

**7th ICAAP: Opening ceremony**  
**HDN Key Correspondent**

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A report from the 7th International Congress on AIDS in Asia and the Pacific  
Kobe, Japan, 1-5 July 2005

"Forgotten lessons" of involving the most affected groups in policy-making

Calling for a "resolute action by all" Professor Dennis Altman, President of the AIDS Society of Asia and Pacific (ASAP), lamented that in our search for engagement by governments, business and international agencies we have overlooked the "forgotten lessons of involving the most affected groups in policy-making" in order to create an environment that encourages and supports the "most effective responses to AIDS."

Altman stressed the need for a more coordinated and integrated approach to building regional partnerships between major stakeholder groups in order to generate an essential "stronger voice of civil society". The need of the hour, he argued, is a joining of forces.

"Linking peak HIV/AIDS bodies, research centres and regional AIDS development organizations enables a stronger coordination for the many groups working on HIV/AIDS across Asia and the Pacific," he claimed.

Speaking during the opening of the 7th ICAAP, Altman also drew attention to the surge in the HIV/AIDS epidemic in Asia and Pacific and urged a more vigorous response to halt it.

ASAP's goal, he explained, is not to "duplicate existing community networks" or "include governmental or intergovernmental agencies," but to supplement their work, all the time stressing the need for strong regional association to hold governments responsible for their lack of commitment towards providing "care and support for people with HIV/AIDS, and effective prevention programmes against HIV".

Altman argued that even when governments do exert their influence, the responsibility of civil society to hold the state accountable becomes all the more profound.

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## **7th ICAAP: Mr JVR Prasada Rao on getting HIV/AIDS back in focus HDN Key Correspondent**

An interview with Mr JVR Prasada Rao, Regional Director, UNAIDS Regional Support Team for Asia and Pacific at the 7th International Congress on AIDS in Asia and the Pacific

Kobe, Japan: 1-5 July 2005

"I THINK GOVERNMENTS ARE PROBABLY MORE AWARE NOW [OF HIV/AIDS] THAN ANYTIME IN THE PAST. BUT MERELY BEING AWARE IS NOT ENOUGH"

Q: The new UNAIDS regional report concludes that the region is at crossroads, in relation to preventing further expansion of the regional HIV/AIDS epidemic. How long do we have before that opportunity is gone?

JVRPR: I think it is closing fast in some countries, I think that they have to act very fast. For example, if you talk about the largest countries in the region, China, India, Indonesia, Pakistan - I think in these countries it will be very fast.

Q: Has the Asia region 'dropped the ball' in terms of HIV prevention?

JVRPR: I think the last couple of years we have ignored prevention in two ways. One is the epidemic is still relentlessly being driven through the so-called vulnerable groups, such as commercial sex workers, injecting drug users and highly mobile population in the region, etc. But somehow or the other these groups have not had the focus that they need. We got into too many generalities, too many global issues; we are talking in general about women, children, young people, without really concentrating on those groups that are actually driving the epidemic. I think we need to bring back that focus.

Q: The report also talks about institutional obstacles. It seems that these are the same barriers that we have been discussing for a long time – are they?

JVRPR: I think governments are probably more aware [of HIV/AIDS] now than anytime in the past. But merely being aware is not enough. You must move from that commitment to doing something positive in the field. I think that is what we are trying to emphasise now. Mere lip service is not enough. You have to lead from the front; that is why we asking heads of government to assume leadership of national AIDS committees and move the programme forward.

Q: You are in the position of leading the regional UNAIDS team, having formerly been the head of the National AIDS Control Organisation in India. What do you think should be the immediate priorities for the Indian programme now?

JVRPR: I think, again, getting back into focus. Somewhere down the line we lost the focus in India also. You know, we started very well in the phase two of the national programme by providing a lot of important targeted interventions to vulnerable groups. And that strategy worked well. I think those interventions have not proportionately increased in terms of coverage. They remained stationary at the 2001 and 2002 level - they were getting into all sorts of other activities, without really focusing on interventions. They now have to re-focus.

Q: And that focus should be on what priorities?

JVRPR: First of all they are not doing enough in northern India. They are the new threats ... large states like Uttar Pradesh and Bihar which have large populations equal to some countries. There is very little programming there. And I think whatever little has been

done is almost coming to nothing. The second thing is again to concentrate more on vulnerable sections of populations. Interventions have to cover at least 60-70% of the vulnerable groups. The injecting drug use situation in the northeast is also key. There are some interventions in places, but they need to do a lot of scale up.

Q: What would you like to see countries doing in relation to drug use? There is clearly a lot of variation in what governments are prepared to commit to regarding principles of harm reduction.

JVRPR: I think drug-related intervention programmes must be scaled up. There are some individual success stories here and there. But in terms of coverage, still the population of drug users who are covered is still very, very low. Increase coverage, number one. Number two is that programmes have to be more comprehensive since needle and syringe exchange is definitely only one component. Methadone substitution is also important. I think you have to look at several of these elements and put them together in the form of a package.

Q: Are you optimistic about that? Do you think it is going to happen?

JVRPR: It is going to happen, but I think if you can secure adequate funding it will happen faster. Unfortunately there seems to be a serious problem of funding these programs. You know because some donors are not coming forward.

Q: Is civil society involvement in the region sufficient, and how can it be improved?

JVRPR: In fact that I think civil society is quite engaged. But the problem is the social mobilisation programmes are becoming more just moving from one event to the other and involving some celebrities. That strategy is fine when the activity is in its infancy but we have reached the stage where civil society needs to look at more successful partnerships. There are excellent grassroots and community-based organizations in many countries, like village women's groups, youth groups [etc], doing excellent work in other social sector programmes. We have not tapped this huge resource that we have at the field level. I would say there is a big gap in our civil society.

Q: Does that mean involving civil society in government and national programmes as well?

JVRPR: Yes, and if you bring these organisations [to the table], interventions will be much more sustainable, because cost-effectiveness of community-based organisations is much better than engaging individual NGO national or international.

Q: Countries have tried, to some extent, with the CCMs [country coordination mechanisms] of the Global Fund in the region. Do you have any sense of whether that is working?

JVRPR: There is room for improvement...the CCM mechanism has not really captured the imagination of either government or civil society and in some cases they got into real problems with the national AIDS authorities themselves: With the CCM on one side and the national authority on the other, not working together properly in a good relationship.

Q: Another major stakeholder, of course, is the UN and multilateral institutions. What do you think of the level of UN coordination on AIDS in the Asia region?

JVRPR: I think the recent recommendations of the UNAIDS Global Task Team [GTT; on improving multilateral and donor coordination] addressed some of these shortcomings. I think the GTT was quite open and frank in admitting that the UN system has not always been well coordinated in certain countries. Even among the UNAIDS co-sponsors in

certain countries there is a lot of overlap in looking after the problem. I think there has been a candid admission that better coordination is needed.

Q: What do you think of ARV expansion in Asia and the Pacific?

JVRPR: In fact this region could have expanded ARV much faster than anywhere else. You know, unlike Africa, at least this region has a stronger health systems. It would have been easy for the governments to mobilise their own health care institutions for the purpose of ARV delivery. But I really do not know why the governments are not being able to mobilise them. Some targets have been kept - that so many people should be covered – but to achieve the necessary coverage there are many things to be done at the local level.

Q: If there is a recognised delay for ARV roll-out, are there other care priorities we should be looking at?

JVRPR: In some of the countries treatment of opportunistic infections has been given some priority, but in others that has been totally forgotten. Even in the ideal case scenario, you won't be able to reach 100% ARV coverage. We have a large number of people who need to be given treatment for opportunistic infections such as TB. I think a long-lasting solution could be to strengthen the programmes dealing with opportunistic infections.

Q: In relation to Asia in the world, what are your expectations for ICAAP?

JVRPR: I think we should come out of the mindset of comparing ourselves with Africa. Asia has its own problems, and they should be dealt with in an Asian way. And we should also look at the Asian epidemic, not just trying to compare how Africa has done and how the epidemic has behaved there. The epidemic in Asia is totally differently than in Africa. Try to find our own solutions for Asia, based on the strengths and weaknesses of the systems here - both government as well as civil society. I hope that ICAAP will showcase some of the strong Asian progress against the epidemic.

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**7th ICAAP Press Release: Expanded harm reduction practices will reduce HIV epidemic and its impact in the Asia Pacific region**  
**2 July 2005**

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Kobe, Japan - Asian governments and other institutions have been too slow in providing services to protect people using drugs from HIV infection, despite evidence stressing that injecting drug use is one of the major driving factors behind the region's epidemics.

According to key presentations and reports released during the 7th ICAAP being held in Kobe, Japan this week, much of the current spread of HIV in China, for example, is attributable to injecting drug use, and there are signs that it is playing a bigger role in India's epidemics than previously thought. In Indonesia, Nepal and Viet Nam, rapid recent rises in HIV infection among drug injectors appear to have spurred subsequent rises in HIV infection among non-injectors who have sexual risk behaviours, thus "kick-starting" wider epidemics.

"Drug-related intervention programmes must be scaled up," said Mr JVR Prasada Rao, Regional Director of the Regional Support Team of the Joint United Nations Programme on HIV/AIDS (UNAIDS). "There are some individual success stories here and there. But in terms of coverage, still the population of drug users who are covered is very, very low."

Unfortunately, this mirrors the situation in much of the Asia Pacific region where injection-related HIV epidemics are currently raging.

"We have more than enough evidence that AIDS in Asia is driven largely by populations of injecting drugs users, due to high levels of needle sharing," added Tariq Zafar, keynote ICAAP speaker from Nai Zindagi, a non-government organisation providing street-based services for drug users in Pakistan. "Although abstinence from drugs is the final way out, not all who inject and share are ready for abstinence - nor do they have access to drug treatment services. For the rest, there needs to be a way to prevent them from sharing or even injecting."

The Kobe Congress has brought together the latest information and opinions linking drug use and the Asia Pacific HIV/AIDS epidemic, but according to some delegates, the significance of drug use as the key 'engine' for HIV/AIDS in the region has been understood for some time.

Executive Director of the Asian Harm Reduction Network, Mr Ton Smits, said some of the new data at the conference was important in identifying the spread of HIV from drug users into the broader community, but that what is urgently needed is action from those governments who have already made a commitment to act on the crisis.

"What we are hearing this week are further important pieces in the evidence puzzle, but is not really telling us anything we didn't already know" said Mr Smits. "What we need is urgent action from the governments and other institutions that have made explicit commitments to do something about the crisis engulfing people using drugs in Asia."

Due to its proximity to the major producers of the world's illegal heroin, and because of entrenched poverty in many places, Asia is home to the largest populations of injecting drug users in the world. In 2004, for example, opium cultivation in Afghanistan grew by 64 per cent, which promises increased trafficking and a steady supply of high-grade heroin for the Asia Pacific region as well as other countries.

Because of the difficulties people face in stopping using drugs, and because other detoxification or treatment programmes services are often scarce, a more pragmatic approach is to reduce the impact and risk-associated effects of drug use. 'Harm reduction' is about reducing the harms of drug use, both to drug users and the wider community - without necessarily reducing drug consumption.

One element of harm reduction is 'substitution therapy' - a treatment approach that helps opioid drug users (e.g. heroin) to reduce the withdrawal symptoms and craving when drug use is stopped or reduced. Methadone is one of the oral medications used for substitution therapy. Because users taking methadone are far less likely to inject drugs, it also has a significant impact on reducing their risk of HIV infection.

Significantly, and on the eve of the ICAAP, the World Health Organization (WHO) announced that it had added methadone to the WHO List of Essential Medicines - a roster of drugs endorsed by WHO, and recommended for basic use by health services throughout the world.

ICAAP delegates were also keen to broaden the way harm reduction services are viewed. Mr Rao of UNAIDS argued that programmes have to be more comprehensive, since needle and syringe exchange and methadone substitution are important, but just one part of the harm reduction and treatment continuum. "I think you have to look at several of these elements and put them together in the form of a package," he said.

Between 5 and 10% of the world's HIV infections are reportedly due to injection drug use. But HIV/AIDS transmission among people injecting drugs and their social networks is preventable, and there is evidence that HIV among this group has a large effect on the dynamics of HIV spread, and so the control of HIV in the general population also needs HIV prevention among injection drug users.

"Closing our eyes to these marginalized populations and behaviours will not make them go away", said Karen Stanecki, who leads the Monitoring the AIDS Pandemic group of leading AIDS experts. "Supporting prevention services for these populations will reduce their risk to HIV and will help prevent the spread to the wider population."

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[The Seventh International Congress on AIDS in Asia and the Pacific (ICAAP) is currently taking place in KObe, Japan: 1-5 July 2005]

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## **7th ICAAP: Methadone comes of age, at last HDN Key Correspondent Team**

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[This is the lead story in the second issue of the ICAAP News, the daily conference newsletter providing on-site coverage on the 7th International Congress on AIDS in Asia and the Pacific (ICAAP), Kobe, Japan: 1-5 July 2005]

PIOT: "THIS IS IMPORTANT. NATIONS WHO WANT TO PROVIDE METHADONE IN THEIR PROGRAMMES WILL HAVE EASIER ACCESS"

Imagine there was a simple, effective and affordable medicine that could reduce the death rate among people who use drugs such as heroin by about two-thirds. Fat chance? Now imagine that medicine does exist, but that because of a reluctance on the part of policy-makers and government officials, it was not widely available in many countries. Hard to believe? Dream no more. The medicine exists and is about to break out of its shrouded history: Methadone is coming of age.

Significantly, and on the eve of the 7th ICAAP, the World Health Organization (WHO) announced that it had added methadone (and buprenorphine, a medicine with a similar clinical profile) to the WHO Model (Complementary) List of Essential Medicines - a roster of drugs endorsed by WHO, and recommended for basic use by health services throughout the world.

"This is important," said Dr Peter Piot, Executive Director of the United Nations Joint Programme on HIV/AIDS (UNAIDS). "Nations who want to provide methadone in their programmes will now have easier access."

Between 5 and 10% of the world's HIV infections are reportedly due to injection drug use and represent a much higher proportion of HIV transmission in some countries - in Asia and Europe in particular. Injection drug use is also now the predominant mode of transmission of hepatitis C virus throughout the world.

Due to the unregulated nature of illicit substances, injection drug users often use drugs of unknown potency and quality, which can frequently lead to overdoses. It is estimated that approximately 2-3% of injection drug users die each year, resulting in a mortality rate for heroin users, for example, of between six and twenty times that seen among those in the general population of the same age and sex.

Substitution therapy using drugs such as methadone, is a treatment approach that helps opioid drug users (e.g. heroin) to reduce the withdrawal symptoms and craving when drug use is stopped or reduced. Methadone is one of the oral medications used for substitution therapy. Because users taking methadone are far less likely to inject drugs, it also has a significant impact on reducing their risk of HIV infection.

In their position paper Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention, the WHO, the United Nations Office on Drugs and Crime (UNODC) and UNAIDS stated that opioid "drug dependence treatment is an

important strategy to improve well-being and social functioning of people with opioid dependence and to reduce its health and social consequences, including HIV infection."

Participation in substitution therapy also provides opportunities for early diagnosis of other health problems, HIV, tuberculosis, hepatitis and counselling and testing, as well as referral for additional services. It is arguably the most effective, and cost-effective, treatment option for injection drug users, and brings them into contact with various other services within the health system.

According to several estimates, every dollar invested in opioid dependence treatment programmes may yield a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs and theft alone. When savings related to health care are included, total savings can exceed substitution therapy costs by a ratio of twelve to one.

IDUs who do not enter methadone treatment are thought to be up to six times more likely to become infected with HIV than injectors who enter and remain in treatment.

Substitution therapy is not a stand-alone solution, however. Another new UNAIDS policy position paper 'Intensifying HIV Prevention', also endorsed by the agency's governing body just days before the ICAAP congress, lists various essential programmatic approaches to reduce HIV acquisition and transmission among drug users. They include voluntary, confidential HIV testing and counselling, prevention of sexual transmission of HIV among drug users, access to primary healthcare, and access to antiretroviral therapy.

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**7th ICAAP: First, do no harm**  
**HDN Key Correspondent Team**

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Interview with Tariq Zafar, Asian Harm Reduction Network (AHRN) Executive Committee Chairperson at the 7th International Congress on AIDS in Asia and the Pacific (ICAAP), Kobe, Japan: 1-5 July 2005

"THE MAIN PRINCIPLES OF SUCCESS ARE REACHING OUT TO POPULATIONS WHO ARE OFTEN HIDDEN AND HAVE NO ACCESS TO SERVICES. THE SUCCESS IS ALSO LINKED TO THE INVOLVEMENT OF THE CLIENTS OR RECOVERING/ED DRUG USERS IN THE SERVICES OFFERED."

Q: Enough evidence has been gathered in support of key HIV prevention services such as condoms, needle and syringe exchange programmes and pharmacotherapy for drug

users. But morally-driven opposition seems to be on the rise. What do you understand from this move and what reach/impact is this likely to have in Asia?

TZ: We have more than enough evidence that AIDS in Asia is driven largely by populations of injecting drugs users, due to high levels of needle sharing. Although abstinence from drugs is the final way out, not all who inject and share are ready for abstinence and/or have access to drug treatment services. For the rest, there needs to be a way to prevent them from sharing or even injecting. Both needle and syringe exchange programs (NSEP) and pharmacotherapy have proven to drastically reduce both sharing and injecting respectively.

Morally-driven approaches are only based on ideological judgements and are not evidence-based. Misunderstanding the context and deliberate efforts to negate the positive impact of such services in Asia could and will have devastating affects on people and drastically increase prevalence of HIV among people injecting drugs and ultimately on the entire region.

Q: What are the successful models for harm reduction in the region that should be replicated and scaled-up?

TZ: There are many examples to cite. Rather than speak of particular organizations I would stress the principles underlying why these initiatives have worked and the various populations they have worked for.

Street children...there are many examples in India, Cambodia and Pakistan where organizations have worked with street children using drugs to prevent both drug use and transmission of HIV, and in particular to help children not to progress to injecting drugs. The principle behind why this works is that they are needs-based services, where street children actually develop and plan strategies and design service provision.

Injecting drug users...there are concrete examples in countries like India, Pakistan and Bangladesh where HIV prevalence among people injecting drugs who have access to services are much lower (1-3%) compared to people who inject but do not have access to services (40-65%).

The main principle of success is reaching out to populations who are often hidden and have no access to services. The success is also linked to the involvement of the clients or recovering drug users in the services offered.

Q: Drug injection is a strong driver of HIV infection in the region - why is it being allowed to continue largely unabated despite explicit periodic political commitments to address it?

TZ: In most situations, resources in the drug sector are mostly for drug supply reduction activities and few for drug demand reduction.

In some cases governments are directed by external sources, that oppose street-based harm reduction services, not to start or to scale up existing programmes. It is also the fault of harm reduction organizations that have over emphasised that harm reduction activities are solely NSEP and pharmacotherapy, which is a distortion since those are only two components of a continuum of services.

Q: Recovering drug users have lower access than other groups to HIV/AIDS treatment and care services as well as preventive measures. What can be done to improve access and use of services by current and recovering drug users?

TZ: Stigma and criminalization of drug users in most countries of Asia make it difficult for them to access health care services. Topped up with HIV/AIDS discrimination, the challenge of access is even greater and more difficult.

Reaching out to people using drugs and involving recovering users as outreach workers is the most effective and cost efficient manner, nevertheless health care access remains unfairly skewed, where less than 10% of current and recovering drug users from the region with HIV are currently accessing ARVs.

Q: Does the existence of a national HIV/AIDS or harm reduction policy mean that related services are available?

TZ: Information and education that is correct and recent is often a very good tool to sustain the deployment of policy. Informing policy-makers and key stakeholders of what is happening - and what needs to be done - is a crucial first step. Examples that employ good principles of engagement and service delivery should be from within the region and context-appropriate and need to be promoted. A continuum of care rather than only NSEP or pharmacotherapy should be highlighted.

Q: While national governments in Asia have a crucial role to play in the scale-up of service delivery as a part of a comprehensive HIV/AIDS prevention and care model, international agencies like the UN also influence national policies and actions. What should such agencies do to influence governments more effectively?

TZ: First, UNODC [UN Office on Drugs and Crime] and UNAIDS [Joint United Nations Programme on HIV/AIDS] need to work closely together and have one firm approach rather than one that often confuses governments. The time to promote pilot programs is over. Now, UN agencies need to advocate for scaling-up, improving coverage drastically and promoting the use of services.

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## **7th ICAAP: Global Fund gets new cash injection from Japan, but may still face deficit**

**HDN Key Correspondent Team**

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This is a report from the 7th International Congress on AIDS in Asia and the Pacific (ICAAP), Kobe, Japan: 1-5 July 2005

JAPAN PM: "THE ISSUE OF FIGHTING INFECTIOUS DISEASES IS A MAJOR CONCERN FOR ALL THE PARTICIPANTS OF NEXT WEEK'S G8 SUMMIT"

During the symposium on the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria held in Tokyo on 30 June, just prior to the 7th ICAAP conference, Japanese Prime Minister Junichiro Koizumi pledged an additional US \$500 million to the fund. This amount is in addition to the US \$327 million Japan has donated to date. Koizumi said the issue of fighting infectious diseases is a major concern for all the participants of next week's G8 summit.

Even with Japan's pledge, however, the Fund is likely to run a large deficit in the coming years unless other countries also increase their commitments.

Since it started operations in January 2002, the Fund has committed US \$3.5 billion to over 300 programs in 127 countries. Substantial results have been already achieved. In March 2005, the fund reported that it had provided antiretroviral treatment to 130,000 people with living with HIV/AIDS, and tested more than one million people.

The Global Fund, however, faces a potentially huge budget deficit. According to analysis by AidsSpan, an independent observer of the Global Fund, in March 2005 the fund estimated that only US \$300 million was available to cover the costs of Round 5 of grant distribution. However, if approval rates are similar to earlier rounds, a record US \$1.25 billion in grants could be approved.

Such a deficit might not be inevitable, however, if new requirements for civil society participation in the Country Coordinating Mechanisms (CCMs) of the fund are adhered to.

Late in 2004, and after a long debate, the fund changed the requirements for the selection of representatives of affected communities (including people living with HIV) and non-governmental organizations (NGOs) on national CCMs. While it was always recommended that these representatives be chosen by members of their own sectors, it is now a requirement. At present, very few national CCMs meet this requirement.

Currently, the majority of NGO representatives are not selected by the NGO sector and do not represent them, but rather by government members who often significantly dominate CCMs.

If the new CCM requirements are strictly enforced, it is likely that many of the Round 5 applications will be rejected before the fund's review panel even considers them. Such strict enforcement would not only force CCMs to be more representative but would reduce the budget pressure by also making many countries ineligible for imminent renewals of existing grants.

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**7th ICAAP Press Release: AIDS drug access increasing in the Asia and the Pacific, but future care needs daunting for region's health systems**  
**3 July 2005**

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Kobe, Japan - Recent progress in delivering antiretroviral (ARV) drugs to people living with HIV/AIDS in Asia and the Pacific has been impressive. But the 8.2 million people living with HIV in the region present a major future care need that national health systems are not ready to absorb in the coming years.

The '3 by 5' target - to provide three million people in low - and middle-income countries with ARVs by the end of this year is providing an important impetus in the overall international efforts towards expanded access to care and treatment services.

The experiences reported this week during the ICAAP congress provide further evidence that large-scale HIV treatment access is achievable, effective and increasingly affordable, even in the poorest and most challenging settings. At the same time, the challenges of expanding coverage beyond current levels and building sustainable systems to support it remain a significant challenge.

In Asia, the region with the second highest need for AIDS treatment, the number of people receiving ARVs has increased three-fold from 55,000 to 155,000 in the past 12 months. Despite this significant progress, the overall proportion of people in the region with advanced HIV infection receiving ARVs remains low, mirroring the global average of around 15%. That means that around one million Asians with HIV who would currently benefit from ARVs do not have access to them. The additional seven million people with HIV in the region - but who do not yet need ARV or other care options - will each inevitably reach the stage where they also require AIDS-related care services in the coming years.

"There is still a significant gap, and the three million target is likely not going to be achieved by the end of the year. But we have shown that the equation is still valid," said Dr Jack Chow, Assistant Director General of the World Health Organization (WHO) and head of their HIV/AIDS, Tuberculosis and Malaria programme. "I think there is a profound opportunity to demonstrate in a creative way that if you introduce teams with educators, citizen leaders and journalists to educate the community in a variety of needs, the uptake will be high and rapid when the programme rolls in," he added.

In India, the Asian country with the largest current and future AIDS care needs, around 65,000 people are taking ARVs. That leaves a further 700,000 for whom ARVs are out of reach. In Thailand, where the delivery of ARVs has been the most effective in the region, about 40% of those who would already need ARVs do not have them.

"We have given a promise to people that ARVs will be made available, and we are clearly not keeping up that promise," said Dr NM Samuel, who runs the Department of Experimental Medicine and AIDS Research in Chennai, India. "If we are unable to provide ARVs on a regular basis to people who require them, can we then seriously think about alternatives, like ensuring prophylaxis and treatment for [HIV-related] opportunistic infections on a regular basis, or providing nutritional supplements. Or are

we going to wait another three years for so many more people to die before these measures come into effect?"

The current gap in all kinds of HIV/AIDS care provision in the region represents a common failure to meet not just the 3by5 target, but the key goals agreed to by all governments in the Declaration of Commitment on HIV/AIDS during the UN General Assembly Special Session (UNGASS) in 2001. In that commitment, leaders from Asia and the Pacific promised, by 2005, to "...develop and make significant progress in implementing comprehensive [HIV/AIDS] care strategies...required to provide access to affordable medicines, including anti-retroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psychosocial care." Once again, just one year ago, in July 2004, 38 governments from the region reiterated that commitment through a ministerial meeting and resulting statement titled Access for All: Political Accountability.

In the opening session of the ICAAP congress Dr Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS drew attention to the lack of sufficient action to make these commitments a reality: "These figures show that the vast majority of countries are doing too little on AIDS overall and in particular on protecting and supporting those who are most at risk."

In mid-2006 a comprehensive review of national performance against the specific targets of the UNGASS Declaration of Commitment on HIV/AIDS will be completed and the level of action on HIV/AIDS by all countries will be placed under a spotlight.

"The likely failure of 3by5 to reach its target is not just another missed target. It is an indictment of leaders in rich and poor countries that failed to back it and save the lives that needed saving," said Leonard Okello, International HIV Coordinator at ActionAid International one of the African delegates attending the ICAAP congress. "The G8 meeting next week has the chance to correct this. They now need to give their backing to a target of universal access for all who need it by 2010 and make sure this happens," he added.

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**7th ICAAP: Where drugs and sex meet - the nexus  
HDN Key Correspondent Team**

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[This is the lead story from the third issue of the ICAAP News, the daily conference newsletter providing on-site coverage on the 7th International Congress on AIDS in Asia and the Pacific (ICAAP), held in Kobe, Japan, 1-5 July 2005.]

"WE ARE LEFT TO WONDER: HOW LONG IT WILL BE BEFORE WOMEN SEX WORKERS WILL BEGIN INJECTING IN NEW SETTINGS WHERE OPIATES AND AMPHETAMINES ARE UBIQUITOUS?"

After four years of ASAP silence, it was initially exciting to hear officials talk about vulnerable groups of people again. We heard Peter Piot of UNAIDS refer to sex workers, injecting drug users (IDUs), and men who have sex with men (MSM) during his opening ceremony address. And we heard about the same three groups again the next day when the Monitoring AIDS Epidemic (MAP) network launched three separate reports recommending increased coverage of prevention services.

Much of the research and data on which the MAP recommendations are based are not new. "The right prevention services for the right people will change the course of the HIV epidemic in Asia," said Karen Stanek, Chair of the MAP network. Few would disagree. The MAP report authors were quick to point out that the three groups are not watertight. They presented data and graphs to show that men who have sex with men also buy sex from women, women sex workers inject drugs, and injecting drug users often buy sex from women. So instead of conceptualising risk on the basis of discreet groups, there may be more value in providing prevention services for these five behaviours. All three 'populations at risk' are based on behaviours rather than self-identity.

Epidemiologists have concentrated on one easily-identified behaviour as an amplifier of the epidemic: men IDUs buying sex. Sharing injecting equipment is a much more efficient way of acquiring and transmitting HIV than unprotected sex. It is a fair assumption everywhere that the majority of drug users are men, and it is true that gender expectations make men more vulnerable to addictions. But women also use drugs. Shortly after the previous ICAAP in Melbourne the report "Revisiting the Hidden Epidemic" described women using drugs in China, Vietnam, Nepal, Philippines, India, Bangladesh, Indonesia, Sri Lanka and Pakistan.

Though there is a dearth of studies on the nexus between sex work and drug use in China, governmental surveillance figures demonstrate that street-based sex workers who are being held in detention centres are known to be HIV infected. Off the record in China, people say that they know that injecting is taking place among sex workers who work in barber shops as well. Women sex workers are beginning to inject heroin in Myanmar. Injecting drug use among women sex workers is not described as common behaviour in most parts of India though many drink alcohol.

Assessments of women's vulnerability to HIV infection through drug use in Vietnam, Cambodia, and India was presented in the ICAAP session 'Drugs Use and Sexual Risk'. From two separate studies in the south of Vietnam we learned that HIV prevalence rates that were dropping until recently are rising again as women begin to inject readily available heroin. In the well-studied southern Vietnamese Ho Chi Minh City, the nexus

between sex work and drug use is clear. Qualitative and quantitative data show that street-based sex workers are more likely to inject drugs and much more likely to be HIV-infected.

Just two years ago there was only one organisation working with street-involved children in Cambodia that had programmes to deal with drug use. A recent rapid survey found extensive use of amphetamines and heroin among women sex workers in Phnom Penh. India's northeast was also featured in a presentation on a situational assessment in Nagaland. Sex workers who used drugs were involved in sexual networks with both the uniformed and non-uniformed military. Although this rapid assessment was funded by the Gates-endowed Avahan project, no appropriate harm reduction activities were available for women with addictions and additional funds needed to be raised. Local nongovernmental organisations that have been supporting sex workers now need to learn quickly how to offer treatment for addictions, needle and syringe programmes, and drug substitution treatment. As one harm reduction expert noted as he left the session: "We have to develop services for women."

The Secretary General of the United Nations noted in his recent UNGASS Declaration of Commitment progress report that (in 2003) targeted prevention services reached only 16 per cent of sex workers. Many of them have heard about condoms but were offered nothing for their problems with drugs.

As we scramble to offer harm reduction services that are women-friendly in these few identified places where women are injecting drugs and sharing injecting equipment, we are left to wonder how long it will be before women sex workers will begin injecting in new places where opiates and amphetamines are ubiquitous.

If pockets of women who sell sex are indeed rapidly crossing over to injecting drugs in very specific locations, as it appears, perhaps a regional quick-response team to provide focused 'quick-start' harm reduction services for them could have an equally swift prevention impact?

We should also ask urgently, how many harm reduction programmes for male IDUs routinely offer sexual prevention services and advice to their clients?

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**7th ICAAP Press Release: AIDS drug access increasing in the Asia and the Pacific, but future care needs daunting for region's health systems**  
**4 July 2005**

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Kobe, Japan - Recent progress in delivering antiretroviral (ARV) drugs to people living with HIV/AIDS in Asia and the Pacific has been impressive. But the 8.2 million people

living with HIV in the region present a major future care need that national health systems are not ready to absorb in the coming years.

The '3 by 5' target - to provide three million people in low- and middle-income countries with ARVs by the end of this year is providing an important impetus in the overall international efforts towards expanded access to care and treatment services.

The experiences reported this week during the ICAAP congress provide further evidence that large-scale HIV treatment access is achievable, effective and increasingly affordable, even in the poorest and most challenging settings. At the same time, the challenges of expanding coverage beyond current levels and building sustainable systems to support it remain a significant challenge.

In Asia, the region with the second highest need for AIDS treatment, the number of people receiving ARVs has increased three-fold from 55,000 to 155,000 in the past 12 months. Despite this significant progress, the overall proportion of people in the region with advanced HIV infection receiving ARVs remains low, mirroring the global average of around 15%. That means that around one million Asians with HIV who would currently benefit from ARVs do not have access to them. The additional seven million people with HIV in the region – but who do not yet need ARV or other care options - will each inevitably reach the stage where they also require AIDS-related care services in the coming years.

"There is still a significant gap, and the three million target is likely not going to be achieved by the end of the year. But we have shown that the equation is still valid," said Dr Jack Chow, Assistant Director General of the World Health Organization (WHO) and head of their HIV/AIDS, Tuberculosis and Malaria programme. "I think there is a profound opportunity to demonstrate in a creative way that if you introduce teams with educators, citizen leaders and journalists to educate the community in a variety of needs, the uptake will be high and rapid when the programme rolls in," he added.

In India, the Asian country with the largest current and future AIDS care needs, around 65,000 people are taking ARVs. That leaves a further 700,000 for whom ARVs are out of reach. In Thailand, where the delivery of ARVs has been the most effective in the region, about 40% of those who would already need ARVs do not have them.

"We have given a promise to people that ARVs will be made available, and we are clearly not keeping up that promise," said Dr NM Samuel, who runs the Department of Experimental Medicine and AIDS Research in Chennai, India. "If we are unable to provide ARVs on a regular basis to people who require them, can we then seriously think about alternatives, like ensuring prophylaxis and treatment for [HIV-related] opportunistic infections on a regular basis, or providing nutritional supplements. Or are we going to wait another three years for so many more people to die before these measures come into effect?"

The current gap in all kinds of HIV/AIDS care provision in the region represents a common failure to meet not just the 3by5 target, but the key goals agreed to by all governments in the Declaration of Commitment on HIV/AIDS during the UN General Assembly Special Session (UNGASS) in 2001. In that commitment, leaders from Asia and the Pacific promised, by 2005, to "...develop and make significant progress in implementing comprehensive [HIV/AIDS] care strategies...required to provide access to

affordable medicines, including anti-retroviral drugs, diagnostics and related technologies, as well as quality medical, palliative and psychosocial care." Once again, just one year ago, in July 2004, 38 governments from the region reiterated that commitment through a ministerial meeting and resulting statement titled Access for All: Political Accountability.

In the opening session of the ICAAP congress Dr Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS drew attention to the lack of sufficient action to make these commitments a reality: "These figures show that the vast majority of countries are doing too little on AIDS overall and in particular on protecting and supporting those who are most at risk."

In mid-2006 a comprehensive review of national performance against the specific targets of the UNGASS Declaration of Commitment on HIV/AIDS will be completed and the level of action on HIV/AIDS by all countries will be placed under a spotlight.

"The likely failure of 3by5 to reach its target is not just another missed target. It is an indictment of leaders in rich and poor countries that failed to back it and save the lives that needed saving," said Leonard Okello, International HIV Coordinator at ActionAid International one of the African delegates attending the ICAAP congress. "The G8 meeting next week has the chance to correct this. They now need to give their backing to a target of universal access for all who need it by 2010 and make sure this happens," he added.

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[The Seventh International Congress on AIDS in Asia and the Pacific (ICAAP) is currently taking place in KObe, Japan: 1-5 July 2005]

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**7th ICAAP Kobe: CARAM News**  
**CARAM Asia Secretariat**  
**4 July 2005**  
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Regional Strategies to Cope with HIV/AIDS among Mobile Populations - A Health Rights Approach

Sharuna Verghis, Regional Coordinator of CARAM Asia (Coordination of Action Research on AIDS and Mobility), speaking at the Plenary on 3rd July called for an integrated and holistic approach with health and human rights as guiding factors in the process of migration. She identified major challenges to regional strategies to address HIV among mobile population. One major challenge 'crossing terminological boundaries in population mobility' and 'quantifying the invisible'. By that she meant the absence of reliable data on migrant population. 'Regulation vs Protection' raised the challenge of

weak political will on the part of the receiving countries that is reflected in the MoU's signed by the countries.

She pointed out 'lack of Human Rights vision' and perspective as one of the challenges. Lack of commitment to sign, ratify and follow the International instruments relating to migrants right to health and particularly those high ideals are not translated into actions in the regional organizations such as ASEAN and SAARC. She highlighted 'absence of NGO and migrants input in these regional and sub-regional dialogues relating to migration' as another challenge.

In the 'roles and responsibilities' towards the end of her address she asked for focus of international assistance on 'core-obligations' of States including non-discrimination of the marginalized and vulnerable groups. The NGO'S working on migration according to her should keep their house in order and link up with other organizations for effectiveness in intervention. The State has a major role to play in terms of 'respect, protect and fulfill the right to health'.

She stated that the international community had a responsibility to put united pressure on Burma. "Burma, is next in line to chair the ASEAN. If a military dictatorship is given this position in ASEAN human rights in the region will disappear. The international community must act so that democracy is restored in Burma and Burma is free from a military dictatorship which has no respect for the lives of its citizens".

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#### Mobile Populations: Interventions Beyond Borders

The oral session on 'Mobile Populations: Interventions beyond borders' had five presentations. The first presentation by Ms. Imadzu Lisa of Japan was on 'possibilities and limitations of a regional approach to HIV/AIDS among the migrant population in Asia - lessons from European experience', highlighted the need for effective regional Interventions as that of Europe. The premise being that Europe address the issue of migration and vulnerability of migrants to HIV/AIDS at the regional level and not at the national level. Thus, their interventions are effective. The model proposed by the presenter is 'from State centrism to new Regionalism'.

Ms. Saetang Jiraporn of Thailand shared her experience 'from research to Action: the Maesot experience'. In the context of one million documented and undocumented workers from Burma only half of them get work-permits to work in Thailand. The study involved 120 women participants to look at the 'pattern of mobility and access to health'.

The study highlighted the unprotected working and living conditions that results in health problems. The migrants experience many forms of violence in the process of migration. Women suffer most as no contraceptive methods are available and they easily fall prey to STI and HIV.

Unplanned pregnancy places women at a disadvantageous position and the harmful abortion that follows. The study resulted in the starting of a 'Women's Centre'. The centre concentrates on 'health knowledge, treatment and health information' directly to women.

Ms. Quesada Amara, of 'Achieve', Philippines highlighted the need for 'institutionalizing HIV/AIDS Education in the training programme of Foreign Service Personnel'. This intervention with the foreign office personnel at the institute where they are being trained resulted in a 'migrant-centred' and 'migrant-friendly' attitude of the officers who had taken up assignments in foreign countries as vice-consuls, Ministers and Embassy officials. Experience of 'Achieve' in working with positive migrants particularly seafarers has given experience to handle such sessions and also a pre-departure orientation seminar for the embassy personnel.

'Strengthening the capacities of female spouses of migrant workers in addressing their vulnerabilities to HIV/AIDS' by Taguiam, Khryss Ann of Philippines stressed the need for organizing the spouses of migrant workers and mainstreaming HIV/AIDS in their capacity building programmes. Women not only emerged with leadership qualities but also negotiation skills that they need in addressing health issues and in bringing up children.

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#### Responding to HIV/AIDS among Mobile Populations in Asia Pacific

The Satellite meeting on 'Responding to HIV/AIDS among mobile populations in Asia Pacific' was organized by the Japanese Foundation for AIDS Prevention in partnership with CARAM Asia (Coordination of Action Research on Aids and Mobility), SHARE (Japan) and Research Institute of Tuberculosis (RIT) Japan.

Ms. Jackie Pollock traced the context in which CARAM network addresses the issues of informal work, forced labour, increasing violence, sub-standard working conditions, bonded labour, and occupational accidents that were primary motivating factors for migration and in this context HIV/AIDS gave an entry point to address the issues relating to migrant workers living and working conditions and health. 'Being safe' should be the guiding principle and to look at migration from the perspective of 'Safe in migration, safe in work and safe in sex'.

'Research on HIV/AIDS and International migration' Yanai Hideki and Imadzu Lisa. The Rationale behind the research being the concern over increasing mobility related HIV cases. Main research question being 'Do migrants contribute to the spread of HIV/AIDS?' the study an empirical one proved that migrant workers are not necessarily in the most 'high risk group'. Ms. Imadzu Lisa pointed out the need for effective regional interventions as that of Europe. The premise being that Europe addresses the issue of migration and vulnerability of migrants to HIV/AIDS at the regional level and not at the national level so their interventions are effective. The model proposed by the presenter is 'from State centrism to new Regionalism'.

Ms. Malu Marin of 'Achieve', Philippines highlighted the contribution of migrant labour to the economy of the country but regretted the lack of protection mechanisms, though available but are inadequate. She raised important issues such as the mobile nature of migrant workers, how to access them and how to sustain their involvement. Lack of capacity of experience in undertaking HIV/AIDS issues, the invisible nature of the work and the worker, testing and the whole area 'confidentiality' in the process of being tested positive are some of the issues she raised in order to involve meaningfully the migrant workers.

Dr. Takashi Sawada of Japan who works with the Thai migrants shared his experience in terms of fear of Thai migrants getting ill. The reported number of AIDS cases according to him is 21 among the undocumented Thai workers of whom 7 died of AIDS. Though treatment is available in Japan the Thai migrant workers do not have access to hospitals as it is expensive according to Mr. Takashi. He reiterated the need for cooperation from the sending countries and suggested interpreters during the time of admission in the hospital and cooperation from the sending countries in providing information in the local language on AIDS.

Mr. Promod Kumar of UNDP shared with the participants the 'Role of International Organizations in addressing HIV vulnerability among the mobile populations' said that the international organizations are good for regional advocacy work, for bringing countries together, for creating regional platforms, strategies, tools and framework. They are good according to him for facilitating transborder collaboration, initiating transborder pilots and scaling up the effectiveness of the programme. International organizations are useful for facilitating knowledge and sharing of knowledge and above all for resource mobilization. He quoted as examples the Regional Coordination Mechanism (RCM) in South Asia, GFATM proposal for 59 million dollars and mobility task force in South East Asia.

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## **7th ICAAP: Making GIPA a reality - by 'using' national frameworks? HDN Key Correspondent Team**

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[This is the lead story from the fourth issue of the ICAAP News, the daily conference newsletter providing on-site coverage on the 7th International Congress on AIDS in Asia and the Pacific (ICAAP), held in Kobe, Japan, 1-5 July 2005.]

"ANOTHER KEY BARRIER TO DEVELOPING PWHA LEADERSHIP IS SIMPLE: A LACK OF MONEY COMING INTO THE COMMUNITIES"

Greg Gray, the Regional coordinator for the Asia-Pacific Network of people living with HIV/AIDS (APN+), rolled his eyes at the mention of 'GIPA' (greater involvement of people living with HIV/AIDS). "Is GIPA working?" he laughs, "It's easy to say how it's not working - there's no PWHA [people living with HIV/AIDS] involved! GIPA has been around for 11 years, and we're no further down the road to achieving it."

More than a decade ago, governments pledged to make GIPA a fundamental principle of their work to stop the epidemic. Today, delegates at the 7th ICAAP are asking themselves a disturbing question: Why has this crucial principle completely failed to become a reality?

A symposium at the conference might offer a clue to the failure: The symposium was held in a cavernous hall that can seat 2000 people. For the session on GIPA entitled "Beyond tokenism", there were fewer than 50 people there.

The audience may have been small, but there were tough questions: One participant challenged the role of larger organisations that 'support' PWHA groups:

"How often do you feel that organisation after organisation puts your name on its glossy report and gets away with calling it 'involvement'? Do you feel co-opted?"

Elden Chamberlain, the manager of the Asia Pacific HIV/AIDS program for the Australian Red Cross and a speaker at the meeting, admitted that at times international agencies might be guilty of 'using' PWHA:

"We invite people with HIV along, they can sit at the table, but they don't have the power to make sure that their voices are heard."

However, he strenuously denied that his organisation has this problem, saying that PWHA participation was "central" to the global strategy of the Red Cross.

The country that appears to be making the most significant progress on its ARV treatment plan in the region, Thailand, may also be the country that is coming closest to achieving the GIPA principles. Greg Gray conceded that Thailand inspires hope: "Thailand is better," he says, "because there is real leadership by the Thai positive community. There is a dialogue with the government...there are some success stories."

Gray is quick to add that these success stories have come despite a lack of support from bilateral organisations or from international agencies. He claims these agencies "are all very good with the rhetoric, but when it comes to the realities, those are not even on the radar. It's all about theory and lobbying government, but they need to see the importance of community, building a sustainable and credible community".

Marcel van Soest, the Executive Director of the World AIDS Campaign, believes this will not happen spontaneously, that it's up to nongovernmental organizations (NGOs) and PWHA groups to organise themselves into a unified voice and demand that governments listen.

"It's clear that civil society needs to organise themselves better," van Soest says, "to be able to develop joint responses and positions." We have GIPA, UNGASS, CCMs...all of these concepts and requirements." However, he stresses that these agreements will only work if NGOs and PWHA groups push governments to live up to their obligations. "The stronger these [agreements] are," he says, "the stronger a tool it is for us to use."

Such leadership and organisation are rare, however, and NGO networks often deteriorate into dead-end discussions or bickering.

Paul Toh worked as "GIPA Advisor" for UNAIDS in Thailand for 7 years, during which time he organised a number of PWHA support groups in neighboring countries. He left in 2004 to work with Action for AIDS, in Singapore. Toh says another key barrier to developing PWHA leadership is simple: a lack of money coming into the communities.

"It's a top down approach where money goes through governments, not directly to groups; this has to change before GIPA will work. It needs to be bottom-up with people at the community level." You have to focus not on "GIPA" but on the realities on the ground in each country or province or community. It's a principle, not just words."

Toh says real involvement of PWA is rare, and is easily measured: "How many PHWAs are decision-makers in HIV/AIDS at country level?" he asks, "How many PHWAs are involved with government policy making?"

The answer for most if not all countries in the region, he says, is probably zero.

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**7th ICAAP: Positive prevention in men who have sex with men**  
**HDN Key Correspondent Team**

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This is a report from the 7th International Congress on AIDS in Asia and the Pacific (ICAAP), Kobe, Japan: 1-5 July 2005

"RESEARCH INTO HOW HIV POSITIVE MSM CAN CONTRIBUTE TO POSITIVE PREVENTION AMONG MEN HAVING SEX WITH MEN NEEDS TO BE CARRIED OUT WITH SOME URGENCY"

It is shocking that after two decades of attempts to address the AIDS epidemic, there are still so few concrete and sustainable programmes addressing the particular sexual health needs of HIV-positive men who have sex with men (MSM). Such programmes have a vital role in preventing the spread of HIV within and among the MSM communities.

While MSM groups are often represented at conferences such as ICAAP, they are still largely invisible in countries within South East Asia. In Bangkok, according to Greg Gray of the Asia Pacific Network of People living with HIV and AIDS, there is a high level of HIV infection among MSM. Relevant research in this area needs to be done as soon as possible in order to halt the spread of HIV among the gay community, not only in Thailand but anywhere else in the region.

MSM with HIV don't usually come forward and participate in efforts to address HIV/AIDS because of the fear of discrimination. They face a double stigma, being both HIV positive and gay. Mr Gray further suggested that HIV positive MSM need to address their own needs first before they start addressing those of others. There is a great need for positive MSM to take a more proactive leadership role, a more responsible role in further minimising the spread of HIV and avoiding infecting their partners, he contends. It is not necessary to create and develop a separate mechanism in addressing the sexual health needs of HIV positive MSM. It is just a matter of integrating these services into the existing facilities and infrastructures, and training health care personnel in the provision of the necessary services in an environment free from judgment and discrimination.

The need to empower HIV-positive MSM in order for them to take full responsibility for themselves, may pave the way to open up a dialogue with communities in a safe and enabling environment. Apparently, few MSM in the Asia Pacific region actually meet with

others outside of their usual social circles, unlike their counterparts in the West, who are often more open about their sexuality and sexual orientation.

Research into how HIV positive MSM can contribute to positive prevention among men having sex with men needs to be carried out with some urgency. The seventh ICAAP in Kobe, where close to 10% of the participants are reportedly MSM, could break the ice in bringing them together in a unique opportunity to discuss and identify issues that affect them and their roles in preventing the spread of HIV and other sexually-transmitted infections, further contributing to their meaningful involvement in the fight against HIV/AIDS.

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