

REDEFINING AIDS IN ASIA

Crafting an Effective Response

Report of the Commission on
AIDS in Asia

Presented to
Mr. Ban Ki-moon,
UN Secretary General,
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Executive Summary

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

THE STATE OF THE AIDS EPIDEMIC IN ASIA

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

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

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

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

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

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

Pooling recent calculations from various Asian countries, the Commission estimates that up to 10 million Asian women sell sex and at least 75 million men buy it regularly. Male–male sex and drug injecting add another 20 million or so to the number of men at high risk of HIV infection once the virus enters those networks. A portion of those men, particularly injectors, may also pass HIV on to the women with whom they regularly have sex, which means that several million more women are also at risk.

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

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

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

NATIONAL RESPONSES TO HIV AND AIDS

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

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

Political engagement and support are vital prerequisites for setting the agenda and driving a potentially effective response. When dealing with issues of stigma and discrimination, and overcoming taboos against the public discussion of sex and sexuality, the role of leaders cannot be underestimated. Clearly political leadership on HIV in Asia holds the key.

Many Asian countries have established National AIDS Commissions (NAC) but a brief overview shows that their political status, authority, capacity, and responses vary greatly. National AIDS Commissions, on the whole, have not been able to effectively coordinate the AIDS response in their countries; too often they lack the mandate required, the secretarial

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

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

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

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

The extent of coverage is vital if prevention programmes are to be effective. Modelling indicates that about 60 per cent of most-at-risk populations need to adopt safer behaviours if HIV epidemics are to be reversed. Importantly, to achieve that level of behaviour change, service coverage has to reach at least 80 per cent.

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

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

the region. In most Asian countries, sex work, drug use, and sex between men remain criminal activities. The criminalization of such activities clearly neutralizes otherwise supportive HIV policies, unless law enforcement agencies and the judiciary can be persuaded to cooperate with such policies. This is more likely to be achieved through political leadership at the highest levels.

COMMUNITY INVOLVEMENT

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

Unfortunately, such involvement is uneven in Asia and in many places is tokenistic. At its most basic, the participation of communities is essential to reach people with information they are likely to trust. Studies in Asia have shown that in some sites, peer outreach workers succeeded in reaching 80 per cent of drug users, where other conventional Government and social mechanisms have failed. Similarly, in a study of over 6,000 sex workers, in the Indian state of Andhra Pradesh, sex workers who did not participate in a sex worker support group were four times more likely to report only occasional or inconsistent condom use, compared with their colleagues who belonged to such groups.

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

The smaller size of community-based organizations makes them less bureaucratic than their Government counterparts, and gives them the flexibility to respond quickly to new situations. If programmes piloted by community-based organizations prove successful at the local level, Governments can consider scaling them up to national level. For example, in China men who have sex with men set up community hotlines to provide support and information on HIV and other issues. By 2007, the Government recognized the importance of working with this group and was funding programmes to support them.

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

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

THE FUTURE OF THE EPIDEMIC IN ASIA

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

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

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

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

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

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

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

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

Although evidence shows that casual sex among young people remains a minor factor in Asia's HIV epidemics, significant resources have been aimed at trying to discourage such behaviour among young people.

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

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

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

THE MANY IMPACTS OF HIV

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

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

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

ADDRESSING CONTEXTUAL FACTORS

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

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

HOW MUCH MONEY IS NEEDED TO CURB HIV IN ASIA?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

POLICY RECOMMENDATIONS

Leadership

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

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

Environment

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

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

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

Impact of Interventions

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

Resources

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

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

Interventions

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

Community Involvement

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

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

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

STRATEGIES AND PROGRAMME IMPLEMENTATION

A. Prevention

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

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

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

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

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

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

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

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

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

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

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

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

B. Treatment and Care

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

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

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

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

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

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

C. Impact Mitigation

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

D. Organizational Issues

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

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

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

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

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