UNITED NATIONS
ECONOMIC
AND
SOCIAL COUNCIL

GENERAL

E/ESCAP/1340
17 March 2005

ORIGINAL: ENGLISH

ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE PACIFIC

Sixty-first session
12-18 May 2005
Bangkok

KEY DEVELOPMENTS AND ACTIVITIES AT THE REGIONAL LEVEL: EMERGING SOCIAL ISSUES

(Item 3 (c) of the provisional agenda)

REPORT ON IMPLEMENTATION OF THE DECLARATION OF COMMITMENT ON HIV/AIDS AND THE ASIA-PACIFIC LEADERSHIP FORUM ON HIV/AIDS AND DEVELOPMENT

SUMMARY

At the twenty-sixth special session of the General Assembly on HIV/AIDS, held in New York in June 2001, 189 Member States adopted the Declaration of Commitment on HIV/AIDS. The Commission, in the second phase of its fifty-ninth session, held in Bangkok from 1 to 4 September 2003, requested the secretariat, through its resolution 59/1 of 4 September 2003, to report on progress in implementation of the Declaration of Commitment in the ESCAP region.

Section I of the present document assesses overall progress in the ESCAP region and identifies the main gaps in achieving the targets established in the Declaration of Commitment. While significant progress has been made in achieving the targets, many challenges remain. Governments in the ESCAP region, in partnership with international bodies, the public and private sectors and civil society entities, will have to increase their efforts to strengthen their accomplishments and achieve the targets for 2005 set in the Declaration.

Strong leadership at all levels of society is essential for an effective response to the epidemic. Section II of the document highlights the Asia-Pacific Leadership Forum on HIV/AIDS and Development as one example of building leadership responses through a regional mechanism.

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INTRODUCTION

1. At the end of 2004, there were over 9 million people living with HIV/AIDS in Asia and the Pacific. The disease has gained a firm foothold in a region that is home to over 600 million young people, all highly vulnerable (ESCAP, 2003).

2. Without a comprehensive response, the epidemic has the potential to reverse the social and economic progress achieved by most countries and areas in the region over the past five decades. For such a response to be successful, it is the responsibility of Governments in the ESCAP region to create an enabling environment for a multisectoral approach that tackles HIV/AIDS as a development challenge.

3. In recent years, many Governments in the Asian and Pacific region have recognized the challenges ahead and have begun to act. The present document provides an update on the progress made in addressing HIV/AIDS in the region.

4. Section I assesses overall progress in the region and identifies the main gaps in achieving the targets in the Declaration of Commitment on HIV/AIDS adopted at the twenty-sixth special session of the General Assembly on HIV/AIDS, held in 2001. The Commission, in the second phase of its fifty-ninth session, held in Bangkok from 1 to 4 September 2003, requested the secretariat, through its resolution 59/1 of 4 September 2003, to identify gaps in implementation, particularly with regard to political and resource commitments.

5. Section II highlights the Asia-Pacific Leadership Forum on HIV/AIDS and Development (APLF) as one example of building leadership responses through a regional mechanism. The establishment of the Forum and its achievements are discussed.

I. THE DECLARATION OF COMMITMENT ON HIV/AIDS: IMPLEMENTATION IN ASIA AND THE PACIFIC

A. The Declaration of Commitment on HIV/AIDS

6. The Declaration of Commitment on HIV/AIDS represents the collective vision of 189 Member States that adopted it in the first step of a global alliance against AIDS. The alliance extends to the private sector and civil society, including organizations of people living with HIV/AIDS and faith-based organizations.

7. The Declaration sets out specific and time-bound targets for 11 HIV/AIDS-related issues: leadership, prevention, care, support and treatment, HIV/AIDS and human rights, reducing vulnerability, children orphaned and made vulnerable by HIV/AIDS, alleviating the social and economic impact, research and development, HIV/AIDS in conflict and disaster-affected regions, resources, and follow-up.

8. In 2003, UNAIDS issued the first progress report on the global response to the HIV/AIDS epidemic. To measure the progress made, UNAIDS developed 22 core indicators, encompassing global/regional commitment and action, national commitment and action, national programme and behaviour, and national impact. Data were collected from 103 countries and areas, including 27 ESCAP members and associate members.

9. Preparations are under way for the second UNAIDS global progress report, which will be issued in the second half of 2005.

B. Regional commitment and action

10. In support of country-level efforts, the Declaration of Commitment clearly spells out the importance of regional, subregional and interregional cooperation (United Nations, 2001, paras. 39-43).

11. To facilitate the achievement of the targets set in the Declaration, the Secretary-General enlisted the assistance of four Special Envoys for HIV/AIDS to promote key issues and advocate for an expanded response to HIV/AIDS in Africa, Asia and the Pacific, the Caribbean and Eastern Europe.

12. Dr. Nafis Sadik, in her capacity as the Secretary-General's Special Envoy for HIV/AIDS in Asia and the Pacific, serves as an important catalyst for the response to HIV/AIDS in the ESCAP region through her numerous visits to the region and consultations with a wide range of stakeholders.

1. ESCAP: strengthening regional commitment

13. The Governments of members and associate members of ESCAP, the largest of the United Nations regional commissions, have initiated clear regional responses to address the HIV/AIDS pandemic in the Asian and Pacific region.

14. In preparation for the special session of the General Assembly on HIV/AIDS in June 2001, the Commission's adoption of resolution 57/1 of 25 April 2001 on a regional call for action to fight the human immunodeficiency virus/acquired immunodeficiency syndrome in Asia and the Pacific marked a watershed in concern over HIV/AIDS in the highest-level intergovernmental forum for economic and social development in the region.

15. Consequent to the Commission's historic decision, the theme topic of the fifty-ninth session of the Commission, the second phase of which was held in Bangkok from 1 to 4 September 2003, focused on HIV/AIDS as an economic and social development challenge, marking a shift away from the dominant medical health paradigm of HIV/AIDS. The President of Botswana, as a special guest of the Commission at that session, delivered a powerful message on the urgency, for the ESCAP region, of learning from the painful lessons emerging from the African pandemic. The Commission adopted resolution 59/1 on regional action in follow-up to the Declaration of Commitment on

HIV/AIDS, in which the Commission called on ESCAP members and associate members to, inter alia, implement the Declaration and to respond to the HIV/AIDS pandemic with political commitment at the highest decision-making levels.

16. The Commission, in its resolutions 60/1 on the Shanghai Declaration and 60/2 on the regional call for action to enhance capacity-building in public health, adopted on 28 April 2004, articulated the unanimous commitment of the 62 Governments of ESCAP members and associate members to develop comprehensive responses to HIV/AIDS and other serious illnesses, including by increasing the availability of affordable quality drugs and enhancing capacity-building in public health.

2. Towards implementation of ESCAP HIV-related resolutions

17. In follow-up to resolutions 57/1 and 59/1, the secretariat, in collaboration with the Government of Thailand, civil society and the private sector, pioneered the development of a public-private-community partnership model to support health-care service delivery to people living with HIV/AIDS. The income-generation mechanism and lessons learned will be disseminated to ESCAP members through a regional resource facility.

18. In December 2004, the secretariat concluded a multi-year HIV prevention project involving six participating countries, Bangladesh, Cambodia, China, India, the Lao People's Democratic Republic and Nepal. The project enhanced government and civil society capacity to design and implement effective youth-focused HIV prevention programmes using life skills and peer-to-peer approaches. Over 1,000 trained peer educators reached more than 20,000 young people in non-formal education settings through community-based training and street theatre.

19. Furthermore, the secretariat supported drug abuse-related pilot training programmes in the Lao People's Democratic Republic, Thailand, Viet Nam and Yunnan Province of China to address the nexus between drug abuse and HIV/AIDS. The programmes reached over 17,000 stakeholders. In its latest endeavour to promote a multisectoral approach, in January 2005 the secretariat initiated a project to improve health and reduce HIV vulnerability among long-distance road transport workers in the Greater Mekong Subregion.

20. As part of its commitment to initiatives that reinforce political resolve for effective HIV/AIDS responses, the secretariat joined the Governments of Australia and Thailand and UNAIDS in supporting the Second Asia-Pacific Ministerial Meeting on HIV/AIDS, held in Bangkok on 11 July 2004, as part of the Leadership Programme of the XV International AIDS Conference, held in Bangkok from 11 to 16 July 2004. Ministers from 38 countries participated in the Ministerial Meeting and adopted a Joint Ministerial Statement. To engage senior advisers who accompanied their ministers to the Meeting, the secretariat, jointly with APLF and UNAIDS, organized a shared learning workshop on multisectoral action to address HIV/AIDS, which was held in Bangkok on 12 July 2004.

21. The secretariat's facilitation of the mainstreaming of HIV/AIDS in the regional health and development agenda is reflected in the inclusion of HIV/AIDS as a priority action area in the Regional Framework for Strategic Action: Promoting Health and Sustainable Development. The Framework was adopted by the first intergovernmental meeting on health and development in the ESCAP region, that is, the first session of the Subcommittee on Health and Development, held in Bangkok from 1 to 3 December 2004.

3. Other regional/subregional initiatives in the ESCAP region

22. Highlights of other significant regional or subregional initiatives in support of action relating to the Declaration of Commitment are described below.

23. The Government of Australia organized the first Asia-Pacific Ministerial Meeting on HIV/AIDS in Melbourne, Australia, on 9 and 10 October 2001 shortly after the adoption of the Declaration. The two key outcomes of the Meeting were a pledge by ministers representing 33 Governments of ESCAP members and associate members to strengthen multisectoral approaches and partnerships at the community, national, cross-border and regional levels, and the conception of APLF.

24. The Second Ministerial Meeting, held in conjunction with the XV International AIDS Conference, critically reviewed achievements since the first Meeting. The Second Meeting recognized "the need for more rapid and effective programme implementation to achieve equitable access for all to prevention, treatment and care". Furthermore, the ministers declared their "commitment to actions emphasizing policy and legislative preparedness, resource mobilization and community engagement" (APMM 2, 2004, para. 14).

25. An important outcome of the Second Meeting was the reaffirmation of commitment by the participating Governments to fulfil the targets of the Declaration. Particular reference was made to follow-up of the implementation of HIV/AIDS-related provisions in Commission resolutions 57/1 of 25 April 2001, 59/1 of 4 September 2003, and 60/1 and 60/2 of 28 April 2004.

26. At the Seventh ASEAN Summit, held in Bandar Seri Begawan on 5 and 6 November 2001, the ASEAN Heads of State and Government adopted the Seventh ASEAN Summit Declaration on HIV/AIDS. The Declaration made strong reference to the Declaration of Commitment and emphasized the need to intensify national, regional and international efforts to address HIV/AIDS in a comprehensive manner. To guide Governments in their national and regional response to HIV/AIDS, the Seventh ASEAN Summit adopted the ASEAN Work Programme on HIV/AIDS.

27. The Vientiane Action Programme, adopted at the Tenth ASEAN Summit, held in Vientiane on 29 and 30 November 2004, reaffirmed the ASEAN commitment to prevent the spread and reduce

the harm of HIV/AIDS and other infectious diseases. The Programme includes the development and implementation of the Third ASEAN Work Programme on HIV/AIDS for the period 2005-2010.

28. The South Asia Inter-religious Council on HIV/AIDS is a significant initiative by faith-based leaders to provide leadership and mobilize communities and resources in responding to the growing HIV/AIDS crisis, especially among young people. UNICEF organized the first meeting of the Council in New Delhi from 19 to 21 November 2004.

29. The South Asian Association for Regional Cooperation is developing its strategy on tuberculosis and HIV/AIDS control. HIV/AIDS activities are coordinated by the SAARC Tuberculosis Centre, Bhaktapur, Nepal.

30. The First Asia-Pacific Women, Girls and HIV/AIDS Best Practices Conference, held in Islamabad from 29 November to 1 December 2004, resulted in the adoption of the Islamabad Agenda for Change 2004, which stressed that the fundamental human rights of all women, men, girls and boys infected or affected by HIV/AIDS must underpin all responses to the epidemic.

31. The second Pacific Regional Strategy on HIV/AIDS 2004-2008 covers all elements of the Declaration of Commitment and reflects the unique needs of the Pacific subregion. At the Pacific Islands Leaders' Forum, held in Apia in August 2004, the Heads of all Pacific Governments endorsed the Strategy, which was developed in close collaboration with stakeholders in all Pacific countries and territories concerned.

32. The landmark inaugural meeting of the Pacific Parliamentary Assembly on Population and Development on the Role of Pacific Parliamentarians in the Fight against HIV/AIDS, held in Suva from 11 to 13 October 2004, provided a forum for mobilizing parliamentarians to champion action against HIV/AIDS.

C. National commitment and action

33. In its 2003 progress report on the global response to the HIV/AIDS epidemic, UNAIDS measured progress in national commitment and action through the amount of national government expenditure on HIV/AIDS and government HIV/AIDS policies.

34. UNAIDS identified four key policy directions for effective national action: development, implementation and mainstreaming of strategic national AIDS plans; prevention of HIV transmission; protection and promotion of human rights; and care and support for people living with HIV/AIDS (UNAIDS, 2003).

35. The overview given below on government HIV/AIDS policies draws on responses, in the period 2002-2004, to the National Composite Policy Index Questionnaire (UNAIDS, 2004c) submitted to UNAIDS by 15 ESCAP members, namely, Bangladesh, Cambodia, China, Fiji, India,

Indonesia, Lao People's Democratic Republic, Myanmar, Nepal, Pakistan, Philippines, Papua New Guinea, Sri Lanka, Thailand and Viet Nam (hereafter referred to as "ESCAP region respondents").

36. This section also provides an overview of national leadership initiatives in the ESCAP region as an essential component of a comprehensive national response.

1. National budget allocation for HIV/AIDS

37. The Declaration of Commitment called for increased national budgetary allocations for HIV/AIDS programmes. Although many Governments in the region have increased their budgetary allocation for HIV/AIDS since 2001, these increases are not sufficient to cover comprehensive national HIV/AIDS programmes.

38. In South-East Asia, with the exception of Thailand, domestic resource allocation does not reflect the priority otherwise accorded to HIV/AIDS. One country, which is experiencing a steep increase in HIV infection, is estimated to have spent only US$ 3.4 million in domestic government funds on HIV/AIDS in 2002 (UNAIDS, 2003).

39. Only in a few cases have Governments in the ESCAP region demonstrated a clear commitment to closing the resource gap. China more than doubled its HIV/AIDS budget, from approximately 390 million yuan in 2003 to 810 million yuan in 2004 (State Council AIDS Working Committee Office/United Nations Theme Group on HIV/AIDS in China, 2004).

40. The Russian Federation, with a well-established epidemic and one of the highest prevalence rates in the ESCAP region, was one of seven middle-income countries that together accounted for 75 per cent of global domestic HIV/AIDS spending in 2002 (UNAIDS, 2003). This trend is not echoed in Central Asia where, despite the alarming growth of the epidemic, Governments have devoted relatively small sums to HIV/AIDS-related activities.

2. Strategic national AIDS plans

41. The Declaration of Commitment required that all countries develop and implement strategic national AIDS plans by 2003. Indeed, many high-prevalence countries in the ESCAP region have developed national plans, including multisectoral strategies, to combat HIV/AIDS.

42. In March 2004, the Prime Minister of Viet Nam approved the first National Strategy on HIV/AIDS Prevention and Control up to 2010 and with a vision to 2020. The Strategy promotes a multisectoral approach to HIV/AIDS and the mobilization of the whole society (UNAIDS, 2004e).

43. Most countries have a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society. In its annual report 2002-2004, the National AIDS Control Organization of India emphasized partnership-building as essential to a government-led multisectoral response to HIV/AIDS. The Organization facilitates the involvement of stakeholders

from diverse sectors, such as education, defence, labour, youth affairs, railways, industry, transport, rural development, and social justice and empowerment, to optimize India's response to AIDS.

44. As the epidemic evolves, countries in the region have recognized the need to revise and update their national plans. In April 2003, the Indonesian National AIDS Council developed a new multisectoral AIDS strategy through a consultative and participatory process with civil society, the provinces, the private sector and people living with HIV/AIDS (UNAIDS, 2003). In 2004, the Ministry of Health of Cambodia revised its strategic plan on HIV/AIDS to take into consideration expanded prevention needs, new developments and needs for comprehensive care and treatment, including the provision of antiretroviral therapy (ART) (UNAIDS, 2004f).

45. However, in many countries in the ESCAP region, the translation of the strategic plan into comprehensive action has been hampered, owing, among other things, to lack of political commitment and shortfalls in funding and human and institutional capacity.

46. The 26 December 2004 tsunami highlighted the lack of awareness among the humanitarian community concerning the need to incorporate HIV/AIDS considerations into emergency responses. UNAIDS has intensified work with the national AIDS bodies in India, Indonesia, Thailand and Sri Lanka, to address the care and treatment needs of people living with HIV/AIDS in emergency relief and reconstruction efforts.

3. HIV prevention

47. Reducing HIV prevalence among young men and women (aged 15-24) is the mainstay of the prevention targets in the Declaration of Commitment. Responses to the National Composite Policy Index Questionnaire from the ESCAP region indicate that general policies or strategies have been developed to promote information, education and communication on HIV/AIDS (UNAIDS, 2004d).

48. Cambodia is undertaking a range of efforts to integrate HIV/AIDS into the activities of the Ministry of Education, Youth and Sport. The Lao People's Democratic Republic is striving to ensure, by 2010, population-wide HIV/AIDS knowledge and awareness (UNAIDS, 2003). This is a major undertaking in view of its numerous ethnic groups, each with their respective languages and cultural practices.

49. In much of the ESCAP region, there is still a low level of knowledge and skills among young people concerning safe behaviour for HIV prevention. India, Indonesia, the Lao People's Democratic Republic, Myanmar, Nepal, Thailand, Timor-Leste and Vanuatu are among those that are at different stages of delivery of life skills-based education through schools. Bangladesh has recently announced that HIV/AIDS issues will be included in its secondary school curriculum in 2005 (*Khaleej Times*, 2005).

50. Only a few countries provided detailed information on targeted interventions for groups with high or increasing rates of HIV infection. Nepal, with international donor assistance, is implementing prevention strategies targeting sex workers, their clients and injecting drug users (IDUs). Indonesia was reported to be developing a national strategy on HIV prevention for cross-border migrants (UNAIDS, 2003).

51. Since 2002, UNAIDS has been supporting ministries of defence and interior/justice in implementing prevention programmes targeting young men and women in uniform. Programmes in Bangladesh, China, Fiji, India, Indonesia, the Lao People's Democratic Republic, Mongolia, Myanmar, Papua New Guinea, the Philippines, Sri Lanka and Viet Nam are in various stages of implementation. These programmes aim to include HIV/AIDS prevention as part of the basic training curricula for all new recruits entering the military and police services.

52. Most ESCAP region respondents indicated that they planned to expand access to preventive measures, including condoms, voluntary counselling and testing, sexually transmitted infection (STI) treatment, and expansion of antiretroviral (ARV) treatment to prevent mother-to-child transmission. In China, a national condom promotion strategy was issued jointly in July 2004 by six ministries and departments to encourage 100 per cent condom use among high-risk behaviour populations (State Council AIDS Working Committee Office/United Nations Theme Group on HIV/AIDS in China, 2004).

53. Kazakhstan more than doubled the number of syringes distributed to IDUs between 2001 and 2002. At the same time, condom distribution doubled and Kazakhstan opened 69 new voluntary counselling and testing sites in 2002 (UNAIDS, 2003).

54. Only 78 per cent of the Asian respondents reported that they had prevention of mother-to-child transmission policies in place (UNAIDS, 2003). This merits attention in a region where mother-to-child transmission of HIV has emerged as a critical public health issue in several countries.

55. With the increased emphasis on care and support for people living with HIV/AIDS, there is an urgent need to maintain a strong commitment to prevention. Prevention programmes and efforts could be strengthened by establishing stronger links between HIV treatment and prevention programmes. This could facilitate the scaling-up of both services. Recent studies show that the most effective way of decreasing new infections and deaths is by combining both services. Estimates for sub-Saharan Africa show that integrating prevention and care could prevent over 29 million new infections and 10 million deaths by 2020 (WHO/UNAIDS, 2005).

56. Treatment provides an opportunity to strengthen prevention. At the same time, increased investment in prevention is needed more than ever to turn the epidemic around.

4. Care, support and treatment

57. The Declaration of Commitment encourages the development of national strategies to provide comprehensive care, support and treatment for people living with HIV/AIDS by 2003. The majority of the ESCAP region respondents indicated that they provided comprehensive HIV/AIDS care and support (UNAIDS, 2004d). These public services included access to medical and psychosocial care, and STI treatment.

58. Peer support for people living with HIV/AIDS can increase the quality of life of those living with the disease significantly, including through home-based care and support of ARV and opportunistic infection treatment. In Thailand, a programme coordinated by Médecins Sans Frontières, Belgium, has established support for people living with HIV/AIDS in over 120 hospitals.

59. In East, South and South-East Asia, 100,000 people were undergoing treatment by the end of 2004. This is twice the number reported six months earlier (WHO/UNAIDS, 2005).

60. In China, by the end of June 2004, 10,388 AIDS patients in 18 provinces had received free ART. China plans to treat another 20,000 to 30,000 AIDS patients with free ART in 2005 (*People's Daily Online*, 2004).

61. On World AIDS Day 2003, the Government of India announced a strong policy commitment to provide ART to 100,000 people with HIV/AIDS, starting implementation on 1 April 2004. Since then, India has initiated ART provision in government hospitals in six high-prevalence States: Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu (WHO, 2003).

62. Cambodia is one country that has made significant progress in increasing ART delivery. At the end of 2004, it provided ART to over 10 per cent of those in need of treatment.

63. Thailand has taken the lead in increasing access to care and treatment services for people living with HIV/AIDS in the ESCAP region. Through a comprehensive policy framework and national programmes that include such people and civil society as key players, by the first half of 2005, the Government of Thailand expects to provide ART to at least half of the HIV-positive persons who need it. This increase would represent more than a trebling of the number, from 13,000 people receiving ART at the beginning of 2003 to over 50,000 in 2005 (WHO/UNAIDS, 2005).

64. Although the level of commitment is encouraging, much remains to be done in the coming years. East, South and South-East Asia together account for an estimated 22 per cent of the global total of adults in need of treatment who do not receive it (WHO/UNAIDS, 2005).

65. The cost of ARV medicines is of particular concern. As of mid-2004, ARV drug costs accounted for 43 per cent of the total resources required to treat 3 million people by 2005, under the WHO/UNAIDS "3 by 5" initiative (WHO/UNAIDS, 2005).

66. Improvements in infrastructure, including human resource capacity, to deliver care and treatment are critical to expanding access to ARV drugs. Developing partnerships with people living with HIV/AIDS, the public and private sectors and civil society is central to addressing the challenges ahead.

5. HIV/AIDS and human rights

67. The Declaration of Commitment requires that countries will have enacted, strengthened or enforced legislation to eliminate all forms of discrimination against people living with HIV/AIDS and to combat HIV-related stigma and social exclusion.

68. Some progress has been made with regard to laws and regulations that protect those people from discrimination. For example, China's new law (August 2004) banning discrimination against people living with infectious diseases has been widely welcomed as an important step to counter abuse and discrimination related to HIV status (Human Rights Watch, China, 2004).

69. The Asian and Pacific region has ranked particularly low in terms of anti-discrimination laws for vulnerable populations (UNAIDS, 2003). Cambodia is a noteworthy exception. In 2001, Cambodia's Ministry of Women's Affairs developed a national policy to promote the rights of women and girls at risk of HIV infection (UNAIDS, 2003). Furthermore, Cambodia has progressed in providing vulnerable populations with more equitable access to HIV-prevention services.

70. In order for such measures to be effective, law reform in the context of HIV/AIDS needs to be approached as part of a systematic national response to the epidemic. In Papua New Guinea, the National AIDS Council was established under an Act of Parliament in 1997. In 2002, Papua New Guinea enacted an anti-discrimination law. This was followed by the adoption, in 2003, of the HIV/AIDS Management and Prevention Act, which lays strong emphasis on human rights, and the formation of a Parliamentary Committee on HIV/AIDS in 2004.

71. Most countries and areas in the ESCAP region, however, do not have laws and regulations that protect from discrimination those identified as being especially vulnerable to HIV/AIDS, including those who engage in high-risk behaviour (UNAIDS, 2004d). In many instances, IDUs, sex workers and their clients and men who have sex with men are not effectively included in the national AIDS response, particularly in HIV prevention.

6. National leadership

72. One of the greatest obstacles to developing effective national AIDS responses is a lack of political will to tackle the HIV/AIDS epidemic or even to talk about it. Only in recent years has political commitment increased in the hardest-hit countries.

73. The three most populous countries have made significant leadership breakthroughs. On 9 February 2005, Premier Wen Jiabao spent the Lunar New Year with HIV-positive people in China's Henan Province, where many farmers had contracted the virus through unsafe blood collection procedures in the early and mid-1990s (Agence France-Presse, 2005).

74. In January 2004, the Government of Indonesia adopted the Sentani Commitment to Combat HIV/AIDS, resulting from a meeting of ministers, senior officials and provincial leaders from six high-prevalence provinces (APLF/UNAIDS, 2005a). The Commitment marks a major step forward in the Government's leadership and commitment to promote condom use, harm reduction, provision of care and treatment for people living with HIV, and in breaking down stigma and discrimination against people living with HIV/AIDS.

75. The President of Indonesia led national observance of World AIDS Day 2004 by expressing his concern over the epidemic and requesting the Ministry of Health to provide him directly with regular updates (APLF/UNAIDS, 2005a).

76. Speaking at the National Convention of the Parliamentary Forum on HIV/AIDS, held in New Delhi on 26 and 27 July 2003, India's first such meeting on the disease, the Prime Minister of India called for an "undelayed response" in fighting the epidemic and an "openness and a complete absence of prejudice toward affected persons" (The Body, 2003). The Convention resulted in the adoption of the Declaration on Political Leadership in Combating HIV/AIDS in India.

77. The Pacific has achieved significant progress in establishing strong leadership in combating HIV/AIDS. The Workshop on Accelerating Action against HIV/AIDS in the Pacific, held in Vuda, Fiji, in March 2004, was hosted jointly by the Great Council of Chiefs of Fiji and UNAIDS. The Workshop witnessed the President of Fiji and the Chiefs committing themselves to Fiji's AIDS response and calling on community, business and religious leaders to follow suit (UNAIDS, 2004a).

78. At the National Conference on HIV/AIDS, held in Ho Chi Minh City, Viet Nam on 31 December 2004, the Prime Minister of Viet Nam called on all ministries and sectors to make 2005 the year of focused action on HIV/AIDS (UNAIDS, 2005).

D. Main challenges and gaps

79. The main challenges to implementing the Declaration of Commitment in the ESCAP region may be identified as follows: insufficient financial resources to implement and scale up interventions; lack of human resources and technical capacity in many areas of HIV programming, especially at the local level; entrenched stigma and discrimination; and weak monitoring and evaluation systems.

1. Insufficient financial resources

80. By 2007, regional resource needs for HIV/AIDS prevention, care and treatment are expected to rise to US$ 5.1 billion. Although funding for HIV/AIDS programming has increased significantly in recent years, ADB and UNAIDS estimate that the resources available are by no means sufficient to fund a comprehensive approach to HIV/AIDS.

81. For Asia and the Pacific, in 2003, only US$ 200 million was available from national and international sources, whereas a comprehensive response would have required US$ 1.5 billion (ADB/UNAIDS, 2004). For South and South-East Asia alone, the United Nations had estimated that by 2005, annual expenditure on HIV/AIDS interventions would need to reach US$ 1,440 million for prevention and US$ 670 million for care and support (Schwartlander and others, 2001, p. 2436). The resource gap is likely to increase unless resource mobilization accelerates to a significant extent.

82. Without scaling up the HIV/AIDS response significantly the economic costs of the expanding epidemic will also increase, thus limiting available resources further. Yearly losses are expected to rise to US$ 17.5 billion by 2010, compared with approximately US$ 7 billion in 2001. These costs are calculated as those borne by households (particularly costs related to sickness and death) and government expenditure incurred through prevention and care. The ADB/UNAIDS estimate is that a comprehensive response would, despite its costs, reduce overall losses to US$ 15.5 billion in 2010, implying savings of US$ 2 billion.

2. Lack of human resources and technical capacity

83. For many countries in the ESCAP region, the lack of human resources and technical capacity is a serious impediment to expanding the response to HIV/AIDS. This is a major factor in creating bottlenecks, both in implementing national strategies and in allocating effectively the national and international resources that are increasingly available for HIV/AIDS programmes.

84. The lack of human resources and technical capacity has a critical impact on health service delivery in particular. Health systems in many countries and areas of the ESCAP region are already overstretched and underfunded. Under these circumstances, it is difficult to expand HIV/AIDS-related services such as voluntary counselling and testing, and ARV and opportunistic infection treatment delivery.

85. On the one hand, the “challenges of scaling up antiretroviral therapy highlight the persistent fragility of health systems overall, attributable both to the impact of the HIV/AIDS epidemic itself and the result of chronic inadequate funding and weak management. This fragility is manifest in weak infrastructure, poorly integrated services and a shortage of personnel fuelled by the on-going exodus of health workers in many countries from the public to the private health sector and to other countries.” (WHO, 2004:14).

86. On the other hand, a successful response to HIV/AIDS could strengthen health systems. HIV/AIDS requires a wide range of interventions to be delivered on an ongoing basis through different points. The challenges presented by the pandemic are common to those of other health priorities, such as tuberculosis, malaria and maternal and child health (WHO/UNAIDS, 2005).

3. Weak monitoring and evaluation systems

87. Limited funding and lack of human and institutional capacity contribute to weak monitoring and evaluation systems. In many cases, this results in limited information on which to base critical programming and funding decisions. Of particular concern is the lack of information in the quality of STI services, HIV workplace policies, ART coverage and preventing mother-to-child transmission initiatives (UNAIDS, 2003).

88. To address the gaps in HIV/AIDS responses more effectively and measure levels of achievement with regard to the Declaration of Commitment, better monitoring systems need to be in place. By the end of 2003, fewer than 50 per cent of countries in the Asian and Pacific region had set up monitoring and evaluation mechanisms as part of their national AIDS control organizations. In response, UNAIDS has been increasing its technical support to more countries for monitoring and evaluation purposes (UNAIDS, 2004d).

89. At the Consultation on Harmonization of International AIDS Funding, held in Washington DC on 25 April 2004, donors and developing countries agreed to the “Three Ones” principle: one AIDS action framework, one national AIDS coordinating authority and one country-level monitoring and evaluation system. These principles provide strategic guidance to achieving the most effective and efficient use of resources and ensuring rapid action and results-based management.

4. Stigma and discrimination

90. Numerous studies indicate how stigma and discrimination affect the lives of people living with HIV/AIDS and have a negative impact on prevention, care and treatment efforts. For example, a four-country study revealed that 54 per cent of the people surveyed in Asia reported experiencing discrimination within the health sector (APN+, 2004).

91. Concern over the consequences of discrimination is a major deterrent to taking an HIV test. The fear of speaking about HIV/AIDS could hinder the use of condoms or lead to a mother living with HIV/AIDS breastfeeding her child for fear of being identified (UNAIDS, 2004a). Pre-employment testing and the loss of jobs by those infected and affected are still commonplace in the ESCAP region.

92. Widespread prejudice against and negative stereotyping of women, ethnic minorities, sexual minorities and other marginalized groups exacerbate their vulnerability to HIV/AIDS. Large numbers

of these groups tend to fall outside prevention programmes and to be discriminated against when they need care and support (UNAIDS, 2004a).

93. Stigma and discrimination could also affect the level of political commitment. Leaders have to be strong to initiate interventions which may seem politically controversial and socially sensitive but which have the greatest impact on the epidemic. Experiences worldwide confirm that the leadership of prime ministers and presidents in directing national HIV/AIDS responses help to ensure that the responses are implemented as the highest national priority: only then can the tide turn in the spread of HIV/AIDS.

II. ASIA-PACIFIC LEADERSHIP FORUM ON HIV/AIDS AND DEVELOPMENT[1]

A. Establishment of the Forum

94. APLF was established in October 2001 to increase leadership against the HIV/AIDS epidemic through building on efforts in the region. The Honourable Alexander Downer, Minister for Foreign Affairs, Australia, officially launched APLF on the occasion of the ASEAN Post-Ministerial Conference, held in Bandar Seri Begawan on 1 August 2002.

1. The first steps

95. In June 2002, the Government of Australia provided the initial funding to establish APLF. Responsibility for coordination and management was given to the then UNAIDS South-East Asia and Pacific Intercountry Team (SEAPICT).[2] Two main features of the original concept of APLF were facilitated shared learning workshops for senior government officials, and training and information exchange through collaboration with regional partners and events.

96. The main target group for APLF was established as key government decision makers in the region and those who influenced the key decision makers, particularly in sectors other than health. Initial APLF activities were set to target senior policy advisers in the offices of prime ministers/presidents, senior women in government and senior civil servants in finance and planning, education, transport and communications, home affairs, law enforcement and social welfare ministries/departments.

97. Following an open tendering process in the second half of 2002, the Australian Management Consortium was contracted for the period 1 April 2003 to 1 April 2004. The Consortium was led by the Burnet Institute and included the Australian International Health Institute, the Australian Federation of AIDS Organizations, La Trobe University and the University of New South Wales.

[1] The information in section II was drawn from APLF monitoring and evaluation documentation, and from personal communication with the APLF Adviser (Bangkok, 2005).

[2] As of 15 March 2005, UNAIDS SEAPICT was renamed the UNAIDS Regional Support Team (UNAIDS RST).

2. Expanding the focus of APLF

98. In early 2004, the Executive Director of UNAIDS initiated an internal review of APLF (APLF/UNAIDS, 2004a). The review reoriented APLF's focus to include the mobilization of leadership among the media, business, religious entities and women.

99. Priority countries for the period 2003-2004 included Bangladesh, Cambodia, Fiji, Indonesia, Papua New Guinea, Nepal, Sri Lanka and Viet Nam. Efforts were initiated to identify two key provinces/States in China and India, respectively (APLF/UNAIDS, 2004a). APLF provided funding to the priority countries, as required. Non-priority APLF countries in the region could request APLF technical support through UNAIDS Country Coordinators. Following the reorientation, government support for APLF was reaffirmed at the Second Asia-Pacific Ministerial Meeting on HIV/AIDS.

3. Goal, objective and activities of APLF

100. As part of the reorientation of APLF, a strategic framework was prepared and finalized in March 2004. This framework clarified APLF's goal, objective, expected results and associated indicators. The framework also included a strong monitoring and evaluation component.

101. The overall goal of APLF is to support and strengthen political and civil society leadership at the national, subregional and regional levels to take action so as to reduce the spread and impact of the HIV/AIDS epidemic in the Asian and Pacific region.

102. APLF's strategic objective is that progressive action be taken towards HIV/AIDS-related policy development in the following 11 key policy areas:

- Overall policy environment for effective responses to the HIV/AIDS epidemic
- Awareness of top policy makers concerning HIV/AIDS issues and supportive policies
- Strategic planning/multisectoral planning
- Engagement of civil society
- Engagement of people living with HIV/AIDS
- Engagement of the business community
- Engagement of the media
- Expansion of HIV/AIDS prevention programmes
- Expansion of HIV/AIDS-related services and care
- Protection of the human rights of people living with HIV/AIDS
- Engagement of the uniformed services

103. In order to achieve its objective, APLF resources will be strategically focused on the potential agents for change or influence for leadership mobilization identified as the five APLF streams: political strategists, media executives, the business community, religious leaders and women leaders. Evidence and case building for high-level political and civil society leadership on HIV/AIDS will be developed and updated to inform and empower leaders to speak out and take the necessary action.

104. There will be a strong country-level focus to mobilize national leadership, complemented and reinforced by subregional and regional approaches. Furthermore, overall APLF efforts will be supported by the identification and mobilization of "champions" to speak out on HIV/AIDS issues.

4. Organization of APLF

105. The UNAIDS Regional Support Team in Bangkok has the lead responsibility for the coordination and management of APLF.[3] The APLF secretariat consists of a manager, three subregional coordinators (South Asia, South-East Asia and the Pacific) and a programme assistant, to support the implementation of APLF activities.

106. At the country level, the UNAIDS Country Coordinator, with guidance from the United Nations Theme Group on HIV/AIDS and the APLF Advisory Group, is responsible for overseeing direct implementation of APLF work plans.

107. The APLF Steering Committee is composed of 11 eminent leaders from the Asian and Pacific region. Their role is to provide guidance on strategic direction and recommend priorities. Members include three former state leaders, recognized civil society and leaders from among people living with HIV/AIDS, as well as the Executive Director of UNAIDS (ex officio) and the Secretary-General's Special Envoy for HIV/AIDS in Asia and the Pacific.

108. Funding support is provided by the Governments of Australia, Japan, New Zealand, the United Kingdom of Great Britain and Northern Ireland and the United States of America, as well as the European Union. As of December 2004, a total of US$ 4,398,830 had been committed by the donors, of which US$ 2,990,092 had been received by APLF. In addition, Australia pledged an additional A$ 3 million over the next three years (APLF/UNAIDS, 2005a).

B. Country-level achievements

1. Shared learning

109. The primary APLF activities included shared learning workshops targeting national government officials. In 2003, the Australian Management Consortium organized three workshops, in Bali, Indonesia (25-29 August 2003), Madang, Papua New Guinea (6-10 October 2003), and Hendala, Sri Lanka (8-12 December 2003). The workshop participants were 43 senior government officials

[3] All APLF activities are undertaken in coordination with, and support from, UNAIDS.

from the ministries of information, education, finance, interior, national planning and development, health, and foreign affairs. The participants represented 15 countries in the ESCAP region, including 5 in South Asia, 5 in the Pacific, 4 in South-East Asia, and China. The participants rated the workshops and their relevance to the respective country responses to the epidemic highly.

110. The follow-up with workshop participants in early 2004 indicated that a large number of participants had held meetings with their superiors and planning sessions to further develop the action plans drafted at the workshops. Much depended on the personal motivation of individual participants to carry out the various components of their plans. Most of them faced considerable obstacles in securing formal approval and institutionalization of the action plans.

111. APLF workshop participants who made significant progress included those in the Pacific. Following the Madang shared learning workshop, participants from Papua New Guinea formed a Leadership Advisory Group chaired by the Governor-General of Papua New Guinea. The participants from Kiribati, including the President of the Kiribati Island Overseas Seamen's Union, developed a series of radio programmes on HIV/AIDS and the Senior Assistant Secretary became a member of Kiribati's HIV/AIDS Task Force. The participant from Tonga, the Deputy Secretary, Prime Minister's Office, became an active member of the National HIV/AIDS Committee (APLF/UNAIDS, 2004c).

112. Upon returning from the APLF shared learning workshop in Bali, participants from Viet Nam drafted a national action plan to address leadership on HIV/AIDS and established the Viet Nam Leadership Forum as the mechanism for implementing the plan.

113. The representatives of Bangladesh who participated in the Hendala shared learning workshop have been actively engaged in HIV/AIDS issues since their return, including through efforts to incorporate HIV/AIDS into the national education curriculum.

2. Leadership engagement

114. The lack of leadership is a primary factor responsible for the rapid spread of AIDS on the Asian continent. In addition to informing and mobilizing senior government officials and decision makers through shared learning workshops, APLF also focuses on establishing direct linkages with a range of leadership partners and initiatives, primarily in those countries that it has prioritized.

115. Leadership engagement activities in Sri Lanka have led to the establishment of the Sri Lanka APLF Leadership Advisory Group. The Group is composed of high-level and respected leaders, including advisers to the President and the Prime Minister. The sister of the President of Sri Lanka, who is also Patron of the AIDS Coalition, chairs the Group (APLF/UNAIDS, 2004c).

116. Engagement of the Pacific leadership has been actively pursued and encouraging progress made. APLF held discussions early in 2004 with the leadership of the Vanuatu Great Council of

Chiefs and government leaders, including the Secretaries for Foreign Affairs, Youth and Sports, Health, and Women's Affairs. Through the UNAIDS Pacific Office, APLF has also been working closely with the Great Council of Chiefs of Fiji, following an initial joint meeting in July 2003.

117. In 2004, meetings were held under the APLF banner with senior government officials in the Federated States of Micronesia, Marshall Islands and Palau. In the Federated States of Micronesia, APLF met with its President, members of the international diplomatic corps, and prominent community leaders to advance leadership involvement and action in the response to HIV/AIDS. In Papua New Guinea, Lady Carol Kidu, Minister for Community Development, was identified as a national APLF "champion".

C. Intercountry achievements

118. A visible APLF achievement is the bringing together of eminent leaders in the Asian and Pacific region to participate in the APLF Steering Committee. Members continue to conduct high-level HIV/AIDS advocacy, in their respective spheres of influence, to advance leadership work on HIV/AIDS in Asia and the Pacific.

119. Noteworthy is APLF/ESCAP collaboration in organizing two special shared learning workshops in conjunction with major events in Bangkok. These were a side event to the fifty-ninth Commission session (1-4 September 2003) and a workshop on HIV/AIDS for the senior advisers of ministers attending the Second Asia-Pacific Ministerial Meeting on HIV/AIDS, organized in conjunction with the Leadership Programme of the XV International AIDS Conference. In addition, APLF prepared three background papers for the Leadership Programme.

120. As part of its efforts to reach parliamentarians across Asia, APLF has built collaboration with the Asian Forum of Parliamentarians on Population and Development.

121. APLF supported the development of advocacy activities in the lead up to and at the Asia-Pacific Economic Cooperation Economic Leaders Meeting, held in Santiago on 20 and 21 November 2004. APLF also works closely with the ASEAN secretariat. Activities include APLF support of preparations for the Eleventh ASEAN Summit, to be held in Kuala Lumpur in December 2005.

122. For 2005, APLF has committed resources to support the development of an implementation plan for the Pacific Regional Strategy and Key Actions on HIV/AIDS 2004-2008, endorsed by Pacific leaders at the thirty-fifth Pacific Islands Forum meeting, held in Apia from 5 to 7 August 2004 (APLF/UNAIDS, 2005b).

D. Development of information and advocacy materials

123. In 2004, APLF developed a range of evidence-based education and advocacy materials to mobilize and support a leadership response to HIV/AIDS. The APLF/UNAIDS toolkit entitled "The

Challenge of HIV/AIDS: Resources for Effective Leadership" was produced to support the APLF shared learning workshops.

124. The APLF/UNAIDS advocacy publication *Act Now* was launched at the XV International AIDS Conference. The publication has been translated and launched in China and Viet Nam, and there are plans for translation into Bahasa Indonesia as well. Also launched at the Conference was a series of critical studies developed jointly by UNAIDS and ADB, in partnership with APLF, to improve the knowledge and evidence base for leadership advocacy.

125. The APLF/UNAIDS publication *Portraits of Commitment* was launched on World AIDS Day 2004, at a commemorative session organized jointly with ESCAP. The publication constitutes a subregional leadership advocacy document that portrays leaders from diverse walks of life who are involved in HIV/AIDS issues across South-East Asia.

E. Taking the next step

126. Since its inception, APLF has faced significant challenges in establishing a leadership programme for the Asian and Pacific region. Identifying and mobilizing leaders at the most senior levels has been a major challenge. There is no single template or methodology for extraordinary leadership engagement in the Asian and Pacific region. In many ways, APLF is entering new territory that requires exceptional innovation and flexibility.

127. At the same time, APLF has faced constraints that have limited its capacity to mobilize leadership on AIDS. The reorientation of APLF delayed design and implementation of the APLF programme. In addition, the provision of donor funding in instalments has made forward programming difficult.

128. In the second half of 2005, APLF will be fully operational. Guided by its strategic framework, including a monitoring and evaluation system, and fully staffed, APLF will be better equipped to deal with the challenges and constraints it faces.

129. The strategic focus established through the 2004 reorientation will remain the same, as will the 10 priority countries (APLF/UNAIDS, 2005b). In 2005, APLF will focus on Guangdong Province in the case of China.[4] A priority State is being identified in the case of India.

130. Building on the progress made in several priority countries and in other countries, particularly in the Pacific, APLF will work towards full implementation of country work plans. At the same time, efforts to mobilize regional leadership will be increased, with a focus on media and religious leaders.

[4] APLF Adviser, e-mail communication of 27 January 2005.

F. The role of ESCAP

131. In view of the ESCAP secretariat's commitment to support Governments in the Asian and Pacific region towards achieving the targets of the Declaration of Commitment, it is well placed to play an important collaborative role in strengthening the regional component of the APLF programme.

132. Since the ESCAP secretariat covers Governments of 62 members and associate members responsible for over 60 per cent of the world's population, the strengthening of APLF collaboration with the secretariat could yield greater benefits. The multidisciplinary nature of the ESCAP secretariat and its access to the economic and social sectors of government, including through the intergovernmental economic and social development forums and training workshops which it convenes, constitute resources for fuller exploration by the Forum. APLF could also involve more strategically the Executive Secretary of ESCAP, as the highest-ranking United Nations official in the Asian and Pacific region, in advocacy and policy follow-up with the highest levels of government and political leadership.

133. ESCAP could promote and support regional efforts to strengthen leadership at all levels through cooperation with the Governments of its members and associate members, civil society, the private sector, sister agencies in the United Nations system and other international institutions such as ADB. As part of its ongoing work on HIV/AIDS, ESCAP could continue to promote a more conducive environment for leaders to speak out and act on sensitive HIV-related issues. This could be achieved through facilitating creative avenues for advocacy, the region-wide dissemination of lessons learned and good public education practices to build awareness and foster behaviour change.

III. CONCLUSION

134. The ESCAP region is awakening to the unprecedented threat posed by HIV/AIDS.

135. Governments that have had success in holding the epidemic at bay are those that have explicitly recognized HIV/AIDS as a threat to development gains, committed sufficient resources for sustained programming, focused early efforts on the most vulnerable groups and adapted their responses to changing patterns in the epidemic.

136. In line with the objectives set out in the WHO "3 by 5" initiative, many Governments in the ESCAP region are increasing access to ART. Public awareness and behaviour change are the thrust areas of campaigns and life skills education. Prevention, treatment, care and support, and compassion towards people living with HIV/AIDS, as a coherent continuum, increasingly underpin programme development.

137. People living with HIV/AIDS are gaining recognition as key players in the fight against HIV/AIDS, an important step in fighting stigma and discrimination. Leaders from all sectors are

increasingly taking public positions that are supportive of action on HIV/AIDS. Myths and taboos regarding HIV/AIDS are gradually being replaced by understanding, sensitivity concerning the rights and needs of people living with HIV/AIDS, and greater willingness to act.

138. Despite significant progress in achieving the targets of the Declaration of Commitment, many challenges remain in the window of opportunity for safeguarding our common future (ESCAP, 2003). Governments in the ESCAP region will have to increase their efforts to sustain and strengthen the gains made in order to achieve the Declaration's targets for 2005. Where complacency has crept in, reversals threaten to unravel earlier gains.

139. In the window of opportunity that remains, the ESCAP region must act to prevent the spread of the epidemic into the general population, which could undermine societies on the same scale as Africa's tragedy. Strong leadership at all levels of society is essential. Leaders from all sectors must express their personal commitment and take concrete action against HIV/AIDS.

140. APLF is one initiative that supports the mobilization of leadership at the highest levels. ESCAP members and associate members are encouraged to seek active partnership with the Forum.

141. For the response to be timely, it has to be comprehensive and multisectoral. The ESCAP region's alliance is central to the great global alliance against HIV/AIDS. Governments of the ESCAP region are encouraged to join in this alliance to fulfil a collective responsibility for saving millions from certain death.

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