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MOVING BEYOND COMPLACENCY TO RECLAIMING OUR FUTURE

Lessons from Africa and Asia for the Commonwealth

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HIV/AIDS - An Expensive Epidemic

As we enter the third decade of the HIV/AIDS epidemic, there is a body of medical literature on the disease; the epidemiology of the virus has a clearly defined trajectory of spread; the socio cultural nuances that lie entrenched in the causes and consequences of the epidemic are now documented; guidelines acknowledging the human rights of people living with HIV have been prepared and endorsed by nation states, and a number of commitments have been made by decision makers at all levels to stem the mutating virus. Above all it is now very well recognised that the accountability and responsibility to stop the spread of HIV/AIDS is a collective one and lies with leaders as well as the society at large. The price we have paid to get this body of knowledge has no doubt been high. More than 40 million people have been infected; close to 15million children have been orphaned and about 3 million men, women and children are succumbing to the mutating virus every year. It has been an expensive epidemic.

The good news however is that in many regions of the world the HIV/AIDS epidemic is still in its early stages. At the turn of the century, while 16 sub-Saharan African countries reported an overall adult prevalence of more than 10%, there remained 119 countries where the prevalence was still less than 1%.¹ This kind of a profile should by no means take us into a zone of comfort and complacency. It is important to remember that all countries have at some point of the epidemic been low prevalence countries. HIV prevalence among pregnant women attending antenatal clinics in South Africa was less than 1% in 1990 – until almost a decade since the virus was detected in the country. Yet a decade later in 2001, the country was experiencing one of the fastest growing epidemics in the world with a prevalence rate among pregnant women reaching 24.5%.² The clear message that these stark figures put before us is that countries that still have low levels of HIV infections should act now.

These kinds of exponential increases amongst women and girls is clearly affirming and reaffirming that gender inequality is driving and determining the impact of HIV/AIDS.

¹ UNAIDS – AIDS epidemic update – December 2001.

² UNAIDS – AIDS epidemic update – December 2001.

Now virtually half the infections in the world are amongst women, and in Africa it stands at 58%, rising to 67% between the ages of 15 and 24. A stark illustration of this is in Botswana, where a new sentinel site study was undertaken in 2003 to establish HIV prevalence, male and female, amongst all age groups. In urban areas, for young women between the ages of 25 and 29, the HIV prevalence rate was 54.1%; for young men of the same age, it was 29.7%.

Unless gender inequality, which rests on power relations, is specifically addressed at every level, our efforts to reverse the epidemic will be stalled. In the case of the epidemic, gender inequality is proving to be fatal.

HIV/AIDS – following a gender unequal path

The discourse on gender and HIV/AIDS is now about a decade old. As the epidemic matures, these gender concerns have become clearer and clearer. In most societies misconceptions about masculinity encourage men to display their sexual prowess through having multiple sex partners and by indulging in alcohol and other substances. This has negative repercussions for women who have to face unsafe sex and violence. Young women and girls are particularly susceptible. Furthermore safe sex practices become all the more compounded by the “culture of silence”, surrounding sex and sexuality which demands that “good women” remain ignorant about their sexuality, remain passive and subservient to men and abdicate all control over their bodies. Furthermore, safe sex becomes all the more difficult for women because the use of barrier methods of birth control can be problematic as bearing children is the ultimate sign of womanhood, of feminine ideal and of wifely duty. Low economic and social status restricts women’s ability to discuss fidelity and insist on condom use. One study found that only 35% of the women in the Philippines and 53% of the women in Iran felt able to talk about sex to their husbands.³ A study of low income women in long term relationships in Mumbai, India illustrates how economic dependency mars women’s ability to control their bodies. In addition to believing that they held too little economic leverage to alter their husband’s behaviour, the women believed that the economic disadvantages of leaving even abusive relationships far outweighed the health risks of staying in those relationships.

As we explore the consequences of the HIV/AIDS epidemic, these issues of gender injustices loom large. With more and more people living with HIV moving into the acquired immuno-deficiency syndrome, recurrent and protracted bouts of illness place an additional burden on already poor households. In most of the developing countries where health infrastructure is relatively weak but the epidemic is mature or is maturing, the financial and material burden of care tends to shift away from hospitals towards families especially the women in the families who provide home based care. This shift is marked by very special nuances.

1. Incomes decline – HIV/AIDS disproportionately strikes young adults at the peak of their productive and earning power. A five year study in Zambia⁴ revealed that the death of a father meant that monthly disposable income for a family fell by more than 80%. A community based study conducted in Zimbabwe it was found that out of the 268 respondents who had experienced a startling and devastating income decline, 77.6% were women.⁵
2. Medical expenses soar also. At the same time that families face the loss of income, they are also burdened with increased health care and transport costs to care for

³ UNDP Issues Paper N0. 3

⁴ Namposya-Srprell, 2000

⁵ Source- Community Impact of HIV/AIDS in Zimbabwe: A community based research report, UNIFEM 1999

those living with AIDS and the costs of burying people who have died of AIDS. The 2002 Human Development Report for Uganda revealed that households with an AIDS patient are spending as much as 61 percent of their existing incomes on health care and treatment alone. Add to this the enormous costs of burials - households in Kagera district, Tanzania were found to spend nearly 50% more on funerals than they do for medical care⁶, and the addition of dependants as a result of the death of extended family or community members. All assets and savings are therefore utilized to manage these costs and ensure the survival of the household.

3. Whilst household debt grows, its consumption decreases – the World Bank’s analysis in the United Republic of Tanzania found that the death of an income earner decreases the household’s food consumption by 15 percent.⁷ HIV/AIDS in a family never means only one death – it is multiple deaths. This kind of impact can be trying. A study in Zambia revealed that 65% of households in which the mother had died had dissolved.

A Treasure Chest of Lessons Learned

Countries that have housed the most mature HIV/AIDS epidemic today, can offer the world a treasure chest of lessons learnt that could be analysed and used effectively by other regions of the globe. Listed below are 3 critical learnings:

1 Including men as partners works! - As a result of campaigns over the last 4-5 years, there is now a recognition by men and women that men are driving the epidemic and women’s vulnerabilities are pushing them into the epidemic. Programmes undertaken in Tanzania and Zambia with men have successfully increased the personal risk awareness of men and increased condom use⁸. Thus some minor shifts in male behaviour have begun to take place through programmes like the MAP (Men as Partners) programme in South Africa or the PROMUNDO project in Brazil with young men.

The MAP programme in South Africa works with a wide range of men and women in both formal settings (such as workplaces, trade unions, schools) and informal settings (such as sports events, community facilities). MAP staff work at grassroots and leadership levels, seeking to increase men’s understanding of gender equality and skills for healthy relationships; improve men’s awareness of and support for their partners’ reproductive health choices; increase men’s awareness of and responsibility for prevention of STIs and HIV/AIDS; improve men’s access to sexual and reproductive health information and services; and mobilise men to take action to prevent domestic and sexual violence.

But there are not enough programmes like this to include men and boys as partners in the fight against HIV/AIDS, and a great deal more effort is needed to build a ‘social movement’ of personal, organizational and political action at community and national level to effectively address the gender dimensions of HIV/AIDS.

2 Peer Education works! - A second learning that has now emerged is that as a modality, peer education for increasing awareness about HIV/AIDS has worked well. Whether it is programmes that work with adolescents in school; or initiatives that are aimed at vulnerability reduction of sex workers and injecting drug users; or efforts at increasing the awareness of policy makers and legislators – it is the modality of peer education, (preferably backed up with access to appropriate services), that makes all the difference.

⁶ World Bank, 1997

⁷UNAIDS Report on the global HIV/AIDS epidemic - 2002

⁸ AIDS, sexuality and gender in Africa – Baylies and Bujra

Critical to this approach is the direct involvement of HIV positive men and women, boys and girls in designing and implementing prevention and awareness initiatives. They are most often in the best position to know what works and why, how to address the key challenges facing people with HIV and promote the need to live positively and responsibly. HIV positive people also play a critical role in breaking down stereotypes and destigmatizing HIV/AIDS amongst their peers.

The International AIDS Vaccine Initiative has been undertaking high level advocacy on the need for an HIV/AIDS vaccine working with parliamentarians in India, UK, Kenya, Thailand and South Africa using the peer counselling approach. The 'Stepping Stones' programme being used widely in Africa has also enabled communities to discuss gender and HIV/AIDS through structured peer education techniques. These efforts have not gone in vain. Peer education has worked at the highest level. In Africa the Heads of State from several countries have come together to form AIDS Watch Africa. At the grass roots level, the Entre Nous Jeunes project in Cameroon has demonstrated empirically that contact with a peer educator was significantly associated with stronger knowledge of contraception and sexually transmitted infections.

However, these efforts have thrown up further challenges and questions for development workers. Perhaps the most important question is that if social mobilisation is key to HIV/AIDS prevention, can peer education programmes be used as a means of social mobilisation? A social mobilization that can challenge stereotypical beliefs through a modality that enhances dialogue between stakeholders and personal interaction with and among those most at risk. In Nicaragua, a feminist NGO called Puntos de Encuentro is trying to focus on gender and sexuality norms through peer education so as to influence public opinion to bring about a cultural change. But as yet no definite results on the success of this initiative are empirically documented. Successful efforts at HIV/AIDS prevention, care and support, using the peer education approach, have been few and have not really moved from a project to an institutional level. In this sense they have not been able to mobilize whole societies. The rate of acceleration of the HIV/AIDS epidemic is today demanding that the "projectisation" of the 1990s gets transformed into "institutionalization" in the first decade of the new millennium. Is this just a fantasy? Can this really be done given the fact that sexuality and gender are two very difficult areas for institutions to internalize and adopt in their work?

The experience of the sex workers project in Calcutta – the Sonagachi project - is demonstrating that with the right vision, approach and determination, this can be accomplished. The project has got transformed into a movement of sex workers. The movement has spread from the red light area of Sonagachi in Calcutta, to other areas in the city and has even engaged in providing solidarity support to the sex workers in neighbouring countries like Bangladesh. This is social mobilization. Above all, HIV prevalence rates among the sex workers of Sonagachi have plateaued and remained at 5% over 7 years when all other red light areas of India recorded exponential increases reaching as high as 55% at the end of these 7 years.

We will now need to move the discourse from small successful projects to institutionalisation of gender and HIV concerns in development so as to catalyse positive change in the lives of large numbers of people. In doing so, capacity building of key stakeholders in "mainstreaming" assumes great importance. To enable this, over the last decade a number of tools and guides on mainstreaming gender and HIV/AIDS issues in development have been produced.⁹ Most of these tools describe how participatory approaches can help participants to identify their concerns and address them for HIV/AIDS

⁹ For more details refer to the Cutting Edge pack on gender and HIV brought out by BRIDGE development – gender compiled by Vicci Tallis - 2002

prevention with a gender perspective. Some are specifically aimed at local action for NGOs, while others give guidance on programmes with a broader reach including across different sectors.

And as we talk of institutional changes, we need to keep in view that institutional and individual changes cannot be achieved in a vacuum. The efforts put into making these changes need to be sustained by working towards transforming society in its entirety through a process of media advocacy¹⁰ and an inclusive political culture that is willing to engage in redefining stereotypes and that values and respects differences. An important learning in this area has been that HIV/AIDS is to a certain extent about “healthy choices” but this forms only one part of the picture. Another part of this scenario is that these choices are influenced by stereotypes and prejudices over which an individual has little control. The Voices and Choices project being implemented by the International Council of Positive Women in Zimbabwe is a case in point. The project succeeded in creating spaces for positive women but has yet to change the environment within which these spaces were located. A coordinated response that is multileveled, multifaceted and multisectoral in which media plays an important role at every stage is needed to transform societies. For this approach to be operationalised, new stake holders, new partners need to be sought, wooed and strengthened. A shift from business as usual has to take place and thinking has to move beyond the box.

3 Voluntary counselling and testing services are critical to HIV/AIDS Prevention - A third learning from the work over the last two decades is that voluntary counselling and testing (VCT) should be the main entry point for any work on HIV/AIDS be it prevention or care and support. It is also abundantly clear now that no work on prevention, on improving health infrastructures to enable access to anti retrovirals or on reducing mother to child transmission is possible without a good VCT system in place. Medical technology is of little use unless people know their serostatus. In addition, ongoing counselling will be needed to ensure that people availing of medical technology like AZT are supported, adhere to regimens and cope with the possible side effects. An example of successful expansion of VCT services comes from Uganda where the country’s AIDS Information centre (AIC) grew from a single site in 1990 to 51 in 2001. These centres have tested more than half a million people and counselled many more in HIV prevention. This has contributed directly in reducing the prevalence rate of HIV/AIDS in Uganda. The World Health Organisation’s ProTEST initiative which links HIV and TB in several sites of Africa and Asia has also shown how VCT can be used successfully as a critical entry point for any work on the AIDS epidemic. In South Africa this initiative has recorded a 95% acceptability of HIV testing following a pre test counselling of all persons attending.¹¹ In Zimbabwe the New Start programme uses franchising to provide VCT services of high quality. This is creating a national VCT network with a common logo and name which is promoted through media and communication campaigns. Unfortunately these success stories are few and far between and VCT is largely unavailable for most people in resource poor settings. Wherever it is available the quality of services offered has much to be desired. Not enough has been invested in the capacity building of counsellors or in the follow up support needed by these counsellors as they work to reduce vulnerabilities in two most difficult areas of women’s oppression – gender and sexuality!

¹⁰ Unfortunately there are any number of instances in which media has either reinforced existing gender stereotypes or created sensational news stories on people living with HIV/AIDS that have not respected the human rights of PLWHAs or people at risk of HIV/AIDS.

¹¹ UNAIDS Report on the global AIDS epidemic - 2002

It is clear however, that access to treatment must be provided alongside VCT and adequate care and support. The Treatment Action Campaign in South Africa is an important example of a community-based approach that has also effectively advocated for policy changes and service delivery, highlighting education and information as key tools. The involvement of HIV positive people has been an integral part of this approach, and has been highly effective in creating increased demand for treatment, access to VCT and other forms of care and support.

Signs of Complacency

A lot has been done, a lot more remains to be done. There are signs of complacency setting in. Some oft heard remarks from some of the most “informed” sections of low prevalence countries like the Asian / Pacific societies, are echoed below

- “The epidemic has a natural limit in Asia and the Pacific and could never “reach the scale being witnessed in Africa”.
- “If national prevalence rates are still low after all this time, there is no cause for concern and HIV prevalence will stay low even without active and sustained interventions. Our culture is going to save us”.
- “An epidemic among vulnerable groups has no implications for the wider society”.
- “Action can be delayed because the epidemic progresses slowly and requires less attention than other more urgent development priorities”.

The validity of these assumptions is highly questionable. Facts and figures are today pointing out that the number of new infections in Asia and the Pacific will be 18.5 m in 2010, as compared to 21 million new infections in Sub Saharan Africa in the same year.¹² In fact many “pockets” within some Asian countries have prevalence rates as high as the African countries. In view of the region’s large population base, even a low prevalence rate would translate into huge numbers. Example - a rise of just 0.1% in the national prevalence of India would increase the national total of adults living with HIV by half a million persons. Prevalence rates therefore are inadequate as warning systems. In fact the “smallness” of prevalence percentages in small populations like in some island countries should be viewed as a sign that could wipe away whole island communities. In the case of countries with large populations, the “smallness” of prevalence percentages should be seen as having a potential of slight increases transforming into large numbers of HIV positive in the population.

Reclaiming our Future

It is now critical that we de-accelerate the epidemic by a massive expansion of prevention efforts. We need to build on the learnings discussed above i.e. including approaches that involve men as partners, that use peer education approaches and that provide skilled counselling and voluntary testing facilities to men and women. The real shift in HIV prevalence levels can be recorded only once we can work at a national scale and not just in small pilots with small numbers of households. To illustrate this point development literature is today recording that the relatively low rates of teenage pregnancy and sexually transmitted infections in countries like Canada, Sweden and France in fact reflect the success of a comprehensive curricula for adolescents applied on a national scale. Programmes for young people are vital and must continue and be strengthened as each new generation approaches sexual maturity but not in pockets, it has to happen on a national

¹² Stover and others 2002 – Can we reverse the HIV/AIDS epidemic with an Expanded Response?

scale. Unless this is done the future looks bleak. An estimated 12 million young people are living with HIV today. But what is more disturbing is that half of all new adult infections are occurring among young people. The sex ratio of PLWHAs in the age group 15-19 years is unacceptably skewed against women. Involving young people in an expanded and comprehensive response to HIV/AIDS is therefore critical.

Effective access to treatment and female controlled prevention methods are critical elements of a gender-sensitive response to HIV/AIDS.

Women are twice more likely than men to contract HIV from a single act of unprotected sex, but they remain dependent on male cooperation to protect themselves from infection. Women need methods to protect themselves from HIV that they can control. A study in Zambia found that only 11% of women interviewed believed that a woman had the right to ask her husband to use a condom – even if he had proven himself to be unfaithful and was HIV-positive. Female condoms are not widely available, are more expensive to buy, have been found to be awkward to use, and still rely on men's consent to use it. Microbicide research is underway, if it becomes an effective prevention commodity, could fundamentally affect women's ability to prevent infection. But availability and affordability will be critical, and a great deal of work is still needed before this becomes an effective means of HIV protection, especially for women and girls.

One of the single most dramatic developments to address the HIV/AIDS pandemic in the recent past is the “3 by 5” Initiative – a decision by the World Health Organization, in conjunction with UNAIDS, to achieve the goal of three million people in treatment by the year 2005. For most people, there has been little incentive to go for an HIV test, and many live in constant fear and dread of finding out that they are HIV positive. Being HIV positive would feel like a death sentence if there was no access to treatment, and the possibility of a vaccine is still a distant dream. Moreover, the stigma of HIV/AIDS is still very great in communities, workplaces, amongst friends and relatives. But the 3 by 5 initiative has galvanised funding and action in many countries, and whilst it is not a panacea, it is an important step. The WHO states in its report “antiretroviral therapy does not cure infection and must be taken for life ... withdrawing or ending treatment will lead to the recurrences of illness and with it the inevitability of premature death. Lifelong provision of therapy must be guaranteed to everyone who has started antiretroviral therapy. Thus, 3 by 5 is just the beginning of antiretroviral therapy scale-up and strengthening of health systems”¹³. Since women make up the largest proportion of people living with HIV/AIDS, it will be essential to ensure that the 3 by 5 initiative ensures equitable access to antiretroviral treatment and care services to women, girls and children.

What have we learnt and where do we go now?

The successful pilots of the last 2 decades have shown us the way forward. We need to now take this light of learning into a much larger domain of action to be able to reclaim our future. The time is short the task is tedious and so a strategic approach is of the essence. The section that follows builds up on the 3 lessons learned described in the preceding section to suggest ways in which we could work to reclaim our future. These approaches are:

- Moving from small pilots to mainstreaming gender and HIV/AIDS issues in large mainstream initiatives

¹³ “Making it Happen” WHO report, 2003

- Identifying strategic partners in systems of governance that can catalyse a well coordinated and gender sensitive multisectoral response.

Moving from small isolated pilot endeavours to mainstreaming gender and HIV/AIDS into large public sector programmes

We are living in extraordinary times of hope and despair, trying to avert possible tragedies. Governments and civil societies have to be empowered to make vital choices. To make these choices in keeping with the emerging needs of men and women requires a gender sensitive leadership marked by vision and courage. Clearly, immediate implementation of a *comprehensive set of interventions* can avert a large number of future infections and reverse the likely course of the AIDS epidemic. What exactly do we mean by a comprehensive set of interventions? A comprehensive set of interventions categorically acknowledges that people have a number of interacting/overlapping spheres that shape their lives and even their destinies. So in order to prevent HIV/AIDS we need to work at 4-5 entry points in a person's life simultaneously. These entry points are the school he or she goes to; the health facility he or she utilizes (not just accesses); the social group he/she flocks with; the political lineage that he/she feels associated with at work and at home. Unless HIV/AIDS prevention issues are addressed at these portals of a person's life, the response remains incomplete and therefore inconsequential in the ultimate analysis. The last two decades of the history of the epidemic is replete with success stories of small very well orchestrated pilots that addressed sexuality education for adolescents in school and /or out of school but did not address the health facility where this adolescent went to seek a service related to his sexual needs.

Orchestrating a comprehensive set of interventions is possible through working with large public sectors that influence the lives of large numbers of people. For example in India the Indian Railways is a case in point. The Indian railway is the largest public sector of the country; employing 1.5 million people. It can bring about changes in behaviour that accelerate AIDS prevention efforts in the country by influencing close to 8 million people including the families of its employees that visit and use the large infrastructure of railway schools, railway staff training colleges, railways wives associations, railway trade unions and the railway hospitals. The lessons learned from such a large pilot can then be mainstreamed into other public sectors like the telecom sector, the postal sector, the mining sector, the plantation sector that have similar entry points all laid out for a comprehensive set of interventions.

Identifying strategic partners in systems of governance that can catalyse a well coordinated and gender sensitive multisectoral response-Translating strategies and plans into meaningful actions through the agency of audit

The operationalisation of a gender sensitive multisectoral approach to HIV/AIDS has as yet not happened in a meaningful manner. To seriously avert the possibility of national governments having to declare HIV/AIDS as a national disaster, a higher level of synergy amongst sectoral ministries is critical to tackle the impending threat. Systems of governance need to be geared up in time. The gap between policy and implementation has always dominated the polemic around HIV interventions. This gap is no longer just a topic of academic ruminations. It is starkly defining the quality of life of the people who were meant to be beneficiaries of HIV related policies and allocations. It is therefore logical and critical to enhance the capacities of the only agency that has the mandate to examine this gap and scrutinize the reasons for it – this agency is that of Audit. The tasks undertaken by the Audit – namely, the scrutiny of expenditures, the analysis of systems, an impartial analysis

of impact, and making policy recommendations implicit in its sometimes scathing observations – are tasks that have the capacity to influence future allocation & spending. This is an influence that is taken notice of at the highest policy making and implementation bodies. In most of the commonwealth countries, none other than the President of the country places the report of the Comptroller and Auditor General before the national parliament.

By working with the agency of audit we can influence the expenditure side of HIV plan interventions so that this expenditure can actually influence overall development. Dr Indrani Gupta, an economist from the Institute of Economic Growth in India, working in the area of HIV for about a decade now, has emphasized yet again that ‘any spending on development activities that does not encourage HIV learning and responses, in fact, counters development gains in the future’. She has, therefore, called for strengthening the impact analyses processes so that scarce resources are not wasted. The urgency with which we need to respond to HIV, demands of us that we challenge and stretch the mandates of various agencies, in order to mobilize, create and sustain informed commentators on HIV in every sector. The Comptroller and Auditor General’s offices are the natural domain of such commentators – influencing the expenditure side of implementation, influencing the weakest link in policy, i.e. implementation

Conclusion

Stover and others have done some interesting calculations. Overall, nearly one third of all global benefits from an expanded and comprehensive intervention package on HIV prevention would accrue to countries with large populations (Stover and others 2002).¹⁴

	New infections, 2002-2010			
	Number of countries	Baseline (millions)	Expanded response (millions)	Proportion averted by expanded response (percentage)
All low- and middle –income countries	126	45.4	16.9	63
<i>By region</i>				
Sub-Saharan Africa	38	21.0	8.8	58
Eastern Europe and Central Asia	24	2.8	1.3	54
North Africa and Middle East	15	0.9	0.3	62
South and South-East Asia	21	18.5	5.7	69
Latin America and the Caribbean	28	2.3	0.7	67

A delayed response would significantly reduce the total benefits measured in terms of new infections prevented. For example, the analyses suggest that a three-year delay in achieving full implementation of an expanded and comprehensive response would reduce by half the total number of new infections averted by 2010 (Stover and others 2002). Each year of delay would diminish the benefit in terms of new infections averted.

Freedom from disease in households will generate positive trends in household incomes, wealth creation, labour productivity, labour force participation, savings and

¹⁴ Sources : John Stover and others, “Can we reverse the HIV/AIDS pandemic with an expanded response ? , “The Lancet, vol.360, No. 9326, p.76.

investment rates among other benefits. Overall they will contribute towards creating a sense of well being among men and women in households. Evidence from Australia and countries in Europe indicates that health improvements over the last 100-125 years increased the pace of long time growth by 30-40%. In the United Kingdom and Northern Ireland, around 1/3 of the economic growth over the last 200 years has been attributed to improvements in health and nutrition. The story is all about creating social capital for human development.

Between 1960 and 1990 a number of countries have been witnessing a period of growth and development (not essentially equitable). They have seen a decline in poverty levels, dramatic reductions in infant and child mortality, increase in life expectancy and improvements in access to income, education, health care and sanitation since 1960. As a result of these improvements, foreign direct investment and tourism in many countries is beginning to strengthen economies. The threat of HIV/AIDS may potentially undo all this social and economic progress. A lot of the burden of disease caused by HIV/AIDS is avoidable; the transmission trends are now predictable. Let us commit ourselves to using this body of knowledge now so that we are not judged harshly by the generations to come! Let us move from complacency and reclaim our future!

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