CHECK AGAINST DELIVERY

Statement by Dr. Nafis Sadik
Special Adviser to the United Nations Secretary-General and Special Envoy for HIV/AIDS in Asia and the Pacific at the

Asia-Pacific Women, Girls and HIV/AIDS Best Practices Conference

Islamabad, Pakistan

29 November 2004

I am delighted to be here on behalf of the Secretary-General and UNAIDS. I am even more delighted that His Excellency the Prime Minister, Hon. Shaukat Aziz, could be here. It demonstrates not only his support for our conference and for the women and girls of the Asia-Pacific region, but his personal commitment and that of Pakistan's Government to confront the HIV/AIDS pandemic.

Introduction

I am here with only one simple message to you as policy-makers and leaders of civil society: HIV/AIDS is the greatest long-term threat to human security, human rights and economic development that the Asia-Pacific region will face in the next decade. Asia-Pacific countries need to act against HIV/AIDS, and they need to act now. No matter what other priorities you may have, no matter what your agenda, fighting HIV/AIDS should be part of it.

There is no cure for HIV/AIDS and none is in sight. The cost of treatment for large populations living with HIV/AIDS is beyond the reach of any government in the region. The social and economic cost is even heavier. At this moment, in the most seriously affected countries in Africa, economic growth is disappearing and societies are collapsing—even in prosperous middle-income countries like Botswana. It could happen in this region: it will happen, unless we act. Prevalence rates are still low in most parts of most countries; but this is rapidly changing.

Let me emphasise – all the conditions are in place for a general outbreak in Asia-Pacific the next ten years.

Experience shows that there is a way to fight HIV/AIDS successfully: by focussing on prevention, and on those most at risk. In the Asia-Pacific region, those most at risk are largely women and girls. Success calls for determination, for focus, and above all for leadership. That is why we are here.

Let me very briefly outline the situation in the region today, and then give some pointers to the future.

The emerging epidemic in Asia

- More than eight million people are already living with HIV/AIDS in Asia and the Pacific, five million in India alone. Over half a million people are dying each year. HIV/AIDS cost the region US$7.3 billion in 2001.
- In 2003, when countries needed US$ 1.5 billion to mount a comprehensive response, they could find only US$200 million from all public sector sources, governments and donors combined.
- This means, for example, that fewer than one in six of the estimated 2.2 million sex workers in South-East Asia receive basic prevention services; only one in 50 pregnant women in the Western Pacific are reached by programmes for preventing mother-to-child HIV transmission; of those who need immediate AIDS treatment, less than five per cent have access to the medicines that would keep them alive.

So far, in most parts of the region, HIV/AIDS has confined itself to the high-risk groups. Prevalence rates are still low. But I want to make two points:

- First, when the infection moves out of the high-risk groups it spreads very fast through the general population. The so-called "low and slow" epidemic is a myth;
- Second, the term "high-risk groups" describes people's behaviour, not their location. The high-risk people are part of our communities and our families. For example, how many of you in this audience:

    - Know of someone who abuses alcohol or drugs?
    - Know of someone who abuses his wife or daughters?
    - Know of someone who goes to sex workers, male or female? Or
    - Know of someone who has sex outside their marriage?

If you can think of anyone in any of these categories, then HIV/AIDS is already close to your life. These are the high-risk behaviours that help to spread infection. The pandemic is already among us: that alone should be a reason for action.

Without action, ten million adults and children will be newly infected between 2004 and 2010; the annual death toll will be over 750,000 by 2010

(compared with 500,000 in 2003); by 2010 the economic cost will be $17.5 billion.

A widening pandemic will mean the end of efforts to eradicate poverty, and empower women and girls, who are most of the poor. Even in Thailand, which has a relatively strong HIV/AIDS programme, an ADB-UNAIDS study suggests that the pandemic may slow poverty reduction annually by 38 per cent between 2003 and 2015. It could slow poverty reduction by up to 60 per cent a year in Cambodia, and by nearly a quarter in India.

In broad terms, Asia-Pacific is where Africa was 12 or 13 years ago. What is happening to the worst-affected countries in Africa could happen here. Let me emphasise: there is nothing whatsoever in our cultures or lifestyles to prevent an African-scale outbreak of HIV/AIDS in Asia. All we can rely on are our foresight; our willingness to learn from the bitter experience of others; and our determination to act.

Women and girls – suffering in silence

We are here to make the case for investment in women and girls. Worldwide, women are almost half of all HIV/AIDS cases. In Asia-Pacific about a third of all infections are among women, and the proportion of women among the newly-infected is rising.

The ***physiological*** fact is that women are more than twice as vulnerable to HIV/AIDS infection as men. The ***sociological*** fact is that women's subordinate status, in marriage and in society at large, makes them many times more vulnerable.

At the same time, women's work underpins the region's economy; and their many other daily roles – as housekeeper, cook, health aide, educator, child-care specialist or nutritionist, for example – hold the family and community together. As a matter of human rights, it is intolerable to expose Asia-Pacific's women unnecessarily to HIV/AIDS; as a matter of practical economics, it is insupportable.

Young women

Between one-half and two-thirds of new infections are among young people 15-24, and a disproportionate number among young women. In South Asia, for example, young women are 62 per cent of infections in the 15-24 age group. This clearly points to the involvement of "experienced"

older men, within marriage or outside it. A survey in India showed that more than a quarter of male clients of male sex workers are married or living with a female partner.

Married women

The closer we look, the more we find to disturb us. For example, recent research in the region shows an unsuspected high incidence of sexual violence and coerced sex on the part of husbands towards their wives. Many of these women are young, some of them very young. They have no redress and no-one to turn to. Cultural norms across the region, especially in the rural areas and among the urban poor, give no encouragement or support to a wife who resists her husband for any reason. In most areas of her life, including sex, she has no choice. Research in South Africa has shown that women in violent or coercive relationships are 50 per cent more likely to contract HIV infection. There is no reason to suppose that the picture is any different in Asia-Pacific.

One result is that in India, for example, more than 90 per cent of HIV-positive women are married and monogamous. I am sure the finding could be replicated elsewhere in the region. What does this say about the men concerned? What does it say about the society that conventionally blames and penalises the wife for her husband's infection?

Sexual violence within marriage is coming under scrutiny and criticism in many countries. I wish I could say the same of sexual abuse of young girls within the family. Here too we find girls suffering at the hands of the men closest to them; and here too we find a culture of silence, to match the silence that surrounds HIV/AIDS.

MTCT

There is little hard information on how many infected women in the region give birth, and how many of their children are themselves HIV-positive at birth. This is itself a reflection of widespread indifference and neglect towards women's concerns – but where the information has been collected as in Thailand, we find that about one-third of children born to infected women are infected at birth. Thailand has made a commitment to provide anti-retroviral drugs to all pregnant women, but it is among the very few countries to do so.

Many married women find themselves in a dilemma when they become pregnant. If they suspect they might be HIV-positive, voluntary counselling and testing may be available; but revealing their status may mean rejection by their husband and condemnation in the community. In many cases, VCT will not help them, because services and care are not available; so many cases go undiagnosed, and many mothers and children suffer in silence.

The complete answer to the suffering of married women lies first in empowering women with health care, education and the power of the purse; and second in changing the behaviour and underlying attitudes of men. This must be a focus of government and civil society activity. It is a hard lesson for men to learn, but eventually they must understand that their interest lies in safety for their wives and children.

In the meantime, programmes must serve women's needs, whether for VCT, advice and care for HIV infection, child care, contraception, or condoms. Education is equally important for married and unmarried women, both for the confidence and self-esteem it brings, and for their access to health information and services. At the moment, 80 per cent of women in Bangladesh, for example, have never even heard of HIV/AIDS.

Civil society and non-governmental organisations are the essential allies of government in the battle to make women the focus of HIV/AIDS prevention. Governments should see strong women's groups as an asset, not a threat. Their demands are realistic and based on human rights as well as women's needs. They can provide information and services for people in places the government cannot reach, and they can identify needs in many cases earlier and more accurately than government.

Sex workers and IDUs

Among NGOs' important contributions is the ability to work with groups on the margins of society, among whom are many of those at highest risk, such as intravenous drug users and sex workers. Sex workers are usually female, highly vulnerable to HIV infection and highly likely to pass it on. UNAIDS found that one in five sex workers in Bangladesh, for example, was HIV- positive. Regulating sex workers and insisting on checkups and the use of condoms can cut infection rates drastically, as Thailand has found. Needle exchange and addiction treatment can help drug users avoid infection, removing another high-risk population from the picture.

The future

But I repeat; high-risk populations are part of society at large. Programmes must be comprehensive; and they must focus on women and girls.

If Asia- Pacific leaders immediately put in place comprehensive HIV/AIDS prevention and care, they can dramatically reduce the number of new infections and the cost of the epidemic in the region.

We are at a make-or-break stage in the fight against AIDS. $5 billion a year in comprehensive HIV/AIDS programmes can avert five million new infections and avoid 100,000 deaths every year by 2010.

In case $5 billion seems like a lot of money, you may wish to reflect that a careful study of the world's most serious problems by eight top economists, among them three Nobel laureates, found that HIV/AIDS offered the best way to spend limited resources. The list of problems included civil conflicts, climate change, hunger and malnutrition, education, governance and financial stability. Of all these problems, the economists said, fighting HIV/AIDS offers the best return on investment.

But leadership against HIV/AIDS calls for change. Leaders must be willing to challenge entrenched attitudes and ingrained ideas – not least, attitudes and ideas about sex, marriage and gender relations. This is not a matter of conservatives versus progressives, of culture versus materialism, or any such thing. It is a battle for survival, first and foremost—and at stake are the very cultures that backward-looking people claim to protect. And it certainly is about ethics—but what ethical value supports the oppression and abuse of women? What ethical value allows coerced sex and enforced infection? What ethical value says that women should have no choice over whether they live or die? If those who claim to teach us about ethics hold such views, we will not argue with them. We will ignore them, and move on.

The question is whether Asia-Pacific countries' leaders are willing to put their leadership to the test. We have a good example here in Pakistan, where the Honourable Prime Minister has made a personal commitment to confront Pakistan's nascent HIV/AIDS epidemic. I hope he will find plenty of enthusiastic colleagues, keen to follow his example.