Speech

Asia and Pacific Overview of the HIV Epidemic and Response

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By

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Good morning distinguished guests, colleagues and friends.
My job today is to give you a brief overview of the epidemic and the regional responses to it. We'll look at where we are today, how we got there, where we'll be if we do nothing, and the state of the response (both regionally and in certain key countries.)
In keeping with the Congress Theme, "Bridging Science and the Community," I'll start with some figures on the epidemic.
That way we will all be working from the same information base before I go to the more contentious issues – what does the data mean, and what do we do about it?
My main message, and the principal thought I want you to leave this session with, is the following**:** There is no let up in the relentless progress of the epidemic in this region. Quite frankly, time is running out to deal with this epidemic at relatively low cost.
We know what needs to be done – that isn't the problem.
Countries need to scale up responses quickly, bridge the shortfall in financing, and target resources where they will do the most good. The UN agencies need to provide better coordinated support. Civil society and the private sector all have essential roles to play.
If they do so, millions of men, women and children will stay free of HIV infection, millions of lives will be saved, and major economic losses will be avoided. We all know this.
And the choice is still ours. But it won't be for long.
So, let's begin with a look at the epidemic itself and its trajectory in this region.
The first thing to understand is the dynamic nature of the epidemic. One way to look at it is through national prevalence over time.
Let's go back to 1985. At a time when alarm bells were ringing in Western Europe, North America and Africa, in this region prevalence was at undetectable levels. But that didn't last long.
Within eight years, already Thailand and Cambodia have over 1 percent prevalence among adults. Major parts of India, and Myanmar register concentrated epidemics and certain parts of these two countries show measurable prevalence in the general population.
1998. Enter Nepal, China, Malaysia, and Papua New Guinea as concentrated epidemics. Prevalence rises in India and Myanmar.
In 2004, almost the whole map has filled up with concentrated epidemics – meaning over 5%

prevalence among certain vulnerable groups.
Of all the Asia-Pacific countries, three in Asia currently have epidemics with more than 1% prevalence among the adult population: Cambodia, Myanmar and Thailand. There is also one country in Pacific – Papua New Guinea - where a severe epidemic is erupting.
HIV continues its rise in China, India, Indonesia and Viet Nam. Only Laos, Bangladesh, Japan, Korea, Philippines, Mongolia, and Sri Lanka remain low-prevalence. Now Asia has the world's second highest levels of HIV infection, after Sub Saharan Africa
Where does that leave us today, in terms of prevalence?
At the end of 2004, we estimate that 8 million adults and children were living with HIV, and the region accounted for over a million new cases during the course of the year. Over half a million people died of AIDS.
By taking a look at prevalence rates, the denialists way cheerily say "Well, that's a relief: 99% of population is un-infected" and where is the problem.
A big mistake.
National prevalence is a useful figure, but it can also obscure important information if it is your only focus. It hides millions of current infections, and sky rocketing infection rates among population subgroups, as can be seen in this next map.
These are the locations that not only have high prevalence among the general population or population sub-groups, but represent millions of people in absolute numbers.
The magnitude of the populations makes direct comparisons difficult with other parts of the world. Take India, for, example. India's adult prevalence is under 1%, but that is 1% of just over a billion people. That means India has nearly as many people living with HIV as South Africa - where prevalence exceeds 20%.
Or take China, The HIV prevalence rate in China is one-seventh that of Brazil, but China has about 180,000 more HIV-infected people than Brazil. In Asia, prevalence rates are therefore misleading. It is a question of real numbers, not percentages. Please also remember you are seeing a partial picture here, as provincial data is unavailable in many places.
The picture also changes greatly when we look at the sub-national level of specific states or provinces wherever data is available
In Myanmar, the national prevalence is about 1.4%, as indicated in the red bar. But two provinces are at or above 5%. Cambodia has a similar situation.
What does this mean in terms of mortality? In sub-national areas with their own advanced epidemics, the toll on life expectancy is comparable to that in certain parts of Sub-Saharan Africa, while one does not witness dramatic changes in national figures.
Let's move back to looking at the impact on development in the region as a whole. Despite its relatively low prevalence, the epidemic is already causing serious injury to the region's developmental gains.
By pushing millions of households further into poverty each year, particularly in rural areas and poorer provinces, it is undermining regional efforts to meet the Millennium Development Goals. This is especially so in the case of MDG 1, which aims to half by 2015 the number of people who live below the poverty line.
The Asian Development Bank and UNAIDS recently modelled these impacts. Because of AIDS, and in the absence of an extraordinary response to the epidemic, poverty reduction in India will be slowed by up to 23 percent each year between 2003 and 2015. This will put India back by an additional 3 to 5 years, if the current scale of response to the epidemic continues.
In more fragile economies, the impact will be even worse. In Cambodia, progress toward poverty reduction will be reduced by up to 60 per cent per year until 2015.
The message is loud and clear: In spite of spectacular economic growth and prosperity in Asia, poverty will deepen unless the HIV epidemic is addressed.
Moreover, except for Thailand and Cambodia, at the current level of response the region is going to miss Millennium Development Goal indicator 6, which aims to reverse and halt the HIV/AIDS epidemic by 2015.
Now let's step back a bit and deconstruct the epidemic in order to think about how to tame it.
As we saw earlier, the first epidemic in this region occurred in Thailand in the late 1980s. Since then, the pattern has been seen again and again in different countries. The epidemic starts among most vulnerable groups such as IDUs and sex workers, and rates of new infection among these groups rise rapidly. If there is a successful intervention the rates of new infections gets proportionately higher among the general population.
Most countries in Asia are still on the rising part of the curve, so a large scale epidemic can be avoided if carefully focused prevention work is done now.

You will get a report released today by the "Monitoring the AIDS Pandemic Network" (or MAP) that describes in great detail how the most vulnerable groups are affected country by country in this region. To give you some figures: HIV prevalence among estimated 3 million IDUs is still on the rise varying from still less than 5% in Laos. Singapore, Bangladesh and Pakistan and more than 20% in Viet Nam, Myanmar, India, Nepal, China, Indonesia, and Malaysia with some sites reporting as high as nearly 90% showing no signs of stabilization in any country .

Male-to-male sex is present in almost all countries, and a large percentage of these men also seem to be engaged in heterosexual behaviour. Moreover, one should not lose sight of the fact that most of them are young people.

In the Pacific, and most visibly in Papua New Guinea, the epidemic works rather differently. Instead of being centered within identifiable vulnerable groups the epidemic is driven by widespread multi-partner sex between men and women.

Unlike in Asia, where prevalence is almost three times higher among men than among women, the male-female ratio is close to even. That is much more the pattern we have seen in Africa, and it takes different prevention strategies to deal with it. Papua New Guinea is therefore of great concern to all of us

So that is the situation. The question is, what can we do about it?

If national responses remain as they are today, we are all in deep trouble. A recent estimate suggests that, if nothing changes, 12 million new infections could occur in the Asia-Pacific region between 2005 and 2010. That's the top line in this graphic.

But it doesn't have to be that way. As the lower line shows, if the region undertakes a determined response of comprehensive prevention, care and treatment, new infections can be held to 6 million.

This will enable the countries to achieve their Millennium Development Goal on HIV /AIDS in time. It is therefore a make or break situation.

As I said earlier, we know what to do. We just aren't doing enough of it.

For example, we all know the list of HIV prevention strategies that are available and have proven effective.

Here is the minimum "package" of interventions, both preventive and care, that we need to make a difference:

- *For sex workers(female and male) and their clients*: prevention of sexual transmission by promotion of condoms, lubricants and treatment of STIs, along with outreach programs and a supportive environment
- *For injecting drug users:* clean needle distribution, and substitution treatment
- *For young people*: behaviour change interventions, including delay of sexual intercourse, monogamy, and use of condoms
- *Voluntary counselling and testing* so people know if they are infected or not
- *Prevention of mother-to-child transmission.*
- *Increased access to antiretroviral therapies and other treatments for people living with HIV*.

In terms of prevention, some of the best strategies were pioneered here in Asia and Pacific. Most notable are Thailand and Cambodia, where the epidemic has been reversed, and Philippines and Bangladesh where epidemic has been kept low. At project level, successful interventions have been demonstrated in India, Indonesia, China and Nepal.

However, the desired impact of a scaled-up response can only be achieved if there is adequate coverage and the response is comprehensive.

The message is that success does not lie in merely carrying out these intervention activities in isolated locations without reaching the critical coverage threshold.

For example, we calculate that if we ensure a 60% level of safe behaviour among key vulnerable groups such as sex workers and their clients, the epidemic can be reversed among those groups. Similarly, 80% of eligible HIV positive persons should receive anti retroviral treatment by the end of this decade for ensuring a comprehensive response.

Why do we need a comprehensive response and not only prevention or only care?

We have examined this in three different scenarios for the future, as I am going to explain in my next slide.

- Scenario 1 is the "No new action" or "Baseline" scenario, which continues the current

2004 levels of prevention and care

- Scenario 2 is a "Treatment centred" scenario, which means expanded antiretroviral access, but prevention stays at the 2004 level
- Scenario 3 is a "Comprehensive Response" where we achieve the minimum package of 60 % prevention and 80% expanded ART by 2010.

We can see that even in the "treatment centred" scenario the financial burden is going to increase in 2015, despite initial gains. What difference will scaling up make to the situation? If we can launch a comprehensive and scaled up response we can see a dramatic change.
By simultaneously scaling up prevention and treatment, cumulative AIDS mortality and new infection by 2010 could be cut by nearly 50%, and annual HIV prevalence in the year 2010 alone reduced by over 40%.
In addition to reducing mortality and prevalence, a comprehensive response could also save billions of dollars by preserving productivity, reducing the economic and social burden on households, and averting or delaying substantial medical costs. As the slide indicates, by 2010, overall annual financial loss can be reduced from an annual figure of US$ 29 billion to US$ 17 billion.
So, if we know all this, how well are we currently doing in our response on a regional level?
The answer is, unfortunately, that the region is falling well short of minimal coverage targets.
Let's look more closely at targets in terms of prevention and care.
A study of 16 countries in the region showed that HIV prevention programmes were reaching only 19% of sex workers, 5% of injecting drug users and 1% of men who have sex with men. Over all, only 8% of all casual sex acts were protected by use of a condom.
We don't need to look far for the explanation. These populations are marginalised and stigmatised across the region. The MSM community is invisible to most policy makers in Asia and the Pacific. In most places, sex workers and injecting drug users are not priority for intervention programs
Care and treatment coverage is similarly low in many places, despite the lower drug costs now available.
In spite of progress in Thailand and Cambodia, few of the region's HIV-positive individuals who need ART are receiving it. For example, although India has a thriving pharmaceutical industry and the second largest numbers of HIV-positive people in the world, only 5% of individuals who need ART currently receive them. The coverage is inadequate in countries like Viet Nam and China as well.
The sad reality is that countries in Asia and the Pacific are not yet carrying out a response capable of reversing the epidemic. I'm not saying that we need 100% coverage for the entire population. What we need is to meet these critical coverage thresholds on prevention and care for specific groups, using the proven strategies I mentioned earlier.
Some realities such as the silent pain due to stigma and discrimination, the positive people face in this region are not even captured by these coverage data,
The reasons for this inadequate response are many. It would be wrong to blame any single group or sector – it is the responsibility of everyone, including national governments, the United Nations agencies, the donor community and civil society.
Let us look at the situation in our host country, Japan. After a long period of stability the total number of new infections is increasing, with a significant jump registered last year alone. Prevalence is also increasing in certain vulnerable groups, particularly men who have sex with men. On the programmatic side, prevention still does not adequately target vulnerable groups like injecting drug users.
Obviously, the problem is one NOT of resources or know-how. Japan is economically one of the most advanced countries in the world. The only explanation, surely, is low prioritisation.
The problem of low commitment is visible in a number of ways. Among 14 countries recently surveyed by UNAIDS and the Asian Development Bank, the Head of State or Prime Minister presides over the National AIDS Committee in only two. This is a critical shortcoming, as the active leadership of a country's top political figure is a major component of successful national programmes.
All countries have multi-sectoral policy whereas only three has own budget and targets for non health Ministries.
On the M&E front, only three countries carry out systematic tracking of the epidemic and only one has a national monitoring system.
And of course, financial resources remain a serious concern.

Available resources are far short of the amounts needed to finance an effective, comprehensive response. This estimate shows that while available funds are currently expected to rise only from US$ 1.2 billion in 2005 to US$ 1.6 billion in 2007, resource needs will more than double from US$ 2.3 billion to US$ 5.1 billion.
However, I would suggest that the funding problem is more artificial than real.
This region is one of the most economically dynamic in the world, and as a whole can easily cover these costs. It is calculated that even investing the full US$ 5.1 billion annually amounts to just 4 per cent of current regional health expenditure several countries in Asia could easily increase public sector investment in their national responses.
The story is different in resource constrained countries. Clearly, donors will be needed to make up funding shortfalls or even to totally fund national efforts. One disturbing development in some countries of the region is the decrease in national commitment to fund prevention programs. This is largely, I think, because of successes that these countries have had in the past.
Here, we can see that the national AIDS budget in the Philippines has fallen sharply since 1998.
This is also the case in Thailand, where there are fears that reduced prevention efforts may provoke a resurgence of HIV. The situation seems worse given that prevention programmes for the country's growing numbers of IDUs have received only limited government funding. The same is true of programmes aimed at men who have sex with men, despite rising infection rates in this population.
A final problem is that policy does not translate to action. Some countries with well-designed policies for vulnerable groups have not actually allocated budgets or developed operational plans.
That said, money alone will not solve the problem. I'd like you to look at a slide which I can not resist showing with animation.
This clearly makes a case for co-ordination and role definition under the Three Ones: one national AIDS coordinating authority, one national AIDS action framework, and one monitoring and evaluation system.
If some of the government responses are inadequate the same applies in varying degree to other partners.
For example, the UN system's work at country level is not without its problems. In many countries, the UN Theme Group on HIV/AIDS has not managed to establish a truly joint programme covering the AIDS activities of all UN cosponsors.
There are also problems with multilateral institutions. A prime example is the overlap in program financing between the World Bank and the Global Fund. Instead of concentrating on what each is good at, they often finance the same types of HIV/AIDS activities. In a number of countries, there is overlap or disharmony between the national AIDS coordinating authority, on the one hand, and the Country Coordinating Mechanism of the Global Fund on the other.
These observations are not my personal judgements. They are contained in a very recent report of a Global Task Team on intensifying the AIDS co-ordination among multi- lateral institutions and international donors.
Civil society organisations do excellent work in their own specialised field with marginalised and sometimes "hidden" vulnerable groups. However, the full potential of civil society, including organisations of people living with HIV/AIDS, has yet to be realised. While it is true that some governments are indifferent or hostile to NGOs, it is also true that lack of coordination among civil society organisations stops them from putting maximum pressure on governments to prioritize AIDS. As well, too often the funding secured by civil society organisations pays only for specific activities and does nothing to build their capacity to improve or extend services.

A variety of other issues must be mentioned while we are on the subject of why responses are inadequate. Gender gets far too little priority in this region. Gender inequality contributes to the spread of HIV by increasing the vulnerability of women and girls. Just to take one example, it is tragic but true that marriage is no guarantee of safety from HIV for many women. Studies in Cambodia, India and Thailand have found that husbands represent the primary source of HIV infection for women.
Another problem is that too many HIV/AIDS activities in this region are event-based. By that, I mean resources are focused on meetings and presentations and shows, much of it in major cities. These may be noticed by the media, and attended by important people, but they

don't actually change behaviour or reach the people who are most at risk. In this region, with its concentrated epidemics among vulnerable populations, interventions have to be applied on a sustained basis, not through one-off events. This will only be possible if grass roots level community based organisations are involved in HIV/AIDS programmes to bring in the much needed sustainability.

By now you may be wondering if I have anything encouraging to say about the region, rather than just presenting the problems.

Well, I do.

I truly believe we can still avert a devastating expansion of the epidemic. But to do so, several things have to happen.

First, we can't take general approaches to specific problems, and spread our efforts too thin over a wide canvas. We have to prioritise our actions based on solid quantitative and qualitative data, and on the needs of those affected or infected by HIV/AIDS.

Second, we need much stronger leadership by national governments. Governments must be guided by the evidence, not by what is politically expedient. For example, injecting drug user, MSM and sex worker interventions are not popular, but they work. True leadership means accepting and acting on this, and doing it in the most public and vocal way as Malaysia has recently done.

Third, we need unified support from international community. We can't afford the overlaps, gaps and inconsistencies in programming that are currently visible due to lack of coordination. A lot of soul searching needs to be done by the external partners in dealing with Asia and Pacific. The needs of the region, and its strengths and weaknesses, must be carefully studied and understood by the international community.

Fourth, we need energetic civil society participation, by organisations that work with governments as partners but equally ready to criticise and lobby when necessary. Grass roots community based organisations doing excellent work in social sector programs need to be mobilised for HIV/AIDS work also.

And finally, we need to find the money, and to spend it efficiently. All the science, all the leadership, all participation in the world will mean nothing if we don't invest sufficient funds to reach the critical coverage levels I mentioned earlier.

Why am I so confident that this is possible, and that these conditions can be fulfilled in this region? It is because the Asia and Pacific region has repeatedly proved itself equal to major challenges. To mention only two: the responses to SARS and to the recent Tsunami show what we can do in a crisis. When we need to, we can mobilise rapidly, assemble the resources, and become extremely creative in figuring out solutions to all manner of problems.

In the final analysis, I think only real barrier to scaling up the response to HIV/AIDS is one of perception. The virus doesn't kill hundreds of thousands at a thunderous stroke, and it doesn't provide vivid television pictures. Rather, it is a Silent Tsunami.

What we need is for decision-makers and ordinary citizens alike to perceive the tragic impact of the epidemic over time, and its growing potential for devastation in the region. That, I believe, would galvanise what we might call an "emergency-like response" to the epidemic.

In summary then, this region still has an opportunity that has passed other regions by. Most of our countries can still carry out effective responses at relatively low cost – if they act now and stay focused.

I hope this Congress will contribute to convincing decision-makers to take advantage of this opportunity.

We <u>can</u> do it. If only we do it right and do it fast.

I would like to finish my speech by a metaphor from Africa that I have adapted for Asia, When we all go away from this conference we should ask ourselves this question : are we all involved in the process or in the result?

If not what more we need to do? All of us should ask ourselves this question.

Thank you.