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XVII International AIDS Conference Regional Session: Asia-Pacific August 4, 2008

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J.V.R. PRASADA RAO: I am Prasada Rao; I am the Director of the Regional Support Team of UNAIDS for Asia and the Pacific, stationed in Bangkok. And I would like to first welcome all of you and also congratulate the AIDS Society, and the ASAP, and particularly Bernard [inaudible] and the whole team for their vision in organizing a regional session on Asia and Pacific. Because for the first time, we see a regional session like this being organized in the International AIDS Conferences. And in a conference of this magnitude, global issues and challenges always take precedence, and rightly so. But it is now quite evident that the epidemic and the response do not always follow a global pattern and has several regional variants.

So, the regional and country-level action is what ultimately makes the difference in terms of implementation of programs and their effectiveness and prevention as well as in treatment. And we all know that Asia and Pacific Rim region are mostly of low and concentrated epidemic countries, but still accounting for almost five million infections, second only to Africa, so it is not a small matter. An additional factor, ladies and gentlemen, is that Asia today is home to some of the fastest-growing economies of the world. Like China, India, Thailand, Malaysia, Vietnam, we are the emerging economies of the 21st century. And millions of people are getting out of

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poverty because of this economic advancement, but the flipside is that all the concomitant risk factors, which contribute to a rapid spread of HIV, are also getting aggravated, due to large-scale migration, disposable incomes in the hands of first-generation migrants, who are mostly young men, and greater demand for paid sex and drug use. There is a [inaudible] of something like 75 million men, young men, seeking paid sex and 10 million women who are ready to sell sex to this 75 million men and that is not a small number. These regional dynamics need to be properly understood, analyzed, and to do this today, we have an excellent panel of experts on the region who will present the various facets of the epidemic and the response before us here today.

But, before doing that, it is my present duty to introduce my co-chair, Professor Myung-Hwan Cho from South Korea. Myung-Hwan Cho is Professor of Konkuk University in Seoul, South Korea. He got his PhD in microbiology and immunology from the University of Arizona, and he also holds a masters degree in public administration from the Kennedy School of Government of Harvard University. He was a visiting scholar at the Center for AIDS Research at Stanford University, and currently Myung is the president of the AIDS Society of Asia and the Pacific, ASAP. As you all know, that ASAP and UNAIDS collaborate together in organizing the regional conferences, the ICAAPS, every two years. So, that way, it is a great

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pleasure to have Myung as my co-chair here, and I now pass the mic to Myung to make his introductory remarks.

MYUNG-HWAN CHO: Yes, thank you, Prasada. Actually, especially in Asia, the civil society engagement and commitment are really crucial in responding to AIDS epidemic, especially because, in Asia, there are not enough resources in fighting off the HIV and AIDS. So, as the custodian of ICAAP, International AIDS Congress, International Congress on AIDS in Asia and the Pacific, we have this biannual meeting. The reason why we are holding, we are organizing this meeting, is that we want to create in across, in a sector and across disciplinary synergies, associations of social science with biomedical science and government with business, and perhaps even communities with business.

And, also, we want to provide opportunities to create network of people, network of civil society to ensure their empowerment. So, last year, we had a successful ICAAP in Sri Lanka and next year, in August 2009, we are going to have our ninth International Congress on AIDS in Asia and the Pacific in Bali, Indonesia. So, I would like to invite all of you to go to the, to come to Bali for this International Congress on AIDS in Asia and the Pacific.

And, so I would like to introduce my colleague, Prasada Rao, and Prasada Rao is the director of the Asia Pacific Regional support team of UNAIDS and is stationed in Bangkok.

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And Prasada is associated with AIDS program for the last 12 years in [inaudible] National Program Director of India's programs. Later, as the permanent secretary of health and government of India, and for the last four years in UNAIDS as the Asia Pacific director. Prasada represented his country in UNAIDS PCV and a transitional working group, which defined architecture of the global fund. Prasada also served as the member secretary of the Commission on AIDS in Asia. We co-chaired the working group on newly emerging economies under the AIDS 2031 initiative.

Today, we will have a chance to look at what impediments which continue to hamper scale-up with presentation from civil society colleagues, addressing stigma, discrimination implication for advocacy. So, each of the four speakers will be given 12 minutes to speak, following which we will have 20 minutes for question and discussion. In the question and the answer session, I hope colleagues from regions, other than Asia, will not hesitate to share and compare from their own experience.

J.V.R. PRASADA RAO: Thank you, Myung, for those introductory words. So, [inaudible], let us get now to the presentations. The first speaker on our list is Professor Aikichi Iwamoto from the Institute of Medical Sciences in University of Tokyo. Dr. Aikichi is a professor at the University; he has been in charge of the HIV clinic and the

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division of infectious diseases in the Institute of Medical Sciences in University of Tokyo since 1994. Professor Iwamoto chairs the National HIV Surveillance Committee of the Ministry of Health, Labor and Welfare of Japan since 2005. He is a government council member of IAS since 2006. He is also an executive committee member of AIDS Society of Asia Pacific, representing IAS since 2008. So, over to Dr. Aikichi.

AIKICHI IWAMOTO, M.D.: Thank you, Mr. Chairman, for kind introduction. Our chairman said my task is usually patient care and clinical biology and immunology in the laboratory, but today I was asked to summarize the current epidemic in Asia and the Pacific. As already Dr. Rao said, in the recent update by UNAIDS, there were five million people living with HIV in Asia and the Pacific in 2007. Three hundred and eighty thousand people were newly infected. Equal number of people died from AIDS-related illness. Countries in Southeast Asia, such as Thailand, Cambodia, and Myanmar were hit by HIV in the 1980s and have still high burden of the epidemic. There are countries with rapidly growing epidemics, such as Papua New Guinea, Indonesia, and Vietnam.

Although at a slower pace, new HIV infections are also increasing steadily in populous countries such as China and Bangladesh. Early wave of HIV epidemic hit Thailand, Cambodia, and Myanmar in mid, in the 1980s. In Thailand, HIV prevalence among injecting drug users rose dramatically from virtually

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zero to 40-percent between 1988 and 1989. Forty four percent of sex workers in [inaudible] were infected with HIV. In 1991, HIV prevention and control were put into the national priority and the budget was increased almost 20-fold. Massive campaigns and 100-percent condom program was initiated. Cambodia echoed the similar strategy; both countries could see substantial decrease of HIV prevalence in the country since late 1990s.

Even the success in the general population, the prevalence among the injecting drug users stayed very high in Thailand. Recently, prevalence of HIV among men who have sex with men has been increasing sharply. In Thailand and Cambodia, HIV epidemic in the marginalized populations such as injecting drug users and female sex workers, led to the subsequent tsunami waves of the epidemic among male clients, their wives, and their children.

Recently, HIV epidemic has spread to other marginalized population, such as men who have sex with men, migrant workers, and so on. These overlooked populations are under strongest stigma and discrimination, which constitute major barriers to access prevention. In Indonesia, estimated number of people living with HIV, almost three-fold from 2001 to 2007. Overlapping lists of drug injection and unprotected sex have been pointed out. In Papua New Guinea, the number increased more than five times from 2001 to 2007. The epidemic is growing in other countries, such as Vietnam.

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There are almost five million injecting drug users in our region. Outbreaks of HIV infection among injecting drug users have occurred frequently in various places since early 1980s. Injecting drug use is a major risk factor of HIV infection in countries such as Vietnam, Malaysia, Pakistan, and China. Injecting drug use is [inaudible] serious epidemic in our region. The population of women living with HIV has increased from 26-percent in 2001 to 29-percent in 2007 in Asia. One hundred fifty thousand children under 15 years old were infected with HIV; 24,000 children were newly infected with HIV; and 80,000 children died due to AIDS in 2007. Even in the era of highly antiretroviral therapy, many people are dying from AIDS. The great majority of countries are in need of urgent access and scale-up of antiretroviral therapy. Even in Thailand, [inaudible] scale-up remarkably needs better regimens. All the generally available regimens contain D4T, which is hardly used anymore in the developed countries.

Each country has different histories of HIV epidemic. Several modes of transmission are present, sometimes in [inaudible], sometimes overlapping. Sixty percent of the population living in Asia, the two most populous countries in the world having over one billion population, one billion people, are present in our region. Even a low prevalence would create a big burden. In India, it was thought once that India has the largest number of people living with HIV in the world,

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although lower estimation was announced recently. It is mainly due to the expanded and improved surveillance system that the epidemic in India has to be monitored carefully.

In conclusion, prevention is extremely important in the densely populated Asia and the Pacific. Strong will and strong commitment of the government and the public to prevent the expansion of HIV epidemic is mandatory. Many people helped me to prepare the presentation; thank you very much. [Applause]

MYUNG-HWAN CHO: Thank you. Our next speaker is Dr. Sujatha Samarakoon. She is presently a medical specialist, National AIDS Control Program of the Ministry of Health of Sri Lanka, and also serves as examiner and supervisor, Postgraduate Institute of Medicine in Columbia. She was co-chair of the very successful eighth ICAAP, which was held in Columbia in August 2007. In ASAP and UNAIDS are the co-primary sponsor of ICAAP. Today, she is going to talk about the [inaudible] from the latest International Congress on AIDS in Asia and the Pacific, and response beyond borders. Dr. Sujatha?

SUJATHA SAMARAKOON: Thank you very much. The key messages from the eighth International Congress on AIDS in Asia and the Pacific and response beyond borders. The eighth ICAAP was held in Sri Lanka, a developing country categorized as a country with a low prevalence of HIV infection. As you see in the slide in front of all of you, we got a team called "Waves of Change, Waves of Hope." We all live in hope whether we are

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HIV-positive or HIV-negative. For HIV-positive people, survival as much as for HIV-negative people, is the important criteria, and the quality of life, which was addressed at the eighth ICAAP. ICAAP gave the opportunity to discuss the epidemic in Asia, which shows great diversity, both in timing and severity.

The two main driving elements of the Asian epidemic, sex workers and men who have sex with men were addressed in several forums. Human rights, gender equality, testing issues, political leadership are areas which I will present today. Focus on MSM, the importance of playing a major role by this important category of people in advocacy and support for regional and global networks, for which would provide the pivot on which people could lead the scaling up of universal access was highlighted over and above all the other presentations. Launch of the Asia Pacific Coalition for male sexual health and HIV was a major milestone at the conference. Human right issues regarding the issues in the Asia Pacific and also the rest of the globe were taken into consideration. A strong statement was issued on under appreciation of basic human rights and concepts of equality and security as applied to rights and sentiments are fundamental. It was stressed that the thrust of the activists is reducing and more momentum should be given for activism across the globe. The group from China highlighted the positive people's difficulties, the denial of right to freedom of association, holding meetings, and accessing legal services

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for protection against harassment. Launch of the handbook on HIV and human rights from National Human Rights Institution took place. It was brought to light that there are no complaint handling mechanisms and immediate action should be taken for provision of the address and compensation for HIV-related human rights violations.

The need to advocate for sound legal and policy frameworks for managing AIDS response at the national level was flagged as a key towards people living with HIV having equal access to a variety of services. The importance of developing health, economic, and social policies, which are responsive to the needs and aspirations of people living with HIV was given due attention. Gender equality was stressed with the role of women playing a key figure in the Asia Pacific region. Prevention of mother to child transmission, particularly if you label it as prevention of parent to child transmission was given due consideration. Sexual and reproductive health linkages have to be established so that people living with HIV and marginalized groups are given high priority. The high level Ministry meeting was attended by several health ministers in the region and their secretaries, moving from the corridors of power to people's backyards was debated. However, we need to see where we are today.

Testing issues were discussed at great length, which is debatable today, whether we are going for [inaudible] or we are

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moving towards provider-initiated counseling and testing. It was emphasized that case finding mission is important, however, not forgetting the fact that informed consent and confidentiality has to be attached to counseling. The issues of migrant workers were tested. Migrant workers being tested without proper counseling at the request of the destination country is being debated continuously without much answers as yet today. Business community in response to AIDS was a very positive move in a low prevalence country where several business leaders got together so that they form a coalition which will promote the promulgation and enacting effective legislation for HIV policies in the workplace. The Coalition will also encompass health, social, culture, economic factors in corporate policy as these are considered as interlinked factors for vulnerability to HIV infection. The launching of the Portraits of Commitment by the Asia Pacific leadership forum was a significant milestone in documenting the tireless efforts of a group of advocates from the South Asia, which inspires the work against fighting of AIDS.

Problems in the Asia and the Pacific were highlighted. UNAIDS with other UN agencies called upon all countries to scale up universal access for prevention, treatment, and care. However, we should still not forget that we have not been able to disperse stigma and discrimination. It was stressed that immediate action should be taken to overcome the barriers faced

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by the most at-risk groups, the sex workers, the drug injectors, the men who have sex with men, the transgenders, and bring them to the forefront of all activities and making them the bigger actors of the universal access team. The success behind the harm reduction and barriers in implementing them were showcased. Legal obstacles to the use of methadone in most countries in the region, despite the fact that methadone has been on the [inaudible] essential list since 2005 was discussed. Attention was given to the launching of the minimum standards for civil society participation in universal access by the Seven Sisters, which is asked to be used as an important tool for promoting greater involvement of the civil society. Specific issues of groups in Papua New Guinea were discussed as their participation was high compared with other countries in the region.

We will need to look forward to the ninth ICAAP to find answers, which were left as gaps in the eighth ICAAP. What happened during the last 24 months? What happened regarding human rights issues? What happened regarding the PICD issues and the linkages of sexual and reproductive health and HIV linkages. We are looking forward for answers to these gaps.

Before I close, just a word on the response beyond borders. It was important to mention the focus at the first Asian Consultation on HIV prevention related to drug use. The policy harmonization is vital as coordination and coherence

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between law enforcement and health sector is essential. Link UNGASS on drugs with UNGASS on HIV. Women who use drugs, they have their special needs, which need to be focused. Hepatitis and injection drug users, the exorbitant prices of some of the drugs need to be closed down. Drug users involvement adds nothing for us without us needs to be looked at.

There is, the eighth ICAAP would not have been a success if not for all these players. The local organizing committee, which worked tirelessly to bring about 2,500 delegates, making a successful eighth ICAAP is highlighted probably in all Asia Pacific region conferences that were held beyond 2007. I take this opportunity to thank all of you for being here, and opening the doors for everyone to take a look at what Asia and Pacific is hitting on. And I take this opportunity to thank Bernard, Maura, and [inaudible] for their valuable advice in preparation of this presentation. Thank you very much. [Applause]

J.V.R. PRASADA RAO: Thank you, Sujatha, for that excellent summary of the issues that were raised in the ICAAP and what need to be taken forward in the next ICAAP. We now have the presentation from Maura Elaripe Mea, who is the current [inaudible] advocacy officer with [inaudible] in Papua New Guinea. [inaudible] AIDS program in Papua New Guinea is a large program, and Maura also serves as a board member of [inaudible] which is the network, national network of the

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People Living With HIV in PNG. As an advisor to the Asia Pacific network of People Living with HIV, the APN Plus, and also the Asia Pacific Women [inaudible] and the International Steering Committee of International Community of Women Living With HIV, the ICW. Maura's work focuses heavily on advocacy and activism, [inaudible] formulation of appropriate policy and programs on HIV, around issues of [inaudible] access to treatment, care and support, human rights, and leadership in Papua New Guinea and also in the Asia and the Pacific region. Maura, you have the floor.

MAURA ELARIPE MEA: Thank you. Well, my topic will be on key advocacy issues. The first part will be looking at Papua New Guinea, the advocacy issues within Papua New Guinea, and the second part will be within the Asia Pacific region as a whole. Some of you might not know where Papua New Guinea is, so here it is just at the northern tip of Australia. An overview of the PNG HIV and AIDS status, PNG has had generalized history of the epidemic which is a one-on-one ratio, and the number of young women infected with HIV is rising fastest. So, a main mode of transmission is through heterosexual intercourse.

Advocacy challenges within PNG. Co-commitment is weak; there is no co-commitment within the political arena. The health system is also very weak infrastructure, the procurement, and lack of champions in key areas, like treatment, prevention, care, and support. And also there are

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geographical issues within our country. We have a diverse culture and 800 different languages, which makes advocacy a real nightmare. The successes at PNG, and I am just going to go through some of the successes. The passing of the HIV and AIDS Prevention and Management Act by the Parliament in 2003, has really helped people living with HIV [inaudible]. And one of the successes was PNG produced the first country report to UNGASS this year, which is a major success, and I would like to thank UNAIDS for their support in assisting PNG in producing the report.

Also, establishment of the National Network of Positive People in Papua New Guinea, which is IGAT HOPE has also been a major step in advocacy. And one of the successes that there has been an establishment of the Independent Review Group, the IRG, reviewing performance of the planned activities against the objectives of the national strategic plan of Papua New Guinea, which is 2006 to 2010. And PNG is one of the countries that has taken up this best practice and it has been a real success for us.

Some of the recommendations are on advocacy for Papua New Guinea is, we have not, we have a national AIDS council secretariat, but we do not have a national AIDS council itself, so it was abolished last year in July. But that needs to be reinstated either to facilitate some of the issues that are affecting our country. And we need to also step up advocacy and

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communication training for positive people in Papua New Guinea. Currently, positive people do not know a lot about advocacy and it is also a challenge and a hindrance to our programs. And one of the other pressing issues is, and this is a recommendation also that to start provider-initiated test without informed consent and pretest counseling, because the provider-initiated testing has been rolled out in PNG and, from what I have seen on the ground, it is a nightmare. Pregnant women have just been tested without their being given the choice to opt out; there is no opt out in this case in PNG.

Advocacy overview within the Asia Pacific region. Drug use and sex works are the major drivers of the Asian epidemic. The recent formation of International Network of People Who Use Drugs in Asia Pacific region was launched at the ICAAP, eighth ICAAP in Sri Lanka, which is a great step towards advocacy issues around drug uses. And the Commission on AIDS report provides great advocacy opportunities as well. We have migrants that are completely left out of this report. Advocacy challenges in Asia Pacific region. Access to second line antiretroviral drugs is a big problem within Asia Pacific region; most of the positive people cannot access [inaudible] and so cannot participate actively in advocacy as well. The meaningful involvement of drug users still remains tokenistic in Asia Pacific region, just like for other at-risk

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populations. And to stop provider-initiated testing without informed consent.

Some of the advocacy successes in Asia Pacific region. The launching of the Australian Harm Reduction project and UNAIDS PCB in April of 2008. Also, the launching of the International Network of People Who Use Drugs for the Asia Pacific region was during the ICAAP. And one of the successes, the launching of the Portraits of Commitment, a book by the Asia Pacific Leadership Forum. And this book is a fantastic book, and I really am thankful to the APLF for producing this. It is a great advocacy tool. And the setup of specific groups within Asia Pacific network of positive people, such as the women, the Pacific Women's Group, the Pacific ID Use Group, and the Pacific MSM Group.

Recommendations. It is recommended that support, there should be continuous support made to the International Network of People Who Use Drugs in Asia Pacific [inaudible] declaration. Second-line ARVs and hepatitis C treatment must be made accessible and available throughout the region. Create income-generating projects for women and children, and stop provider-initiated test where there is no informed consent or pretest counseling involved. And I do not know about other regions and other countries, but for what I have seen within PNG, it is a real problem where people are not opting out and healthcare workers, because there is the imbalance and the

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power dynamics between the healthcare workers and the clients. The clients cannot opt out and healthcare workers tell clients that you have no right to, I know what I am doing, you should all go through testing. And this is wrong. It is a clear breach of human rights.

Lastly, I just want to leave this quote with all of you. "If we cannot now end our differences, at least we can help make the world safe for diversity." Thank you. [Applause]

MYUNG-HWAN CHO: Well, I think this has been a very good first joint session, so right now, I would like to give you a chance to ask questions and comments. Oh, one more; I am sorry. Okay. I love Vince. Okay, Mr. Vince Crisostomo is coordinator of the Coalition of Asia Pacific regional network on HIV and AIDS, which was formerly known as the Seven Sisters with regional headquarters in Bangkok. Vince is going to talk about the key learning and lessons from Asia Pacific. Vince?

VINCENT CRISOSTOMO: Okay. Good afternoon, everyone. I will be talking a little bit about the Commission on AIDS in Asia, and then I will be highlighting a successful objective in the region. The Commission on AIDS in Asia was an independent body that was established in July 2006, and it was chaired by Doctor— I am sorry; I cannot read the slide. Sujatha, can you help me with this? Can you say the name? Okay. Sorry about that; I apologize. Who was chairman of the [inaudible] Advisory Council to the prime minister of India. It brought together

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nine of the regions leading development, economists, epidemiologists, policy makers, and civil society representatives working on the AIDS epidemic. In 2007, a report was produced and analyzed the HIV epidemic in Asia from a wider socioeconomic perspective, and also medium to long-term implications.

What Asia can share with the world. In a few instances, strong and focused efforts here brought striking results on a large scale as examples of Cambodia, Thailand, and the Indian state of Tamil Nadu reveal. And I just want to break a minute from my slide presentation because one of the other lessons that is learned, which is actually not going to be covered in my presentation, is that this independent commission on AIDS in Asia, the report, it also featured a consultation by civil society where over 600 people responded. And from this consultation, we were able to get, come up with a programmatic framework that those of us in civil society working in the field can use as an advocacy tool. And it also showed that what we, as a region, because it is often said that it is so hard to work in Asia, it is so hard.

But, honestly, with a little effort and a little support, and what, and I really do feel that Farika, who should be doing this presentation, said to me, she needs to be acknowledged, because she is a young woman living with HIV. She is a leader in our community, but she took it upon herself to

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do this consultation, but she could not do it without the help of everybody— UNAIDS RST, who were incredibly supportive. And, in the end, we in civil society have a tool that not only talks about the issues of our region, but also gives us a framework in which we can connect to the other regions.

So, for me, it is an even more universal tool. And when this was launched in March of 2007, this year at the UN, Secretary Bonki Moon has made several comments, which supporting MSM and drug users, which for our region is really historic. And so I just wanted to put that out there; it is not in my presentation and I hope that is okay, but for our community to hail this hero, Farika and her work, it really is a lesson that I think needs to be acknowledged.

So, I am going to talk about this presentation here, this intervention, this project that happened in Tamil. Okay, so the first case of HIV infection in India was detected in Tamil Nadu in 1986, and as the number of infections grew, the AIDS Prevention and Control Project, APAC, was started in [inaudible] in 1995 under a tripartite agreement between voluntary health services, VHS, which is a noncharitable government organization in Chennai. The APAC concentrated on high risk population groups for targeted interventions, including long distance truck drivers, female commercial sex workers, tourists, slum populations, factory workers, men having sex with men, and migrant workers, a network of 72

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carefully selected NGO partners, which delivers the intervention programs in [inaudible]. The program designed for implementation was for high risk behaviors, not only to protect people that practice high risk behaviors, but also to those who are contracting, like the slide says, HIV, but preventing the spread into the general population. The programs were implemented in 21 districts of Tamil Nadu and Pondicherry since 1995, and the program cost U.S. dollars, about 25 million for the second phase.

The agreement between the representatives of the community organizations, government and funding agencies, this is how it worked. A community needs assessment was carried out and determined which materials were required for behavior change. There were specific policies and procedures that were developed and 72 NGOs delivered the programs. The program was governed by a Project Management committee where its members included governments, NGOs, and donors, and the program was carefully monitored and evaluated. Thematic areas of the intervention, these are all the groups that it hit, prevention along the highway; it was PATH. Women in prostitution, which was WIP; slum intervention program, which was SIP; tourist and women, prostitution, industrial intervention program, men having sex with men, MSM, and the migrant intervention program, which was MIP. And all those names are very cute.

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So, the strategies that were adopted. Spreading culturally sensitive messages through peer education, promoting condom use, street plays, promotion of quality services, interpersonal communication, behavior surveillance surveys. And it created a healthy environment for people living with HIV, so that they and their families can lead normal lives.

Okay, the results. Condom usage among female sex workers with clients has increased from 56 in 1996 to 85.9 in 2004. The volunteer procurement of condoms has shown a steady increase to— I am sorry, I cannot read my slides. Eighty seven percent in 2004 from 11-percent in 1996. Risk perception among the female sex workers has increased from 42-percent at baseline in 1996 to 77-percent in 2004. And involvement of truckers and helpers with a nonregular partner has declined to 35.7-percent in 2004 from 48-percent in 1996. Other results are condom usage of truckers and helpers with paid partners has increased by 88.5-percent in 2004, from 55 in 1996. Increase in condom distribution from 17,000 outlets in 1996 to 56,505 outlets in 2004. And an increase in sale of condoms to one million pieces in 2004. And this is kind of just a chart that kind of maps the results of the VSS. And I think I would just leave it at that, and we can open the floor for questions.

[Applause]

J.V.R. PRASADA RAO: Thank you, Vince, for the presentation. What Vince tried to do was just speak [inaudible]

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recommendation out of the Commission on AIDS in Asia, that is focused programs, and then tried to illustrate it with an example from India. Now, we have time for question-and answer session, and I thank all the speakers to sit through the time. In fact, they have allowed a little more time for discussion by completing their presentations in a shorter time.

So, those who would like to ask questions, there is a mic up here, you may kindly come here, introduce yourself and the organization you represent, and also the panelist to whom you want to pose the question. If the questions are in English, they are not a problem, but if there is a question which is asked in Spanish, there is an arrangement for translation I think that can be utilized. So, now the floor is open for questions.

ROBERT BALDWIN: It is Robert, Robert Baldwin from Asia Pacific Network of People With HIV. My question is directed to Maura, and thanks for a great presentation, Maura. You mentioned several times about problems to do with provider-initiated HIV testing and nonconsent, particularly in your experience in Papua New Guinea. Would you like to share any ideas you have for how we could challenge this appalling state of health provision?

MAURA ELARIPE MEA: Thank you, Robert. From what I have seen in the PNG experience is that PICT, they are just starting to roll it out. But what I would like to see is to train

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healthcare workers properly in this area and to also get consult with civil society organizations. Because in the PNG experience, civil society organizations were not consulted before the government went ahead and rolled out the program. And it has been a real concern to all of us. And the National Network of Positive People, which I belong to in PNG IGAT HOPE is also concerned about this because once we are testing people left, right, and center without their consent and they are tested positive, what services do we have in place? What kind of treatment do we have? Because treatment is a big issue in PNG as well, and services are not reaching the people. So, what I would like to see is if we want to scale up [inaudible] scale up treatment, scale up care and services, care and counseling services, train healthcare workers, and get the procurement and infrastructure of the healthcare system in place. Thank you.

FEMALE SPEAKER: Good afternoon. I am [inaudible] from the YWCA of the Philippines. Thank you for the very nice presentations, very enlightening, and I have realized how the extent of your work in the Asia Pacific region. My first question, I have two questions. My first question is addressed to all the panelists. To what extent is the role of young women in the [inaudible] as well as those young women who are tested positive? And my second question directed to the lady in the middle. You mentioned about mandatory testing on destination

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countries. What is the extent of mandatory testing upon return to their respective countries of all migrant workers?

J.V.R. PRASADA RAO: Thank you. I think the first question is about the young positive men and how they [inaudible]; am I correct? Yes, I think maybe, Sujatha, you can try to answer this question. And the second question can go to Maura.

SUJATHA SAMARAKOON: Regarding young women, I think most countries are concentrating to the civil society organizations to reach out to young women, particularly if you look at prevention of mother-to-child transmission. In low prevalence countries, the first prong, that is to prevent HIV among young men and women, is being brought to light. So, in that context, and also preconception counseling, couple counseling, those are coming up in the Asia Pacific region, so that women are given an insight to gender equality, their decision-making, their role as mothers to be, and their role as mothers. So, it is emerging. I think in the eighth ICAAP, there was so many young women groups who started advocating for their rights and equality.

Then your second question about mandatory testing. The decision is by the destination country, but on what rules and regulation they emphasize on the mandatory testing? I really do not know. But as I told you, this debate has been going on and

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on. But as far as I know, there is not a positive answer. That, again, is without any consent and counseling.

FEMALE SPEAKER: My name is [inaudible]; I am from India. This question is for the chair, Mr. Prasada Rao. Two questions. The AIDS Commission report is indeed very nice, but the UNGASS report that was unveiled, and UNGASS did show that none of the countries in Asia Pacific, except for Thailand, has been able to reach closely even 50-percent of target set for universal access. So, I just want to know where we are with that, and what are the plans for scaling up so that we at least reach 50-percent, if not universal access, by 2010? That is number one. And in your remarks you said India, China, and Vietnam, all of the developing global economies. And the three of the countries does produce antiretroviral drugs. If you could talk about were there any plans for UNAIDS and others to facilitate dialogues in getting second-line drugs free to all the countries.

J.V.R. PRASADA RAO: I think maybe I will answer the questions when I do the summing up. Is it okay? Because I do not want to take the time of the panelists. So, when I do my final summing up, I will try to answer your questions. Thank you. Next?

THOMAS SMITH: Hello? Okay, thank you. My name is Tom Smith, representing the Asian Harm Reduction Network based in Thailand. And thank you all very much, the panelists, for the

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presentations, but also both the co-chairs for the use of introductions. I have actually two questions/comments, one actually for the co-chairs and one for Vincent. Maybe I can start with the latter one. Looking at the Asia Pacific region to quite an extent, we are looking at countries with what I would consider nondemocratic systems.

Now, how do we take on the challenge to put in place the democratic principles also for vulnerable groups within those nondemocratic systems, especially when drug use, sex work, and in quite a few places men having sex with men are criminalized issues. So, I see that as a major challenge for the democratic principle and I would like to hear his views on that.

The second question is relating to resource allocation; in particular, we have heard from several speakers here and before how significant the IDU component is in driving epidemics in the region. Yet, when we reflect on the HLM meeting in New York and presentations there, we know actually that very little funding is allocated for prevention, in general; lots of it goes to treatment. And of the prevention, even a smaller proportion goes to HIV prevention, in particular, for the vulnerable groups such as drug users. So, while we know it is most effective in containing epidemics there in early stages, actually very little goes there. So, it

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would be good to have some suggestions on how we can move forward on that agenda. Thank you.

J.V.R. PRASADA RAO: Thank you. Once again, I think for the second question, was the first question addressed to Vince? Maybe, Vince, you can answer that.

VINCENT CRISOSTOMO: Okay. In my opinion, in order for some of these things to happen, there is a few things. First, there has to be a conscious effort made to include people living with HIV in all response to the epidemic. When it comes to what is meaningful, I think that needs to be determined by them. And there is also, I think— this is, again, my opinion— I think, right now, that we are on the verge of like something really different happening. Like, I know from my work in Indonesia, I think we are ready for a change, but I think civil society needs to keep population [inaudible] networks. I really do believe that we have to come together, and we have to kind of put aside our differences and work together so we can maximize. The global fund has created these positions on the CCM, so I think we need to come together. We need to figure out a process, just figure out who represents us, who they want, who, when they speak, they are speaking for and get them into these positions. Because one of the things that if they are going to create these positions for, so we have to be there.

At the same time, those people in charge of these positions, these processes, like the CCMs and wherever, their

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processes need to be transparent. They need to share information. They need to consult, and by consult, I do not mean just bring people into a room and ask them what they want. They actually have to act on what people say. Often in this region, when we are brought to a consultation, we are asked what we think and what we feel and all these things, and then it just seems to go in one ear and out the other. And I think we have to also hold each other accountable to these because I think all of us know about a lot of the things that happened, and we either just look the other way or we do not.

But I think it is everybody working together. And looking at the opportunities that we have, because I think we really do, there are a lot of opportunities now. And, like I said, one of the things that kind of always bothers me when we are in, is like when we talk about the issues, that the issues never seem to change. So, I think that we who represent who are from these networks, these most vulnerable populations, we need to figure out so how can we change that, and really take it upon ourselves to do so. And that is actually why I wanted to mention Farika in my presentation because she is someone who is doing that.

J.V.R. PRASADA RAO: Thank you. About the first question, again, I will try to answer it at the end. The next?

CHARLES FARTHING: Hello. Charles Farthing from Philadelphia and New York. My question is for Vincent. Vincent,

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I was incredibly impressed with that project in Tamil Nadu that you told us about. And I wonder is that going to be, to grow and to go to other states in India? And is it going to be highlighted a lot? It seems to me that that should be used as an example of what can be done and be spoken about a lot.

VINCENT CRISOSTOMO: Well, I think part of the reason for including this, that in this presentation, was to show that there have been successful programs and projects in India, in this region. And I am hoping that people would take it upon themselves; that is why we talk about what works. [inaudible] Asia, often people relate more to what does not work, but that is just me. But I think that is why we presented it here so that hopefully people can see that this is something that has been done. It is something that should be commended, and it is something that should be duplicated.

J.V.R. PRASADA RAO: Thank you. Last question. One more, sorry.

FEMALE SPEAKER: My name is [inaudible] and I am with the Lawyers [inaudible] in India. My question is to no one in particular, but I guess the panel can answer. In Asia, we have seen that the epidemic is pretty similar and the response required is also similar for countries. But we have had a peculiar situation where it seems that countries are not learning from each other. We have had countries that have exemplary legislation, antidiscrimination legislation, but

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other Asian countries lag behind. We have best practices on harm reduction, but the [inaudible] neighbor has the worst practice when it comes to dealing with drug use. I am talking about China and Thailand.

So, would you consider that the potential from learning from each other countries cross learning, etc., has been explored, not explored, and what can the Commission and its report do on that front? And a related question is, is there a potential for Asian countries to also, given the very leaning on the similar problems, to take up common or similar positions at international level, which actually reflect the interest of Asian people? And, here, I am talking about, say, the talks at the World Trade Organization when it comes to access to medicines or the forthcoming review of the UNGASS on drugs at the CND where Asian countries can forge a common position in support for drug treatment and harm reduction. And if that is possible, what would it require on our part as civil society?

J.V.R. PRASADA RAO: Thank you. I think, Sujatha, maybe you can answer because the cross learning is something which Sri Lanka has done [inaudible] delegation to some of the Asian countries, so maybe you can try to answer this question. Why countries are not learning from each other? That is a very good question.

SUJATHA SAMARAKOON: It is a very difficult question to answer why people are not learning from each other. But, of

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course, as mentioned, the legislature need to be changed, learning from certain exercises, and that is not an easy thing to do. I think somebody mentioned undemocratic approaches. So, we need to change the undemocratic to a democratic framework, but I think all this takes a little time. But, as you suggested at an international level, there should be some kind of a harmony of international laws and regulations and what is happening in the Asia Pacific field, and learning the best practices and across borders to have a mixture, so that your legal framework, your cultures, and your religious attitudes are not hampered by copying what is being conducted in another country. But I think that is a very difficult task to achieve, but nevertheless, you need to go ahead.

J.V.R. PRASADA RAO: Thank you. Last question.

MALE SPEAKER: Hi. My name is Dennis [inaudible]. I am from, I work for the New York State AIDS Institute. I just want to make a point. Probably a lot of people already know that attitude change is totally different from behavioral change in healthcare prevention. Let me give you an example. Last, two years ago, New York City implemented a program to distribute free condoms. And after a year, New York City distribute about three million condoms. But does people actually using it? Not necessarily. This year, there is a research program [inaudible] to identify how many people actually using condom in New York City. There is about 40-percent of the people who has more than

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one partner, sex partner, but they are using, so that means around 55 to 60-percent of the people who has more than one partner did not use condom recently. So, I just wanted to point out in a healthcare prevention, attitude change and behavioral change, people get a condom, they may not actually use it. So, thank you.

J.V.R. PRASADA RAO: Thank you. That is a very interesting observation. And any of the panelists would like to take that? It is attitude change which is needed, not just behavioral change. One of you? Sujatha, again? Maura, would you like to answer that? Maybe Sujatha can field the question.

SUJATHA SAMARAKOON: I do agree. As much as there needs to be a behavior change, the attitudes of the healthcare workers, the policy maker, the people living with HIV, all these attitudes need to be changed if we are going to achieve some of these UNGASS indicators, the targets, which we are not even halfway through. I think if we all work together and assess by even like a [inaudible] or some UNAIDS or some agency and see, why are not we reaching the targets? Is it the attitude or is it because we really cannot make a behavior change? I think attitudes precedes all this, but there should be concrete evidence.

J.V.R. PRASADA RAO: Thank you very much. I think that brings us to the end of the question and answer session. I think there have been excellent presentations and really very

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stimulating questions. And some of the issues which were raised are so typical for Asia and the Pacific region, so it really, again, highlights why we need to address the problems of this region in a very special manner. This region accounts for almost 60-percent of the world's population and I would just regard it as one of the seven or eight regions in the world. It is the most important region. If you really want to control AIDS in the world, it has to be controlled in Asia. The biggest battles for AIDS have to be won in Asia; I think that is the message probably, which we need to do. For example, the foreign [inaudible] provider-initiating testing and counseling. Maura is absolutely right; maybe in a high prevalence civil setting, PICT is something, which has not been prescribed. But then if you just applied across the board to all the other regions, which are local, like in Asia, you are going to end up with this sort of a problem.

So, who are [inaudible] policy and who are [inaudible] programs need to look at the sensitivities at the regional level, at the country level, and then apply those things. We cannot just look at every problem to a global length. We need to look at the country and regional length. That is a very strong message which has come.

There are a couple of questions about resource allocation. I think, definitely, resource allocation to prevention, especially prevention with provisions and impact.

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We still are very much suboptimal in this region. It has come out a number of observations, including the report of the Commission on AIDS in Asia, and even among those groups, which are addressed, the injecting drug user and men who have sex with men; still get a much lesser share of the resources by prevention programs.

But, definitely, we could see some improvement here, mainly because of some strong programs taken by donors like [inaudible]. We have now three very large [inaudible] funded programs running in this region, addressing injection use and harm reduction. So, I think countries are also now coming forward to put more resources into injection drug use interventions, which is a very positive thing. And the same is happening in MSM also, not so much because the countries want to do, but because there is somewhat less pressure from below. I think the [inaudible] is a great thing that has happened in this region and this particular organization, the way they have been able to highlight the issues; the ways they have been highlighting the problems with MSM populations I think is really great. And I am sure that the countries who take notice and will allot greater resources.

The question by [inaudible] about UNGASS. Well, definitely UNGASS monitoring is being done by government, by UN, but also there is a need to do monitoring by the civil society. And I think the ICAAPs are excellent platforms for a

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civil society type of monitoring on UNGASS. What Sujatha has presented here is something like a monitoring exercise as to what are the problems identified in Columbia, [inaudible] they have not addressed, and where we are moving on that.

Maybe we have to find answers to that in Bali. That is a parallel exercise where we need to go, but the government monitoring definitely has shown we have recently done an analysis, that to help categorize the countries into three. The achievers, the early achievers, countries which are on course, providing really a very strong push, and parties that still have to do a lot of work if they have to come anywhere near their [inaudible] targets. And you are right. Except Thailand and Cambodia, today, I do not think any country can be called [inaudible] this country is going to achieve the universal access target. And that is a very, very, very disturbing thought [inaudible]. The same is the case in other regions also, yesterday we heard in the plenary.

So, I think the next three years are going to be really crucial and we need to put a lot of effort both in the government, civil society, donors, community, everybody, to see that some of these countries which are lagging behind to put the resources and then they do that, tremendous amount of programming in the next three years [inaudible] these targets.

The other question that was asked was about the Tamil Nadu program. I think you are right; it is not just one

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program. Vince has just projected one such program. I think there is a good amount of acceleration in terms of repeating [inaudible] such programs in India. Maybe Sujantha, who is here who knows better about this, but I think definitely the focus intervention programs, especially focusing on sex workers, ID use, and MSMs, I think received a tremendous boost. And many of them followed the type of example, which Vince has shown here. So, that is, again, something which is a good pointer.

About second-generation drugs, yes, there should be a regional dialogue. I believe there are three or four countries in this region, like China, India, Thailand, which produce generic drugs. Maybe at some point of time, we need to come together. We need to have some regional position on making available generic drugs. And Thailand has found a way by issuing [inaudible] licenses on generic drugs for antiretroviral treatment. I think that needs to be done by other countries also when there is a need, but where is the need? Do we have an [inaudible]? If the [inaudible] are all shut down, then maybe [inaudible] countries may have to go for that type of extreme [inaudible] under the WHO possible, so countries need to use it. But, then, a regional position is absolutely essential; that is, again, something which the Commission on AIDS in Asia has mentioned. So, I have these few points to summarize on this and I now request my co-chair, Myung, to give his observations.

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MYUNG-HWAN CHO: Actually, the International Congress on AIDS in Asia and the Pacific has provided really excellent platform for, in several, in different types of stakeholders to share their knowledge and experience. So, and I would just like to have a chance to promote again the Ninth International Congress on AIDS in Asia and the Pacific, so we are going to have the Ninth ICAAP in Bali, Indonesia, next August, 2009. So, I hope to see all in Bali, Indonesia, next year. Please come to Bali next year and share your experience and knowledge with your colleagues. Thank you. [Applause]

J.V.R. PRASADA RAO: Thank you very much, and thank you for your excellent patience, understanding, and cooperation. I think this session has been extremely useful. Thank you very much. [Applause]

[END RECORDING]