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BACKGROUND PAPER

1. HIV and AIDS

HIV, the Human Immunodeficiency Virus, was originally isolated in Paris in May 1983 by Luc Montagnier. HIV attacks the body's immune system, infecting key cells (known as CD4 cells), leaving the body with a weakened defense against infections and cancer. HIV is transmitted in the following ways:

- through unprotected sexual intercourse with an infected partner (the most common route of transmission);
- through blood-to-blood contact, for example through sharing needles among injecting drug users;
- through blood transfusions or from infected blood products;
- from infected mother to baby during the course of pregnancy, birth or breast-feeding.

Whatever its initial entry point into a population, HIV eventually spreads as a sexually transmitted infection (STI), most commonly through heterosexual sex.

Being infected with HIV does not instantly lead to **AIDS** (Acquired Immune Deficiency Syndrome) and an HIV-infected person can lead a healthy life for several years before developing AIDS. Nevertheless, if left untreated, HIV can progress to AIDS - the most serious stage of HIV infection, resulting from the destruction of the infected person's immune system. There is no single test for AIDS: doctors will look for one of the “opportunistic infections” or cancers in the presence of underlying immune deficiency.

No cure currently exists for AIDS. Although periods of illness may be interspersed with periods of remission, AIDS is almost always fatal. Research is currently under way into vaccines but none is viable as yet. Anti-retroviral drugs are available that slow the progression of the disease and prolong life; at present these are very expensive and consequently unavailable to most people with HIV in low-income countries. [See Section 7 for more information on treatment.]

2. Global and Regional HIV Prevalence

The most recent “AIDS Epidemic Update” report released by UNAIDS/WHO in December 2004 shows that the number of people living with HIV at the end of 2004 reached its highest number recorded of 39.4 million. The number of women living with HIV has risen in each region of the world over the past two years.

In Asia, some 8.2 million adults and children are estimated to be living with HIV. Home to 60% of the world's population, the fast growing Asian epidemic has huge implications globally. In South and South-East Asia alone, 7.1 million people are living with HIV.

Given the scale of the pandemic, HIV/AIDS is no longer simply a public health problem: it has socio-economic, gender, cultural and political implications. The impact of the virus poses an unprecedented threat to family and community life, socio-economic growth and security. In the worst affected countries, it is reversing gains in life expectancy made in the last 40 years.

AIDS is one of the greatest threats to eradicating poverty and to achieving the Millennium Development Goals (MDGs). At a national level, HIV/AIDS will significantly slow economic growth because of the depletion of the workforce, the decline in the provision of public services and productivity of the private sector. It has been estimated that in sub-Saharan Africa, economic growth rates could be reduced by 1 - 2% per year. This may seem modest, but the resulting effect on government revenue and expenditures will significantly weaken the capacity to mount an effective response. At the same time as HIV/AIDS is draining public services – particularly education and health – it is also placing new demands on them. Strengthening health systems is integral to combating HIV/AIDS and to achieving the MDGs.

3. HIV/AIDS Challenge in South Asia

The epidemic in Asia is at a relatively early stage compared to sub-Saharan Africa where almost two-thirds of the world's people with HIV/AIDS live. However, there is no cause for complacency. Although regional prevalence in South and South-East Asia is low – at less than 1% on average – this figure masks the scale of the epidemic. The sheer size of the populations in Asia means that even when prevalence among the general population is low, millions of people are infected with HIV.

Awareness and knowledge of the disease remain low, and only a very small proportion of those infected know their status. In South Asia, high sensitivity of the sexual context of the disease has created a stigma around those infected. Stigma and discrimination undermine HIV prevention by making people afraid to find out whether they are infected, and they may prevent people from seeking treatment for HIV/AIDS. Stigma can prevent the use of condoms or can lead to HIV-positive women breastfeeding their infants for fear of being identified.

In Asia, the HIV epidemic remains largely concentrated among people engaging in high-risk behavior such as injecting drug users, refugees, migrants, men who have sex with men (MSM), sex workers and their clients. Many South Asian countries are experiencing a low national HIV prevalence, with significantly higher rates among vulnerable sub-populations. However, this could change quickly. In populous countries such as India, the size of these high-risk groups is extensive, increasing the threat of a rapid spread of infection to the population at large unless urgent prevention is undertaken.

According to the World Bank, significant socio-economic factors prevail which put South Asia at risk of a full-blown AIDS epidemic:

- More than 35% of the population live below the poverty line;
- Low levels of literacy;
- Cross-border and rural-urban migration of male populations;
- Trafficking of women and girls into prostitution;

- High stigma related to sex and sexuality;
- Structured commercial sex and casual sex with non-regular partners;
- Male resistance to condom use;
- High prevalence of STIs;
- Low status of women, leading to an inability to negotiate safer sex.

While risky sexual behavior may be the direct cause of HIV transmission, underlying factors drive risk such as poverty, vulnerability and cultural norms. According to UNAIDS, most new HIV infections in Asia occur when men buy sex. Many men visiting sex workers are also married and therefore risk not just contracting HIV, but also passing it on to their wives. In addition, there is immense social pressure on men to marry and have children; a well established homosexual identity is non-existent in Asia, and MSM are often married too. In a household study in India, 57% of men reporting sex with other men were also married. Provision of effective prevention measures to groups such as sex workers and MSM is inadequate, partly because of stigma and discrimination.

Asia: HIV/AIDS Facts and Figures

- AIDS claimed some 540,000 lives in Asia in 2004.
- The pace and severity of epidemics across Asia vary. According to UNAIDS, while some countries were affected early (such as Cambodia and Thailand), others are only now experiencing rapidly expanding epidemics (including Indonesia and Nepal). Countries such as Bangladesh, Pakistan and the Philippines are still seeing low levels of HIV prevalence and have golden opportunities to prevent serious outbreaks. Because of their sheer size, China and India are experiencing several distinct epidemics.
- In South and South-East Asia, there are 7.1 million adults and children living with HIV - this figure has risen by almost 11% compared to just two years ago.
- India is home to the second largest HIV-positive population in the world after South Africa, with 5.1 million people infected. The epidemic is extremely diverse: there are large differences between states, with localized pockets of the virus witnessing high prevalence rates: in Tamil Nadu, HIV prevalence of 50% has been found among sex workers. There are signs that injecting drug use is playing a bigger role in India's epidemics than previously thought. In the southern city of Chennai, for example, 26% of drug injectors were infected with HIV in 2000 - by 2003, 64% were infected.
- In Pakistan, overall prevalence is low however there are reports of high HIV prevalence among injecting drug users, indicating the widespread risk of HIV transmission. According to UNDP, poor availability of epidemiological data precludes a proper assessment of the HIV situation in Pakistan.
- In Nepal, HIV prevalence in the general population is still low, but is rising rapidly. Risky behavior in parts of the population, particularly the capital, is so extensive that it could be just a matter of time before epidemics erupt. Unsafe injecting drug use is the wellspring of Nepal's epidemic with widespread use of non-sterile injecting equipment.

There is still a window of opportunity for governments in South Asia to act to prevent the devastating social and economic impacts of the AIDS epidemics in sub-Saharan Africa. However, in the absence of an effective response, by 2010, more people will be infected in Asia than in Africa.

4. **Effective HIV/AIDS Responses**

South Asia is indeed on the threshold of an unparalleled AIDS epidemic. Action taken now will determine its development. Countries such as Brazil, Cambodia, Senegal, Thailand and Uganda have made progress in curbing the spread of the disease, showing it is possible to reduce or slow HIV by introducing strong programmes to prevent, treat and educate people about AIDS. It is now clear that linking care to prevention and dealing with the impact of AIDS can increase the effectiveness of HIV/AIDS responses. Availability of treatment and care can provide a strong incentive for people to seek HIV testing, and to access behavioral counseling and advice.

Effective strategies for combating HIV/AIDS may include the following interventions:

- ✓ Strong political commitment and leadership.
- ✓ A comprehensive, multi-sectoral approach backed up by sufficient financial and human resources.
- ✓ A coordinated national response based on partnerships between the government, civil society, NGOs and the private sector, involving people living with HIV/AIDS.
- ✓ A strong evidence-based prevention programme [*see below for more information on prevention.*]
- ✓ Care and treatment of people living with the virus, including increased access to anti-retroviral (ARV) therapy.
- ✓ Tackling underlying factors in the spread of HIV and addressing the causes of vulnerability such as stigma, discrimination and gender inequality.
- ✓ Blood screening and harm reduction initiatives for injecting drug users.
- ✓ Programs for orphans and vulnerable children.

5. **Prevention: What Works**

Prevention must be the cornerstone of national HIV/AIDS strategies in countries where the HIV prevalence is low - as in the majority of South Asian nations - in order to keep infection rates down. This calls for programs that can curtail the spread of HIV among the most vulnerable population groups with high-risk behavior, such as MSM, injecting drug users, sex workers, migrants and people living in poverty. National prevention strategies need to be comprehensive in nature, based on the evidence of successful prevention initiatives, and incorporating the elements endorsed in the UNGASS Declaration of Commitment on HIV/AIDS (June 2001).

Current HIV prevention coverage is extremely low. According to UNAIDS' "2004 Report on the Global AIDS Epidemic", globally, less than one in five people has access to basic HIV prevention services. Prevention programs are not reaching the people who need them, especially two highly vulnerable groups – women and young people. It is important for governments to go beyond pilot projects to scale up by increasing coverage and quality at the local, regional and national levels.

To be effective, HIV/AIDS prevention efforts must include the promotion and dissemination of condoms. The condom is the only technology currently available for protection against HIV/AIDS and other STIs. [*See Section 8 for information on new prevention technologies*]. When used correctly and consistently, condoms provide nearly total protection against HIV. Expansion of prevention programs, including condom

distribution, to rural areas is vital, as HIV spreads into the most remote regions. Thailand has employed the social marketing of condoms to great effect in its “100% Condom Use” program targeting sex workers and their clients. Social marketing combines market research and advertising techniques with health promotion through mass media. Condoms are usually the product that is marketed, often with a “dual protection” message to help protect against HIV and unplanned pregnancy. Strong logistical systems are a prerequisite for the timely shipping, storage and delivery of high quality condoms.

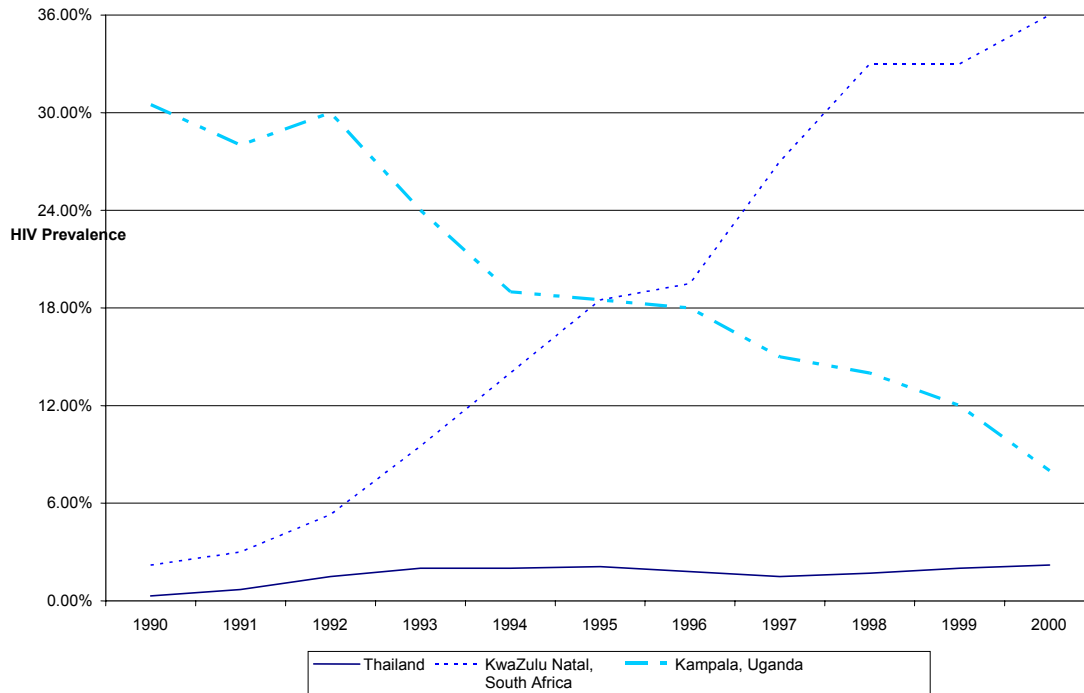
How to Succeed – Lessons Learnt in Prevention

Asian countries that have introduced large-scale prevention programmes addressing sexual transmission of HIV - notably Cambodia and Thailand - have recorded significant declines in the levels of new HIV infections. Key components include:

- ✓ promotion and widespread distribution of male and female condoms, including free and subsidised provision through the health system and social marketing;
- ✓ information and education to raise awareness of HIV/AIDS (particularly among young people);
- ✓ behavior change communication to reduce high-risk behavior;
- ✓ voluntary counseling and testing (VCT) - VCT is fundamental to addressing HIV prevention need, to addressing people’s rights to know their status and it challenges misconceptions about what it is to be HIV positive;
- ✓ provision of sexual and reproductive health information, education and services;
- ✓ prevention of mother-to-child transmission (MTCT).

Many countries in South Asia are now in the situation where Thailand and South Africa were in 1990. The response of those two countries – and the impact on the spread of the virus – is telling. Whereas Thailand mounted a national prevention campaign, South Africa’s approach has been characterized by denial. In Thailand, national adult HIV prevalence stood at 1.5% at the end of 2003, whereas South Africa has the highest number of people living with HIV in the world, with HIV prevalence among pregnant women of 27.9% in 2003. Thailand achieved this reduction through early decisive action, government leadership and a robust prevention program, which illustrates that a well-funded, politically supported and pragmatic response can change the course of the epidemic (please see the graph below).

HIV Prevalence Thailand, Uganda, South Africa 1990-2000



The ABC Model

Senegal and Uganda have implemented strong prevention programs incorporating behavior change communications and condom promotion to great effect. In Senegal, early decisive action to invest in HIV prevention and awareness programs to curtail the spread of the disease has paid off.

The “ABC” model: **A** – *abstain*, **B** - *be faithful*, **C** - *consistently use a condom*, is the mainstay of many HIV prevention programmes and has proven to be effective in Uganda. In Uganda, national prevalence fell from 33% in the early 1990s to 4.1% by the end of 2003. The national program focused on the promotion of safer sex behavior through condom marketing and distribution, radio and TV advertising and peer education. The significant increase in condom use also contributed to the decline in teenage pregnancies.

Sexual and reproductive health information and services are essential to HIV prevention. There are many advantages – although some challenges too – to integrating HIV/AIDS programs with sexual and reproductive health programs, so that they are complementary and not competitive. Improved access to family planning services enables increased condom use for HIV prevention, and reduction of mother-to-

child transmission of HIV (MTCT). Integrated services for the prevention, screening and treatment of sexually-transmitted infections (STI) and HIV/AIDS harness limited resources more effectively.

In each country where the response to HIV/AIDS has been successful, civil society - in the form of community-based organisations - has influenced national prevention plans so that they meet the needs of the most affected communities. To develop authentic ownership of a global prevention strategy, the participation of civil society, particularly people living with HIV/AIDS, in all aspects of the strategy should be promoted.

6. Addressing the Needs of Women, Young People, Orphans and Vulnerable Children

Women

Early in the epidemic, men vastly outnumbered women among people infected with HIV. Today, nearly half of all adults living with HIV globally are women. In Asia, the number of women living with HIV has increased by 56% since 2002, bringing the total number of women currently living with the virus to around 2.3 million. Factors affecting the spread of HIV/AIDS among women and girls in South Asia are poverty, early marriage, trafficking in persons, sex work, migration, lack of education and gender inequality.

Women's vulnerability to HIV is primarily due to inadequate knowledge about the disease, insufficient access to HIV prevention services, inability to negotiate safer sex, and a lack of female-controlled HIV prevention methods, such as microbicides. Women are also biologically more vulnerable to infection. In summary, they are twice as likely as men to contract HIV from a single act of unprotected sex, yet they remain dependent on male cooperation to protect themselves from infection. The female condom exists but is not as readily available as the male condom, and, unless subsidized, costs more.

HIV prevention efforts are failing women and girls as they continue to be infected with HIV: across the world many HIV-positive women were infected by their husbands or long-term partners. Marriage is no protection against HIV, with many women put at risk of HIV from their husband's behavior rather than their own. Across the developing world, the majority of women will be married by age 20 and have higher rates of HIV than their unmarried, sexually active peers. A World Bank study in India found that 90% of infected women were married and had had sex with only one man: their husband.

Although the ABC model has been successful, it can be limited because in countries where sexual violence is widespread, abstinence or insisting on condom use is not a realistic option for many women and girls. Because of their lack of social and economic power, many women and girls are unable to negotiate relationships based on abstinence, fidelity and use of condoms.

In poor countries, six million people with HIV/AIDS need anti-retroviral (ARV) treatment immediately, and women and children make up a large proportion of those who need care, treatment and support. Scaling up ARV treatment will also mean scaling up testing, counseling and prevention efforts. Now that treatment has become a real possibility in many countries, it is vitally important to ensure that women, children and other marginalised groups, such as injecting drug users and sex workers, have equal access. Given the global distribution of HIV by gender, women should constitute at least half of the people expected to gain access to ARVs in coming years.

Young People

The epidemic is disproportionately affecting young people, with the rate of HIV infection among young people worldwide growing rapidly. Half of all people infected with HIV worldwide are aged between 15 and 24 years. According to the Population Resource Center, among newly infected 15-24-year-olds in the developing world, young women outnumber young men by two to one. This trend is of particular concern since this is the largest generation of young people in history. However, young people also represent the greatest hope for turning the tide against HIV/AIDS.

Protecting the rights of young girls is key to lowering HIV prevalence among young people. Preventing sexual violence, including rape, is vital. Across the world, between 20% and 50% of all girls and young women report that their first sexual encounter was forced.

For young people, knowledge and information about HIV/AIDS are essential, and yet education about the virus is still far from universal. Attendance at school plays a central role in HIV prevention and is a key defense against HIV infection. Studies show that the longer girls stay in school, the less likely they will become infected with HIV. Improving access to education and implementing measures to address gender inequality are essential, as are HIV/AIDS programs aimed at meeting the special needs of young people, with confidential information, education and access to condoms.

Orphans and Vulnerable Children

AIDS is creating a new generation of orphans. UNICEF estimates that by 2003, 15 million children under the age of 18 had been orphaned by HIV/AIDS. When HIV/AIDS infects one or both parents, the very fabric of a child's life falls apart. Children, especially girls, must often drop out of school to go to work, care for their parents and look after their siblings. These children are often at increased risk of malnutrition and becoming victims of violence, exploitative child labor, discrimination or other abuses. In Cambodia, a recent study found that one in five children in AIDS-affected families had to start working to support their family. All of the children surveyed had experienced high levels of stigma and stress, with girls more vulnerable than boys.

Programs need to support the rising numbers of children orphaned by AIDS, and other young people made vulnerable by the impact of HIV and AIDS. Ensuring access to education is critical in responding to the orphan crisis. Children's needs must be taken into consideration in national programmes, including education and health services.

Resources for providing support to orphans and other children made vulnerable by HIV/AIDS have increased in recent years, not least through the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the creation of the US President's Emergency Plan for AIDS Relief (PEPFAR). However, not enough is being done to adequately protect and support this group. A wide range of government and civil society stakeholders need to provide financial help to vulnerable children, families and communities, along with HIV prevention, care and support.

7. Scaling up Treatment, Care and Support

The development of new and improved treatments both for underlying HIV infection and opportunistic infections has significantly altered the natural history of HIV and AIDS. During the last decade, researchers

have developed powerful ARV drugs that check the replication of the virus and can significantly reduce the viral load. Early use of today's ARV therapies, before HIV-related symptoms develop, may reduce an individual's risk of developing an AIDS-defining illness. Furthermore, many people with very advanced disease, including those with a prior AIDS diagnosis, have experienced remarkable recoveries in physical health. The use of ARVs during pregnancy can play an important role in preventing mother-to-child transmission as well as improving the health of the mother.

Treatment and care, including ARVs, can help keep people in the work force and keep parents alive longer, helping to build the economy and reduce or delay the number of orphans. By maintaining livelihoods and economic productivity, care and treatment can prevent or delay widowhood and orphanhood, thereby mitigating the factors that cause further vulnerability to infection.

Anti-Retroviral Therapy

- ARV drugs slow down the replication of HIV in the body and therefore the spread of the virus by interfering with its replication process in different ways. ARVs must be taken for life and are highly toxic.
- The use of ARVs in combinations of three or more drugs has been shown to dramatically reduce AIDS-related illness and death. For ARV treatment to be effective for a long time, different drugs need to be combined - known as “combination therapy”.
- The term “Highly Active Anti-Retroviral Therapy” (HAART) is used to describe a combination of three or more anti-HIV drugs. If one drug is taken on its own, it has been found that over a period of time, changes in the virus enable it to build up resistance to the drug and the drug is no longer effective. If two or more ARV drugs are taken together, the rate at which resistance develops can be reduced substantially.
- Triple combination therapy has long been the standard for treating HIV infection. The pharmaceutical industry is contributing to the simplification of treatment regimens through developing fixed-dose combination drugs, permitting all three drugs to be taken in one tablet or capsule, or, in the future, in a syrup for children.
- Generic ARVs are now being produced in a number of countries, including India, Brazil, Argentina and Thailand. These companies often supply the pharmaceutical companies that make branded ARVs. Generic drugs are often much cheaper than the lowest price offered by the manufacturer of the branded equivalent.
- Generic producers must carry out studies to show that their product has an equivalent profile to the branded product. In order for ARVs to be listed by the WHO, officials must inspect the manufacturing processes.
- Trade barriers can prevent affordable drugs from reaching other countries. The key WTO agreement of August 2003 - although complex - allows countries without their own manufacturing capacity to import cheaper, generic drugs, and, as such, is a step forward.

Recent reductions in the price of ARVs – helped by various initiatives and the availability of generic drugs – mean that treatment is becoming more affordable. However, even though the price of ARVs has plummeted, low-income countries still find it difficult to make the drugs accessible to the poor. WHO estimates that the price of certain generic combinations of ARVs is \$300 per person per year. The high cost of the medicines, inadequate health care infrastructure and lack of financing has prevented wide use of combination ARV treatment in low- and middle-income countries. According to UNAIDS, in 2004, fewer than 6% of people who needed ARV treatment immediately in Asia were receiving it.

Few countries worldwide have followed Brazil's lead in providing ARVs to children and young people as part of a national treatment program. The heavy reliance on ARVs in Brazil was facilitated by significant price discounting on locally manufactured generic drugs and the fact that there is a reasonably robust health system. In India, however, positive examples exist of increased access to ARV drugs. For instance, the William J. Clinton Foundation has succeeded in securing substantial reductions in the price of generic ARVs. It has brokered a deal with three Indian generic drug companies (Cipla, Ranbaxy and Matrix) to offer two key ARV cocktails for as little as US \$0.38 a day – less than half the price of the cheapest drugs previously available in India.

Nevertheless, the pricing of drugs is not the only challenge. The poorest countries are not able to take advantage of lower treatment prices because they do not have strong enough health systems to administer the drugs. Strengthening health systems and improving the health infrastructure in Asia in order to administer ARV drugs are vital. This entails providing technical assistance, training health workers, establishing the logistical supply lines, and upgrading every aspect of the health systems infrastructure. It is essential that vertical or parallel HIV/AIDS care and treatment programs are not developed separate to national health services, but rather that efforts focus on strengthening and making more effective existing health systems.

In order to boost support for access to treatment, in December 2003, WHO and UNAIDS launched an ambitious campaign - known as the "3 by 5" Initiative - to ensure that three million people living with AIDS in developing countries receive HIV/AIDS treatment by the end of 2005.

8. New Prevention Technologies

To answer the call for greater prevention options, new technologies such as vaccines and microbicides are currently undergoing research and development.

Microbicides are chemical compounds that women could apply topically before sex to block HIV transmission. They are being researched in the form of a gel, film, sponge, lubricant or suppository. The Global Campaign for Microbicides is an international effort to build support among policy-makers, opinion leaders, and the general public for increased investment in microbicides.

The International AIDS Vaccine Initiative is a global not-for-profit organization working to accelerate the search for a vaccine to prevent HIV infection and AIDS. Since it is unclear when new technologies will be available and how effective they will be, it is important to continue with other methods of prevention (the female condom stands as the only female-initiated barrier to infection.) A preventive AIDS vaccine would elicit an immune response to protect the body from HIV infection. A vaccine would be administered via injection or potentially orally, and could offer women more control than current prevention methods, as its

use is not associated with sexual acts. It can potentially be taken without a partner's knowledge in cases in which a woman may fear that informing her partner would place her at risk of violence. The goal is to have an effective vaccine available so that women can be vaccinated before engaging in behavior that puts them at risk.

9. Global Funding

In recent years, HIV and AIDS have moved much higher up the international agenda. In turn, this has led to more money being made available for programmes. The creation in 2001 of the Global Fund to Fight AIDS, Tuberculosis and Malaria signaled a boost to funding for HIV/AIDS and the US Government's announcement in January 2003 of PEPFAR, a five-year \$15 billion initiative to fight AIDS, set a new global benchmark for HIV/AIDS resources.

According to the latest information from UNAIDS, global funding (domestic spending, bilateral, multilateral donors and the private sector) has increased to an estimated US\$ 6.1 billion in 2004, and access to key prevention and care services has improved. However, this increase is not sufficient to meet the need for HIV prevention, care and treatment programs. UNAIDS estimates that by 2007, US \$20 billion will be needed for prevention and care in low- and middle-income countries. It is also important that developing country governments prioritize HIV/AIDS funding within Poverty Reduction Strategies. Fully funding the response to AIDS will require immense effort and extraordinary leadership.

In addition to mobilizing increased resources, co-ordination and co-operation between donors should be improved. Many developing countries are struggling to keep up with the requirements of individual donors. To this end, in April 2004 a number of major donors endorsed three key principles that would underpin their support for nationally-owned action against HIV/AIDS. Known as the "Three Ones", the principles aim to improve coordination by calling for one HIV/AIDS action framework; one national AIDS coordinating authority and one agreed country-level monitoring and evaluation system.

10. Importance of Political Leadership in Addressing HIV/AIDS

The international community – and the governments of developing countries themselves – have been slow to recognize the enormous scale of the AIDS epidemic. South Asia combines all the elements necessary for a very high potential for rapid HIV transmission, both within its vulnerable groups and to the wider population. Although most South Asian countries have established national HIV/AIDS policies and coordinating bodies through their health ministries, few have mounted a comprehensive, multi-sectoral response to the virus by scaling up effective pilot prevention programs or openly confronting high-risk sexual behavior.

However, the good news is that countries such as Brazil, Cambodia, Senegal, Thailand and Uganda have turned the tide against HIV/AIDS. Integral to the success of countries such as these is early decisive action, a comprehensive multi-sectoral response and, crucially, strong government leadership.

To combat HIV/AIDS not only requires mounting effective HIV/AIDS programs providing prevention, care and treatment, but also mobilizing public opinion to change attitudes and behavior, opposing the discrimination and stigma against people living with HIV and tackling underlying factors which fuel the spread of HIV. Responding to HIV/AIDS requires societal action, public advocacy and a political response from governments and members of Parliament (MPs). Parliamentarians can ensure that actions are stepped

up to fulfill both the UNGASS Declaration of Commitment on HIV/AIDS (June 2001) and the “Kathmandu Call Against HIV/AIDS in South Asia: Accelerating Actions and Results” (February 2003).

Strong and sustained political commitment and will to tackle HIV/AIDS are essential to a successful strategy. In all countries where the spread of the epidemic has been curbed, governments and MPs have shown an openness and willingness to act. Conversely, its rapid spread is fuelled by a denial of its existence. If South Asia is to mount an effective response to HIV/AIDS, the challenge must become a central priority for national legislators. South Asian parliamentarians can exercise a key function in mobilizing resources, influencing policy, raising awareness of HIV/AIDS and speaking out at local, regional, national and international levels. The role of parliamentarians, as policy-makers and opinion-leaders, is crucial in bringing about change.

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