The decentralization of behavioural surveillance systems, as has been done in many countries, poses another set of programming purposes. As a consequence, programmes and interventions continue to be designed without the use of or behavioural HIV/AIDS surveillance data are not readily available in a ‘user-friendly’ manner for planning and regional bodies for the monitoring and timely assessment of responses. At the national level, epidemiological or region, nor is there a systematic data reporting mechanism in place to facilitate cooperation between countries and tasked with systematic collection and the continuous updating of a HIV/AIDS database for the East Asia and the Pacific and reporting of progress towards the Millennium Development Goals (MDGs). Moreover, there is no regional entity to another.

There are countries where data collection efforts are challenged by social, cultural or political sensitivities surrounding unsafe sexual practices by ‘non-formal’ populations, including unmarried youth and married men, or in regard to the collection of data on women exposed to forced or coerced sex.

For HIV prevention and care interventions to be effective, it is important to obtain an accurate profile of the populations infected, as well as those who are vulnerable, not only to HIV risk, but to drug use, sex work and unsafe sex. To facilitate systematic interventions including voluntary and confidential testing and counseling, age and sex segregated data are important, especially at the sub-national level. Focused local outreach must accompany public education, including the education of children (beginning in primary school) to incite a strong sense of what constitutes a healthy lifestyle, before risk behaviors are developed. However, baseline data to guide such outreach are either unavailable, or not regularly collected or used to inform programming in most countries.

Problems in using HIV/AIDS data for effective interventions

There is still a lack of consensus on definitions about what is being measured and/or who is being targeted for HIV/AIDS prevention or care. For example, definitions of population sub-groups such as ‘vulnerable’ or ‘highly vulnerable youth’ at risk’, ‘vulnerable children’ or ‘children affected by HIV/AIDS’ frequently vary from one government and/or agency, to another.

Data on the coverage of interventions that target certain population groups are also rarely available, and even when they are, are often limited to small-scale programmes with no impact at the national level. Age or gender disaggregated data are also rarely available.

Globally, limited data on groups such as young people and children affected by AIDS hampers the effective monitoring and reporting of progress towards the Millennium Development Goals (MDGs). Moreover, there is no regional data systems to facilitate collaboration between countries and regional bodies for the monitoring and timely assessment of responses. At the national level, epidemiological or behavioural HIV/AIDS surveillance data are not readily available in a ‘user-friendly’ manner for planning and programming purposes. As a consequence, programmes and interventions continue to be designed without the use of the following steps are key to controlling the HIV/AIDS epidemic:

• Build consensus on common definitions of what constitutes risk groups as marked by their vulnerability to HIV/AIDS and including young people and children at risk of drug use and sex work. Similarly, build consensus on definitions in regard to children affected by AIDS, who may or may not have become orphans, and whose conditions merit special attention.
• Improve national capacity for the design, collection, analysis and utilization of sentinel surveillance data. For example, there is also a need to initiate systematic collection of data on the number of orphans and children affected by AIDS.
• Improve the frequency of screening and surveillance among sub-groups, particularly considering that the epidemic can progress very quickly within a very short period of time.
• Improve the age, sex and occupational profiling of risk groups and those infected in order to facilitate more effective programming and to improve the use of data for strategic planning, including prioritizing and identifying types of interventions for different population groups.
• Improve epidemiological and survey research, which has been done to-date in capturing the spread of HIV in new communities and among groups who are at risk as a consequence of new behavioral patterns. This would include survey research on HIV and AIDS related knowledge studies as well as studies that investigate practices among different segments of the population.
• Improve the tracking of social attitudes and use feedback to form a combination of national media and focused community campaigns to tackle stigma and discrimination.
• Improve the use of data for the costing of interventions and to meet data quality standards that would lead to an improved quality and coverage of programming.
• Collaborate closely with UN agencies and international donors for the timely sharing of national HIV/AIDS data to enable regional and global advocacy for HIV/AIDS response, to increase resources, and to facilitate improved programmes by international partners.
• Improve evaluation of all HIV and AIDS programmes: only through scientific research can there be certainty that programmes are yielding beneficial effects. To obtain a better picture, there is a definite need to assess changes in knowledge, attitudes, intentions, practice and HIV status regularly through behaviour surveillance, and linking such monitoring to large-scale, targeted prevention programmes.

The availability of data is fundamental to the effective control of HIV/AIDS and for the monitoring of progress towards national commitments, including the MDGs. The leadership of national governments and the international community is vital for the strengthening of data collection and improvements in data quality. The following steps are key to controlling the HIV/AIDS epidemic:

- Improve the use of data for the tracking of social attitudes and use feedback to form a combination of national media and focused community campaigns to tackle stigma and discrimination.
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While HIV surveillance is in place in most countries, current data collection does not provide for a full understanding of the HIV epidemic can progress very quickly within a very short period of time.

A marked, sudden increase of HIV prevalence has occurred among sub-populations in a number of countries, and those experiencing a generalized epidemic bring lessons about the importance of proactive, early actions. Often countries have acted too late when the prevalence among sub-populations has begun to spread through what is known as ‘bridge populations’ or people closely associated with these sub-groups. These bridge populations include clients of sex workers, their wives and girlfriends as well as sex partners of injecting drug users and men who have sex with men.

Of equal importance is the fact that HIV prevalence increases because more people are entering the sex trade, buying and injecting drugs - many of whom are young. Addressing the vulnerability factors that put young people and women at risk of drug use and unsafe sex is just as important as tackling their exposure to HIV.

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The issue: low national prevalence tasks localized epidemics

Although overall adult HIV prevalence in Asia is low (~0.4 percent compared to 7.4 percent in Africa) - national prevalence varies widely. Within countries of the region, there are disturbingly high prevalence rates among some sub-populations and within various geographic areas. These locations and sub-populations are where concentrated epidemics build up, with substantially higher HIV prevalence than national prevalence levels can adequately capture. Table 1 provides a snapshot of national and sub-national HIV prevalence levels in selected countries.

A marked, sudden increase of HIV prevalence has occurred among sub-populations in a number of countries, and those experiencing a generalized epidemic bring lessons about the importance of proactive, early actions. Often countries have acted too late when the prevalence among sub-populations has begun to spread through what is known as ‘bridge populations’ or people closely associated with these sub-groups. These bridge populations include clients of sex workers, their wives and girlfriends as well as sex partners of injecting drug users and men who have sex with men.

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The resources needed for a comprehensive HIV prevention, care and treatment response in 2003 was estimated at USD1.5 billion for countries in the Asia and Pacific. However, for the same year only USD 200 million, in total, was made available by governments, the public sector and donors combined. This underscores the critical need in many countries to scale up resources and scale up response. Some key concepts:

HIV prevalence refers to the number of HIV-infected people in a population at a particular time. For example, the prevalence of HIV in a country in 2010 might be 0.5%, meaning that 0.5% of people living in that country have HIV.

AIDS prevalence refers to the number of people with AIDS in a population at a particular time. For example, the prevalence of AIDS in a country in 2010 might be 0.2%, meaning that 0.2% of people living in that country have AIDS.

Incidence refers to the number of new HIV infections in a population at a particular time. For example, the incidence of HIV in a country in 2010 might be 0.3%, meaning that 0.3% of people living in that country become infected with HIV in that year.

The number of new infections is an important indicator of the spread of HIV, as it shows the increase in the number of people who are infected with the virus. A high incidence rate can indicate that the epidemic is growing, while a low incidence rate can indicate that the epidemic is declining.

The number of new infections is also an important indicator of the impact of HIV prevention efforts. For example, if the incidence rate is decreasing, it may indicate that HIV prevention efforts are effective in reducing the number of new infections.

The number of new infections is also an important indicator of the burden of HIV on the population. For example, if the incidence rate is high, it may indicate that a large number of people are becoming infected with HIV, which can lead to increased healthcare costs and decreased productivity in the affected population.

Consequently, countries with high incidence rates may need to increase their HIV prevention efforts, while countries with low incidence rates may need to focus on other priorities.

The number of new infections can also be used to monitor the effectiveness of HIV prevention programs. For example, if the incidence rate decreases following the introduction of a new prevention program, it may indicate that the program is effective in reducing the number of new infections.

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