if the fight has to be won.

To treat HIV/AIDS as a taboo subject or deny its existence and potential as an epidemic means delaying action – a very costly delay.

What works in overcoming stigma and discrimination in South Asia - some lessons.

- Continued advocacy for social change and improved gender equality working with people with HIV/AIDS, religious and political leaders, including parliamentarians, NGOs and young people
- Promotion of life-skills based education and counselling
- Comprehensive care and counselling, including voluntary counselling and testing
- Raising awareness so that families and communities can access interventions
- Holding authorities accountable for services
- Legal protection of people living with HIV/AIDS
- Appropriate reporting and enforcement mechanisms
- Code of conduct, code of ethics for service providers

Source: UNICEF/UNAIDS, HIV/AIDS Related Discrimination and Stigma in South Asia: A Violation of Human Rights, Issues paper for the South Asia High Level Conference, February 2003.

Within South Asia there is still a wide belief among political and religious leaders at all levels and the family that talking about HIV / AIDS is taboo. Talking to children and young people about sex is unacceptable. This is precisely the type of response that has to be overcome and instead an environment of awareness and understanding inculcated.

Stigma and discrimination associated with HIV / AIDS are two of the greatest barriers in the fight against the disease all over the world. South Asia is no exception. They are barriers in the prevention of HIV / AIDS among young people and in providing adequate care, support and treatment. The existence of stigma and discrimination against those who have HIV / AIDS is also linked to the denial of individual's human rights and fundamental freedoms.

South Asian countries are not new to the concept of stigma and discrimination per se. Many existing cultural practices in South Asia already result in stigma and discrimination of various sections of society, particularly women and girls. In such an environment the stigma attached to HIV / AIDS can easily result in the 'underground' growth of the disease. Such an outcome will be highly detrimental because it fuels the epidemic, delays response, allows the disease to grow un-detected and makes it difficult to address through the policies and strategies set in place. Combating stigma and discrimination is a difficult task. Centuries old values, social attitudes and beliefs are seemingly threatened and it is easier to deny the existence of the unspeakable than to admit and take action.

The lessons from Africa and East Asia show that delays in actions can be costly. Yet Thailand and Uganda have shown the effectiveness of actions in dealing with stigma and discrimination by politicians, bureaucrats, religious leaders and communities. These groups need to talk about and encourage open discussion not by making statements once or twice but repeatedly to lead the process of changing attitudes. They need to keep prevention of HIV / AIDS on top of the national agenda. To treat HIV / AIDS as a taboo subject within society – not to be talked about or deny its existence and potential as an epidemic, means delaying actions – a very costly delay. Knowledge about HIV / AIDS should be part of essential education of everyone, particularly young people.

Innovative approaches involving a wide range of partners will have to be found to overcome stigma and discrimination. Lessons from around the world show what works. Strong leadership which is not afraid to repeatedly talk about and act works.

RESULT 2:

All young people are aware about HIV/AIDS and use preventive measures.

An estimated 1.1 million young people aged 15-24 years – 62 per cent male and 38 per cent female - are living with HIV / AIDS in South Asia. Globally more than half of those newly infected with HIV today are in this age group.

To prevent the growth of the epidemic among and through young people, it is important that they know how to protect themselves and practice such measures. In India only four out of ten married women and only 18 per cent of illiterate women have ever heard about AIDS. In Bangladesh, 86 per cent of married girls between 15 and 19 years don't know how to protect themselves. Recent data for Bangladesh and Nepal confirm that knowledge about HIV / AIDS and preventive measures is higher among those wiht more education (Figures 19 & 20).

States and provinces in countries with lower literacy rates generally have lower awareness. However, in some states in India where there has been a concentrated effort awareness about the disease is higher despite low literacy rate (Figures 21& 22). This suggests a two-fold response. One that even as South Asia acts to increase enrolment and learning achievement at the primary and secondary levels of education, it is possible to increase awareness about the disease among the illiterate populations. Countries cannot wait for higher levels of education to have an impact on curtailing the diseases with the long-run gestation period of 5-6 years for primary and another 6-7 years for secondary education. These efforts must be coupled with increasing awareness among the general population.

In every country where HIV transmission has been reduced it has been among young people (and with their determination) that the most spectacular reductions have occurred.

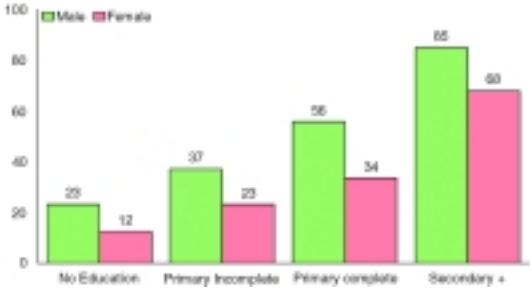
(UNAIDS, Report on the Global HIV/AIDS epidemic, 2002, p.16)

Ten Step Strategy for Prevention of HIV/AIDS among young people

- End the silence, stigma and shame.
- Provide young people with knowledge and information
- Equip young people with life skills to put knowledge into practice.
- Provide youth friendly health services.
- Promote voluntary and confidential HIV counselling and testing.
- Work with young people, promote their participation.
- Engage young people who are living with HIV/ AIDS
- Create safe and supportive environments.
- Reach out to young people most at risk.
- Strengthen partnerships, monitor progress.

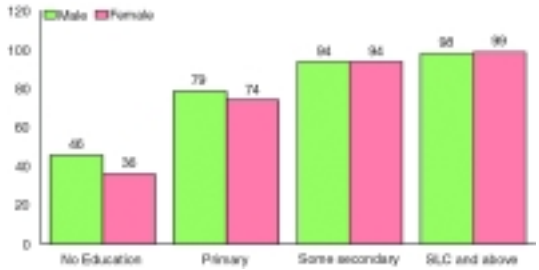
Source: UNICEF, UNAIDS, WHO (2002) Young people and HIV/AIDS – Opportunity in Crisis.

FIGURE 19: **Bangladesh: Percentage of ever-married women and currently married men who have heard of AIDS by level of education**



Source: National Institute of Population Research and Training (NIPORT), Mitra and Associates (MA), and ORC MACRO (ORCM). 2001. *Bangladesh Demographic and Health Survey 1999-2000.* Dhaka, Bangladesh and Calverton, Maryland (USA).

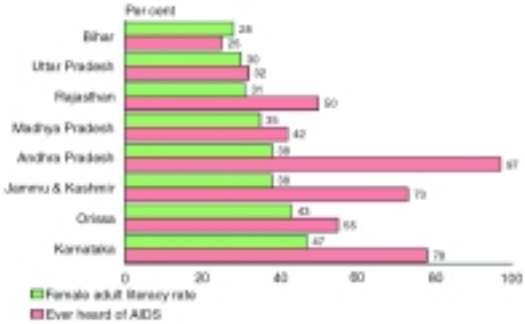
FIGURE 20: **Nepal: Percentage of women and men who have heard of AIDS and who believe there is a way to avoid HIV/AIDS**



Source: Ministry of Health (Nepal), New ERA, and ORC MACRO. 2002. Nepal Demographic and Health Survey 2001. Calverton, Maryland, USA: Family Health Division; New ERA; and ORC Macro.

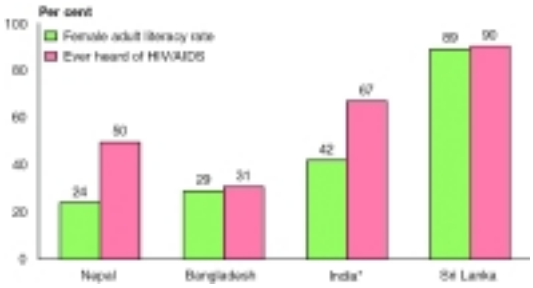
Young people must be part of the army to fight HIV/AIDS and all mediums of communication, particularly through the media, one of the key weapons.

FIGURE 21: **India: Female adult literacy rate and awareness of HIV/AIDS among married women in low literacy states**



Source: United Nations Children's Fund, Multiple Indicator Survey (2000), India Summary Report, Department of Women and Child Development & UNICEF, India, 2000. India Ministry of Health and Family Welfare, National AIDS Control Organisation, National Baseline General Population Behavioral Surveillance Survey, 2001.

FIGURE 22: **Literacy and awareness of HIV/AIDS among ever-married women 15-49 years in selected countries of South Asia**



Note: *Awareness data for India is for married women

Source: Literacy; United Nations Children's Fund, The State of The World's Children 2003, UNICEF, New York, 2002. Heard of AIDS: Nepal: Ministry of Health, New Era, and ORC Macro, Nepal Demographic and Health Survey 2001. Nepal, 2002. Bangladesh: Mitra and Associates, National Institute of Population Research and Training, and ORC Macro. Bangladesh Demographic and Health Survey, 1999-2000. Bangladesh, 2001. India:Ministry of Health and Family Welfare, National AIDS Control Organisation, National Baseline General Population Behavioral Surveillance Survey (2001), 2001. Sri Lanka: Department of Census & Statistics, Demographic and Health Survey 2000, Sri Lanka, 2001.

Strategies for prevention of MTCT

- primary prevention of HIV among prospective parents;
- prevention of unwanted pregnancies among HIV-positive women;
- prevention of transmission from mother to child.

Source: UNAIDS, *Report on the Global HIV/AIDS Epidemic,* 2002.

Experience in South Asia and elsewhere has shown what works among young people. Educating young people about HIV and teaching them how to make informed choices, to abstain from sex, and to be able to say 'no' to pressures to have sex in unsafe situations are critical. To achieve these results, specific actions have to be taken with the right groups on a large enough scale. Underlying the implementation of a strategy for young people must be the firm belief that focus on young people is important as both their right and for achieving results in the fight against HIV.

Young people are not just another target group towards whom actions to halt the disease must be addressed. Young people are able and capable of participating in actions that affect them in this fight and they must be partners. Young people must be part of the army to fight HIV and all forms of communication, particularly the media, one of the key weapons.

Prevention is possible and behaviours can change particularly among young people. If we can prevent HIV / AIDS among young people by changing their behaviours we can choke off its spread in South Asia.

RESULT 3:

The cycle of transmission from mother-to-child is broken.

Every child born has a right to be born free of HIV. Every child born with HIV has the right to treatment and care. The responsibility extends from the mother to the extended family, the community and society as a whole.

There is international agreement on the approach to preventing mother-to-child transmission (MTCT). Experience shows that prevention strategies work. Relatively simple and inexpensive antiretroviral treatment has proven effective in reducing the risk of perinatal transmission and mothers with HIV need to be given the means to make informed choices about breastfeeding in order to reduce the transmisson through this route. However, the strategies that have been identified need to be implemented on a large enough scale to ensure that those affected are able to get the preventive treatment, care and attention that is needed. Unfortunately, doing what is needed is faced with the similar challenge of overcoming the stigma and discrimination. HIV infected mothers and children are stigmatised and discriminated against by their own families and families of their husbands and fathers. Particularly after the death of their husbands, the mother and child are highly prone to being treated as 'outcasts' and being abandoned by their families. The values, attitudes and practices in many parts of South Asia are a major obstacle to the prevention of MTCT. When coupled with stigma and denial, mothers and their children face a grim future. In South Asian countries with inadequate access to and quality of health services, in both the public

and private sector, treatment of mothers and children who are victims of MTCT should be a priority for receiving adequate resources.

RESULT 4:

Vulnerability of young girls and boys and women is reduced by fighting violence, sexual abuse and exploitation

Violence, sexual abuse and exploitation of young girls and boys allows for the rapid growth of HIV / AIDS. Girls are particularly disadvantaged. South Asia has been classified as the most gender insensitive region in the world. For example, it has one of the most distorted sex ratios – 940 females to 1000 males. The gender insensitivity and the status of girls and women in society often leads to the difficulty in them being able to say "No" to their male sexual partners even if they feel that this would be unsafe sex. The roots of the vulnerability of women lie in biological factors with women being more susceptible to sexually transmitted infections and in their social and economic status. The attitudes and behaviour in both men and boys towards women and girls are deep seated in societal norms but they must be challenged and greater awareness created among boys and girls, men and women of the implications of such behaviour on them and their families. Protection measures exist. They have been shown to work. Behaviours have been seen to change and South Asia needs to promote them using strategies that work.

RESULT 5:

There is adequate investment in HIV/AIDS prevention, treatment and care.

It is true that prevention and treatment of HIV / AIDS will cost money. It is also a true that the slower the response and the more the epidemic is allowed to progress along an increasing trajectory, the more it will cost. The costs are not just financial for prevention, treatment and care. Lessons from other countries have shown that there are many types of social and economic costs that families, communities, corporate sector, governments and society as a whole has to bear. In a period of globalisation and increasing dependence of countries on others for their own growth, factors affecting international confidence in countries as potential regions for investment or dependence for their imports can impact negatively on the development of the countries. At a time when South Asian countries are competing with others to be global players and use the benefits of global markets, the cost of combating the effects of HIV / AIDS is something they cannot afford.

Since costs are involved, someone has to pay. Investing adequate resources in the prevention, treatment and care is surrounded by a number of myths. For example, the first myth is that it is largely a private good. It is a myth that the costs are or should be borne only by those who have contracted the disease and their families. Knowing

If we can prevent HIV/AIDS among young people, we can choke off its spread in South Asia.

What works in South Asia in reducing vulnerability of young girls and boys and women due to violence, sexual abuse and exploitation.

Do no harm

- Do not perpetuate gender stereotypes - design interventions based on data on women's and men's lives in particular community or setting
- Do not assign blame to men as perpetrators

Gender sensitive programmes

- Address the gender specific needs of men and women, boys and girls

Transformative programmes

- Community based
- Couple counselling as a method to transform gender relations

Interventions to address violence against women

- Legislative actions and improved enforcement
- Counselling cells, shelters, legal aid services
- Psycho-social services
- Public advocacy

Source: UNICEF/UNAIDS, Violence, sexual abuse and exploitation in South Asia Increases Young Girls' and Boys' vulnerability to HIV/AIDS.

the manner in which the disease is spread and its implications, prevention of HIV / AIDS should be a 'public good'.

Myth 1: Prevention, treatment and care of HIV/AIDS is a private good – responsibility of individuals.

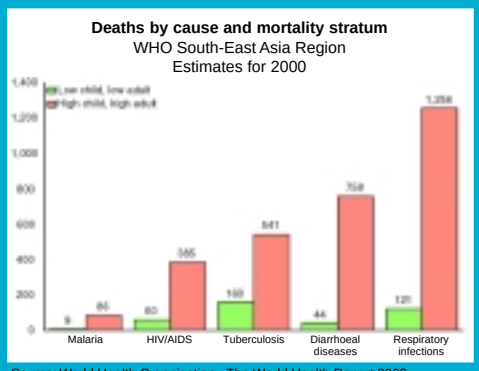
Response: Given the nature of the epidemic and its large scale public consequences, prevention is very much a "public good" and treatment and care must be both a private and public responsibility with the government providing the enabling environment affordable by society.

In the context of South Asian countries, where health systems are not sufficiently developed, treatment, particularly of children, must also be considered a public good. It must be a public good at least for those who cannot afford it or are discriminated against or stigmatised by their families and society. At the same time every effort needs to be made to reduce costs of treatment.

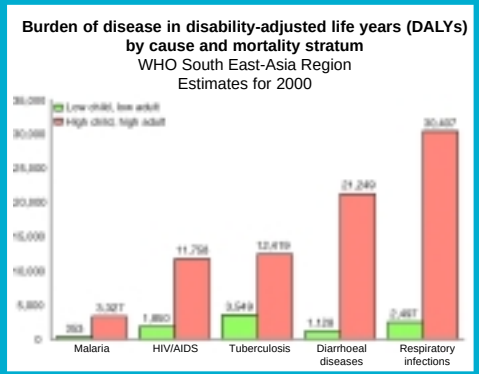
A second myth is that HIV / AIDS is one of many other killer diseases, such as malaria and tuberculosis, that prevail in South Asia and there is a trade-off between investing in its prevention, treatment and care with other public health hazards, some of which currently may be killing more people than HIV / AIDS. Other diseases, which result in death, also need to be addressed, but a trade-off with HIV / AIDS should not exist. No other disease would arguably have the same growth trajectory and the widespread and high costs than HIV / AIDS.

Myth 2: There are many other killer diseases that prevail in South Asia which need to be addressed and which are claiming more lives than HIV/AIDS. There is a trade-off between investing in other killer diseases, such as malaria and tuberculosis, and investing in HIV/AIDS.

Response: Other killer diseases also need to be addressed but a trade-off with HIV/AIDS should not exist. There is no other disease, which has the same trajectory and potential for growth as HIV/AIDS and its devastating consequences.



Source: World Health Organization , The World Health Report 2002, Reducing Risks, Promoting Healthy Life, WHO, 2002.



Source: World Health Organization , The World Health Report 2002, Reducing Risks, Promoting Healthy Life, WHO, 2002.

Various attempts have been made to estimate the costs of prevention, treatment and care of HIV / AIDS. These costs have also been extrapolated to indirect cost implications for the country as a whole. Estimates for India by the World Bank in 2000, when there were around 3.5 million infected persons, indicate that it would cost around $159 million for prevention as opposed to $1000 million for treatment resulting in unit costs of $45 for prevention and $286 for treatment.

It is no doubt possible to project costs for prevention and treatment. All countries in South Asia should be encouraged to do so. The bottom line is that the cost of treatment can be astronomical and there is value and virtue in preventing them from becoming reality. Cost estimates have been an effective advocacy tool in Thailand since they can shock the society and leadership.

Combating HIV / AIDS is an investment in the future of South Asia and its children and young people. The cost of prevention should be eminently affordable if considered in the context of the discounted future benefits of having combated the disease successful. While countries continue to invest in the prevention of a large-scale epidemic and the reversal of the current epidemic, investment is equally needed in treatment and care of those infected. It is only when they are treated on an equal footing that it will be possible to achieve more than what would be accomplished by investing in prevention alone.

The issue is not only how much needs to be spent to curb the epidemic or how much is being spent but what results have been achieved so far and who is accountable.

Accelerating the momentum in the fight against HIV/AIDS requires accountability and monitoring of results

This paper has argued that there are lessons for South Asia in the HIV/AIDS experience of Sub-saharan Africa and East Asia both from countries that are in the midst of an epidemic and those that have managed to control it. It has argued that in terms of some key social and economic indicators, South Asia is worse off than many of the Sub-saharan African countries, which are suffering from the epidemic. South Asia cannot afford to add HIV/AIDS to its many existing challenges. It must act firmly to combat it early.

Experience in South Asia shows that the region is capable of taking action but results are slow to come. This should not happen in the case of the response to HIV/AIDS. Governments and civil society in South Asia have not been complacent to the threat of an HIV/AIDS epidemic. A number of actions have and are being taken. However, to guide the process of achieving results it is equally important to assign accountability for various actions and results and to effectively monitor them on a timely basis.

The government, corporate sector, families and individuals are all accountable and responsible for their actions but leadership must come from the government. The accountability chain starts with the government and leaders at the central, provincial/state level and extends to the district and local governments, sub-district and village committees, schools and communities, and families and individuals. While the responsibility to protect people, particularly children and young people, from HIV/AIDS is universal, accountability must rest with government and leaders to ensure that results are achieved. The challenge is to have accountability and effective monitoring mechanisms which will ensure progress in the fight against HIV/AIDS at an accelerated pace.

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