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**POLICY ISSUES FOR THE ESCAP REGION: INTEGRATING ECONOMIC  
AND SOCIAL CONCERNS, ESPECIALLY HIV/AIDS, IN MEETING  
THE NEEDS OF THE REGION**

(Item 3 (b) of the provisional agenda)

*Note by the secretariat*

**SUMMARY**

HIV/AIDS poses an emergency development challenge. It has serious implications for all aspects of development, including human resources development, educational progress, health care, agriculture and food security, industrial productivity and commercial transactions. Falling life expectancy, increasing numbers of orphans and the break-up of households and communities are among the costs. No country in the region, however large, and no territory, however small, are immune from the virus. At the end of 2002, an estimated 7.5 million adults, youth and children were living with HIV/AIDS in Asia and the Pacific. With approximately 62 per cent of the world's population living in the region, even a relatively small rise in overall HIV prevalence would add millions to the ranks of people living with HIV/AIDS. An expanded and comprehensive response can help to prevent the number of people living with HIV/AIDS from soaring. Governments in the region have a window of opportunity to act now. Unless immediate action is mobilized throughout the region, and takes root at all levels of society, many economic and social gains may unravel over the next decade. HIV/AIDS does yield to human intervention. The situation calls for courageous and visionary leadership. Choices are proposed for tackling the pandemic as a development issue; they underscore prevention, with special attention to care, treatment and support.



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## I. SUSTAINING ECONOMIC AND SOCIAL GAINS

### *(a) Developments*

1. The integration of sound economic policies with social priorities has helped to spur remarkable economic and social progress in the Asian and Pacific region. The achievements of the “tiger” and “miracle” economies are sterling examples of the positive links that can be forged between policies that promote social development and those that can encourage economic growth.

2. During the last three to four decades of the twentieth century, the top eight economies of East, North-East and South-East Asia grew faster than those in all other regions of the world, 3 times faster than economies in Latin America and 25 times faster than those in sub-Saharan Africa (World Bank, 2002).

3. Success has not been limited to the “tiger” economies, however. In the past half-century, there have been dramatic improvements across the Asian and Pacific region in both social and economic indicators, ranging from lowered poverty levels to falling infant and child mortality rates. Overall, the current infant mortality rate in Asia, at 53 deaths per thousand live births, is 71 per cent lower than it was in the early 1950s. Average life expectancy at birth rose by 26 years during the same period (United Nations, 2001a). For example, in this period, Bangladesh, India and Indonesia all saw life expectancy grow by 22, 24 and 28 years, respectively.

### *(b) Social progress and economic growth*

4. Many successful economies in the ESCAP region focused their attention on two fundamentally important social sectors: health and education. Their record confirms the positive and mutually reinforcing relationship that can be achieved between equitable provision of health care and education, and robust economic growth. The good health and educational status of a population, particularly women, fuels improved economic performance, which in turn provides a platform for further raising a society’s standards of health and education (WHO, 2001a).

5. Significantly, the high-growth economies of the ESCAP region achieved progress on the health and education fronts very early in their development process, when national incomes were still low. Their experiences demonstrate that it is possible to achieve a high level of social development – and mitigate the worst manifestations of poverty – before achieving robust economic growth, if Governments set the correct priorities and implement appropriate policies (Mehrotra, 2000). Indeed, the ESCAP region’s experience indicates that strong social development is a precondition for healthy, sustained economic growth.

### *(c) Unfinished tasks*

6. Nevertheless, huge challenges remain, not only in consolidating the gains made, but also in extending them. The social and economic progress of the past half-century has not occurred uniformly

across the region. In addition, the recent Asian financial crisis slowed the pace of social gains in many countries and retarded it in others.

7. The most recent data available on progress in realizing “education for all” indicate that, of 857 million illiterate adults worldwide, 616 million were living in this region (UNESCO, 2002). Parts of the ESCAP region continue to experience significant levels of poverty, child malnutrition and gender imbalance. Currently, 515 million Asians are chronically undernourished, accounting for about two thirds of the world’s hungry (FAO, 2001).

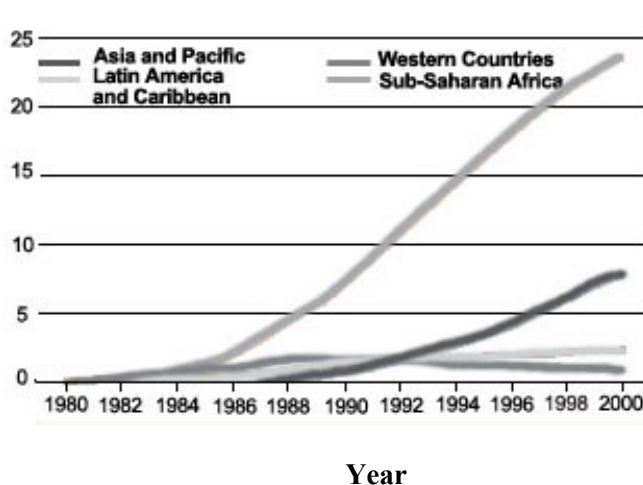
8. The region also faces challenges such as the impact of environmental destruction on the livelihood of the poor, the rapid ageing of populations and high rates of death and disability resulting from infectious diseases. One of the most significant threats is the HIV/AIDS pandemic, which could wreak havoc in the Asian and Pacific region.

## II. HIV/AIDS: WHERE IS THE PANDEMIC HEADING IN THE ASIAN AND PACIFIC REGION?

### (a) Global dimension

9. Globally, the scale of the pandemic dramatically exceeds even the most pessimistic scenarios of a decade ago. At the end of 2002, there were 42 million PLWHAs (people living with HIV/AIDS) around the world (UNAIDS/WHO, 2002). Over 3 million people are estimated to have died of AIDS worldwide in 2002, including 610,000 children aged under 15. A startling 5 million people acquired the virus in 2002.

**Percentage of HIV seroprevalence in regions of the world**



*Source: Compendium of Reports, 2001.*

10. The global HIV/AIDS epidemic has yielded three inexorable facts. First, no country is immune from a serious HIV epidemic. Second, currently low HIV prevalence rates are no guarantee of low rates in the future. Third, the current highest national infection levels in the region of 2 to 3 per cent of the general population do not represent a natural limit imposed by behavioural patterns (Brown, 2001).

*(b) Regional dimension: cause for serious concern*

11. The Asian and Pacific region threatens to displace sub-Saharan Africa as the new centre of the global HIV/AIDS pandemic (see figure). The region has 62 per cent of the world's population and 19 per cent of the world's PLWHAs and the HIV/AIDS pandemic could reverse the social and economic gains made in the past half-century in Asia and the Pacific, unless an expanded and comprehensive response is mounted across the region.

12. In the present scenario, several developments underscore the need for concern among Asian and Pacific Governments and leaders (UNAIDS/WHO, 2002):

- (a) Currently, one in five new HIV infections worldwide occurs in Asia and the Pacific;
- (b) Roughly half of all new infections are among young people. In the ESCAP region, by the end of 2001, 2.6 million of the 7.5 million PLWHAs were aged 15 to 24;
- (c) The pandemic is growing at an alarming pace, including in parts of Central Asia, where HIV infection rates are rising steeply;
- (d) At the current rate of HIV spread in the Central Asian Republics, China, India, Indonesia and the Russian Federation, the total number of people living with HIV/AIDS in the ESCAP region could eventually match and surpass that in sub-Saharan Africa;
- (e) In 2002, AIDS claimed approximately half a million lives in the ESCAP region, while an estimated 1.2 million adults, children and youth were infected with HIV.

13. At present, the main mode of HIV transmission in the region is sexual intercourse, both heterosexual and homosexual. In many parts of the region, serious epidemics are also under way among injecting drug users. Other significant modes of transmission include the use of unclean needles and syringes, and unsafe blood and blood products.

*(c) Current country trends*

14. Country trends in the ESCAP region may be separated into three categories.

15. In the first group are those countries where HIV/AIDS has reached serious levels, with adult HIV prevalence rates of over 1 per cent. It includes Cambodia (whose prevalence rate is over 2 per cent), Thailand, parts of India and Myanmar, and Papua New Guinea (UNAIDS, 2002a).

16. The second group includes countries where the epidemic is still in a transitional stage, but where HIV prevalence is rising rapidly in specific populations and geographic areas. These include Armenia, China, Indonesia, Kazakhstan, Nepal, Malaysia, the Russian Federation, Uzbekistan and Viet Nam.

17. The third group includes countries and territories where extensive spread of HIV/AIDS is not evident: Bangladesh; Hong Kong, China; Islamic Republic of Iran; Lao People's Democratic Republic; Mongolia; Pakistan; Philippines; Republic of Korea; Sri Lanka and Turkey; as well as several small Pacific island countries and territories. In the case of the Pacific, limited information is available on the spread of HIV/AIDS. Nevertheless, conditions favour the rapid spread of HIV in many of these countries and territories.

18. However, macro-level trends do not always reveal the full picture. India (which has states in all three groups) and China illustrate how a low national HIV prevalence rate can hide serious localized epidemics (UNAIDS/WHO, 2002). HIV epidemics always begin as geographically localized outbreaks and only later spread more widely across countries, territories and societies.

19. There is no guarantee that low prevalence rates will stay that way. Indonesia and Nepal, which are in the second group, are seeing a rapid rise in HIV infection rates, following years of consistently low rates. In Ho Chi Minh City, Viet Nam, HIV infection among sex workers increased from virtually nil in 1996 to over 20 per cent in 2000. In the Russian Federation, within eight years, HIV/AIDS epidemics have been discovered in over 30 cities and 86 of 89 regions. In that country, the total number of reported HIV infections climbed by over 1,800 per cent between the end of 1998, when the reported number was 10,993, to mid-2002, when the number was 200,000 (UNAIDS/WHO, 2002).

*(d) Driving the epidemic: poverty and uneven development*

20. Several broad development issues feature significantly in the spread of HIV in Asia and the Pacific (Compendium of Reports, 2001). These dynamics include poverty, gender inequalities, illiteracy, population mobility and lack of access to basic services and opportunities, as well as to information, especially among young people and other vulnerable groups (such as sex workers, injecting drug users and migrant workers).

21. The poorer countries of the world are home to the vast majority, some 95 per cent, of people living with HIV/AIDS. In several cases, income inequality appears to correlate significantly with HIV prevalence. There are indications that high rates of extreme poverty (measured as income of less than US\$ 1 a day) also appear to be associated with HIV prevalence rates, as do poor rankings on the United Nations Development Programme (UNDP) Human Poverty Index (Bloom and others, 2002).

22. Household data from Cambodia and Viet Nam show strong correlations between levels of wealth, education and vulnerability, and HIV/AIDS. In Cambodia, which has one of the most advanced epidemics in the ESCAP region, the poorest segments of society have much less access to knowledge of how HIV is transmitted and prevented, are more likely to have sex at a younger age, use condoms less frequently and, in the case of young women, are more likely to turn to sex work as a means of supporting themselves and their families. Micro-level data from other Greater Mekong Subregion countries show that poverty drives many women into the commercial sex industry, where they face higher risks of HIV infection.

23. The development process itself can help to spur the spread of HIV/AIDS (Bloom and others, 2002). Widening inequalities (often associated with the earlier phases of development) can spur internal and cross-border migration, as people move in search of income and employment. Infrastructure development (especially transport networks), urbanization, rising disposable incomes (especially for men), the greater importance of cash in agriculture and growing mobility are often associated with more extensive sexual activity and growth in the commercial sex industry. These reflect some of the HIV-related vulnerabilities associated with development.

*(e) Driving the epidemic: cultural taboos*

24. In many countries, open discussion of sex and sexual behaviour is taboo. Thus, it is difficult to openly address issues of unsafe sex, casual sex, multiple sex partnering, male-to-male sex, use of sex worker services and sexual abuse and violence. Such taboos seriously hamper prevention efforts.

*(f) Driving the epidemic: unfounded assumptions*

25. Spreading alongside the HIV/AIDS epidemic are a host of unfounded assumptions that encourage denial, complacency and inaction. They include the notions that:

(a) The epidemic has a natural limit in Asia and the Pacific and could never affect a significant proportion of the population;

(b) The very nature of some societies guarantees that HIV prevalence will stay low even without active, sustained interventions;

(c) Currently low national prevalence means the situation is under control;

(d) An HIV/AIDS epidemic among vulnerable groups has no implications for the wider population;

(e) The epidemic moves very slowly, so action can be delayed, especially in the face of other, more pressing development priorities;

(f) Antiretrovirals (ARVs) have transformed AIDS into an easy-to-manage chronic disease.

26. The validity of these assumptions is highly questionable, a fact which must be taken into account in any HIV/AIDS programme.

### III. PEOPLE'S VULNERABILITY: CHALLENGE TO LEADERSHIP

#### (a) *Predictable transmission trends*

27. As the pandemic enters its third decade, it is now well established that HIV/AIDS generally follows a predictable path, although the speed and eventual extent of its spread vary depending on the specific circumstances of a country (UNAIDS, 2002a).

- (1) In phase I, the virus is introduced into a country, and is usually transmitted mainly among individuals or groups with higher levels of those behaviours that transmit HIV (e.g., sex work and use of commercial sex services, sex between men and injecting drug use). The virus then spreads widely among those at higher risk. Comparatively small investments in prevention and care during this phase can reap huge benefits;
- (2) In phase II, the virus spreads to lower-risk partners of these individuals, thus establishing itself in the wider population. Once a substantial number of people are HIV-positive, the epidemic can then spread even more widely. The costs of prevention and care swell dramatically during this phase.

28. The spread of HIV/AIDS, as described above, affects society in many ways, at the level of vulnerable groups and certain other population groups, and with regard to social sectors, especially health and education. The combined effect poses a major development challenge. The nature of that challenge is detailed below.

#### (b) *Vulnerable groups*

29. Many of the social groups most vulnerable to HIV/AIDS are also subjected to systematic stigmatization, discrimination and marginalization. They include injecting drug users (IDUs), sex workers, men who have sex with men (MSMs) and prisoners (UNAIDS, 2002a). Their perceived association with HIV/AIDS often invites further discrimination, trapping them in a vicious cycle of prejudice and enforced secrecy that blocks prevention efforts.

##### (i) *Injecting drug users*

30. Drug use and HIV in the ESCAP region are largely hidden mainly because of national legal sanctions against the illicit use of drugs. Injecting drug use is a primary driver of the epidemic in many countries of the region. For IDUs, most of whom are young men, sharing needles is not the only risk of HIV infection. Many are sexually active, and some sell sex in order to support their drug habits. Unprotected sex is often rife. Such a linkage between injecting drug use and unsafe sex adds significant impetus to the spread of HIV, particularly in countries where repressive legislation and social sanctions keep this group's activities underground.

(ii) *Commercial sex workers*

31. Once HIV spreads in communities of sex workers, its prevalence typically rises sharply. The HIV prevalence rate among brothel-based sex workers in Thailand rose from 3.5 per cent in 1989 to 33 per cent in 1994. In Mumbai, India, rates jumped from just 1 per cent in 1987 to 51 per cent in 1998, while in parts of Myanmar they soared from 4.3 per cent in 1992 to 18 per cent in just three years (Roger and others, 2002). In Viet Nam's main urban centres of Hanoi and Ho Chi Minh City, HIV prevalence rates rose sharply in the late 1990s. Recent studies in Donetsk, Moscow and St. Petersburg indicate HIV prevalence rates of 13 to 17 per cent among sex workers (UNAIDS/WHO, 2002). At risk are sex workers, their sex partners and the families of the clients who buy sex services.

(iii) *Men who have sex with men*

32. In many societies, MSMs meet with public scorn. Many ESCAP countries prohibit sex between men, while others deny that it occurs in their societies. MSMs are vulnerable to infection because prevention campaigns ignore them and they are driven underground, which makes them hard to reach. Nevertheless, studies show that sex between men is a significant phenomenon throughout the region. In Cambodia, 15 per cent of MSMs were living with HIV in 2000 (MAP, 2001). Similar levels were found among Thai male sex workers in the same year. The HIV prevalence rate among MSMs in several Malaysian states was around 10 per cent. Three out of 10 sentinel sites in the Philippines recorded HIV infection in MSMs. HIV infection among Japanese MSMs increased sharply in the late 1990s, accounting for twice as many infections as in heterosexual men. In addition, data from countries such as India, Pakistan and Thailand confirm that many men who have unprotected sex with other men also have unprotected sex with women (UNAIDS, 2002a).

(iv) *Mobile groups*

33. As people move, so does the virus. Of the Filipinos reported to be living with HIV/AIDS, 28 per cent were workers who had returned home after working overseas. Around 41 per cent of Bangladesh's PLWHAs had been migrant workers. In Nepal's *terai* (plains) region, the 17 per cent of sex workers who had worked in India accounted for over 75 per cent of the HIV/AIDS cases. Ten per cent of migrants returning from Mumbai, India, to Doti District in the far west of Nepal were HIV-positive, compared with just 2 per cent of non-migrants (MAP, 2001; UNAIDS, 2002a).

(v) *Uniformed service personnel*

34. Uniformed service personnel face high levels of risk owing to their young age, as well as the nature of their work, which involves high mobility, long periods of absence from home and risk-taking behaviour (UNAIDS/WHO, 2002). The special nature of their vulnerability has been recognized in the General Assembly's Declaration of Commitment on HIV/AIDS (United Nations, 2001b). There are troubling signs that HIV infection is a serious problem among uniformed services

in the ESCAP region, a state of affairs that could eventually have implications for national security. In Cambodia, 4.7 per cent of the police force was found to be HIV-positive in 1999, over one third higher than the national adult HIV prevalence rate at the time (NCHADS, 2000).

*(vi) Prisoners*

35. Throughout the ESCAP region, prisoners' HIV prevalence rates demand greater attention. In very few cases do prevention programmes extend into prisons, despite evidence of high risk and soaring HIV infection rates in prison populations. In 2001, 10 prisons in the Islamic Republic of Iran reported HIV infection among IDUs, with one site recording a staggering 63 per cent prevalence rate (MAP, 2001; UNAIDS, 2002a). Prisoners constitute around 15 per cent of registered HIV cases in the Russian Federation (Frost and Tchertkov, 2002). HIV prevalence among jailed IDUs in a prison in Bali, Indonesia, was reported to be 53 per cent (UNAIDS, 2002a).

*(c) Population groups: youth, children, women and girls, older persons*

36. The HIV/AIDS epidemic affects all social groups. However, certain groups are more vulnerable: youth, children, women and girls, and older persons.

*(i) Youth*

37. Roughly half of those newly infected with HIV today are aged between 15 and 24 years. Young people in the sex trade, young IDUs, sexually abused youth, youth in armed conflicts, street youth and orphaned youth are especially vulnerable. Rapid social change often results in pressure to embark early on unprotected sexual experimentation and alcohol and drug use, while limited access to youth-friendly information and health services, high mobility and high unemployment increase the risk that young people could contract the virus. In most Asian and Pacific countries and territories, the number of young people is significant yet their needs are disregarded when policies are adopted and budgets allocated. How the epidemic evolves in the ESCAP region will depend largely on whether young people are provided with adequate knowledge and equipped with the means to protect themselves from HIV/AIDS.

*(ii) Children*

38. In 2001, about 1.9 million (or just under 3 per cent) of 65 million orphaned children in the Asian and Pacific region had lost one or both parents to the HIV/AIDS epidemic (UNAIDS, UNICEF and USAID, 2002). In 2005, it is estimated that over 3 million children in the region will have been similarly orphaned. By 2010, that number is expected to rise to over 4.3 million. Such developments would compromise the rights of children as enshrined in the Convention on the Rights of the Child, which all Governments in the ESCAP region have ratified, particularly the right to parental support (article 9), health (article 24), education (article 28) and protection against sexual exploitation and abuse (article 34).

(iii) *Women and girls*

39. The HIV/AIDS pandemic is often driven by prevailing gender discrimination against girls and women. Such discrimination is especially pronounced in societies where masculinity is associated with male dominance, sexual prowess, alcohol and other substance abuse, and aggression. Poor access to education and health services, a lack of opportunities for economic and social advancement and widespread social discrimination undermine the status of women and rob millions of the ability to protect themselves against HIV/AIDS and its impact. In practice, many women cannot insist on safe sex and condom use. They are unable to shape the terms of their relationships and escape abusive and violent partners. Gender inequality in access to health services curtails women's access to treatment, care and support.

(iv) *Older persons*

40. The effects of HIV/AIDS on older persons are poorly appreciated. Once introduced, prevention efforts are usually aimed at young people, while care and support initiatives seldom reflect the fact that older persons generally serve as caregivers to their ill children and grandchildren. As societies in this region progressively age, the HIV/AIDS-related requirements of the older members of society will intensify.

(d) *Everyone is vulnerable*

41. If allowed to spin out of control, the HIV/AIDS epidemic will reshape the demographic structures of societies in the form of increased morbidity, mortality, population loss and declining life expectancy. That, in turn, would affect birth rates, age structures and population growth rates.

42. Already, calculations made for four countries (Cambodia, India, Myanmar and Thailand) show that they can expect 2.2 million additional deaths due to HIV/AIDS in the period 2000-2005 (United Nations, 2001a).

43. Adult death rates can be dramatically affected in the short term, since HIV/AIDS strikes young adults disproportionately. Estimates indicate that when the adult HIV prevalence rate reaches 4 per cent, HIV/AIDS can account for one third of all adult deaths (ESCAP, 2002; UNAIDS, 1998). Although no country in the ESCAP region has reached such prevalence rates yet, badly affected areas in several countries of the region (for example, some provinces in northern Thailand, South-Central China and some states of India) (ESCAP, 2002) could soon experience HIV prevalence rates of 4 per cent or higher unless concerted prevention efforts are undertaken soon.

44. The spectacular progress in child survival achieved in the region is also under threat. As the HIV/AIDS epidemic matures, mother-to-child transmission of HIV typically causes infant and under-five mortality rates to rise. Some projections for Thailand, for example, warn that child mortality in 2010 could be 30 per cent higher as a result of AIDS (Rhucharoenpornpanich and Chamratrithirong, 2001; ESCAP, 2002).

45. A growing epidemic slows — and eventually can even reverse — improvements in life expectancy. By the period 2010-2015, life expectancy in Cambodia is projected to be 59.2 years, that is, five years less than it would have been without HIV/AIDS (United Nations, 2001a). HIV/AIDS is projected to reduce life expectancy at birth in Botswana and Zimbabwe by approximately 36.1 and 33.6 years, respectively, in 2000-2005 (United Nations, 2001a). Based on the 45 countries for which such projections are available, a 1 per cent increase in the national adult HIV prevalence rate reduces life expectancy by approximately one year (United Nations, 2001a; ESCAP, 2002).

#### IV. SAVING OUR FUTURE

##### *(a) Costs of inaction*

46. Projections for the Asian and Pacific region suggest that billions of dollars and millions of lives can still be saved this decade if Governments invest urgently in prevention measures (Compendium of Reports, 2001). In the 2010 “costs-of-inaction” scenario, young, productive citizens will be lost to the pandemic, business profits will slump, household income and standards of living will plummet and economies will stagnate.

47. In the worst-affected countries of the world, HIV/AIDS is reversing annual economic growth rates by as much as one to two percentage points (Compendium of Reports, 2001). In some countries, if the epidemic remains unchecked, economic wealth in the form of GNP could decline substantially by 2020. National studies of two African countries with adult HIV prevalence rates higher than 30 per cent indicate that their economies will grow by 2.5 and 1.1 percentage points less by 2015, respectively, than they would have in the absence of AIDS (UNAIDS, 2002a; ESCAP, 2002). Higher morbidity and mortality levels also drain national economies by reducing the volume of available savings and changing the way in which savings are used. Ultimately, this too affects economic growth.

##### *(i) Direct costs outweighed by indirect costs*

48. The direct costs triggered by an HIV/AIDS epidemic include the costs of treatment and care provision, care for orphans, funerals, prevention and testing, and the expansion and upgrading of the health system. The most important indirect costs stem from losses to households, extended families and communities due to the deaths of young adults (ESCAP, 2002). Together, they trigger far-reaching consequences.

49. Longer-term macroeconomic effects of the epidemic stem from the changes the epidemic induces in dependency ratios, along with related labour force shortages and human capital erosion. The toll that AIDS claims among young adults disproportionately reduces the size of the economically active population. The epidemic depresses labour productivity, largely as a result of increased absenteeism caused by illness and caregiving (ESCAP, 2002).

(ii) *Household-level costs*

50. The impact of HIV/AIDS on household income is potentially disastrous, especially in a region where an estimated 870 million people live below the poverty line of less than US\$ 1 per day. Those most likely to contract the virus are generally in their prime productive age (15-49 years) and are often at the peak of their earning capacity.

51. As people living with HIV/AIDS succumb to illness, their income-earning abilities weaken. At the same time, household or family incomes shrink when family members have to adapt their work lives to care for the ill. Studies have shown that the incomes of households with a person living with HIV/AIDS can fall by as much as 80 per cent (Compendium of Reports, 2001).

52. As incomes become depleted, household savings are often tapped to meet health-care costs associated with HIV/AIDS. Studies in the region suggest that over half of all households affected by HIV/AIDS reduced their consumption of goods and services by 40 to 60 per cent in order to help to meet health-care costs (Pitayanon and others, 1997; ESCAP, 2002).

53. As more and more people living with HIV progress to AIDS, the financial and material burden of care tends to shift away from hospitals towards the kin and friends of the patients, through home- and community-based care (ESCAP, 2002). AIDS deaths, following asset and wage losses, and care costs, often push households deeper into poverty.

(iii) *Cost to business*

54. The devastating consequences are not confined to households. HIV/AIDS has knock-on effects on the broader economy. Worker incapacitation and death and shrunken household incomes lead to reduced spending and lower demand for goods and services. Consequently, some business sectors can suffer decreasing sales and profits.

55. HIV/AIDS drains productivity mainly through increased absenteeism, disrupted production, weakened workforce morale and the loss of skills and organizational memory, all of which force costs up and drive productivity down. Ultimately, international competitiveness could decline, reducing investment flows, trade revenue and job creation.

(iv) *Cost to the health sector*

56. The HIV/AIDS pandemic inflicts a high cost on the health status of societies. It also has a multiplier effect on other already prevalent diseases such as tuberculosis (TB) (WHO, 2001b). By weakening and eventually destroying the immune system, HIV increases people's susceptibility to a variety of opportunistic infections, including active TB. Indeed, people carrying TB who become infected with HIV face a 30- to 50-fold increase in their risk of developing active TB. It is estimated that most countries of the Asian and Pacific region can expect an increase of 5 to 10 per cent in HIV-related TB cases (ESCAP, 2002).

57. The HIV pandemic will have a dramatic impact on the capacity of health systems and associated costs. In recent years, in the provincial hospital in Chiang Mai, northern Thailand, about half the beds have been occupied by HIV-positive patients (ESCAP, 2002). In 2002, Cambodia's health-care system had no additional capacity to provide appropriate treatment for the estimated 12,000 PLWHAs in need of care and support (communication received from the Secretary-General, National AIDS Authority, Cambodia, 22 February 2003).

58. HIV/AIDS poses occupational risks for health workers, who could acquire the virus (e.g., through needle-stick injuries) or contract other opportunistic infections. It undermines morale in the absence of prophylactic treatment, as workload and stress levels increase, and as people experience the death of children, young adults and colleagues. Furthermore, the loss of health professionals to the pandemic may lead to a further deterioration of already strained health services in many countries in the region.

(v) *Cost to the educational sector*

59. School enrolments are likely to fall as students are taken out of school to care for ill parents and family members. Poor families are particularly likely to suffer this impact and often face increasing difficulty paying school fees and other related expenses. Girls in particular are likely to be taken out of school to care for ill family members. At the same time, AIDS may lead to a reduction in the number of qualified teachers and administrators and make it impossible for the education system to fulfil its mandate and provide children with quality schooling. The effects can be especially harsh in rural areas, where schools often depend on one or two teachers.

60. Unless adequate prevention and impact mitigation measures are put in place, countries in the region that have reached high standards of literacy and education could see some deterioration in terms of quality and loss of skilled personnel. Those countries still striving to reach the goal of providing quality education for all could see their efforts stall in the face of HIV/AIDS.

(vi) *Cost to the rural/agricultural sector*

61. Large-scale migration of mostly young rural people to urban areas exposes them to high risk. Long absence from home, stressful living conditions and inducement to engage in high-risk behaviour expose them to HIV. On return to the rural areas, they can then transmit the virus to their sex partners. Furthermore, many return to their families for care once the AIDS symptoms are manifest. This can dramatically decrease the productivity of the agricultural labour force. The impact of a serious epidemic may be more pronounced where a large proportion of the labour force is employed in the agricultural sector, for example, in China, India and Indonesia (ESCAP, 2002). In severe epidemics, food production and supplies, even food security, can be threatened as HIV/AIDS-related morbidity and mortality worsen.

62. For example, in Papua New Guinea, by 2020 rural income is projected to decline by up to 8 per cent in a worst-case HIV/AIDS scenario (Compendium of Reports, 2001). The effects on smallholder agriculture could be even worse with output plunging by as much as 24 per cent over the same period.

63. Despite such risks, national responses to HIV/AIDS have tended to follow health-based, urban-focused approaches that neglect agriculture and rural development, potentially compromising food security and rural livelihoods.

*(vii) Cost to government development spending*

64. HIV/AIDS potentially affects the functioning of Governments and the public sector in numerous ways. At the most basic level, there is mounting pressure for higher health spending to cope with increased pressure on health resources. Such pressures are likely to draw resources away from other key government investments in such areas as education, infrastructure and governance.

*(b) Resources*

65. Trends show increased financial resources for HIV/AIDS. Globally, total international donor disbursements to affected countries for HIV/AIDS programmes grew significantly from US\$ 297 million in 1996 to US\$ 1.8 billion in 2002 (UNAIDS and François-Xavier Bagnoud Center, 1999; UNAIDS, 2002b). In the same period, national governmental and NGO spending in the affected countries exceeded US\$ 500 million.

66. In terms of geographic distribution, in both 1999 and 2000, the largest share of international donor assistance for HIV/AIDS was destined for sub-Saharan Africa, with the Asian and Pacific region ranking second (UNAIDS, 2002b). Spending on HIV/AIDS has been increasing in absolute terms. Between 1996 and 2002, spending on HIV/AIDS from all sources is estimated to have increased from US\$ 500 million to approximately US\$ 3 billion.

*(i) Resource needs and availability*

67. As the HIV/AIDS epidemic grows, available funding is not matching the needs of countries in its path. Significant new resources are required to address the HIV/AIDS pandemic in low- and middle-income countries. By 2007, prevention costs are expected to represent 39 per cent of total funding needs, ARV therapy funding requirements to increase to 25 per cent and treatment for opportunistic infections to be 8 per cent of total funding (UNAIDS, 2002b). It is estimated that, in 2005, US\$ 10.5 billion and, in 2007, US\$ 15 billion would be needed annually to expand the global HIV/AIDS response to a point at which the spread of the pandemic can be reversed and its impact significantly diminished (UNAIDS, 2002b). By 2007, low- and middle-income countries in the ESCAP region would need US\$ 7 billion, that is, almost one half of the total resource requirements (UNAIDS, 2002b). Such a funding level would require a dramatic increase in global resources for HIV/AIDS.

68. The US\$ 10.5 billion and US\$ 15 billion estimates for 2005 and 2007, respectively, do not include infrastructure development costs. If the latter costs were included, the WHO Commission on Macroeconomics and Health has estimated that an additional US\$ 13.6 billion and US\$ 15.4 billion would be needed for HIV/AIDS prevention and care, respectively, in 83 selected low- and middle-income countries by the year 2007 (WHO, 2001a).

69. It is estimated that, already in 2003, it will take US\$ 3.5 billion to bridge the gap between total funding needs and funding availability for fighting HIV/AIDS globally (UNAIDS, 2002b). As to the ESCAP region, conservative estimates suggest a resource gap of 80 per cent between resource needs and availability for mounting an effective HIV/AIDS response (Stover, 2003).

#### **V. WINDOW OF OPPORTUNITY: ACT NOW!**

70. The Asian and Pacific region stands at a critical crossroads. A concerted and sustained response can hold the epidemic in check. But further delay in mounting effective prevention and care efforts would see the region forfeit its opportunity to prevent the epidemic from spinning out of control.

71. Many Governments in the region recognize the challenge and have begun to act. Those Governments that have had some success in holding the epidemic at bay have publicly recognized the true nature and extent of the HIV/AIDS threat, committed sufficient resources, focused early efforts on the most vulnerable groups and adapted their activities to new developments in the epidemic.

*(a) AIDS is preventable and prevention is cost-effective*

72. The pattern and course of the pandemic are predictable and well known. This means that the epidemic yields to appropriate and sustained interventions (e.g., youth-focused prevention education, high levels of condom use in sex workers and casual sex settings, low levels of needle-sharing, use of safe blood and blood products). HIV/AIDS can be controlled.

73. Initially, the virus spreads mainly among vulnerable social groups and might remain so for several years. This tends to encourage the notion that the epidemic will stay confined mainly to those groups. In reality, none of the groups are sealed off from the rest of society. The epidemic eventually spreads among the broader population. Where circumstances favour the rapid spread of HIV, the consequences can be calamitous (UNAIDS/WHO, 2000). The best course of action is early action.

74. In the early stages of the epidemic, comprehensive prevention among vulnerable groups is most cost-effective and could reduce new infections by over 60 per cent. The longer the delay, the flimsier the payback in terms of infections prevented. For example, delaying by three years the introduction of a comprehensive prevention programme could mean that twice as many people acquire the virus (Stover and others, 2002).

75. The types of approaches that boost results are also now better understood. Countries that have brought epidemics under control have cultivated wider acceptance of people living with HIV/AIDS, shown greater tolerance towards marginalized groups, effected large-scale improvements in access to treatment and care and mounted prevention programmes that focus especially on vulnerable groups (UNAIDS, 2002a).

76. Cambodia and Thailand, for example, launched large-scale HIV/AIDS campaigns in the early stages of the epidemic, concentrating on groups most at risk of infection. This enabled them to reduce the spread of HIV and saved millions of citizens from infection, illness and eventual death. Thailand could have had an estimated prevalence rate of 10 to 20 per cent and lost an additional 6 million lives were it not for effective interventions launched early in the epidemic (Brown, 2001).

(b) *What works*

77. Societies are not powerless against the HIV/AIDS epidemic. The Asian and Pacific region provides some of the leading global examples of success against HIV/AIDS. Experiences worldwide confirm that the leadership of prime ministers and presidents in directing national HIV/AIDS responses helps to ensure that the responses are implemented as the highest national priorities. There is evidence of such leadership in the ESCAP region. For example:

- Successive Thai prime ministers since the early 1990s have served as chairpersons of the National AIDS Committee;
- The prime ministers of Cambodia, India, Indonesia, Malaysia and Papua New Guinea have personally endorsed national efforts to tackle the epidemic.

78. Many countries in the region are adopting a multisectoral approach and are extending their HIV/AIDS responses across various ministries. Examples of this include the following:

- *Resource allocation and AIDS prevention, Thailand:* The 1996 AIDS budget of the Government of Thailand covered 91 per cent of all expenses in the country's AIDS programme. Creative prevention measures included life skills empowerment of youth, 100 per cent condom coverage of all sex service users and strategic alliances with PLWHAs;
- *National coordination, Cambodia:* The Government set up a national body composed of 13 ministries, all provincial and municipal governments and the Cambodian Red Cross;
- *School AIDS education, Australia, Philippines and Myanmar:* Ministries of education have included AIDS in school curricula;
- *Protecting defence forces, Bangladesh, Lao People's Democratic Republic and Nepal:* Ministries of defence conduct HIV prevention among the military;

- *Transport mode and mobile youth, China and Mongolia:* Ministries of railways conduct AIDS education and HIV prevention for young migrant workers;
- *Infrastructure construction workers, Cambodia and Lao People's Democratic Republic:* HIV prevention among workers and surrounding communities at Sihanoukville International Port, Cambodia, and on National Road 8, Lao People's Democratic Republic.
- *Mobilizing the media, India:* The Press Information Bureau helps to sensitize the Indian media on HIV/AIDS issues.

79. Although there is no cure for HIV/AIDS, ARV treatments reduce mother-to-child transmission, prevent premature death and postpone debilitating illnesses. Providing wide and equitable access to treatment and care is a vital part of an effective response. The region lags far behind on this front. Fewer than 50,000 of the estimated 1 million people in need of ARVs receive them. Despite recent drops in prices, the prohibitive cost of patented ARVs still makes them unaffordable for most people who need them. However, generic versions (manufactured in India and Thailand, for example) are available at much lower prices. In certain countries of the region, national health insurance schemes underwrite the costs of ARVs for low-income groups.

(c) *Vital choices*

80. The United Nations Millennium Declaration, adopted at the Millennium Summit (September 2000), enjoined heads of State and of Governments to halt and begin to reverse the spread of HIV/AIDS by 2015. All Governments reaffirmed their commitment to this goal by adopting the Declaration of Commitment at the United Nations General Assembly special session on HIV/AIDS (June 2001). At the regional level, at its fifty-seventh session, ESCAP adopted resolution 57/1 of 25 April 2001 calling for action to fight HIV/AIDS.

81. Against this background, Governments in the region face vital choices if they are to control the HIV/AIDS epidemic. Making those choices will require leadership marked by extraordinary vision and courage. Below are five sets of choices: policy environment; resource generation and flow; institutional mechanisms; re-engineering government processes; and action on commitments.

(1) *Policy environment*

- (a) **Integrate HIV/AIDS issues into national development planning, sectoral plans and poverty reduction strategies, for the full mobilization of all sectors and levels of government:** Address the HIV/AIDS epidemic as a development issue, with education, health and nutrition, gender equity and social justice dimensions at the centre of a national HIV/AIDS response. Promote respect for the rights of PLWHAs and introduce anti-discrimination measures.

- (b) **Focus on preventive and promotive health, with special attention to HIV/AIDS:** Develop a wide spectrum of measures to prevent the spread of HIV infection among vulnerable groups. These include prevention fundamentals: focusing on young people, achieving a better understanding of the main modes of transmission, acceptance of PLWHAs, promoting condom use as a simple and effective prevention measure and using clean needles and syringes, safe blood and blood products. Develop women-friendly measures that enable women to boost their autonomy and take decisions that protect them from HIV/AIDS. Assist in the development of HIV prevention vaccines that are best suited to Asian and Pacific conditions. Expand coverage of a comprehensive response to HIV/AIDS through improving the design and reach of current efforts and increase the coverage of geographic areas and vulnerable groups.
- (c) **Strengthen the integral link between prevention and care/treatment/support:** Include treatment and care for PLWHAs as an essential component of a national response to HIV/AIDS, whose long-term foundation is prevention. Provide vulnerable group-friendly services (condoms, clean needles and syringes, safe blood and blood products, sexually transmitted infection treatment) and foster conducive environments for accessing these services.
- (d) **Guarantee equitable access to ARV treatment and other HIV-related medicines:** Intensify action by Governments and the pharmaceutical industry to increase the availability of affordable drugs. Initiate negotiations in appropriate forums to remove the patenting of ARVs from national legislation governing intellectual property rights. Provide an exemption from patent protection for ARVs until 2016 in the case of least developed countries. Reform national legislation to achieve the lowest prices for quality pharmaceutical products and ensure that Governments are able to exercise the flexibility permitted under WTO agreements.
- (2) *Resource generation and flow*
- (e) **Ensure that adequate resources are available to implement the national HIV/AIDS response:** Secure domestic resources for an effective, sustained and region-wide response, with essential coverage of areas and vulnerable groups and urge an increase in international resources, such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria.
- (f) **Mobilize the full potential of the corporate/private sector to operationalize the national HIV/AIDS response:** Create an enabling environment for the corporate/private sector to discharge its social responsibility and demonstrate good corporate citizenship by playing a larger role in the HIV/AIDS response, generating resources, implementing HIV/AIDS workplace programmes, supporting treatment and care for employees living with HIV/AIDS and boosting care activities for orphans of workers who die of AIDS.

- (g) **Make special provisions for the smooth flow of funds:** Enact regulations and adopt practices for speedy fund transfer and disbursement of HIV/AIDS resources to executing and implementing agencies, to expedite timely receipt and utilization. Where necessary, establish new channels for expeditious fund transfer.

(3) *Institutional mechanisms*

- (h) **Locate the national focal point for HIV/AIDS in the office of the head of Government/State:** Accord the highest national priority to HIV/AIDS by locating the national HIV/AIDS focal point under the direct leadership of prime ministers and presidents.
- (i) **Constitute a national committee of ministers of relevant ministries, such as health, education, finance, planning, urban and rural development, agriculture, information and broadcasting, industry and transport, chaired by the head of Government/State, to formulate a comprehensive national response to the epidemic, and with the powers to ensure its implementation:** Guarantee resource availability, and optimize its utilization, by entrusting the key ministers for economic and social development with the responsibility of meeting the challenge of HIV/AIDS.
- (j) **Decentralize implementation of the national response:** Design the national response to meet local needs and priorities adequately through delegation of authority and resources to implementing agencies and personnel at the local level.
- (k) **Develop a wide network of agencies and organizations to implement the national response:** This could include government agencies, civil society groups and the corporate/private sector.

(4) *Re-engineering government processes*

- (l) **Establish social auditing of HIV/AIDS programmes:** Identify institutions and organizations for conducting social audits of responses to HIV/AIDS issues and entrust them with the responsibilities and resources for this. Guarantee that the social audits are participatory, with the active involvement of PLWHAs and community members. Make available the audit results in the public domain, to improve transparency and accountability.
- (m) **Establish an effective monitoring and evaluation system:** Establish a credible system to monitor and evaluate the national response under the national committee of ministers (see [b] above). Foster a culture of taking prompt corrective action based on monitoring and evaluation.

(5) *Action on commitments*

- (n) **Implement commitments made in United Nations forums:** Formulate an action plan for implementing international commitments made to tackle HIV/AIDS, including at the special session of the General Assembly and the fifty-seventh session of the Commission.
- (o) **Strengthen regional cooperation in tackling HIV/AIDS issues:** This includes sharing knowledge and resources, as well as nurturing a common regional commitment to tackling the HIV/AIDS epidemic.

82. The Asian and Pacific region holds the key to the future of the HIV/AIDS pandemic. Governments of the region have a window of opportunity to act now and save millions of lives. Immediate action, at the highest decision-making levels, could protect the economic and social gains of the region from unravelling. High investments are required in low-prevalence countries to save our future.

*“If you can mobilize resources for war, why can’t you mobilize resources for life?”<sup>1</sup>*

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