ASIAN DEVELOPMENT BANK

DEVELOPMENT, POVERTY AND HIV/AIDS:
ADB'S STRATEGIC RESPONSE TO A GROWING EPIDEMIC

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ABBREVIATIONS

ADB	–	Asian Development Bank
ADF	–	Asian Development Fund
AIDS	–	acquired immunodeficiency syndrome
ART	–	antiretroviral therapy
AusAID	–	Australian Agency for International Development
CBO	–	community-based organization
CCM	–	country coordinating mechanism
CIDA	–	Canadian International Development Agency
CSP	–	Country Strategy and Program
DFID	–	Department for International Development
DMC	–	developing member country
GFATM	–	Global Fund for AIDS, Tuberculosis and Malaria
GIPA	–	Greater Involvement of People living with AIDS
GMS	–	Greater Mekong Subregion
HIV	–	human immunodeficiency virus
ICT	–	information and communication technology
IDU	–	injecting drug user
IOM	–	International Organization for Migration
JFPR	–	Japan Fund for Poverty Reduction
Lao PDR	–	Lao People's Democratic Republic
MSM	–	men-who-have-sex-with-men
MTCT	–	mother-to-child transmission
NGO	–	nongovernment organization
PNG	–	Papua New Guinea
PLWHAs	–	people living with HIV or AIDS
PRC	–	People's Republic of China
RST-AP	–	Regional Support Team – Asia and the Pacific
STD	–	sexually transmitted disease
STI	–	sexually transmitted infection
TA	–	technical assistance
TB	–	tuberculosis
TRIPS	–	Trade-related aspects of intellectual property rights
UNAIDS	–	The Joint United Nations Programme on HIV/AIDS
UN	–	United Nations
UNGASS	–	United Nations General Assembly Special Session
UNICEF	–	United Nations Children's Fund
US	–	United States
USAID	–	United States Agency for International Development
VCT	–	voluntary counseling and testing
WHO	–	World Health Organization

NOTE

In this report, "$" refers to us dollars.

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EXECUTIVE SUMMARY

HIV/AIDS is a human tragedy and a real and growing threat to Asia's economic prosperity. It is a fundamental development issue that the Asian Development Bank, as a broad-based development institution focused on poverty alleviation, must address. UNAIDS expects that Asia will overtake Africa in the number of HIV/AIDS cases by 2010. HIV/AIDS devastates people in the prime of their working lives. Given current trends, annual poverty reduction estimates will be reduced throughout the region including by as much as 60% in Cambodia and 23% in India. In the face of these trends, it can be expected that ADB's overarching goal of poverty reduction in Asia and the Pacific will significantly suffer. The question is therefore not whether ADB should be involved in the fight against HIV/AIDS, but how.

HIV/AIDS is not simply a health issue and cannot be addressed through the health sector alone. Its spread is fuelled by both economic development (including prominently the increased connectivity that comes with improved roads and other infrastructure) and poverty and is perpetuated by the social and cultural sensitivities long deemed untouchable. Leadership in the fight against this spread must therefore come from the top of governments and include comprehensive support from national planning agencies, finance, energy, transport and communication ministries, as well as civil society and the private sector. ADB has a key role to play in mobilizing and supporting this leadership given its long-standing relationships and reputation for working with these non-health agencies. Moreover, ADB can provide leadership and fill an existing gap in the region by developing approaches to HIV/AIDS that mitigate the risk and impact of HIV/AIDS spread in sectors such as transport and energy.

HIV/AIDS in Asia and the Pacific. HIV/AIDS is spreading rapidly in the region. UNAIDS estimates are that 8.2 million people were living with HIV in Asia at the end of 2004, including 2.3 million women – an increase from 7.2 million in 2002 (1.9 million women).[1] In 2004, 1.2 million people became newly infected in this region and 540,000 adults and children died due to AIDS. The growing epidemics in PRC and India dominate the region. Myanmar, Cambodia, Thailand, Papua New Guinea and several states of India have infection rates that show the epidemic has spread beyond high-risk groups to the general population. The rapid rise of infection among injecting drug users in Central Asia and high rates of tuberculosis infection in this region fuel the epidemic.

The spread of HIV/AIDS in Asia has been different to that in Sub-Saharan Africa due largely to the role of injecting drug users and sex workers – groups that are often inter-connected because of social marginalization and economic pressure. The spread from these high-risk groups to the general population happens through the clients of sex workers to their wives and then to children. Men-who-have-sex-with-men also play a role because many also have sex with women, including wives. Mobility and migration play an important role in the region. The populations of Asia are remarkable for their movement within and beyond the region. Construction sites, ports, road transport routes and cross-border areas are 'hot zones' for the confluence of high-risk groups and high-risk behaviors.

The epidemic impact. The impact of rising infection rates is already evident in the strain on health care systems and decreasing life expectancy figures. Less obvious, but increasingly understood, is the impact on poverty. HIV/AIDS affects people in the prime of their working lives

[1] The UNAIDS categorization of Asia comprises ADB's South Asia, Southeast Asia and Mekong countries plus the People's Republic of China. Separate regional data for ADB's DMCs in the Central Asia and Pacific region are not available. For country-specific data see Appendix 1.

and households, carers and children are vulnerable to the economic impact of prolonged illness, lost income and missed education opportunities.

Intervention options. Prevention, care and treatment are the intervention options. Prevention must extend from harm reduction initiatives for injecting drug users to initiatives aimed at reducing the risk of sexual transmission. This includes education among high-risk groups, condom provision and empowerment for women, including legal and social protection. Care requirements extend from those ill with AIDS and associated diseases to social support to carers (including particularly women and the elderly), families and children. Treatment has become increasingly viable with reduced prices for antiretroviral treatments but remains constrained by a range of factors including lack of testing and counseling, health system capacity, and the social structures necessary to make treatment effective.

International aid agencies have played a critical role in financing, and advocating for, the response in developing countries. However, analyses of the resource and program needs for a comprehensive response clearly show that large financing gaps remain and, importantly, that many agencies and donors have struggled to design and implement effective multi-sectoral programs with impacts outside of the health sector.

ADB's comparative strengths. ADB's strong relationship with finance, planning and infrastructure ministries, and its experience in regional cooperation gives it a position to contribute to the fight against HIV/AIDS like few other international bodies. This is precisely why agencies such as UNAIDS and WHO are keen to see ADB increase its work in this area. Leaders need tools and knowledge to support their role, and ADB is well placed to advocate for, and generate analyses on, the interaction of HIV/AIDS with economic development and poverty alleviation. Through its financing of transport projects, ADB can lead by example and work with governments to design and implement activities that mitigate risk and enhance prevention opportunities. The increased financial resources ADB will have for HIV/AIDS from 2005 will also help to fill financing gaps.

ADB's strategic direction. ADB will support DMCs to achieve MDG 6/Target 7: *to have halted and begun to reverse the spread of HIV/AIDS by 2015*. The purpose of ADB's intervention is to have an effective response to HIV/AIDS in place at the country and regional levels in Asia and the Pacific.

The **priorities for action** are to be:

1. Leadership support: strengthen the commitment of regional leaders to address HIV/AIDS;
2. Capacity Building: increase capacity at country and regional levels to address HIV/AIDS; and
3. Targeted Programs: expand HIV/AIDS interventions that mitigate risk among the poor, the vulnerable and the high-risk groups.

In pursuing activities in each of the areas outlined above, ADB will subscribe to **principles** of country and government leadership; partnership and consultation with other development agencies, civil society and people living with HIV/AIDS; mainstreaming gender; targeting and capacity building based on sound technical knowledge; flexibility and innovation; and timely monitoring and evaluation.

I. INTRODUCTION

One in four infections in 2003 happened on this continent. There is no time to lose if we are to prevent the epidemic in Asia from spinning out of control.
Kofi Annan, Secretary General, United Nations, Bangkok, July 2004.

1. The continuing spread of human immunodeficiency virus (HIV) and the associated disease condition of acquired immunodeficiency syndrome (AIDS) in the Asia-Pacific Region is a human tragedy that goes beyond the immediate impact of the epidemic on the patients and their families. Because of the links between HIV/AIDS, poverty and development, the spread of the epidemic is a direct threat to achieving poverty reduction. Where HIV prevalence has risen to high levels, key development indicators, such as mortality rates and life expectancy, will be increasingly eroded,[1] and efforts to reduce both income and non-income poverty will be undermined.

2. The dramatic impact of the epidemic has been recognized by the international community. The 6th Millennium Development Goal (target 7) aims *to have halted and begun to reverse the spread of HIV/AIDS by 2015*. It is imperative that the Asian Development Bank (ADB) joins the global effort against the epidemic using its comparative strengths to assist its developing member countries (DMCs). This paper outlines a strategic direction for ADB in responding to the HIV/AIDS epidemic through regional efforts and targeted assistance to its DMCs, to be undertaken in close cooperation with other development partners.[2]

II. THE HIV/AIDS EPIDEMIC: AN OVERVIEW

3. In December 2004, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that globally, 39.4 million people were living with HIV, comprising 21.8 million men and 17.6 million women (including 2.2 million children). In 2004, it is estimated that 3.1 million people died and another 4.9 million were newly infected. A rapidly growing epidemic is often not evident at the national or regional level for some time because those infected are not sick and remain unaware of their infected status[3], making it difficult for governments and other authorities to appreciate that urgent attention is needed. In the few countries that have mobilized comprehensive responses, the growth of the epidemic has been reduced. But in most parts of the world, prevention efforts remain inadequate and the virus continues to spread at a steady or accelerating rate.

A. The Growth of HIV/AIDS in the Asia-Pacific Region

4. While 70 percent of current infections are found in Sub-Saharan Africa, the large populations of Asia are under serious threat of bearing a heavy proportion of the global HIV burden in the next decade. In Asia at the end of 2004, UNAIDS estimates are that 8.2 million people including 2.3 million women were living with HIV. This has increased from 7.2 million (1.9

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1 Paragraph 29 gives some examples of how mortality rates and life expectancy figures in specific countries have been affected by HIV/AIDS.

2 This paper is based on technical consultants' inputs, internal reviews, and external consultations with DMC officials and representatives from academe, NGOs, UNAIDS and people living with HIV/AIDS.

3 It is usually between 7 and 10 years before an infected person starts to become ill although this period has been observed to be shorter where malnutrition and other infectious diseases are prevalent.

million women) in 2002.[4] UNAIDS estimates that in 2004, 1.2 million people became newly infected in this region, and 540,000 adults and children died due to AIDS.

5. The growing epidemic in the People's Republic of China (PRC) and India dominate the region even though official prevalence figures for both countries remain low. In PRC, the official estimate of infected in 2003 was 840,000, more than double the 2002 figure, and it is widely suggested that the actual number might be several times this. In India, data from pre-natal clinics have shown infection rates between 3.8% and 5.8% of those tested, suggesting a more generalized epidemic in these areas. India is marked by widely varying infection rates between states and regions making it hard to predict how and where the epidemic might grow, but should it go as it has in some states across the country, national prevalence rates could be between 3% and 4%.[5]

6. Myanmar, Cambodia and Thailand have HIV epidemics that have already moved beyond high-risk groups, and in Viet Nam and Indonesia, the epidemics also appear to be spreading beyond high-risk groups into the general population. High-risk behaviors exist in several countries, including widespread injecting drug use and sex industries that threaten to lead to increased levels of HIV. In Central Asia, although HIV prevalence remains low, the rates of increase have been high in recent years. The World Bank estimates that by 2015 the uncontrolled spread of HIV through the region could slow economic growth in Kazakhstan and Kyrgyz Republic by 10%, and in Uzbekistan by 21%.[6] Driven largely by injecting drug use to date [60–90% of reported cases are among injecting drug users (IDUs)], sexual transmission is growing quickly with increasing numbers of young people at risk. The trafficking of drugs, women and children and poor health services contribute to a critical situation. Some countries, such as Mongolia, Sri Lanka, Maldives and Bhutan apparently have very low levels of HIV, but surveillance data are not comprehensive making it difficult to know the actual situation.

7. In the Pacific, the worst epidemic is in Papua New Guinea (PNG). It is estimated that 1%--3% of the population is now infected, with a rate of new infections growing exponentially since the mid-1990s. A recent joint assessment of World Bank, the Australian Agency for International Development (AusAID), and ADB estimated that 50,000 adults are living with HIV in PNG, mostly in rural areas. Economic enclaves in rural areas—mining, fishery, logging, road construction sites and oil palm plantations—have become high-risk zones for workers and the surrounding populations.[7] The greatest numbers of reported cases outside the capital Port Moresby are in the provinces along the Highlands Highway, the country's major transport route. For other Pacific nations the situation is less dramatic, but threatening. Over the past decade there has been a steady increase in the number of reported cases. Recently, Kiribati, Tuvalu, and Fiji have had sharp rises in reported HIV infections. It is thought that cases in the region are under-reported by at least a factor of 10.

8. Table 1 describes the different stages of epidemic development in ADB's DMCs and Appendix 1 provides data on key HIV measures for all DMCs.

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[4] The UNAIDS categorization of Asia comprises ADB's South Asia, South East Asia and Mekong countries plus the People's Republic of China. Separate regional data for ADB's DMCs in the Central Asia and the Pacific region are not available. For country-specific data see Appendix 1.

[5] Eberstadt, N. 2002. The Future of AIDS. *Foreign Affairs*. November/December.

[6] World Bank. 2004. HIV/AIDS and Tuberculosis in Central Asia. World Bank Working Paper No. 20. Washington, D.C.

[7] World Bank/AusAID/ADB. 2004. *Control of HIV/AIDS in Papua New Guinea: A Situation Assessment and Proposed Strategy.* Port Moresby.

Table 1: Classification of the HIV/AIDS Epidemic in ADB's DMCs.

Stage of Development	Stage Description	Country or Region
Generalized epidemic	HIV is firmly established in the general population. Proxy indicator: HIV prevalence consistently over 1% among tested pregnant women in sentinel sites.	Cambodia, Thailand, Myanmar, PNG and six States in India
Concentrated epidemic	HIV/AIDS has spread in a defined sub-population but not in the general population. Proxy-indicator: HIV prevalence consistently over 5% in at least one defined sub-population such as men-who-have-sex-with-men (MSM), IDUs, sex workers, etc.; and, HIV prevalence less than 1% among pregnant women attending urban antenatal clinics.	Indonesia, Nepal, Malaysia, Viet Nam, PRC
Low Prevalence	Proxy indicator: HIV prevalence is less than 5% in any defined sub-population	Other ADB DMCs in Asia and the Pacific

Note: This commonly used classification of HIV epidemics is based on levels of infection found in high-risk groups such as sex workers and IDUs, and among women attending prenatal clinics; the latter are taken as a proxy for the general population.
Source: UNAIDS and WHO. 2000. *Guidelines for Second Generation HIV Surveillance*. Geneva; and UNAIDS. *2004 Report on the global AIDS epidemic. 4th global report*. Geneva.

9. It took less than a decade for Africa's HIV-infected population to rise from 7 million to 25 million. While some observers believe this will not happen in Asia, history shows that the spread of HIV has been consistently underestimated. In Asia, experts believe the potential exists for HIV to infect 3–5% of adults over the next decade in lower risk countries and, in the absence of effective prevention efforts, 8–10% in moderate to higher risk countries. The situation in Asia is unlikely to reach the scale of Africa in terms of percentage of populations infected (with the possible exception of PNG), but the vast populations of Asia lead to some predictions that by 2010 more people will be living with HIV in Asia than in Africa. ADB's DMCs could soon represent the world's most HIV-affected region by number, with all the health, social and economic consequences this implies.

B. The Transmission of HIV/AIDS in the Region

10. The HIV/AIDS epidemic in Asia and the Pacific, due largely to injecting drug use and sex work, is distinctly different from that in Sub-Saharan Africa. The spread from IDUs to other population groups often starts with the spread to sex workers given cultural and economic pressures. As people who are marginalized—often with similar illegal status—IDU men partner with women who are sex workers, or themselves become sex workers to support their drug needs. The spread from sex workers to their clients is inevitable without the use of condoms. The clients of sex workers are from all parts of a broader community, single and married, and include mobile workers and MSM who lead ostensibly heterosexual lives. Other sexually transmitted infections (STIs) increase susceptibility to HIV infection when untreated, and a high prevalence of STIs fuels the epidemic. As a result, the region is witnessing an epidemic in which women and youth are an increasing proportion of the number of new infections each year.

1. Injecting Drug Use

11. The epidemic in Asia is characterized—and often started—by high levels of HIV transmission through the re-use of injecting equipment among IDUs. Countries in the region that have documented a concentration of HIV infection among IDUs include Bangladesh, India, Indonesia, Kazakhstan, Malaysia, Myanmar, PRC, Tajikistan, Thailand, Uzbekistan, Viet Nam, and more recently, Pakistan. In the early stages of an epidemic that starts among IDUs, a large proportion of cumulative infections will be among IDUs, such as in Viet Nam (80%), and Kazakhstan (86%). As the epidemic dynamics change, the proportion of current infections due to IDU drops as infections due to sexual transmission rise. Poverty and lack of opportunity underlie drug use, and youth are particularly at risk. In Kazakhstan three quarters of those diagnosed with HIV—mostly IDUs—were unemployed, while in Jakarta a survey of IDUs found 40% to be between the ages of 15 and 24 years.[8,9]

12. The spread of HIV infection among IDUs can be rapid. A 1988 survey in Myanmar found hardly any infections among IDUs, while a year later the figure had risen to over 70%.[10] In Pakistan, HIV prevalence among IDUs increased from 0.4% in December 2003 to 7.6% in 2004.11 Asia is the center of opium production in both the famed "Golden Triangle"—where the borders of Lao People's Democratic Republic (PDR), Myanmar and Thailand meet—and the "Golden Crescent," encompassing the Northwest Frontier Province of Pakistan, Afghanistan, and the Baluchistan area of Iran. Trade routes carry the heroin from these sites to areas throughout the region and beyond, and the number of drug users increases along routes of transshipment.

2. Sexual Transmission

13. The sex trade in Southeast and South Asia has been a major source of HIV transmission. The rate of spread among sex workers appears to be dependent on the number of clients per day and the percentage of adult men who visit sex workers. Sex workers can be male, female, or transgender (mostly male-to-female). Transgender roles in the Asia-Pacific region are widespread and traditional, including *warias* in Indonesia, *hijras* throughout South Asia and *fa'a'fafini* in Samoa. Clients of sex workers include traveling businessmen, truckers, civil servants, construction workers, sailors, dockworkers, students, traders and other mobile men. For the majority of sex workers, the main reason for entry or for remaining in the trade is the lack of alternative means of earning as much money. Most samples of female sex workers reveal much higher levels of illiteracy than in their country's general female population.

14. Studies show that 3%-5% of men in Asia have sex regularly or preferentially with other men. Of these, 20%-50% also have sex with women[12], including wives, and their hidden sexual lives have no implication on their public identity. The much higher probability of transmission of HIV through anal intercourse is the issue of importance. Studies indicate high prevalence levels

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[8] Stachowiak, J. and Bayerer, C2002. HIV Infection Follows Heroin Trafficking Routes. Paper presented at the conference Health Security in Central Asia: Drug Use, HIV and AIDS, Dushanbe, October. Available: http://www.eurasianet.org http://www.eurasianet.org/health.secruity/presentations/hiv_trafficking.shtml.

[9] UNAIDS. 2004. Report on the Global AIDS Epidemic. 4th Global Report. Geneva.

[10] Stimson, G. 1996. *Patterns of Drug Use in Developing Countries.* Available: http://www.worldbank.org/aids-econ/confront/backgrnd/riehman/indexp4.htm

[11] No author. 2004. *Pakistan IDU Witness a Rise in HIV Prevalence Rate.* Karachi, 10 September. Available: http://www.youandaids.org/News/

[12] Brown, T. 2004. Overview: Epidemiological and Behavioral Research among MSM in Asia. In *XVth International AIDS Conference* Abstract #: WePC2068.

of HIV among MSM, e.g. 14% in Cambodia and 20% in Mumbai.[13, 14] Legal codes against male-to-male sex in some countries, along with harassment and social stigma, hinder education programs targeting MSM, particularly in relation to HIV/AIDS.

15. Pacific island cultures differ considerably from those of Asia. Sexual networking is often wider and less dependent on organized commercial sex. However, transactional sex, i.e., sex in exchange for gifts or cash but without an overt commercial intention, is widespread. PNG in particular appears to have sexual partner exchange rates higher than some African countries. Sexual violence, especially gang rape, is also a contributing factor to the spread of HIV.

16. Trafficking of women and children has implications for the spread of HIV. Where women (or men) are subjected to abusive working conditions in which they cannot control their own sexual safety, HIV infection is a likely result. The sexual abuse of domestic servants, garment workers, and women in many types of low-level jobs is often considerable, and child sexual abuse is more widespread than usually acknowledged.

3. Other Modes of Transmission and Risk Factors

a. Mother-To-Child-Transmission (MTCT)

17. With the links between IDUs, sex workers and their clients, and MSM (many of whom are often also husbands) it is inevitable that increasing numbers of women who are wives will become infected. Without prevention measures approximately 30–35% of babies of HIV-infected mothers will be born with the virus or will acquire it through breast milk. Inexpensive drug treatments are available that can reduce prenatal and birth-related transmission by about 50%, but they need to be administered in the context of functioning health care systems (including pre-natal care, HIV testing and counselors) and prepared families and communities. Such systems exist in only a few parts of the region. The safe use of breast milk substitutes is also rare given the need for adequate quantities of infant formula (at considerable expense) and safe water. In some areas, the risk of a baby dying from diarrhea by 24 months of age is as great as the risk of acquiring HIV through breastfeeding.

b. Blood Safety and Safe Injections

18. In 2000, the World Health Organization (WHO) estimated that 5%-10% of HIV infections in Southeast Asia[15] were a result of blood transfusions, while in 2003 UNAIDS reported that 17% of known HIV infections in Pakistan were acquired through contaminated blood.[16,17] Many countries in the region have problems assuring consistently safe blood supplies.[18] More difficult to address is the widespread use of contaminated needles for injections. In many countries, particularly in rural areas, people seek injections for a range of ailments from untrained persons.

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[13] Girault, P. et al. 2004. HIV, STIs, and Sexual Behaviours among Men Who have Sex with Men in Phnom Penh, Cambodia. *AIDS Education and Prevention* 1(1):31—44.

[14] Mathur, M. et al. 2002. An Experience of MSM Surveillance in a Tertiary Care Center in Mumbai. In *XIVth International AIDS Conference*, Barcelona Abstract #: TuPeG5681

[15] WHO's South East Asia region comprises Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor Leste.

[16] Sharma, R. 2000. South East Asia Faces Severe Shortage of Safe Blood. *British Medical Journal.* 320 (15 April): 1026.

[17] Terzieff, J. 2003. AIDS in Asia: The Continent's Growing Crisis. Pakistani Woman Battles AIDS Stigma in her Country. *Chronicle Foreign Service.* 22 March.

[18] WHO advocates blood safety through voluntary, unremunerated regular donors, testing of all units of blood with appropriate technologies, and quality assurance and control systems covering each step of the transfusion chain.

Single-use syringes remain relatively expensive. Initiatives to reduce risk from injecting and blood exposure in medical settings must also extend to the proper use of protective clothing and the handling of a range of bodily fluids collected in a clinical setting. Implementing these procedures requires considerable discipline, supervision and funding that is often not available.

c. Risk Factors for Transmission

19. **Marginalization.** The intolerance, fear, and misunderstanding associated with marginalized groups (most particularly IDUs, sex workers and MSM) become a risk factor in itself. These groups are isolated from information, education and health care services, and from the economic and social security that enables them to protect themselves and their partners.

20. **Weak health systems.** Poorly functioning health care systems are not only more adversely affected by a growing HIV epidemic but also become a risk factor for the further spread of HIV. Without effective capacity within health care systems, including capacity to operate safe blood supplies, treat STIs, provide counseling and testing, and prevent MTCT, the risk of HIV transmission remains high and grows as infection spreads.

21. **Youth and vulnerability.** Vulnerability and risk differ for men and for women, and at different ages. Apart from a physiologically higher vulnerability to the virus, women are at a higher risk of infection because of sociocultural factors, reflecting different norms, roles and expectations, and economic factors, reflecting differences in command over assets (including productive resources, employment, and education). Young people also between the ages of 15 and 24 years, who constitute approximately 20% of Asia's population,[19] are already seriously affected by the HIV/AIDS epidemic. Of those living with HIV in Asia, 22% are between the ages of 15 and 24 years. The cultural resistance to teaching youth about the realities of sex (and drugs) has been one of the greatest obstacles to protecting the next generation from HIV and other STIs.

22. **Mobility and migration.** In both Asia and Africa, people on the move have proven to be a significant factor in the spreading of HIV. When large numbers of men migrate for work, leaving their families behind, high-risk behaviors increase and the spread of HIV is almost inevitable. Increasingly, women are on the move as well. In Pakistan, a retrospective study done in 1998 found the majority of HIV/AIDS cases were among men who had worked in the Middle East,[20] while in Sri Lanka health authorities have estimated that up to 40% of HIV infections among women involved those who had been working in the Gulf States.[21]

23. Several factors place migrants at risk of HIV infection. In the region, migrants often are young with low levels of education, little social support due to their relocation and usually do not know the language of the host nation. They have far fewer rights than citizens, but they have money and thus purchasing power for sex as well as alcohol and drugs in recreational environments that can increase high-risk behavior. Undocumented migrants have to hide from authorities and are therefore hidden from health services and education programs. Female migrants are at greater risk of sexual and other abuses.

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[19] No author. 2002. In the year 2000. In *The Future of Population in Asia.* Available: http://www2.eastwestcenter.org/pop/6-youth.pdf

[20] Baqi, S., et al. 1999. Epidemiology and Clinical Profile of HIV/AIDS in Pakistan. *Tropical Doctor* 29(3):144–148.

[21] Poudel, K., et al. 2003. Mumbai Disease in Far Western Nepal: HIV Infection and Syphilis among Male Migrant-returnees and Non-migrants. *Tropical Medicine and International Health* 8(10):933–939.

24. Mobility, as distinct from migration, also increases vulnerability, and applies to occupational groups such as truckers, sailors, fishermen, construction workers, traders and sex workers moving where opportunities arise. Mines, logging camps, construction sites, ports and other economic enclaves in which large groups of men with money can be found, attract women who sell sex. Mobile women, including sex workers, seasonal workers and factory workers are also in situations of vulnerability. The vast numbers of people in Asia who are on the move for economic reasons create wide networks for the spread of diseases.

C. The Impact: Health, Poverty and Social Consequences

1. Health and Health Systems

25. The risk of contracting HIV is greater among people with certain other conditions, and the incidence and severity of illness associated with HIV/AIDS occurs sooner and is greater when people are co-infected. For example, the transmission of HIV is far more likely when people are infected with other STIs, particularly the ulcerative conditions such as primary syphilis, chancroid and genital herpes. Tuberculosis (TB), closely associated with poverty, has a serious interaction with HIV. Unlike other opportunistic infections common among HIV-infected people, TB is easily spread to other people whether they have HIV or not, resulting in a steep increase in the number of TB cases globally. While the infection usually remains latent and leads to disease in only about 10% of people, where HIV is prevalent and weakens the immune system TB will become active, leading to illness and source of further transmission. In Chiangmai, Thailand the proportion of HIV-positive TB patients rose from 1.5% in 1990 to 69% in 1998.[22] Studies of the interaction of malaria with HIV show that a pregnant woman infected with both malaria and HIV is at greater risk of higher parasite load, anemia and low infant birth as well as at an increased risk of transmitting HIV to the newborn.[23] Hepatitis C is also emerging as a serious co-infection, particularly among IDU populations.

26. Treating HIV/AIDS and the associated conditions is a heavy burden for health care systems. In poor countries where there are limited numbers of doctors, nurses and hospital beds (especially those that are affordable to the poor), priority will have to go to the sickest at the expense of preventive and other health care services for those less sick.

2. Poverty

a. Individuals and Households

27. The economic impact of HIV is great, particularly among poor and nearly-poor individuals and households. While all chronic diseases take their toll on human productivity, HIV is markedly worse because it affects people in their prime productive years of 15-49 years of age. Many studies have documented the impact on families and communities, particularly due to the loss of income from both the infected persons and those who care for them, expenditures on health care and funerals, loss of future earnings and investment as children drop out of school to earn money or help caretakers, decreased agricultural production due to lack of labor, lost savings, lost homes, land sold to cover health costs and increased indebtedness.

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[22] WHO. 2003. *Regional Strategic Plan on HIV/TB*. Regional Office for Southeast Asia. New Delhi.

[23] Ayisi, J. et al. 2004. Maternal malaria and perinatal HIV transmission, Western Kenya. *Emerging Infectious Diseases*, 10(4):643–652. Available: http://www.cdc.gov/eid

28. Studies by ADB and UNAIDS looked at the household impact of HIV/AIDS in four countries (Cambodia, Thailand, India, Viet Nam).24 In Cambodia, catastrophic illness including HIV/AIDS was found to be the most common cause of loss of land among landless households. A recent death in a poor household was more likely to be associated with lower school enrollment, lower household wealth, unemployment and high indebtedness. In India, the average financial burden on households living with HIV was found to be 49% of household income, ranging from 82% among the poorest quintile to just over 20% among the richest quintile. The study found that at current estimates of the epidemic's growth, annual poverty reduction estimates and trends may be reduced by as much as 60% in Cambodia and 23% in India, and that in every year from 2003 to 2015 an average of 5.6 million people in the four countries will become poor or fall deeper into poverty.

b. Communities at Risk

29. There is increasing evidence that low national prevalence figures disguise situations where certain areas—provinces, states and cities—are experiencing much larger epidemics. An ADB-UNAIDS study looked at the situation in four countries—Cambodia, Thailand, India and Vietnam—where national adult prevalence figures were 2.6%, 1.5%, 0.9% and 0.4% respectively.[25] The findings underline the importance of focusing on sub-national epidemiological and socio-economic trends:

- In Thailand's Chiangmai province, at the peak of the national epidemic in 1993, HIV prevalence among adults reached 8%–10%, three to four times greater than national prevalence. In this province, life expectancy at birth fell by nearly five years, in contrast to a two-year reduction attributable to HIV nationally.

- In Cambodia's Siem Riep province, HIV prevalence is 6%, more than double the national average. It is estimated that life expectancy in 2007 will be 7.3 years lower than it would otherwise have been because of HIV/AIDS, whereas national life expectancy will be 2.3 years lower.

- The adult prevalence in India's Andhra Pradesh state is close to 2%, more than double the national rate. In 2004, one in eight hospital beds in the state was needed for people with HIV/AIDS-related illness, approximately five times the national average.

30. This indicates the need for responses based on localized assessments, including infection surveillance and behavioral studies and for interventions tailored to local conditions. Moreover, where conditions and needs vary across a country, more focused and intensive efforts should be made in those regions and communities more severely affected. The threat of HIV/AIDS to indigenous populations and endangered cultures, especially in the Pacific, must also not be overlooked.

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[24] ADB/UNAIDS. 2004. The Impact of HIV/AIDS on Poverty in Cambodia, India, Thailand, and Viet Nam. *ADB/UNAIDS Study Series Paper III.*

[25] ADB-UNAIDS. 2004. Comparison of Impact of HIV/AIDS at National and Selected Sub-national Levels in Cambodia, India, Thailand, and Viet Nam. *ADB-UNAIDS Study Series: Paper II.* Manila.

3. Social Impact

a. Stigma and Discrimination

31. The association of HIV with sex, drug use and death stigmatizes those who are affected, and incomplete and inaccurate information breeds fear. In such environments, studies show that people's efforts to avoid infection lead to unnecessary and cruel discrimination, isolation and being denied employment, access to schooling, housing and health care. Often this extends beyond the infected person to family, friends and the communities in which they live. Such rejection and stigmatization is not only inhumane but it fuels the epidemic as infected and affected people become isolated from information, support and economic opportunities (including schooling), and thus are more likely to engage in high-risk behavior (sex work, drug use and unprotected sex).

32. One study of stigma and discrimination comparing Thailand, the Philippines, India and Indonesia, showed that while HIV-positive people were refused housing, jobs and schooling, health workers exhibited some of the most discriminatory practices.[26] Over half of 764 persons surveyed had experienced some form of discrimination in the health sector, including forced HIV tests without proper counseling and confidentiality regarding results, and refusal of health care or referrals. In Southeast Asia some women testing positive were sterilized without their knowledge, and discrimination in employment has been widely reported. Women were found to be more likely than men to experience ridicule, harassment, physical assault and discrimination, particularly within their family and community. They were also much more likely to have to change their place of residence—often several times—because of their HIV status. These situations highlight the need for attention to the gender and legal dimensions of HIV/AIDS and to structural reforms through legal and social support systems to ensure protection.

b. Women, Men and Gender

33. Women are more physically susceptible to HIV through sexual transmission than are men: male-to-female transmission is twice as likely as female-to-male transmission. Younger women are especially susceptible due to immature vaginal tissues. But gender regimes, defined by social and cultural norms, are even more powerful in producing vulnerability in most societies. Men are nearly always in a stronger position in sexual relationships. Where women's economic and social safety is largely dependent on their men's occupations and status, women have little choice in determining their own sexual safety.27 The pattern of infection in countries where heterosexual transmission predominates shows this clearly. Commonly a defined group of female sex workers becomes infected, often following earlier outbreaks among IDUs. This is followed by transmission to their male partners who then pass on the infection to their other female partners (often wives). As the epidemic matures, increasing proportions of women become infected for whom their only risk factor is being a married woman. A 1999 study in Thailand found that 75% of HIV-infected women had been infected by their husbands.[28] In India, marriage actually increases a woman's HIV risk, particularly among younger newly married

[26] Asia-Pacific Network of People Living with HIV/AIDS. 2003. Documentation of AIDS-Related Discrimination in Asia. *Final report of the APN+ Human Rights Initiative.*

[27] Go, V., C. Sethulakshmi, et al. 2003. When HIV-prevention Messages and Gender Norms Clash: The Impact of Domestic Violence on Women's HIV risk in Slums of Chennai, India. *AIDS and Behavior* 7(3): 263–272.

[28] Bennetts, A. et al. 1999. Differences in Sexual Behavior between HIV-infected Pregnant Women and their Husbands in Bangkok, Thailand. *AIDS Care* December 11(6):649–661.

women. In Africa, this pattern has progressed until 60% of all infections are among women from either husbands or, for young women, from older male partners.[29]

34. The impact of HIV/AIDS differs markedly along gender lines, reflecting men's and women's different roles and responsibilities in household and market activities, and critical gender differences in access to and control of resources. Women—often also infected with HIV—are nearly always the caretakers of males who are sick, in addition to their other housekeeping, child and elderly care roles. Violence against women is also an important factor. Studies have revealed high levels of domestic violence and coercive sex in many countries. Both rape and partner violence, including against sex workers, have been associated with increased risk of HIV.[30] Trafficking of women and girls for the sex trade is another arena of serious harm to women, producing increased risk of HIV.

35. Male gender roles also need attention. Common notions of masculinity that drive risk-taking, including taking drugs and having multiple sex partners, as well as violence towards women, have to be addressed at broad societal levels. In an era of AIDS, sexual privilege and capacity for risk-taking have a significant downside. In many countries a significant proportion of men form the bridge between MSM, female sex workers and female spouses.

c. Orphans and Vulnerable Children

36. Although predictions of the number of children orphaned by HIV/AIDS (defined as a child under 18 years of age who has lost one or both parents to HIV/AIDS) in Asia and the Pacific are presently difficult, one analysis estimates that the total number of orphans in Asia may reach 4.3 million by 2010.[31] Orphaned children are especially vulnerable because they are highly stigmatized, often without adequate adult care, frequently unable to finish school (due to lack of social and financial support) and usually psychologically affected. AIDS is more likely than other causes of death to produce double orphans (i.e., both parents deceased).

III. INTERVENTION: PREVENTION, CARE AND TREATMENT

37. There is need for a comprehensive approach to the epidemic, encompassing prevention, treatment and care. As long as no vaccine is available, effective prevention programs are highly cost-effective and must be seen as a long-term investment in health services that otherwise would need to provide more costly treatment and care. Conversely, improved access to treatment enhances prevention efforts. People are more likely to seek testing and modify risky behavior if they believe there is a prospect that something can be done if they find themselves infected. The availability of effective treatments is important for reducing the fear and stigma now faced by people living with HIV/AIDS (PLWHAs) as well as providing positive externalities for the community by increasing people's willingness to use voluntary counseling and testing (VCT), and thus in turn, increasing the probability that they will take appropriate measures to minimize further spread.

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[29] UNAIDS/United Nations Children's Fund/United States Agency for International Development. 2004. *Children on the Brink 2004. A Joint Report on New Orphan Estimates and a Framework for Action.* New York: UNICEF.

[30] Dunkle, K., et al. 2004. Gender-based Violence, Relationship Power, and Risk of HIV Infection in Women attending Antenatal Clinics in South Africa. *The Lancet* 363:1415–1421.

[31] UNAIDS/United Nations Children's Fund/United States Agency for International Development. 2004. *Children on the Brink 2004. A Joint Report on New Orphan Estimates and a Framework for Action.* New York: UNICEF.

A. Prevention

38. Among IDUs, needle exchange can help slow the spread of HIV, but interventions need also to address the primary risk factor—drug use. Addiction to opiates is a chronic, relapsing mental disorder. While some of those addicted eventually manage to stop use completely, almost all make many attempts before succeeding. Investment in treatment programs for opiate addicts has rarely been a government priority, and few countries have adequate services to meet existing needs. In some countries drug injecting is increasing despite investments in supply control. School-based programs and media campaigns are also used to prevent the use of illicit drugs.

39. Preventing sexual transmission of HIV requires a comprehensive program that includes:

- targeted and general social marketing of condoms;
- community mobilization, including peer-based behavior change interventions with groups such as high-risk youth, sex workers, MSM and mobile populations;
- promotion of VCT, including for couples;
- addressing legal and structural barriers and supportive environments;
- use of multiple communication channels, including effective message development by target groups for target groups; and
- provision of accessible, efficient STI diagnostic and treatment services.

40. Female condoms are not widely used, and microbicides[32] are not yet technically developed, but as female-initiated prevention methods there must be ongoing attention and investment to their development and promotion.

41. Sex workers are generally very receptive to HIV/AIDS prevention programs, and with adequate attention to educating their male clients, prevention programs for sex workers have been shown to be successful in many countries around the world. Programs that target sex workers with large numbers of clients have been shown to have a rapid effect on decreasing infection rates in Thailand and Cambodia as well as in low prevalence settings such as Bangladesh and some cities of India.

42. The prevention of mother-to-child transmission —a success story in the fight against HIV— and infection through contaminated blood in large part requires strengthening of health care systems. Infected mothers need to be aware of their status and in contact with a health care system that can provide counseling, appropriate drug regimens at the appropriate time and follow-up care and support. The provision of safe blood and safe injecting in health care systems requires training, regulation and quality assurance systems, and a reliable supply of the commodities necessary to ensure safety (e.g., blood screening supplies and syringes).

43. The majority of young people, just like the majority of adults, are not at high risk of acquiring HIV. But when having multiple sexual contacts at a young age is a normal pattern---as is the case in some ethnic minorities and social groups—the risk is high, particularly because of peer pressure. Some youth are at risk and behavior change programs for these youth must be targeted rather precisely at the settings and situations in which risk is facilitated, because most young people cycle in and out of risky behaviors. Education programs at schools have been shown to delay the initiation of sexual intercourse and improve condom use among the sexually active. While the period of formal schooling presents an opportunity to efficiently reach many

[32] An effective microbicide would be applied in the vagina before intercourses to kill the HIV virus.

who may later become clients of sex workers, drug users or adopt other high-risk behaviors, special programs are needed for out-of-school youth, who are at greater risk.

B. Care and Treatment

44. Care extends beyond providing antiretroviral treatment (ART) to a range of health and social issues including the health care services for the opportunistic infections that precede full-blown AIDS, and social and economic support of those infected and their families. This especially includes children of sick parents, and older parents, particularly women, who often take care of their grown-up children affected by the disease.

45. Effective ART became available in the mid-1990s, but at a price (approximately $20,000/year) that meant only a small number of those infected—predominantly in developed countries—could access the drugs. However, as the numbers of infected people becoming sick in poor countries began to grow, it became increasingly evident that the exclusion of so many from effective treatment on the basis of cost was untenable. A massive mobilization of civic, government and corporate[33] "activism" developed, aimed at increasing access to ART. This has included modifying international trade rules, and in particular the trade-related aspects of intellectual property rights (TRIPS) provisions of the World Trade Organization, to allow generic drug manufacture and importation under special conditions. These efforts have reduced the annual cost of treatment to less than $250/year. While this is a critical achievement, efforts are still required to address persistent and new trade and economic barriers to affordable drugs.

46. Increasing the numbers of people on treatment requires an increase in the availability and use of VCT services as most infected people in the majority of countries have never been tested for HIV and are unaware of their status. If and when a person becomes aware of their status, the decision to go on treatment can be a complex personal one. In most cases this means acknowledging their infected status and then seeking, and being able to access, regular medical care. ART regimens require monitoring and strict adherence to ensure effectiveness and to reduce the risk of developing resistance. The most successful treatment programs occur where there is psychosocial support from the patient's family, workplace and health care providers. Creating these kinds of environments is expensive, complex and places significant demands on public resources.

47. The social and economic justification for treatment is high. A person on treatment can remain healthy and productive for long periods of time (10 years or more). Studies have shown that at the reduced prices, the savings in health care and averted socioeconomic losses (i.e., loss of earnings, care of children, etc.) compared to the cost of ARTs make the cost-benefit to national budgets, particularly health care systems, highly positive. In 2003, WHO adopted an international goal of having 3 million people on treatment by 2005, commonly known as the "3x5" initiative. If successful, "3x5" would represent treatment for approximately half of those thought to be in need globally. The need and demand for health care and social systems that support access to care and treatment as well as support for families and children orphaned by HIV/AIDS is great, and part of a comprehensive response to the epidemic. The increased availability of effective ART has transformed AIDS into a chronic disease that can be controlled. This poses a great challenge to most governments and international agencies on how to balance the allocation of limited resources between treatment and prevention programs.

[33] Including name brand and generic drug manufacturers.

IV. RESPONDING TO HIV AND AIDS: NATIONAL AND INTERNATIONAL ACTION

48. The HIV/AIDS epidemic has required national governments, civil society, bilateral donors and international agencies not only to strengthen existing health systems, but also to develop new programs. In resource-constrained environments the challenge has been to respond effectively to a growing epidemic where scientific and other knowledge remains incomplete and changing, and where the needs and priorities of those affected—and those that might be—sometimes conflict and extend beyond available resources. Ongoing programs need to be updated and refocused, and new resources rapidly mobilized. Given the large number of institutions involved in the response, it is important to consider current activities and the role of each player, and to identify where gaps and opportunities for cooperation remain so that new resources and programs, such as those that will come from ADB, can be efficiently planned and effectively targeted.

A. International Principles and Policies

49. As the international community has become increasingly active and experienced with HIV/AIDS programs, a number of principles and policies have been developed based on improved knowledge and lessons learned. In 1994, 42 countries agreed to support an initiative to strengthen the capacity and coordination of networks of PLWHAs by working to ensure their full involvement in the response at national, regional and global levels. This has become known as the Greater Involvement of People Living with HIV/AIDS, or GIPA, principle. Over the years much work has been done to strengthen networks and support groups for PLWHAs, although it is widely recognized that much more work and involvement is still needed.

50. In June 2001 the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS led to the 'Declaration of Commitment on HIV/AIDS: Global Crisis – Global Action' adopted by Heads of State and Representatives of States and Governments in attendance. The UNGASS declaration is a broad statement of commitment to principle and action and is now widely cited as the cornerstone for national and international mobilization.

51. In April 2004 UNAIDS led a meeting of officials from a broad group of national governments, multilateral and bilateral agencies, NGOs and the private sector to discuss the complex, often confused nature of HIV/AIDS programming at national levels and the urgent need for greater coordination, collaboration and co-funding. The meeting affirmed a commitment to what has become known as the "Three Ones" principle:

- **One** agreed national AIDS Action Framework that provides the basis for coordinating the work of all partners.
- **One** national AIDS coordinating authority with a broad based multi-sector mandate.
- **One** agreed country-level monitoring and evaluation system.

52. The Millennium Development Goals (MDGs) also provide direction and support for the international community's response to HIV/AIDS. MDGs have the overarching aim of reducing poverty, and were agreed upon by the global development community. Goal number 6, target 7 focuses on HIV and AIDS, and includes indicators for measuring progress as follows:[34]

- **Millennium Development Goal 6:** Combat HIV/AIDS, malaria and other diseases

[34] United Nations Statistics Division. 2004. *Millennium Indicators Database.* New York. UN. Available: http://millenniumindicators.un.org/unsd/mi/mi_goals.asp

- **Target 7:** Have halted by 2015 and begun to reverse the spread of HIV/AIDS.
  - Indicator 18: HIV prevalence among pregnant women aged 15 to 24
  - Indicator 19: Condom use rate of the contraceptive prevalence rate
  - Indicator 20: Condom use at last high-risk sex
  - Indicator 21: Percentage of 15–24 year-olds with comprehensive, correct knowledge of HIV/AIDS
  - Indicator 22: Contraceptive prevalence rate
  - Indicator 23: Ratio of school attendance of orphans to school attendance of non-orphans, ages 10–14

B. Governments – National and Sub-national

53. The spread of HIV cannot be addressed solely through medical and clinical approaches, and a response confined to the health sector is ultimately constrained and ineffective. In many countries, the Ministry of Health leads the response but does not have the power to bring other ministries into an active role. Multi-sectoral committees are formed but have often been ineffective, with little capacity or power. For this approach to work, decision-makers in each major government department should be educated about HIV/AIDS and have a budget for activities, although this is seldom the case. Where central agencies, such as finance or planning, take the lead in coordinating, success has been greater. In some cases the head of state has assumed a leadership role and this has led to greater mobilization of resources. Thailand was one of the first countries in the region to develop an effective multi-sectoral approach headed by the Prime Minister and including key public sector ministries (e.g., public health, military, education and culture), as well as NGOs, foundations and the private sector. Across all sectors, public and private, the ability to address HIV/AIDS in and through the workplace should also be developed as part of a multi-sectoral approach.

54. Where market failures preclude the provision of pubic goods, governments must intervene. In responding to HIV/AIDS, government actions might include:

- assuring access to programs providing basic prevention information and skills, the commodities required (condoms, STI medications, needles and syringes) and VCT;
- providing the policy environment for the protection of the rights of all persons to access these services in a manner that threatens neither their lives nor livelihoods;
- coordinating all donors, government departments, private companies, implementing agencies, community representatives and other stakeholders in such a way that a coherent national plan is developed and priorities of that plan are met;
- financing essentials that cannot be funded otherwise, including salaries of government staff dedicated to HIV/AIDS work;
- encouraging parliamentarians (or the equivalent), provincial, city and other government officials as well as local leaders and communities to learn about HIV/AIDS and speak out to their constituencies, advocating involvement, compassion and action;
- assuring sound and transparent financial management, with mechanisms of rapid disbursal;
- assuring basic medical services for STIs, opportunistic infections, palliative care and ART for those in need; and
- encouraging sound research, and monitoring and evaluation of the effectiveness of the response.

55. Resource constraints and the delayed onset of HIV-related illness mean many governments have not yet responded with comprehensive programs and appropriate budgets. This can be because of fears of economic impact in some sectors if the scale of the epidemic is measured and acknowledged (such as impacts on tourism and foreign investment), political and cultural sensitivities in acknowledging and addressing the needs of high-risk groups, as well as a lack of technical capacity. In many countries these factors have combined to produce slow responses, complacency and sometimes denial.

56. The most successful responses have come when national leaders and governments at all levels have taken a leadership role in resourcing and coordinating a national HIV/AIDS program. Thailand and Cambodia are successful examples of this approach:

- In 1997, 96% of Thailand's national HIV/AIDS budget was financed by the Royal Thai Government although total expenditures were much greater with over $100 million per year provided by the business sector, and expenditure by private citizens.[35] Concomitant with this period, the number of new HIV infections in Thailand declined steadily and effects on tourism and business investment were minimized.
- The Government of Cambodia has led a proactive, coordinated response and has managed to stem the growth of an epidemic that could have become one of Asia's most serious. From the early 1990s the Government has had good international funding support and has led programs that target high-risk groups (especially sex workers), provide strong surveillance systems, and work with civil society and PLWHA groups.

57. The preconditions for a successful response to HIV/AIDS include government commitment and leadership to support and change the situation of the groups at greatest risk; general recognition of the need for a multi-sectoral response; the acknowledged need for a gender-responsive, anti-discrimination policy and legal frameworks. Law reform, especially gender-responsive, is a viable policy tool for enhancing the impact of national AIDS programs. It may contribute to protecting PLWHAs through anti-discriminatory legislation in the workplace and regulatory measures to enforce anti-stigmatization practices; promotion of public-private partnership modalities; and strong involvement of civil society, including NGOs and PLWHAs. Experience also shows that effective responses come from the establishment of a national AIDS authority or committee that facilitates and coordinates a national program (ideally based on a comprehensive national strategy) including a broad range of stakeholders, to implement a multi-sectoral response. National authorities/committees are often complemented by, and work in concert with, a 'Theme Group' mechanism that coordinates UN and other international, NGO and donor agency inputs.

C. The Role of Civil Society

58. Governments are not well placed to do all that is needed, particularly in targeting and working with socially isolated and stigmatized groups. NGOs, including community-based organizations (CBOs), have demonstrated their capacity to play an important complementary role in mobilizing resources and working with high risk groups such as IDUs, sex workers, ethnic minorities and affected communities in both prevention and care. Several international NGOs have developed expertise in specific areas such as condom social marketing, behavioral surveillance, home-based care and treatment and capacity building for small, local NGOs. Other NGOs are helping to build capacity within government or independent health services for

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[35] World Bank. 2000. *Thailand Social Monitor: Thailand's Response to AIDS: Building on Success, Confronting the Future.* Bangkok.

delivering ART. The role of NGOs and CBOs in promoting changes in gender-based power relations is also critical to reducing individual and community vulnerability to the risk of HIV/AIDS in the region. Where central governments are unable or unwilling to allow the development of local NGOs, international NGOs are often accepted. Government-recognized and supported mass organizations are sometimes the functional equivalent of NGOs in single party systems, such as in PRC, Lao PDR, Myanmar and Viet Nam, and can be effective in implementing HIV/AIDS programs. The active involvement of PLWHAs and their families is essential for effective interventions. Most often, however, local NGOs and PLWHAs require capacity building, for example in financial management, disbursement and procurement, to become effective partners.

59. Academic and private sector research institutions also play a major role in the response to HIV/AIDS by conducting social and behavioral research as well as biomedical research. Testing the effectiveness of a particular approach to behavioral change contributes to evidence-based programs, and policy-related research plays a valuable role in advocacy. Building national research capacity is an important part of responding to the epidemic.

D. The Private Sector

60. The private sector has played a critical role in expanding the response globally but particularly in Sub-Saharan Africa through workplace programs including prevention and treatment provision. In many workplaces, such as mines and transport companies, these responses came largely from economic necessity, when employers faced the reality of more than 20% of employees infected. While the scale of the epidemic in the Asia and Pacific Region has not yet required this of most employers, the private sector can and should play a critical role. Workplace prevention and care programs and public-private partnerships that facilitate community action are effective approaches that can be further developed.

E. The International Community

61. The international community plays an important role in galvanizing and supporting national and regional responses to the HIV/AIDS epidemic. International agencies can also help countries learn from each other, produce and disseminate needed information, and facilitate access to the tools of prevention and care. Private foundations, international corporations, international research institutions, global business associations, and many others have also assumed a role in responding to HIV/AIDS.

62. Even though there are many agencies involved, analyses show that funding and program gaps remain, particularly for the leadership and responses needed outside of the health sector. Tracking the many programs and funding commitments of international agencies at a regional level has proved to be nearly impossible given the highly dynamic and diverse nature of funding sources, and it is generally considered to be not worth the resources that would be required to keep track of the situation. The US government, the World Bank and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) are the largest funding agencies, providing financial support through several channels, but don't themselves keep a constant track of their programs. More important for avoiding duplication is to ensure there are strong coordination mechanisms at the country level, nominally the national AIDS authority or similar body. Advocating that all international agencies work with the national authority and support the national AIDS strategy, as is the intent of UNAIDS "Three Ones" principle is intended to ensure there is a dynamic, effective process of coordination at all times. The information below gives a brief overview of what various agencies are doing, with more information in Appendix 2.

1. UNAIDS and Multilateral Agencies

63. The Joint United Nations Programme on HIV/AIDS, UNAIDS, formed in 1996, is a program of ten United Nations system organizations36 that aims to promote leadership and advocacy, strategic information, monitoring and evaluation, partnerships across sectors, civil society engagement and the mobilization of resources. Each partner agency has its own central focus area based on its particular work as an agency, e.g., WHO on treatment and surveillance and UNICEF on children. UNAIDS has its own secretariat and some technical capacity for facilitating its aims through its co-sponsors. The UNAIDS Regional Support Team – Asia and the Pacific (RST-AP)[37] coordinates and support the efforts of these co-sponsors for the Asia-Pacific Region, including South Asia and Afghanistan but not including Central Asian (there is no equivalent regional structure for these countries, except from UNAIDS headquarters in Geneva).

64. The World Bank has been a large financier—mainly through lending—of HIV programs in the Asia-Pacific Region since 1992. In its East Asia-Pacific Region, the World Bank had lent approximately $100 million for 11 health projects with HIV/AIDS activities in seven countries[38] although only two were exclusively for HIV/AIDS (Indonesia and Viet Nam). Other projects included HIV/AIDS as part of an infectious disease, maternal health or broader health systems project. In PRC $25.6 million has been provided for HIV/AIDS prevention and control components as part of major health infrastructure lending projects. Since 1992 in South Asia, $380 million has been committed to support national HIV/AIDS control programs in Bangladesh, India, Pakistan, Sri Lanka and Bhutan, mostly in the form of loans but including some grant components in recent years. In Central Asia, the World Bank is co-financing with DFID a new regional program in Kazakhstan, Kyrgyz, Tajikistan, and Uzbekistan.

65. The European Union is another major multilateral donor in the region, mostly through contributions to the GFATM and through programs in the South Pacific, PNG and Myanmar.

2. Bilateral Donors and Foundations

66. The United States, through USAID, is the largest bilateral donor in the region. In 2003, approximately $35 million was available for programs in Cambodia, Viet Nam, Indonesia, India, Nepal and Bangladesh, and $33 million was provided for programs in the Central Asian Republics. USAID's Regional HIV Office also has a budget of about $11 million for countries and regions such as PRC (Guangxi and Yunnan provinces), Thailand, Pakistan, Sri Lanka, Myanmar, Lao PDR and PNG. In addition, the US government supports international HIV/AIDS work through their National Institutes of Health (NIH) and Center for Disease Control and Prevention (CDC). In mid-2004 the US President's Emergency Plan for HIV/AIDS Relief (PEPFAR) expanded to Asia and named Viet Nam as the 15th designated recipient country with $20-25 million for prevention and ART purchasing programs.[39] Nearly all USAID funds are allocated to international NGOs that may sub-contract local NGOs.

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[36] Partners are: the United Nations Children's Fund (UNICEF), the World Food Programme; the United Nations Development Programme; the United Nations Population Fund; the United Nations Office on Drugs and Crime; the International Labor Organization; the United Nations Educational, Scientific and Cultural Organization (UNESCO); WHO, the United Nations High Commissioner for Refugees (UNHCR) and the World Bank.

[37] Previously called *South East Asia and Pacific Intercountry Team (SEAPICT)*

[38] Borowitz, M., et al. 2003. *Responding to HIV/AIDS in the East Asia and Pacific Region. A Strategy Note for the World Bank.* Washington D.C.: World Bank.

[39] Viet Nam is the only country in the Asia-Pacific region included to date.

67. The UK's DFID spent about $62 million in 2003 for HIV/AIDS programs in South and Central Asia, the Far East, Oceania, and Asia40 and supports HIV/AIDS programs in PRC, Bangladesh, India, Pakistan, Cambodia, Lao PDR, Nepal and Myanmar as well as the GFATM. Programs include condom social marketing, second-generation surveillance and behavior change interventions.

68. Other important bilateral donors in the region include Australia, Canada, the Netherlands, Sweden, Germany and Japan. In many cases, their funds are given directly to a UN agency, for example to WHO for ART work in PRC (Sweden). Of this group of donors, only the Netherlands is known to fund local NGOs directly. Australian aid has funded the establishment of the Asia-Pacific Leadership Forum on HIV/AIDS and Development (APLF) run by the UNAIDS RST-AP office.

69. Several foundations also fund HIV/AIDS work in ADB's region including the Bill and Melinda Gates Foundation, the Rockefeller Foundation, the Ford Foundation, the John and Catherine MacArthur Foundation and the Soros Foundation.

3. The Global Fund for AIDS, Tuberculosis, and Malaria (GFATM)

70. The GFATM began its work in 2002 and supports country proposals developed by a country coordinating mechanism that is designed to include government agencies, civil society and the private sector. The country proposals address issues, including ART purchasing, that often are not covered by funding from other sources. In the first four rounds of grants (2002-2004), GFATM approved two-year grants totaling $304.5 million for countries in ADB's region.[41] The performance of countries receiving large GFATM grants has become an issue of concern for many donors and those working in HIV programs because disbursement rates have been very low.

F. Limitations to Current International Response

71. Despite the massive scale up of international policy and funding responses there are widely recognized weaknesses in the current mode of operations. Criticisms leveled at international donors and agencies include the dominance of donor-driven agendas and priorities compared to government priorities, inattention to the cultural fabrics and epidemiological needs of a country, cumbersome bureaucratic administration demands unique to each agency, the inability to move beyond traditional agendas and the slow disbursement of funds – particularly loan funds. Most critically, the international community has been noted for its lack of coordination, and the resulting inefficiencies have been decried for the limitations they have placed on mobilizing effective responses.

V. ADB'S RESPONSE

72. The first information paper on HIV/AIDS for ADB staff was prepared in 1991, and ADB has been responding with support for HIV/AIDS projects in the region since 1993. Support has been predominantly through technical assistance (TA) grants with several focused on cross-border risk factors, particularly in the Mekong region. Several other TA grants have been put in place as part of loan-financed projects, particularly in the transport sector. Regional activities

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[40] Janjua, H. 2003. UK AIDS Aid. An Analysis of DFID HIV/AIDS Expenditure. *Actionaid.* November.
[41] For a complete listing of grants approved see www.theglobalfund.org

have focused on improving regional coordination and the knowledge base for planning responses. On the whole, ADB supported activities to date have been somewhat ad-hoc and not guided by an institution-wide consensus of how and in what particular areas ADB is best placed to support its DMCs. A list of ADB TA projects from 1993 to 2004 is at Appendix 3.

A. Country-Level Responses

73. Support for national responses has varied by DMC depending on specific circumstances, such as the nature of the epidemic in the country, the status of health infrastructure, the strength of existing HIV/AIDS programs, involvement of other donors and development agencies and availability of resources. ADB interventions started in Greater Mekong Subregion (GMS) countries and PNG. ADB has worked closely with other international agencies, and in most instances with the national AIDS authority. ADB's support has included advocacy and policy dialogue to raise awareness, with the aim of incorporating discussion of HIV/AIDS-related issues in regular dialogue with policy makers, and for capacity building. In Cambodia, ADB has provided support strengthening the National AIDS Authority, particularly its multi-sectoral responses and its analysis of surveillance data. In 2003, ADB approved a project in PNG with WHO to establish pilot HIV treatment and care centers.[42,43] Health sector projects in Cambodia, Lao PDR, Mongolia, Tajikistan, Uzbekistan and Viet Nam include components to ensure a response to HIV/AIDS is integrated into primary health care systems, or to strengthen community support for safe blood supplies.

74. ADB has also sought to integrate HIV/AIDS interventions in its projects in a range of non-health sectors. Recognizing the close linkage between mobility and spread of HIV/AIDS, ADB is integrating HIV/AIDS components into a number of transport projects. Since 1999, larger HIV/AIDS components have been, or will be, incorporated in at least 16 transport projects, including in Bangladesh, PRC (2 projects), India (5 projects), Kyrgyz Republic, Lao PDR (3 projects), Mongolia, Nepal and Indonesia. Since 2001, a covenant dealing with HIV/AIDS has been incorporated into most transport infrastructure loan agreements, requiring contractors to make information available on HIV and other STIs to all workers.

B. Regional Support

75. At the regional level, ADB has sought to enhance the fight against HIV/AIDS by facilitating cross-border activities and enhancing the knowledge base for responding to the epidemic. ADB has supported regional projects, such as the Community Action for Preventing HIV/AIDS project, which is focused on HIV/AIDS prevention activities in source and destination areas of mobile populations in Cambodia, Lao PDR and Viet Nam.[44] In partnership with UNESCO, a project is being supported in the same cross-border area that uses information and communication technology for HIV/AIDS prevention education.45 ADB has also supported the development of a tool kit for organizing HIV/AIDS prevention programs for migrant sex workers, construction workers, truck drivers and seafarers.46 In collaboration with several UN and

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[42] ADB. 2000. *Technical Assistance to the Kingdom of Cambodia for Capacity Building for HIV/AIDS Prevention and Control*. Manila.

[43] _____. 2003. *Technical Assistance for the Establishment of Pilot HIV/AIDS Care Centers in Papua New Guinea.* Manila.

[44] ADB. 2001. *Grant Assistance for Community Action for Preventing HIV/AIDS*. Manila. Supported by the Japan Fund for Poverty Reduction.

[45] _____. 2003. *Technical Assistance for ICT and HIV/AIDS Preventive Education in the Cross-Border Areas of the Greater Mekong Subregion*. Manila.

[46] _____. 1999. *Technical Assistance for Preventing HIV/AIDS Among Mobile Populations in the Greater Mekong Subregion.* Manila.

bilateral agencies, ADB has supported international and regional conferences including the 4th and 6th International Congress on HIV/AIDS in Asia and the Pacific.[47,48] More recently, ADB, in collaboration with UNAIDS, sponsored a session during the XVth International AIDS Conference (Bangkok, July 2004) on resource requirements for an expanded response to the epidemic.[49,50]

VI. DEVELOPING A STRATEGIC APPROACH

76. In the closing session of the XVth International AIDS Conference (Bangkok, July 2004), the Executive Director of UNAIDS, Dr. Peter Piot, noted that "every community needs to rewrite the rules of how it deals with those sensitive issues at the heart of the epidemic – sex, homosexuality, commercial sex, drug use, rape, gender, masculinity" and summarized the key issues facing the global community in responding to HIV/AIDS as follows:[51]

- HIV is an exceptional epidemic;
- Responses must be local. International agencies must cease imposing agendas and let local people manage the epidemic on their own terms;
- Prevention is paramount. Treatment programs will never be sustainable if the epidemic continues at its current pace;
- We need to avoid "over-medicalizing" prevention—capacity must be built in communities, not just in hospitals;
- Efforts, including funding, must be long-term in addition to reacting promptly to immediate needs. They need to include programs to improve nutrition, educate girls, and reduce poverty and many other sources of vulnerability;
- Capacity must be built, developed, fostered and mentored in every project and every country; and
- International agencies must coordinate and cooperate. Fragmentation has been harmful to many countries.

A. What's Needed and What's Missing?

77. The above review of the current status of the HIV/AIDS epidemics in ADB's DMCs and the responses in place leads to a number of conclusions that provide a good basis for defining a strategic direction for any agency or organization:

- Country epidemics and programs range from those in a very preliminary stage of development (e.g., Central Asia) to mature epidemics (e.g., Thailand).
- Strong, high-level leadership is needed but rare, and only a few governments have demonstrated commitment through substantial budgetary allocations (e.g., Pakistan, Thailand and recently PRC).
- Innovative approaches are needed to better reach the poor and vulnerable.

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[47] _____. 1997. *Technical Assistance for Support to the Fourth International Congress on HIV/AIDS in Asia and the Pacific.* Manila.
[48] _____. 2001. *Technical Assistance for Support to the Sixth International Congress on HIV/AIDS in Asia and the Pacific.* Manila.
[49] _____. 2003. *Technical Assistance for Financing Needs for HIV/AIDS Prevention and Care in Asia and the Pacific.* Manila.
[50] _____. 2003. *Technical Assistance for Financing Needs for HIV/AIDS Prevention and Care in Asia and the Pacific.* Manila.
[51] Piot, P. 2004. Plenary Address for Closing Ceremony. Getting Ahead of the Epidemic. *XV International AIDS Conference.* Bangkok: UNAIDS.

- Scaling-up of known successful approaches requires improved policies and harmonization between national governments and international agencies.
- Effective collaboration to assure efficient use of national and external resources occurs in only a few countries (e.g., Cambodia, Thailand, Lao PDR).
- Increased funding will challenge governments and NGOs with weak financial systems. Most countries will require strengthening of national capacity to absorb resources and mount effective programs, and agencies need to be wary of projects requiring heavy administrative efforts.
- The production and use of strategic information to guide policy and programming decisions is urgently needed in numerous countries because there is often a discrepancy between what is perceived to be needed (or politically favorable to provide) compared to what international good practice suggests should be provided.
- Planning and implementation need to be multi-sectoral and not confined to health.
- Greater effort is needed to challenge stigma and discrimination, particularly against marginalized people such as PLWHAs, sex workers, MSM and women, and there is a need for enhanced efforts to involve PLWHAs in responses to the epidemic.
- Innovative approaches to financing the implementation—including program support—of national AIDS strategies are needed, as opposed to burdening available capacity with heavy project administration burdens.
- Comprehensive, well resourced programs can change the course of a rapidly growing epidemic as evidenced in Thailand and Cambodia.

78. In addition, while funding to fight HIV/AIDS has increased significantly in the region in recent years, the response is not yet adequate given the growing demands for expenditure on care and treatment, which cannot be filled at the expense of prevention. The threat of HIV/AIDS in the Asia-Pacific Region has inspired only a few governments to mobilize substantial resources in response to the epidemic. A joint ADB-UNAIDS study estimated that in 2003, countries in the region required $1.5 billion to finance a response that comprehensively addressed all areas of HIV/AIDS prevention, care and treatment. The study found that only $200 million was available from all sources combined, including international agencies and governments' own resources.52 By 2007, resource needs will spiral to $5.1 billion. The needs of a country will vary according to the size of the population, the severity of the epidemic and the unit costs of prevention and care. Of the total $5.1 billion required in 2007, almost 70% will be needed in India and PRC.53 No less important than increased financing is the need to improve the effectiveness with which resources are allocated – to be achieved through improved policies and programs based on evidence and expanded monitoring and evaluation.

79. Even at the relatively low levels of infection compared with those in Sub-Saharan Africa, failure to immediately establish comprehensive and effective prevention, care and treatment programs will result in an estimated 10 million adults and children in the region becoming infected between 2004 and 2010; the annual death toll will rise to 0.76 million by 2010, and annual financial losses will reach $17.5 billion. The ADB-UNAIDS study estimated that if a comprehensive response was established in 2004, cumulative new infections could be kept down to 4 million in 2010, deaths to 0.66 million, and annual financial losses to $15.5 billion (Table 2). While the economic benefits are initially small, the long term savings and benefits of prevented infections and averted deaths will translate into much greater amounts.

[52] ADB and UNAIDS. 2004. *Asia Pacific's Opportunity: Investing to Avert An HIV/AIDS Crisis.* Bangkok.
[53] ADB/UNAIDS. 2004. Funding Required to Confront the HIV/AIDS Epidemic in the Asia-Pacific Region. *ADB/UNAIDS Study Series* Paper I. Bangkok.

80. The response to HIV/AIDS requires interventions focused on prevention, treatment and care (psychosocial and physical). Target groups include (i) people at risk of infection, (ii) peer groups of those at risk, (iii) people who are living with HIV/AIDS but are unaware of it, (iv) people who are sick and need medical care and access to treatment, and (v) people who support and care for the sick. While the international debate is ongoing about the proportions of funding and available human resource capacity that should be devoted to each of these areas, more attention to all these areas is necessary to ensure an effective response.

81. In the area of prevention, support is needed for programs providing voluntary counseling and testing for people at risk of infection, and programs are needed to assure safe blood supplies. But the focus will continue to be on behavior change, particularly in high-risk groups. Reports to the International AIDS Conference in July 2004 made it clear that other forms of prevention, such as vaccines, will not be available for at least 10–15 years. Behavior change interventions include the promotion of condom use (along with improved condom availability), clean needles available for IDUs, promotion of abstinence and delayed first intercourse, and monogamy. Considerable progress has been achieved in preventing the transmission of virus from mother to child during pregnancy, at birth, and during the infant-feeding period through the use of drug regimens and alternative feeding methods. Access to this care remains limited, however, and must be improved in many countries.

Table 2: Burden of Disease and Summary of Direct and Indirect Financial Costs Of HIV/AIDS for Asia and the Pacific, 2001 and 2010

Cost Items and Burden of Disease	2001[a]	Baseline Response 2010 [b]	Comprehensive Response 2010 [b]
Direct Health Costs ($'000,000)			
Prevention	218	3,338	3,180
Care	35	1,999	1,743
Subtotal	**253**	**5,336**	**4,923**
Indirect Costs by Household ($'000,000)			
Funeral, transport, etc.	171	272	238
Carer (lost income)	17	28	25
Sufferer (lost income)	6,907	11,869	10,352
Subtotal	**7,095**	**12,170**	**10,615**
Total Financial Cost ($'000,000)	**7,348**	**17,507**	**15,538**
Burden of Disease ('000)			
Number of HIV cases	6,510	11,570	6,189
Loss of Disability-Adjusted Life Years [c,d]	13,660	24,201	19,854
Deaths	431	760	663

Source: ADB/UNAIDS Study Series. Manila and Geneva. July 2004.
[a] HIV prevalence taken from UNAIDS. 2002 Report on the Global AOIDS epidemic. 3rd global report. Geneva.
[b] Derived from Stover *et al.* 2002. Can We Reverse the HIV/AIDS Pandemic with an Expanded Response? *The Lancet* 360:73–77. Baseline prevention assumes a comprehensive response has not begun by the end of 2010, in contrast to the comprehensive scenario, in which an expanded approach is implemented from 2004.
[c] Calculated by estimating the years of life lost to morbidity (time spent in less than full health) as well as mortality (time lost due to premature mortality).
[d] In 2003, WHO ranked HIV/AIDS as the leading cause of disease burden in the world, as measured by DALYs, followed by unipolar depressive disorders (2nd) and tuberculosis (3rd). HIV/AIDS was also the leading cause of death among adults aged 15 to 59 followed by heart disease (2nd) and tuberculosis (3rd). Reference: WHO. 2003. The World Health Report 2003: Shaping the Future. Geneva.

82. Given that many countries in the Asia-Pacific region, including in Central Asia, are experiencing an epidemic driven largely by injecting drug use, governments and international agencies have to address the potentially controversial need for harm reduction programs (treatment and counseling for IDUs and access to clean needles) if they are to stem the spread. The concern for an escalating epidemic lies in the simple axis of transmission between IDUs

and sex workers (many IDUs support their drug habit through sex work), to the clients of sex workers, their partners (usually wives) and then children. Interventions that focus on high risk groups are not yet adequately resourced, particularly in relation to the provision of commodities such as condoms and clean needles that enable protective measures to be taken.

83. Until recently, the options for treatment in resource-poor settings were limited. Antiretroviral therapies have been available in wealthy countries since the mid-1990s. These therapies, which prolong the life expectancy of PLWHAs by more than 10 years, remained highly expensive. In recent years, due to public and political pressure, a growing sense of corporate social responsibility, and increased competition from generic drug manufacturers, many drug companies have reduced their prices to levels that make their use in resource-poor settings more feasible. While international efforts to increase access to treatment (largely encapsulated in the "3x5" initiative of WHO and UNAIDS – see para 47) have been great, significant constraints remain. Apart from addressing TRIPS-related legal issues, there is a critical need to develop and improve the health services delivery systems in many DMCs to ensure ART and other care is effective.

84. An expanded response to HIV/AIDS is hampered by the weak institutional capacity and policy environment in most DMCs. The AIDS epidemic tends to strike hardest in countries with the weakest capacity to respond to it. The epidemic in turn erodes technical and administrative capacity in the health and other sectors, further constraining the ability to respond effectively. As countries face increased demand for health services, they also face an increased burden of disease from opportunistic infections associated with AIDS, including TB, malnutrition, diarrhea and pneumonia. These increasing demands and burdens in turn create conflicting demands for limited financial and human resources capacity. Responding to these challenges requires trained health personnel and strong health systems. It also requires supportive policies, strategies and programs. Addressing these policy and institutional gaps will be critical for an effective response to the epidemic and must be addressed through improved evidence, operational plans, budget allocations and mechanisms for monitoring and evaluation. Further, effective responses to the epidemic should be linked to poverty reduction strategies.

85. An effective response to the epidemic requires strong coordination among international agencies, national authorities, civil society and the private sector. Since the creation of UNAIDS, coordination has been repeatedly advocated, but challenges remain. Thus commitment by national governments, multilateral and bilateral agencies, NGOs and the private sector to the "Three Ones" principle—one strategic framework, one national coordination authority, and one monitoring and evaluation mechanism—will be critical. Support for this concept and partnership around common national plans will be essential to remedy current problems of national efforts unnecessarily hampered by lack of coordination and limited resources poorly expended.

86. In summary, the response to HIV/AIDS in the region is still lacking in resources, effective prevention initiatives, sufficient support and care for those infected and affected by HIV/AIDS, institutional and human-resource capacity at all levels and in all sectors, and strong and effective coordination.

B. The Rationale for ADB

87. HIV/AIDS infection is a direct threat to the region's progress in reducing poverty. HIV infection reduces the income-earning capacity of households and increases their expenditure on health care. This is particularly burdensome for the poor and almost poor, whose incomes are most dependent on their labor and who are least able to bear such heavy expenses.

Conversely, widespread poverty and income inequities further fuel the spread of AIDS. The poor are more likely to adopt high-risk behaviors such as sex work and IDU; poor women in particular are less likely to be able to negotiate or take effective preventive measures in these vulnerable situations. The joint ADB-UNAIDS study found that in Cambodia, India, Thailand and Viet Nam, up to 5.6 million people will either become poor or be pushed into poverty due to the epidemic, and that poverty reduction efforts will be slowed in all countries, including by up to 60% every year between 2003 and 2015 in Cambodia.

88. An HIV/AIDS epidemic of sufficient size and severity can disrupt a country's medium to long-term development prospects. As seen in the most seriously affected Sub-Saharan African countries, HIV/AIDS can ravage the labor force, strain social services, overextend public resources, decimate accumulated human capital, and reduce the development options available to a country. This is exacerbated by the fact that HIV/AIDS disproportionately targets men and women at the age of prime economic productivity. As noted in Table 2, governments and households face rising economic and social losses without an expanded response. The long lag time between infection and disease onset hides these impending impacts and can make it hard for governments and others to rationalize prevention and care investments in the short term.

C. ADB's Strengths

89. With the needs of the region in mind, it is apparent that ADB should support activities that fill existing gaps selected on the basis of its relative strengths and policy priorities, and that complement and reinforce its operations in other areas. The interaction of HIV/AIDS with poverty presents a special challenge to ADB as it continues to pursue its overarching goal of fighting poverty. ADB has the experience and expertise as well as internal mechanisms required to ensure that interventions target those most at risk, and that interventions comprehensively consider the social and economic needs of the poor.

90. ADB is recognized for the opportunities it has to engage and access leaders in key economic sectors, including finance, planning and infrastructure ministries. Agencies that are leading global advocates for HIV/AIDS, such as UNAIDS and WHO, are keen to see ADB play a role in this area. As a regional partner in economic and social development, ADB stands well placed to do this. Leadership in responding to HIV/AIDS in a multi-sectoral way is needed, as is regular dialogue across borders and in subregional and regional forums. ADB is well placed to facilitate and support these processes in relation to HIV/AIDS. It also can support the development of knowledge products that assist leaders in national and regional forums, particularly in areas such as economic and poverty impact. Importantly, ADB's experience in regional cooperation will help address more efficiently an epidemic that ignores borders.

91. Capacity at all levels—from national program planning and implementation to health systems that provide care and treatment—is severely constrained and is not being adequately addressed. ADB has considerable experience in developing capacity across a range of sectors and as an integral part of development, making it strategically placed to help fill a fundamental gap in the fight against HIV/AIDS. Notably, ADB experience in improving health services delivery through comprehensive health systems reform could make a critical contribution to enhancing the capacity in this sector in a systematic and sustainable way.

92. As a major supporter of projects in transport and other infrastructure sectors that potentially create or exacerbate high-risk environments, ADB not only has a comparative advantage but a responsibility to address and mitigate those risks.

93. The implementation of national and regional HIV/AIDS strategies requires a range of approaches and additional financing. ADB's experience and capacity to offer various project and program modalities—loan or grant financing, a combination of the two, stand-alone projects, program financing, integration of HIV/AIDS components into projects for infrastructure and sectors and regional projects—make ADB a valued partner to DMCs and regional bodies. ADB can and should offer them a range of options that facilitates flexibility, increases resource levels, and maximizes effectiveness and efficiency.

VII. A FRAMEWORK FOR STRATEGIC ACTION

94. ADB's vision as a regional multilateral development bank is an Asia and Pacific Region free of poverty. Its mission is to help its DMCs reduce poverty and improve living conditions and the quality of life. The strategic agenda for pursuing this mission is three-fold: sustainable economic growth, inclusive social development, and governance for effective policies and institutions. ADB's goals are aligned with the MDGs, and the targets and indicators therein provide a basis for ensuring comprehensive and equitable outcomes. ADB's vision and strategic agenda and the MDGs are the starting point for formulating ADB's strategic direction in response to HIV/AIDS in the Asia-Pacific Region. Other factors to take into account include

- the current situation of the HIV/AIDS epidemic in the region and in individual DMCs;
- the nature and scope of the response to date, including resource commitments, national government programs and the policies, and the program priorities of other donors and multilateral agencies;
- ADB's overall program of projects and other activities, including the sectoral profile of lending in recent years; and
- ADBs technical capacity as well as its ability to mobilize financial resources.

95. A strategic framework for ADB's response to the HIV/AIDS epidemic is outlined in Box 1. The goal of ADB activities is to support DMCs to achieve MDG 6/Target 7: *to have halted and begun to reverse the spread of HIV/AIDS by 2015*. The purpose of ADB's interventions is to ensure that an effective response to HIV/AIDS is in place at the regional and country levels. This strategic approach is consistent with, and supportive of, a number of other ADB sector policies and strategies, including the Poverty Reduction Strategy,[54] the Policy for the Health Sector,[55] and the Social Protection Strategy.[56] ADB's education policy[57] outlines a need for partnerships and innovative approaches, and it is recognized that such will be particularly important in the face of HIV/AIDS and its impact on children, as well as the need to focus on youth as a target group for prevention activities.

A. Priorities for Action

96. Three priorities for action are identified for the achievement of the goal and objectives of the strategic framework, with due consideration of ADB's role and capacity in the region:

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[54] ADB. 2004. Fighting Poverty in Asia and the Pacific. The Poverty Reduction Strategy of the Asian Development Bank. Manila.
[55] ADB. 1999. Policy for the Health Sector. Manila.
[56] ADB. 2001. Social Protection Strategy. Manila.
[57] ADB. 2002. Policy on Education. Manila.

(i) **Leadership support**: strengthen the commitment of regional leaders to address HIV/AIDS.
(ii) **Capacity Building**: increase capacity at country and regional levels to address HIV/AIDS.
(iii) **Targeted Programs**: expand HIV/AIDS interventions that mitigate risk among the poor, the vulnerable and the high-risk groups.

97. ADB will consider both country and regional priorities based on the severity of the epidemic, the current level of available resources for a comprehensive response in the country or region, and the need for strategic inputs that fill gaps in the current response and are consistent with ADB's objectives and priorities for action (further information in Appendix 4).

Box 1: Framework for Strategic Directions

STRATEGIC DIRECTIONS FOR ADB IN RESPONSE TO HIV/AIDS IN THE ASIA AND PACIFIC REGION
Goal
❑ To achieve Millennium Development Goal 6, Target 7 – have halted by 2015 and begun to reverse the spread of HIV/AIDS.
Purpose of ADB's Intervention
❑ An effective response to HIV/AIDS in place at the country and regional level in Asia and the Pacific
ADB Activities – Priorities for Action
Leadership Support – strengthen commitment of regional leaders to address HIV/AIDS.
❑ Conduct policy dialogue on HIV/AIDS with DMCs.
❑ Produce evidence for advocacy and decision-making.
❑ Support regional activities to raise awareness and commitment.
Capacity Building – increase capacity at the country and regional level to address HIV/AIDS.
❑ Support formulation of HIV/AIDS strategies at national and regional levels
❑ Support implementation of HIV/AIDS strategies at national and regional levels.
❑ Support health systems to improve efficiency and effectiveness of HIV/AIDS programs.
Targeted Programs – expand HIV/AIDS interventions that mitigate risk among the poor, the vulnerable, and the high-risk groups.[1]
❑ Integrate HIV/AIDS activities in ADB infrastructure projects that potentially interact with, create or enhance high-risk environments or behaviors for HIV/AIDS.
❑ Integrate HIV/AIDS activities in ADB projects in other sectors (non-health and non-infrastructure sectors).
❑ Support NGOs and programs targeting groups with high-risk behavior.
❑ Support HIV/AIDS projects that specifically target women and girls in selected DMCs.[2]
Operational Principles
(i) Support for **country ownership** and **government leadership**, and strict adherence to the "Three Ones" principle.[3]
(ii) A commitment to **partnership**, **consultation** and **involvement** of civil society and people living with and affected by HIV/AIDS, and with other development agencies to ensure coordination and maximum efficiency and effectiveness.
(iii) A commitment to mainstreaming **gender** considerations in all activities.
(iv) A commitment to evidence-based **targeting** and **capacity building**, based on sound technical knowledge, to ensure all resources are used for maximum impact and efficiency.

STRATEGIC DIRECTIONS FOR ADB IN RESPONSE TO HIV/AIDS IN THE ASIA AND PACIFIC REGION

(v) A commitment to **flexibility** and **innovation** where possible, but linked with rigorous and timely **monitoring and evaluation,** in coordination with regional, national and community-based partners, to ensure critical review and learning and to build capacity.

[1] In the Asia - Pacific region high risk groups are predominantly IDUs, sex workers and MSMs.

[2] DMCs = Developing member countries of ADB

[3] The "Three Ones" are a set of operating principles proposed by UNAIDS and supported by bilateral and multilateral agencies supporting HIV/AIDS activities. These principles are: one national AIDS coordinating authority, one national HIV/AIDS strategy, and one national monitoring and evaluation system.

1. Leadership Support

98. Since the beginning of the epidemic it has been recognized that truly effective responses, whether they be in developed or developing countries, are made only when leaders from all sectors—politics, religion, business and others—step forward and talk openly about the reality of the epidemic—how it is spread, who is at risk, how infection can be prevented and how communities should respond. Moreover, leadership at the government level must be multi-sectoral, extending beyond the health sector to ministries of finance, transport, planning and energy. The stigma and mystery that surrounds HIV/AIDS otherwise remain barriers to an effective response.

99. Globally there are now many clear examples of how leadership can change the course of an epidemic. In Australia, an early government response to the risk of spread among IDUs led to the introduction of harm reduction initiatives, notably needle-exchange programs, despite community resistance. As a result, the spread of HIV among and beyond IDUs was much less than in other countries. In Uganda, government leaders began to speak openly about the causes and risk of HIV spread at a time when no other leader in Africa would—when their national epidemic could have become one of the worst on the continent. In combination with resources for comprehensive programs that support the rhetoric, a distinct decline in the number of new infections has begun. Similarly, the spread of HIV/AIDS and the number of new infections declined in Thailand when government collaborated with religious and business leaders in the mid-1990s and led a response that acknowledged the causes of the spread and the necessary response.

100. To engender and support leadership is a long-term, strategic endeavor. Leaders must be informed themselves and comfortable with the issues. They must understand the social and medical dimensions as well as the economic dimensions. They need knowledge that is relevant and salient to their areas of concern, whether it is electorates, profit lines or congregations. They must match their rhetoric with realistic, effective actions. As a trusted, regionally-based development partner, ADB is well placed to support leaders, particularly in the economic sectors, with some of the necessary tools for leadership. As a regular dialogue partner with government leaders in critical sectors such as finance, public works and treasury, and in the increasingly important subregional forums such as the GMS, ADB can strengthen the growing awareness of the economic dimensions of the epidemic. Leadership extends beyond national government leaders to government leaders at all levels (provincial, district, city/urban areas) and to leaders in other sectors, such as religion, business, community-based organizations and the entertainment and sports industries (particularly for youth). ADB will work with UNAIDS and other regional partners to develop the knowledge and evidence to support this dialogue and

advocacy. ADB will provide leadership support by producing evidence for advocacy and decision-making; conducting policy dialogue on HIV/AIDS with DMCs; and supporting regional activities to raise awareness and commitment.

101. Examples of the types of activities that might be pursued include support for improved surveillance and coordinated knowledge building and sharing in the Pacific region; support for policy development in critical areas such as cross-border migration and harm reduction; and support for regional leadership forums and other exchanges among Asia-Pacific leaders.

2. Capacity Building

102. It is widely recognized that a critical constraint to the current response to HIV/AIDS in the region is the lack of technically skilled, efficient and effective human resource capacity. Ultimately, the effectiveness and impact of any country or regional response will be only as good as the quality of resources—human and institutional—available to plan, implement, monitor and evaluate every policy, program, project and intervention. Every agency, including ADB, will utilize and rely on the available capacity. ADB must therefore make, at a minimum, a commensurate contribution to supporting and building the capacity and resources needed for effective program implementation. Such capacity building should be done to ensure that skills developed serve not only current needs, but also contribute to the longer-term needs of the country or region. In order for a country to undertake longer-term planning and management of the capacity needed for its response to HIV/AIDS, a comprehensive national, multi-sectoral HIV/AIDS strategy will be needed, as will a strong national AIDS authority to implement such a strategy and strong NGOs (including those involving PLWHAs) and CBOs working in HIV/AIDS prevention, treatment and care. As with leadership support, capacity building is needed across all sectors, not just for health.

103. ADB has experience in multi-sectoral capacity building and is able to make a valued and strategic contribution, both for multi-sectoral planning per se and for capacity to respond to HIV/AIDS outside of the health sector at a national and regional level. The capacity of health systems is an area of special concern in pursuing expanded responses to HIV/AIDS, particularly in relation to care and treatment. ADB has a track record of supporting comprehensive reforms of health systems, particularly in the era of decentralization, and is well placed to work with governments to ensure ongoing reforms take into account the need for health systems to provide care and treatment in response to HIV/AIDS. The primary categories of activities ADB should address in this priority area are:

- Support for formulation of HIV/AIDS strategies at national and regional levels.
- Support for implementation of HIV/AIDS strategies at national and regional levels (including monitoring and evaluation systems).
- Support for health systems to improve the efficiency and effectiveness of HIV/AIDS programs.

104. The types of activities that might be pursued include building capacity within government in areas such as multi-sectoral planning, monitoring and evaluation, and capacity building for local NGOs, particularly for developing and scaling-up successful locally-focused interventions. Technical support will be needed for all these activities and the regional resources available might be enhanced where appropriate.

3. Targeted Programs

105. The HIV/AIDS epidemic in the Asia-Pacific Region remains, for the most part, concentrated in groups with high-risk behaviors—IDUs, sex workers and men-who-have-sex-with-men. A window of opportunity still exists to address the risk of a more general spread of the epidemic by targeting effective interventions to high-risk groups. Such interventions are usually more difficult to plan and implement given the often marginalized status of the people at most risk, and because of the sensitivities of the issues that must be addressed. Nevertheless, this strategy is ultimately the most socially and economically rational given the potentially explosive costs to society and economies should the epidemic expand significantly beyond these groups. The special vulnerability of the poor to the risk and impact of HIV/AIDS must be recognized as part of ADB's comprehensive response to poverty reduction. For those affected or at high risk, this could potentially include broad approaches to risk reduction such as education and vocational training to expand labor market and social opportunities. Institutional, legal and structural barriers to effectively reaching those at risk must be addressed.

106. In addition to groups with high-risk behaviors, ADB must address high-risk environments, especially where they occur as part of an ADB project or activity in any sector. More than 50% of ADB lending in 2003 was for projects in the infrastructure sector, predominantly roads and other transportation infrastructure. Each of these projects presents an opportunity and responsibility to mitigate risk and enhance the capacity of affected local communities to be resilient to the HIV/AIDS epidemic. ADB activities aimed at expanding the number and scope of targeted HIV/AIDS interventions in the region can therefore be summarized as:

- Integration of HIV/AIDS activities in ADB infrastructure projects that potentially interact with, create, or enhance high-risk environments for HIV/AIDS.
- Support for projects that target the poor and vulnerable, including those already affected by HIV/AIDS, in selected DMCs for HIV prevention and care.

107. Examples of the types of activities that might be pursued include: HIV/AIDS components in ADB infrastructure projects; support for expanded TB control efforts through health systems development; support for developing innovative education, learning and behavior-change methods, particularly for groups with high-risk behaviors such as IDUs, MSM and sex workers, and for youth and adolescents; and support for commodity procurement for prevention and care given identified supply gaps. Further details are in Appendix 4. Support for treatment initiatives may be considered under either capacity building or targeted programs on a case-by-case basis with reference to competing demands, national priorities and ADB's technical capacity.

B. Operational Principles

108. In pursuing activities in each of the areas outlined above, ADB is committed to support:

(i) **Country ownership** and **government leadership,** and strict adherence to the "Three Ones" principle.
(ii) **Partnership, consultation** and **involvement** of civil society and people living with, and affected by, HIV/AIDS, and with other development agencies to ensure coordination and maximum efficiency and effectiveness.
(iii) Mainstreaming **gender** considerations in all activities.
(iv) **Evidence-based targeting** and **capacity building, based on sound technical knowledge,** to ensure all resources are used for maximum impact and efficiency.

(v) **Flexibility and innovation** where possible, but linked with rigorous and timely **monitoring and evaluation,** in coordination with regional, national and community-based partners, to ensure critical review and learning to build capacity.

C. Implementation

109. The purpose of defining a strategic direction is to broadly guide program and project implementation. ADB will have dedicated resources to ensure that the directions outlined in this paper can be implemented, but attention to the capacity and resources within ADB will be necessary to ensure resources are efficiently and effectively used.

110. The Asian Development Fund (ADF)[58] eighth replenishment, known as ADF IX (2005-2008), was finalized in May 2004. Two percent of the replenishment is earmarked for grant expenditure for activities targeting HIV/AIDS and other communicable diseases in all ADF-eligible countries. Implementation will begin in 2005. This fund will play a valuable role in developing a strong, well-balanced portfolio of HIV/AIDS-specific activities consistent with the directions set out in this paper. In February 2005, ADB established a HIV/AIDS trust fund[59] with an initial contribution from the Government of Sweden. This Fund may eventually be multi-donor, and would provide support for activities complementary to those that can be financed by ADF IX, including support for pilot projects that could eventually be scaled up or replicated, and the development of regional and national knowledge products that support program and policy planning. Aside from project lending, policy based lending for issues such as drug and people trafficking, legal reforms and drug rehabilitation programs might also be a financing modality.

111. ADB will need to further build its own technical capacity to ensure that ADB-supported interventions are strategic, technically sound and strongly supported and monitored during implementation. ADB currently has about ten staff with expertise and/or experience in HIV/AIDS work. In-house awareness-building and training and strong technical consultant inputs will be needed. ADB currently is working with other agencies to identify opportunities for in-house capacity-building. Consideration will be given to developing ADB's own workplace HIV/AIDS policy, consistent with such action by other international organizations, including UN agencies and the World Bank.

112. The major role in implementing ADB's strategic directions in HIV/AIDS will be with ADB's operational departments working at the subregional and national level. Country Strategies and Programs (CSP) should incorporate, for each country, an assessment of the HIV/AIDS epidemic, its impact at the national and local levels as well as on households and individuals, the quality and effectiveness of the national HIV/AIDS program, and the gaps in the program interventions. As the HIV/AIDS epidemic ignores borders, a similar assessment is required at the subregional level. Based on this assessment, a medium-term program to fight the spread or to prevent the HIV/AIDS epidemic should be developed in accordance with this Strategic Response and in collaboration with the concerned national AIDS authorities and UNAIDS.[60] Advocacy and leadership support for a national HIV/AIDS program should become part of ADB's dialogue with the Government, in particular with the country leaders and the core ministries (Finance, Planning, Budget, etc.). Considering ADB's strengths and opportunities, it is

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[58] The ADF is the major instrument of concessional financing at ADB and available to 29 of ADB's DMCs as listed in Appendix 2.
[59] *Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific*
[60] ADB and UNAIDS signed a Memorandum of Understanding strengthening their collaboration in fighting the HIV/AIDS epidemic on 21 February 2005.

essential that it consider options both to mitigate the risks and to promote effective prevention in every sector that it supports, and with the participation of all stakeholders. The CSP will identify projects (technical assistance, ADF grants or loans) that can support the national and regional HIV/AIDS programs, and assess whether adding an HIV/AIDS component to some projects (in infrastructure and other sectors for example) can efficiently support the country's and the subregion's HIV/AIDS program.

113. The Regional and Sustainable Department (RSDD) will have a role in supporting implementation given its mandate at the regional level (sectoral support and oversight, knowledge development), coordination with other agencies (and in particular with UNAIDS), and management of the HIV/AIDS trust fund. RSDD will have responsibility for oversight and monitoring of the implementation of ADB's strategic directions as set out in this paper. The design and monitoring framework at Appendix 5 outlines the basis for monitoring and evaluation of ADB's strategic approach to HIV/AIDS. Performance targets are set for each goal, purpose and outputs/activities. These are based on international goals and measures as well as on specific ADB-focused measures that seek to ensure sensitivity and responsiveness. Progress against each of the activity areas will be monitored and reviewed regularly, at least annually. Projects and programs developed will use these targets and monitoring mechanisms as a starting point to track specific progress, and will report against these targets for overall program monitoring.

HIV/AIDS ESTIMATES AND DATA FOR ASIA AND THE PACIFIC, 2003

ADB Regional Department	No.	Country or Region	ADF Eligible Country	Total Population (x1000) 2003	Population 15-49 Years (x1000) 2003	Population Living with HIV/AIDS (all age groups) 2003	HIV Positive Prevalence in Population 15–49 years 2003
Southeast Asia	1	Indonesia	X	220,178	122,215	110,000	0.1
	2	Malaysia		23,431	12,251	52,000	0.4
	3	Philippines		80,089	41,437	9,000	<0.1
	4	Singapore		4,260	2,354	4,100	0.2
		Subtotal		**327,958**	**178,257**	**175,100**	
Mekong	5	Cambodia	X	14,113	6,727	170,000	2.6
	6	Lao People's Democratic Republic	X	5,659	2,709	1,700	0.1
	7	Myanmar	X	49,526	26,643	330,000	1.2
	8	Thailand		65,083	37,293	570,000	1.5
	9	Viet Nam	X	81,287	45,428	220,000	0.4
		Subtotal		**215,668**	**118,800**	**1,291,700**	
South Asia	10	Afghanistan	X	24,204	11,260	?	?
	11	Bangladesh	X	146,409	76,151	9,950	<0.2
	12	Bhutan	X	2,257	1,040	?	?
	13	India	X	1,057,077	554,669	4,900,000	0.9
	14	Maldives	X	318	152	?	?
	15	Nepal	X	24,721	11,709	61,000	0.5
	16	Pakistan	X	152,519	71,892	74,000	0.1
	17	Sri Lanka	X	19,471	10,900	3,500	<0.1
		Subtotal		**1,426,976**	**737,773**	**5,048,450****	
East and Central Asia	18	Azerbaijan		8,194	4,704	1,400	<0.1
	19	People's Republic of China	X	1,303,473	736,964	840,000	0.1
	20	Hong Kong, PRC		7,123	4,172	2,600	0.1
	21	Kazakhstan		15,968	8,918	16,500	0.2
	22	Kyrgyz Republic	X	5,103	2,754	3,900	<0.1
	23	Republic of Korea		47,701	27,640	8,300	<0.1
	24	Mongolia	X	2,617	1,498	<500	<0.1
	25	Tajikistan	X	6,216	3,277	<200	<0.1
	26	Taipei, PRC		22,603	?	?	?
	27	Turkmenistan		5,022	2,654	<200	<0.1
	28	Uzbekistan		25,970	14,196	11,000	0.1
		Subtotal		**1,449,990**	**806,777****	**884,600****	
The Pacific	29	Cook Islands	X	18*	?	?	?
	30	Fiji Islands		840	451	600	0.1
	31	Kiribati	X	85*	?	?	?
	32	Marshall Islands	X	54*	?	?	?
	33	Federated States of Micronesia	X	107*	?	?	?
	34	Nauru	X	11*	?	?	?
	35	Palau		18*	?	?	?
	36	Papua New Guinea		5,147	2,601	16,000	0.6
	37	Samoa	X	176*	?	?	?
	38	Solomon Islands	X	476*	?	?	?
	39	Timor-Leste		750*	?	?	?
	40	Tonga	X	100*	?	?	?
	41	Tuvalu	X	10*	?	?	?
	42	Vanuatu	X	196*	?	?	?
		Subtotal		**7,998**	**3,052****	**16,600****	
		TOTAL		**3,428,580**	**1,844,659****	**7,443,850****	

NOTES. 1. * = data for 2001. 2. ** = Totals are underestimates as countries that have no data available are not included. 3. ? = data are not available. 4. ADB=Asian Development Bank, ADF =Asian Development Fund, DMC = Developing Member Country, HIV/AIDS=human immunodeficiency virus/acquired immune deficiency syndrome. Source: Shiroishi, Yukihiro. 2004. Asian Development Bank, Manila. With data from UNAIDS. 2004. *Report on the Global AIDS Epidemic.* Geneva, and United Nations Population Division. *World Population Prospects: 2000 revision (Medium variant).* New York.

MULTILATERAL AND BILATERAL DONORS AN OVERVIEW OF APPROACHES AND PROGRAMS[1]

1. UNAIDS, its Co-sponsors, and Multilateral Agencies

1. The Joint United Nations Programme on HIV/AIDS, UNAIDS, is a program of ten United Nations system organizations: the United Nations Children's Fund (UNICEF), the World Food Programme (WFP); the United Nations Development Programme (UNDP); the United Nations Population Fund (UNFPA); the United Nations Office on Drugs and Crime (UNODC); the International Labor Organization (ILO); the United Nations Educational, Scientific and Cultural Organization (UNESCO); WHO, the United Nations High Commissioner for Refugees (UNHCR) and the World Bank. UNAIDS was formed in 1996 and aims to promote leadership and advocacy, strategic information, monitoring and evaluation, partnerships across sectors, civil society engagement, and the mobilization of resources. Most countries have a UNAIDS Country Coordinator. Each partner agency has its own central focus and niche area based on its particular focus and expertise, while UNAIDS has its own secretariat and some technical capacity for facilitating its aims through its co-sponsors. UNAIDS core budget ($125.3 million in 2004) comes from a number of bilateral donors while partner agencies receive a portion of the Unified Budget but must raise funds their own funds to achieve program goals. In the Asia-Pacific Region, the UNAIDS Regional Support Team – Asia and the Pacific (RST-AP) coordinates the efforts of these co-sponsors for the Asia-Pacific Region, including South Asia and Afghanistan; the RST-AP does not handle this role, however, in the other Central Asian Republics that are ADB DMCs. There is no equivalent regional structure for these countries, which are overseen from UNAIDS headquarters in Geneva.

2. The World Bank is a large financier—mainly through lending—of HIV programs in the Asia-Pacific Region. The aims of the World Bank are to

- prevent the further spread of HIV/AIDS among vulnerable groups and in the general population;
- promote countries' health policies and multi-sectoral approaches (e.g. by working in education, social safety nets, transport, and other vital areas); and
- expand care and treatment activities for those affected by HIV/AIDS including families, and children whose parents have died of AIDS, and other vulnerable children.

3. The World Bank has financed HIV prevention and control activities since 1992 in its East Asia-Pacific (EAP) Region.[2] Up to 2002, it had lent $100 million for 11 health projects with HIV/AIDS activities in seven countries of the EAP region. Of those 11 projects, only 2 were exclusively for HIV/AIDS: Indonesia HIV/AIDS and STD Prevention and Management Project ($25 million), which closed in 1999, and the Viet Nam Blood Supply Management Project ($38.2 million). The other projects either included HIV/AIDS as part of an infectious disease project, a maternal health project, or a broader health systems project. The most significant financial support has been in the PRC, with a small HIV/AIDS component in Health V (Infectious and Endemic Disease Control) and VII (Health Promotion) Projects, culminating in $25.6 million for HIV/AIDS prevention and control in Health IX. A new regional strategy includes provision for

[1] This appendix is an expansion on the information provided in Section IV.E.
[2] Borowitz, M., et al. 2003. *Responding to HIV/AIDS in the East Asia and Pacific Region. A Strategy Note for the World Bank.* Washington D.C.: World Bank.

grant funding as well as loans, and calls for support of public health surveillance/monitoring and evaluation, prevention, care, treatment and support, and health services delivery.

4. In the South Asian region, since 1992 the World Bank has committed US$380 million to support national HIV/AIDS control programs in Bangladesh, India, Pakistan, Sri Lanka, and Bhutan. Projects have mostly been in the form of loans, including one to India for $191 million for the Second HIV/AIDS Control Project (1999–2004). In recent years support included grants or grant components, such as those for Pakistan ($36 million—100% grant for the HIV/AIDS Prevention Project, 2003–2007) and Sri Lanka ($12 million—25% grant for the HIV/AIDS Prevention Project, 2002–2006). Projects generally include a focus on highly vulnerable sub-populations through service delivery and community mobilization and empowerment; interventions aimed at increasing knowledge and reducing stigma among the general population; management and prevention of STDs; strengthening surveillance systems and monitoring and evaluation; blood safety; care and treatment for people living with HIV/AIDS; promoting and sustaining political and societal commitment and leadership to fighting HIV/AIDS; and strengthening public and private institutions for a multi-sectoral response. The World Bank is also co-financing with DFID a new regional program in the four Central Asian Republics of Kazakhstan, Kyrgyz, Tajikistan, and Uzbekistan worth $25 million.

5. The European Union through the European Commission (EC) is another major multilateral donor for AIDS in the region, although most of its investments are directed through its substantial contributions (€120 million in 2002 and €340 million for 2003–2006) to the Global Fund against AIDS, TB and Malaria (GFATM). The EC is the single largest contributor to the GFATM.[3] In addition, the EC provided €70 million to WHO for improving access to medicine in developing countries. The EC also has financed programs in the South Pacific, through the South Pacific Commission, for peer education among youth on three islands (1996–1999), and in PNG to reduce transmission in youth and high-risk groups ($3.5 million for 2003–2007). In Myanmar, the EC financed a program for social marketing of condoms.

2. Bilateral Donors

6. USAID is the largest bilateral donor in the region. In 2003, funds available for its Asia-Near East Bureau were approximately $35 million, covering Cambodia, Viet Nam, Indonesia, India, Nepal, and Bangladesh. In the same year, $32.7 million was committed to programs in the Central Asian Republics. USAID's Regional HIV Office has a budget of about $11 million for countries that do not have a USAID representative, such as PRC (Guangxi and Yunnan provinces), Thailand, Pakistan, Sri Lanka, Myanmar, Lao PDR , and PNG. In addition, there are international HIV/AIDS budgets for the region from the US Government's National Institutes of Health (NIH)-Division of AIDS, and the Centers for Disease Control and Prevention (CDC). USAID funds cover behavioral change interventions for high-risk groups, behavioral and epidemiological research, second-generation surveillance, policy research and advocacy, social marketing of condoms, STD services, and the training of government and civil society in a variety of needed skills. Nearly all USAID funds are allocated to international NGOs that may sub-contract to local NGOs. NIH has sponsored the development of research and researchers in several Asian countries and funds a large research program in PRC. CDC conducts research with collaborators, and initiated the Global AIDS Program that funds local NGOs to carry out care and prevention programs. In mid-2004 the US President's Initiative Fund (originally called the President's Emergency Plan for HIV/AIDS Relief---PEPFAR) expanded to Asia and named

[3] *European Commission Action against HIV/AIDS*. November 28, 2003.

Viet Nam as the 15th designated recipient country.[4] This fund of $20--25 million will be spent ma to facilitate ART purchasing, expand VCT, and continue prevention programs.

7. The UK's DFID spent about $62 million in 2003 for HIV/AIDS programs in South and Central Asia, the Far East, Oceania, and Asia (unspecified).[5] It finances many large HIV/AIDS programs in the PRC, Bangladesh, India, Pakistan, Cambodia, Lao PDR, Nepal, and Myanmar. Funds are allocated to condom social marketing, second-generation surveillance, behavior change interventions, STD services, capacity building for government multi-sectoral efforts, school-based education, and research. Additionally, DFID has developed a policy framework for HIV care and treatment and is contributing to the GFATM. DFID policies permit grants up to $6--8 million to international NGOs with strong capacity, such as CARE, and through such arrangements and subcontracts funds reach smaller local NGOs. Policy preferably directs DFID funds to government bodies, but such grants may be administered by a UN agency where conditions are difficult.

8. AusAID is investing in a variety of HIV/AIDS programs. It is financing large multi-year projects in Indonesia, Xinjiang Province of PRC, Nepal, and PNG, with smaller investments in Cambodia, Lao PDR, Tibet Autonomous Region (TAR), PRC, Bangladesh, Myanmar, India, Thailand, and East Timor. The Government of Australia announced in July 2000 an Australian dollar (AUD) 200 million Global HIV/AIDS Initiative, which was increased to AUD600 million in July 2004. Allocations include $1.36 million yearly to UNAIDS in support of the Asia-Pacific Leadership Forum on HIV/AIDS and Development (APLF) and country and regional programs. A Regional HIV/AIDS Project is spending about $8 million from 2002 to 2006 to strengthen the capacity of health and public security sectors in PRC, Myanmar, and Viet Nam to reduce the transmission of HIV among IDUs. This project is important because it is one of the few effectively addressing the rights of IDUs to prevention and treatment in the region, through a direct hands-on, peer-to-peer approach with the police in each country.

9. The Canadian International Development Agency (CIDA) has committed $7 million to reduce vulnerability among mobile populations in Southeast Asia. The funding will go to a consortium made up of CARE Canada, PATH Canada, and the Canadian Society for International Health. This 4-year initiative, to be implemented in Cambodia, Thailand, Viet Nam, and Lao PDR, will expand HIV prevention beyond the traditional health sector into other sectors such as transportation, labor, and agriculture. CIDA also has small projects in Pakistan, Nepal, India, Cambodia, and Viet Nam. CIDA has taken a strong lead on supporting WHO's "3 by 5" initiative.

10. Other important bilateral donors in the region include the Netherlands, Sweden, Germany, and Japan. In many cases, their funds are given directly to a UN agency, for example to WHO for ART work in PRC (Sweden). Of this group of donors, only the Netherlands is known to fund local NGOs directly.

11. Many foundations also fund HIV/AIDS work in ADB's region. These include the Bill and Melinda Gates Foundation, the Rockefeller Foundation, the Ford Foundation, the John and Catherine MacArthur Foundation, and the Soros Foundation. The Rockefeller and Ford Foundations' approach is often broad, incorporating gender and sexuality, economic development at the local level, and equity of rights to health and education. The Bill and Melinda Gates Foundation has become the largest private contributor in Asia. To date, all of their funds

[4] Viet Nam is the only country in the Asia-Pacific region included to date.
[5] Janjua, H. 2003. UK AIDS Aid. An Analysis of DFID HIV/AIDS Expenditure. *Actionaid.* November.

for Asia have gone to India ($200 million), but they are presently designing a project in PRC. The Bill and Melinda Gates Foundation also announced recently that it will contribute $50 million to GFATM, bringing its total contribution to HIV/AIDS work to $150 million, as well as an additional $44.7 million grant aimed at curbing HIV-related TB.

3. The Global Fund for AIDS, Tuberculosis, and Malaria (GFATM)

12. The GFATM is a fund promoted by the UN Secretary General that began its work in 2002. The fund considers country proposals developed by a country coordinating mechanism (CCM) that is designed to include government agencies, civil society, and the private sector. The country proposal is expected to address pertinent issues, including ART purchasing, that are not covered by funding from other sources. In the first four rounds of grants, GFATM approved two-year grants totaling $304.5 million for countries in ADB's region.[6] This represents approximately 14% of the estimated financial needs of the region in 2004. The performance of countries receiving grants from the Global Fund has become an issue of concern for many donors and those working in HIV programs. Many countries have not signed an agreement with GFATM more than a year after their proposal was approved, and disbursement rates are low.

[6] For a complete listing of grants approved see www.theglobalfund.org

APPROVED ASIAN DEVELOPMENT BANK TECHNICAL ASSISTANCE PROJECTS RELATED TO HIV/AIDS 1993–2004

TA No.	Country	Project Title	Total Value ($)	Source of Funds	Approval Date
4364	MON	Awareness and Prevention of HIV/AIDS and Human Trafficking	350,000	TASF	21 Jul 04
6173	REG	Strengthening the Response to HIV/AIDS in Asia and the Pacific	150,000	TASF	21 May 04
4208	PNG	Establishment of Pilot HIV/AIDS in Asia and the Pacific	450,000	TASF	30 Oct 03
4142	PRC	Preventing HIV/AIDS on Road Projects in Yunnan	800,000	PRCF	14 Jul 03
6106	REG	Financing Needs for HIV/AIDS Prevention and Care in Asia and the Pacific	150,000	TASF	16 May 03
6083	REG	ICT and HIV/AIDS Preventive Education in the Cross-Border Areas of the Greater Mekong Subregion	1,000,00	JFICT	19 Dec 02
5982	REG	Support to the Sixth International Congress on AIDS in Asia and the Pacific	150,000	TASF	30 Mar 01
9006	GMS	Community Action for Preventing HIV/AIDS	8,000,000	JFPR	08 May 01
5881	REG	Preventing HIV/AIDS among Mobile Populations in the Greater Mekong Subregion (supplementary)	160,000	TASF	21 Dec 00
5881	REG	Preventing HIV/AIDS among Mobile Populations in the Greater Mekong Subregion	450,000	JSF	16 Dec 99
3511	CAM	Capacity Building for HIV/AIDS Prevention and Control	600,000	JSF	03 Oct 00
5752	REG	Fourth International Congress on AIDS in Asia and the Pacific	100,000	TASF	26 Sep 97
5751	REG	Cooperation in the Prevention and Control of HIV/AIDS in the Greater Mekong Subregion	150,000	ATAG	17 Sep 97
5541	REG	Study in the Economic Implications of the HIV/AIDS Epidemic in Selected Developing Member Countries	300,000	TASF	20 Jul 93

NOTES. ATAG = Australian Technical Assistance Grant, CAM = Cambodia, GMS = Greater Mekong Subregion, HIV/AIDS=human immunodeficiency virus/acquired immune deficiency syndrome, JFICT = Japan Fund for Information and Communication Technology, JSF = Japan Special Fund, MON = Mongolia, PNG = Papua New Guinea, PRC = People's Republic of PRC, PRCF = Poverty Reduction Cooperation Fund, REG = Regional, TA = technical assistance, TASF = Technical Assistance Special Fund
Sources: ADB Loan, TA and equity Approval database

PRIORITIES FOR ACTION
EXAMPLES OF COUNTRIES, REGIONS AND ACTIVITIES

A. Countries and Regions

1. Pakistan. The Government of Pakistan has been proactive in starting up national AIDS planning, until recently mostly using government funds. There is a national strategic plan and policies, and recently some funding from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), the United Kingdom Department of International Development (DFID) and the World Bank. However, critical areas are still not funded [as highlighted in a recent review by the World Health Organization (WHO)],[1] including prevention services for high-risk groups such as men-who-have-sex-with-men (MSM), female sex workers and injecting drug users (IDUs). (An outbreak of HIV has recently been identified in the latter group.) WHO concluded that there is still an opportunity to prevent what could otherwise be a large epidemic through strategic and timely action.

2. The Central Asian Republics. ADB DMCs in this region remain at an early stage of the epidemic but the risk factors are prevalent and much could be done to avert a widespread assault. Weak health care systems undermine responses and there is a need to target high-risk groups such as IDUs and youth. The World Bank and DFID are co-financing a new regional effort to bring about change, but more funding is needed and opportunities may exist to complement their programs.[2]

3. Papua New Guinea. PNG is currently experiencing one of the fastest growing epidemics in the region, and it has already reached a severe stage. PNG is in receipt of funding support form the GFATM and the Australian Agency for International Development (AusAID) as well as several smaller donors, but activities seem hampered by social and bureaucratic constraints. ADB has already participated in joint planning missions with the World Bank, and donors await the development of a National Strategic Plan with clear priorities. At the same time, ADB's involvement in the fisheries sector presents a key opportunity and need for comprehensive programs that address risk and impact of HIV in the sector.

B. Activities

1. Leadership Support

4. Support for improved surveillance and coordinated knowledge building and sharing in the Pacific region. The HIV/AIDS epidemic in Asia. The issues around HIV transmission in this region are different and require tailored responses. Funding support to date has been limited.

5. Support for policy development. This is particularly needed in areas of stigma and discrimination, cross-border migration, workplace policies, and harm reduction for people both before and after they acquire an HIV infection. In many nations, various policies developed without concern for HIV/AIDS now require revision in order to harmonize with good public health practice. In some cases, formal legal reviews and reforms are needed, for example in the insurance industry or with regard to drug users. Beyond the public sector other policies, such as

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[1] WHO. 2004. *Inventory of HIV control activities in Pakistan*. Karachi.

[2] Godinho, J., et al. *2004. Reversing the Tide: Priorities for HIV/AIDS Prevention in Central Asia*. ECSHD/ECCU8. Washington, DC: World Bank. (draft, July)

for the workplace, are needed to reach a wider section of the population with prevention and care services. While equity of access to care and treatment has been easily accepted in many countries, it has been more difficult to ensure equity in access to prevention services for youth, MSM, IDUs, and certain groups of sex workers. Policies are only as good as their implementation. Any policy effort should include components that help bring policies into action and develop mechanisms of oversight.

6. Support for regional leadership forums and other exchanges among Asia-Pacific leaders. The opportunity for regional leaders in all sectors to learn from each other and share experiences needs to be facilitated. As a partner to leadership forums in other sectors, and a regular interlocutor with regional leaders in a range of sectors, ADB is well placed to play a role. There are some efforts already underway in the region, such as the Asia Pacific Leadership Forum on HIV/AIDS, but further support and expansion of these activities, particularly to leaders in non-health sectors, is needed.

2. Capacity Building

7. Building capacity within governments. There are numerous activities that should properly be carried out by government personnel in the AIDS field, but many have never had the opportunity to learn the necessary skills. Proper financial oversight stands out as one set of skills needed in many countries. Another is establishing effective multi-sectoral AIDS committees and programs. A third is the establishment of an ethical and technical review body for HIV-related research. A fourth is the development and implementation of different types of monitoring and evaluation schemes.

8. Increasing the capacity of local NGOs. There are numerous worthy efforts begun by local people, often with little funding and little opportunity to learn technical approaches that could be used to greater effectiveness. Increasing the capacity of this type of organization will be essential for scaling-up any programs nationally. ADB could fund programs at a regional, national, or subregional level to build knowledge and management skills in this sector. Resource persons could be drawn from international NGOs, successful local NGOs, and UNAIDS.

9. Capacity development for regionally based HIV/AIDS consultants. The region is in need of greater capacity to address the technical aspects of HIV/AIDS work. Several years ago the International AIDS Alliance brought together a group of people already experienced with sex worker projects and provided training in the various skills needed by consultants. The aim was to increase the pool of consultants for work around the world. The exercise was judged to be successful and could serve as a model for a more expansive program of consultant development in the region.

3. Targeted Programs

10. HIV/AIDS components in ADB Infrastructure Projects. This is a natural niche for ADB, and one in which many agencies are looking to ADB for leadership given ADB's large infrastructure project portfolio. Infrastructure projects, particularly roads and other transport developments, represent a unique confluence of risk factors. These projects often have large worker populations that are predominantly male and often with migrants, all of whom have a regular supply of money from their work and are more likely and able to access commercial sex. The projects often result in the increased mobility and exposure of local communities to HIV/AIDS—both during construction phases and after. Developing a straightforward and effective way of assessing what needs to be done in each case will be challenging. Often the

local situation will not be visible until the road, for example, is under construction, or even after it is completed. Making assumptions may be necessary, but without the involvement of affected people, little in the way of behavior change interventions can be designed, except in broad terms. ADB is already accumulating experience with this type of project and is well placed to develop and implement effective programs, including strong monitoring and evaluation systems and contributions to local capacity building.

11. Tuberculosis control. Within health systems projects and specific HIV programs, attention to the diagnosis and treatment of TB is a cost-effective investment. This applies to much of Asia but particularly Central Asia. In addition to supporting public health care systems, there is also potential to involve the private sector in developing and delivering TB control programs.

12. Support for developing innovative methods of learning and behavior change. There is still a need for testing and scaling-up innovative approaches, especially for high risk and hard-to-reach groups. For example, several pilot projects have been carried out with youth, slum dwellers, ethnic minority adults, IDUs and others in which interactive learning with computers has been shown to be very effective. A recent study demonstrated greater retention and greater enthusiasm for learning more among IDUs in treatment who received the computer-assisted intervention vs. those receiving counseling and a video.[3] Approaches such as this would appear to have great potential for high-risk youth throughout Asia and the Pacific.

13. Support for commodity procurement for prevention services. A recent study by the Policy Project in conjunction with the United States Agency for International Development, the Joint United Nations Programme on HIV/AIDS, WHO and the United Nations Children's Fund found a critical gap in the region in the availability of basic prevention commodities such as condoms, needles and syringes.[4] In the capital cities of Bangladesh, Bhutan, Cambodia, Indonesia, and Lao PDR the study found that 5% or less of estimated condom needs were met. These are the basic tools of prevention, and programs are ultimately constrained in their effectiveness without them.

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[3] Marsch, L. and Bickel, W. 2004. Efficacy of computer-based HIV/AIDS education for injection drug users. *American Journal of Health Behavior* 28(4):316—327.

[4] USAID/UNAIDS/WHO/UNICEF/Policy Project. 2004. *Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003*. Washington, DC.

HIV/AIDS STRATEGIC DIRECTIONS
DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets[1]/Indicators	Data Sources/ Reporting Mechanisms	Assumptions and Risks
Impact			
To halt, and to begin to reverse, the spread of HIV/AIDS in Asia and the Pacific by 2015 *(Millennium Development Goal No.6 - Target-7)*	• The 2015 data indicate that the prevalence of HIV infections among adults 15--49 years-old in Asia and the Pacific, in percentage of the population, has not been increasing for the last 2 years. • The 2015 data indicate that the prevalence of HIV infections among adults 15--49 years-old, in percentage of the population, has started to decrease in at least one-third of ADB's DMCs.[2]	• Country reports • UNAIDS reports	
Outcome			
Effective response to HIV/AIDS in place at the country and regional levels in Asia and the Pacific by 2010	• The amounts of resources mobilized to fight HIV/AIDS, as estimated by most recent regional and country studies are regularly increasing • All countries in the region have developed and are implementing a national program to fight HIV/AIDS. • The national HIV/AIDS programs include: prevention, treatment, rehabilitation; support of orphans; support of the families / parents of people infected by HIV • As an indicator of reduced stigmatization, the number of persons fired from work or excluded from schools because of HIV/AIDS does not increase.	• UNAIDS reports • Country reports • National budgets • National Health Accounts • Country UNAIDS report • Countries' HIV/ AIDS program • National AIDS committee's report • Reports from international and local NGOs • Laws, regulations, by-laws of Chambers of Commerce or private sector associations	**Assumptions** • The supported interventions, reflecting the best up-to-date knowledge about the HIV/AIDS epidemics, are assumed to be effective. • Increasing resources (from donors and from within the region) available to fight the HIV/AIDS epidemics **Risks** • If new more effective interventions are identified (e.g., vaccine), resources should be shifted towards these interventions • Resources diverted either to other regions or to other major health issues

[1] All performance targets are for 2010 unless otherwise stated. Regional quantitative targets will be developed in close consultation with the Regional Departments early 2005.

[2] Although behavioral surveillance data, assessing the impact of specific interventions focusing on behavioral changes, may be a more sensitive indicator of program effectiveness and impact, zero-prevalence data are more regularly collected and available

Design Summary	Performance Targets[1]/Indicators	Data Sources/ Reporting Mechanisms	Assumptions and Risks
Outputs			
1. Strengthened commitment of regional leaders to address the HIV/AIDS threat	• Funds earmarked for HIV-AIDS activities in national budget in all DMCs by 2010 • At least 20% increase in national budget of all DMC country allocations for HIV/AIDS activities from the 2004 level by 2010 • All DMCs participate in regional forums on HIV/AIDS	• National budget documents • National Health Accounts • Regional forums web sites and reports	**Assumption** • An effective response to HIV/AIDS requires financial resources. Leaders' commitment and instructions to actively address the epidemic are essential to raise awareness and keep HIV/AIDS among the priorities.
2. Increased capacity at the country and regional levels to address HIV/AIDS	• Intersectoral national HIV/AIDS program under implementation in all member countries • All national HIV/AIDS programs include specific interventions/mechanisms/ services targeting people with high risk behavior (sex workers, IDUs, MSM) • All national HIV/AIDS programs include specific interventions to protect women and the poor • All national HIV/AIDS programs include specific interventions to support families, and in particular orphans and older parents of HIV-infected people	• UNAIDS reports and country assessments • National HIV/AIDS programs • Reports and web-sites of international and local NGOs dealing with HIV-AIDS among high risk groups	**Assumptions** • The existence of a national program under implementation is a proxy for capacity • Due to the weakness / lack of social security mechanisms, families of people living with HIV/AIDS are particularly affected, in particular, orphans, older parents and care-givers **Risk** • Donors-driven program without country ownership
3. Expanded HIV/AIDS interventions targeting the poor, the vulnerable and the at-risk groups	• Roadmaps of ADB HIV/AIDS activities for each DMC by 2006 • All ADB-financed projects that present a risk of facilitating the spread of HIV/AIDS, include mitigating measures (as recommended by experts)	• CSP and CSPUs • Monitoring and evaluation of project activities • Project evaluation reports (internal from operation departments and OED, and external reports on ADB projects)	**Assumption** • Successful interventions that prevent spread of HIV/AIDS among the poor and vulnerable will have the biggest social and economic impact for the community

Activities with Milestones	Inputs
1.1 Conduct continuous policy dialogue on HIV-AIDS with DMCs. Situation analysis and recommendations on HIV/AIDS reflected in all CSPs or CSPUs. 1.2 Produce evidence for advocacy and decision-making. At least two studies or other tools related to HIV/AIDS in Asia and Pacific published by ADB every year. 1.3 Support regional activities to raise awareness and commitment. Regional awareness-raising and knowledge-building activities financed by ADB at least one/year. 2.1 Support formulation of HIV/AIDS strategies at national and regional levels. National strategies and interventions are evidence-based in all countries in the region. 2.2 Support implementation of HIV/AIDS strategies at national and regional levels. Financial and human resources available to all countries in the region to implement evidence-based programs are increasing. 2.3 Strengthen the health system to improve efficiency and effectiveness of HIV//AIDS programs. Resources and interventions are in place/ increasing to improve national systems for (a) information campaigns, (b) epidemiological surveillance, (c) voluntary testing, counseling, (d) treatment of opportunistic infections, (e) ART treatment (procurement, distribution, treatment administration and monitoring), (f) Palliative treatment, and (g) support of families, elderly and orphans 3.1 Integrate HIV/AIDS activities in ADB supported infrastructure projects. All infrastructure projects consider the HIV/AIDS risk and incorporate mitigating measures as appropriate. 3.2 Integrate HIV/AIDS activities in ADB supported projects in sectors other than health and infrastructure. HIV/AIDS interventions (even limited) are systematically considered and incorporated in projects when appropriate 3.3 Support NGOs and programs against HIV/AIDS targeting groups with high risk behaviors. Financial resources (at least $100,000/year) and support available to HIV/AIDS-concerned NGOs dealing with people with high-risk behaviors, with the agreement of the national governments. 3.4 HIV/AIDS projects in selected DMCs specifically target women and girls, and the poor. If grant resources are available, at least 2 projects per year that specifically target the poor and vulnerable, and all ADB-supported projects or project component dealing with HIV/AIDS address issues concerning women, girls and the poor.	a. Financial Resources • ADF IX resources • OCR • HIV/AIDS Trust fund • Other trust funds b. TA operations • Country technical assistance • Regional technical assistance c. Loan Operations • HIV/AIDS projects • HIV/AIDS components in other sectors' projects d. Support of NGOs - dealing with HIV/AIDS, particularly in high-risk groups e. Knowledge sharing • Within ADB • With DMCs and the public

ADB = Asian Development Bank, ADF = Asian Development Fund, CSP = Country Strategy and Program, CSPU = Country Strategy and Program Update, DMC = developing member country, HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome, NGO = nongovernmental organization, OCR = ordinary capital resources, RETA = regional technical assistance, TA = technical assistance, UNAIDS = The Joint United Nations Programme on HIV/AIDS.