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UNFPA's Response to HIV/AIDS: A South & West Asia Perspective



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1. Background and Scope of the presentation

This brief paper providing a perspective on UNFPA's response to HIV/AIDS in South and West Asia has been prepared for a panel presentation at UNFPA's Regional Corporate Meeting to be held in Bangkok on 15-18 December 2002. The focus on the presentation is primarily UNFPA's support in this area in the context of the Fund's mandate and the HIV/AIDS situation in the region. Section 2 highlights the Fund's global corporate strategy on HIV/AIDS prevention, the articulated institutional priority and situates the analysis in the organisation's HIV strategic directions framework. Section 3 provides a brief regional context on the current HIV/AIDS trends in South and West Asia and highlights critical issues. A summary of HIV prevention interventions reported in UNFPA country programmes as well as inter-country and regional initiatives is provided in section 4. Section 5 analyses the Fund's response from available evaluations of results achieved. A brief of the findings as well as 'lessons learnt' from the recent global thematic evaluation of UNFPA's support to HIV prevention is included here. Section 6 concludes with suggestions on strengthening HIV prevention in UNFPA country and development of value added regional/inter-country initiatives for HIV prevention in the region.

2. HIV Prevention: UNFPA's mandate and institutional priority

This section discusses the Fund's HIV prevention mandate and articulations as an institutional priority to situate this presentation in the organisation's mandate, particularly since feedback from the field shows that there is need for clarity on the same.

2.1 HIV prevention: UNFPA's institutional priority

Several UNFPA documents mention that HIV prevention has been given institutional priority. Firstly, the recent memos issued by UNFPA's Executive Director. In her 5 July 2002 memo the ED states "*..to ensure that all country offices take the priority of HIV prevention on board*" & "*..need to further strengthen our response*". Two memos in 2001 [24 May and 13 December] on the subject "Intensifying action for HIV prevention" articulate key areas for the Fund to focus and raise concern that "many of UNFPA's contributions in response to the HIV/AIDS epidemic are often overlooked or unknown even in the UN system, bilateral donors and public at large. This must change and among our responsibilities is to publicize and proactively inform all audiences *about UNFPA's active role in HIV/AIDS prevention.....*" A specific memo was issued on "Condom programming for prevention of HIV infection" which stated that "the purpose of the circular was to reiterate the importance of condom programming in HIV prevention and to underline our responsibility both at headquarters and

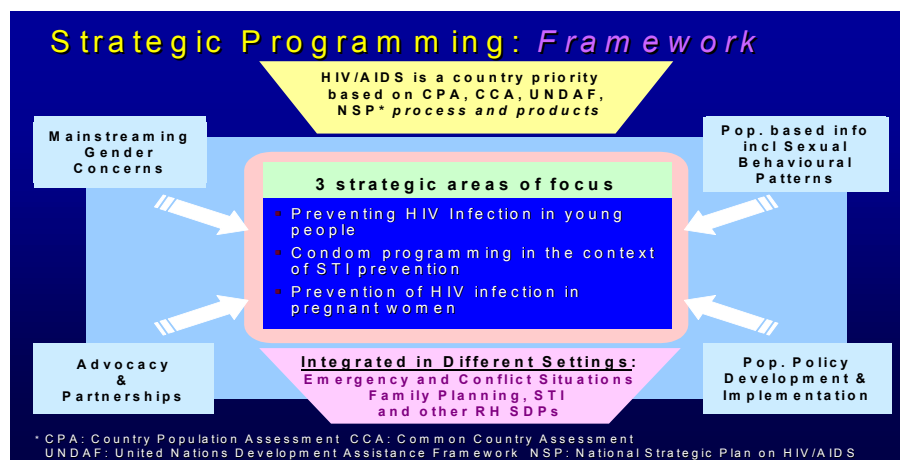
in the field to ensure that adequate support is provided for comprehensive condom programming at country level”.

Secondly, recent global actions within the Fund such as development of the HIV Strategic Directions document, establishing an HIV branch and technical capacity strengthening initiatives, tracking expenditures on HIV/AIDS, global thematic evaluations on HIV initiatives in UNFPA, UNFPA conferred the convening agency status BY THE UNAIDS CCO¹ in two areas- young people and condom programming- provide examples of the Fund’s commitment to HIV prevention and increasing responsibilities as a strong cosponsor. At global level an interdivisional working group on HIV/AIDS has been established to maximise UNFPA’s response to HIV/AIDS. Finally in the regional context, a recent August 2002 UNFPA document “Asia and the Pacific- A region in Transition” mentions that ‘.....Since HIV prevention has been given institutional priority, it has been integrated into RH/FP programs around the world.....’

2.2 HIV prevention strategic directions

The Fund’s strategic directions framework articulates that preventing and decreasing the number of new infections is the mainstay of UNFPA’s contribution to the global fight against HIV/AIDS. Prevention is also the challenge most appropriately and directly linked to the Fund’s primary mandate – to help ensure universal access to high-quality sexual and reproductive health services to all couples and individuals by 2015. In the overall framework for UNFPA action, in accordance with the ICPD Programme of Action, HIV/AIDS is an integral component of reproductive and sexual rights. The figure 1 below provides the UNFPA strategic programming framework. UNFPA proposes, for the period 2001-2005, to concentrate its support in three core areas: (1) Preventing HIV infections in young people (2) Condom [both male and female] programming in the context of STI/HIV prevention and (3) Preventing infections in pregnant women.

FIGURE 1



¹ Committee of Cosponsoring Organisations.

The key elements to which the Fund's HIV/AIDS prevention focus will contribute to progress being made in the Multi Year Funding Framework goals and outputs, namely, advocacy, strengthening national capacity, using an evidence and knowledge based approach, and promoting, strengthening and coordinating partnerships. However, in translating the Fund's global framework and strategic directions for country-level programming several aspects would need further contextual analysis. The next section discusses the South and West Asia context.

3. HIV/AIDS Situation in South and West Asia

A brief only on the HIV situation in South and West Asia and salient issues for the region is provided in this section as a context for discussion on UNFPA programming. For a more detailed review refer to other CST SAWA papers on HIV in the region and individual country profiles on HIV situation and responses.

3.1 Analysing SAWA² country data and statistics

As can be seen from the table and the SAWA region map at figure 2 below, the national HIV prevalence in SAWA countries is below 1 percent. Of the global 42 million people living with HIV/AIDS as of end 2002, 7.2 million are from Asia and Pacific and 4.14 million, that is, about 58 percent are in SAWA countries³. Best current projections⁴ suggest that an additional 45 million people will become infected with HIV in 126 low and middle income countries between 2002-2010 and more than 40 percent of those infections would occur in Asia and Pacific [currently accounts for 20 percent of new annual infections].

	Country	Total Population [thousands]	Number HIV+	HIV Prevalence (%)
1	India	1,025,096	3,970,000	0.8
2	Nepal	23,593	58,000	0.5
3	Pakistan	144,971	78,000	0.1
4	Sri Lanka	19,104	4800	<0.1
5	Maldives	300	<100	<0.1
6	Bangladesh	140,369	13,000	<0.1
7	Bhutan	2,141	<100	<0.1
8	Iran	71,369	20,000	<0.1
9	Afghanistan	22,474	NA	NA

Source UNAIDS 2002

(i) **Diversity:** The low national prevalence averages in SAWA are not particularly meaningful since they mask the dramatic diversity within countries and conceal serious localised epidemics. For example, India's national adult HIV prevalence

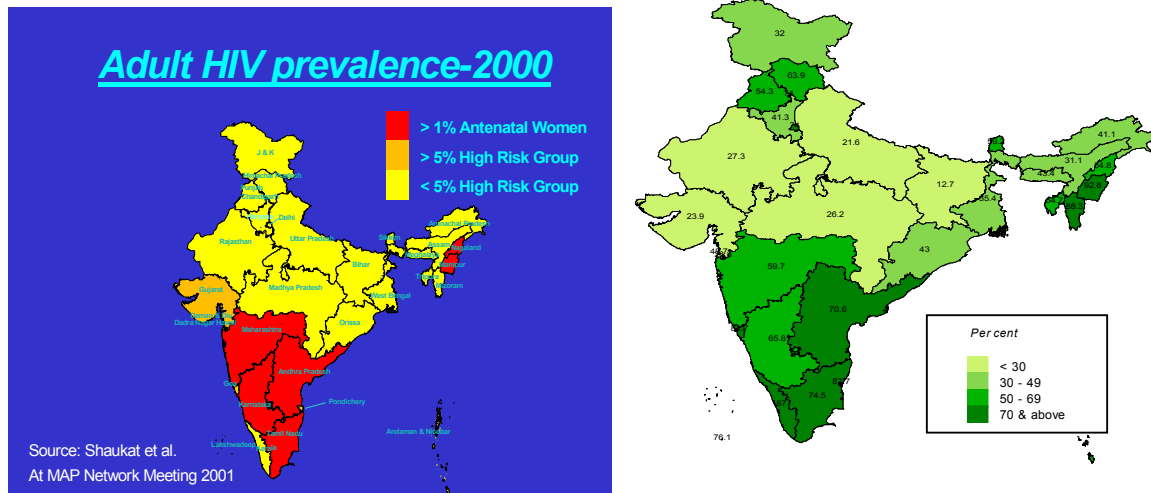
² SAWA stands for South and West Asia and includes nine countries in the UNFPA CST regional division.

³ Not including Afghanistan since no data is available from this country.

⁴ UNAIDS December 2002. HIV epidemic update

rate of 0.8 % offers little indication of the serious situation facing the country. Detected prevalence of HIV among pregnant women was higher than one percent in the states of Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu. Besides the varied epidemiological patterns in the sub region-high [selected states in India] concentrated [Nepal], low [Bangladesh, Sri Lanka, others], the countries have diverse capabilities to develop and support public health programmes.

FIGURE 2. Diversity within countries: Example India
% of women 15-45 who have heard of HIV



(ii) **Large population base & rapidly growing epidemic:** The low prevalence rates in the region also lose meaning because the population base is so large that even low rates imply that huge numbers live with the virus. Reports mention that the Asian epidemic is the fastest growing epidemic and that the ‘epicentre of the AIDS pandemic has shifted to Asia’⁵. Even in countries where the epidemic is localised or prevalent among specific population groups, there is a serious threat of it spilling over into the wider mainstream population. The future course of the AIDS pandemic will depend upon not only what happens in Africa but in Asia and Pacific. The sheer size of the region, being home to 60 percent of the world’s population, would significantly influence the overall impact of the AIDS pandemic.

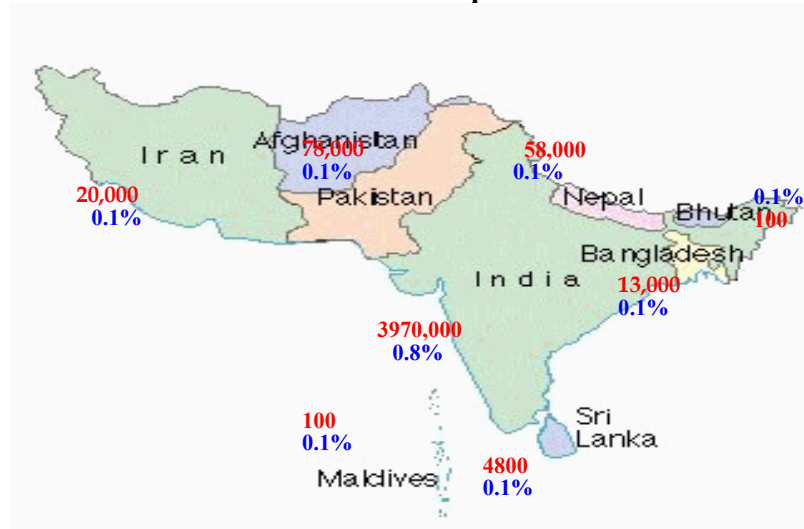
3.2 Low levels of HIV but signs of risk

High-risk behaviours such as unprotected sex between clients and sex workers, between men, and needle sharing are the major causes of spread of the disease in the region. Cross border migration in search of employment, proliferating sex trade, rising urbanisation, trafficking of women and displacement of refugees are worsening the situation. Movement of populations from low prevalence areas to areas of high prevalence and back again causes HIV to move with these populations. In Bangladesh and Nepal fewer than half of the sex workers have reported using

⁵ Asia and Pacific- A Region in Transition. UNFPA august 2002.

condoms with every client. Situations of conflict, violence and instability in some countries [Nepal, Sri Lanka] have increased the risk of HIV/AIDS in these countries. The section below discussed five issues relevant to UNFPA programming.

FIGURE 3 HIV Prevalence and positive cases in SAWA



(i) Knowledge and Awareness on HIV/AIDS: An analysis from the region on HIV knowledge and awareness shows that in general awareness and knowledge remains weak in rural areas and women [data from India and Nepal]. The new national behavioural surveillance conducted in 2001-2002 in India highlights difficulties in reaching key groups including large sections of the wider population [notably women living in rural areas]. More than 80 percent of the urban men recognized the protective value of consistent condom use compared to just over 43 percent women. As can be seen from the table below from the DHS data 19 percent women in Bangladesh had heard about HIV/AIDS compared to 90 percent in Sri Lanka.

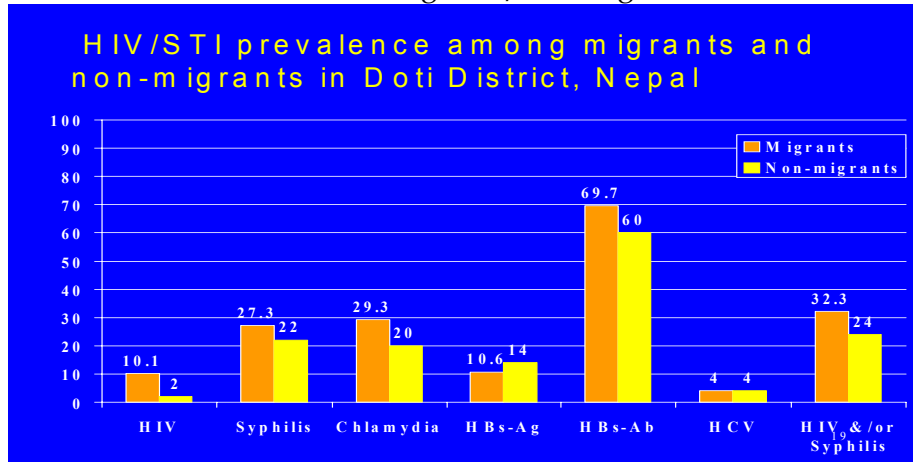
Table 2 Knowledge and Awareness on HIV/AIDS

Countries	Proportion of respondents who had heard of AIDS		Knowledge of ways to avoid getting AIDS -	Source/year
	Males	Females	Proportion of females not knowing any way	
Bangladesh	33.1	18.7	68.9	1999/2000 DHS
Sri Lanka	-	90.3	25	DHS
India	-	40.3	32.8	NFHS II 1999-2000
Pakistan	77 [overall]	42	-	RHFP Survey 2001
Nepal	72	50	58	DHS 2001

(ii) Migration and mobility: There is considerable external as well as internal migration in South Asia. Besides Nepal, Bhutan and India which share an open border, legal and illegal cross border mobility with huge refugee population is an issue in Pakistan and Bangladesh. About four million Pakistanis are estimated to be working abroad and most of them leave their families back home. Internal migration to urban areas and between states in India, workers in island resorts staying away

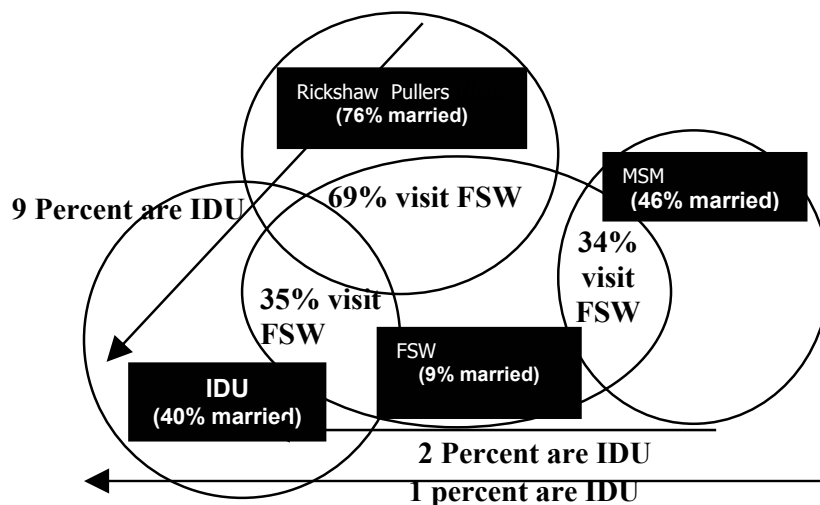
from their families in Maldives are other examples from the region. In Doti district in Nepal 44 percent of households had at least one member who had migrated to India for work. Table 3 below provides data on STI/HIV prevalence among migrants and non-migrants. The length of time spent in India was highly related to HIV infection.

Table 3. HIV & STIs in male migrants/non migrants in Doti District [Nepal]



(iii) **Sex work and bridging populations:** Commercial sex though illegal is prevalent in India, Bangladesh, Pakistan, Nepal. What determines whether or not an HIV epidemic spreads outside the groups of people with highest risk behaviour is the sexual linkages between the populations with highest risk behaviour with those with low level of risk. The links are not necessarily between only one group and another. One example from central Bangladesh [figure 2] shows these multiple simultaneous links.

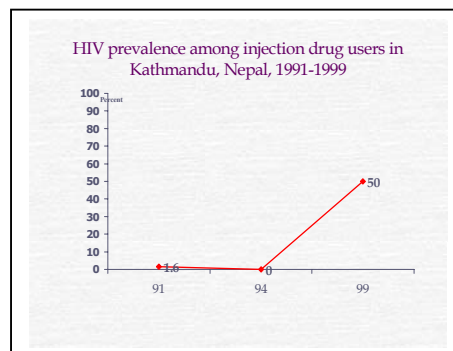
FIGURE 4. Potential spread of HIV from high risk groups to the general Population Central Bangladesh



(iv) Intravenous drug use in the region:

One of the first populations to be affected by HIV in Asia were injecting drug users. In areas where drug in injection has been long established, such as Manipur in North-Eastern *India*, HIV prevalence rates of over 40 percent have been recorded for several years. In 1999 a startling survey in 19 cities of *Nepal* showed a national overall HIV prevalence of 40 percent with Kathmandu registering 50 percent of its IDU population positive (figure 5).

FIGURE 5



HIV infection surfaced in drug injectors in *Iran* in prison populations in 1996. 29 percent of injectors were found to be HIV infected even though testing throughout the early 1990's found only sporadic cases. By 2001, 10 prisons reported HIV infection among injectors with one site reporting as high as 63 percent. Increasing number of drug addicts with a rise in IDUs is reported from *Pakistan* [60,000] mainly in urban areas. The Maldives HIV Strategic plan 2002-06 mentions the threat of injecting drug use though currently this is not the main form of drug administration in this country. Majority of the IDUs are young people. Also a large proportion of the population in SAWA countries in youth.

(v) Poverty and Gender:

Apart from being very populous, the region is dominated by high levels of poverty in many countries. Women in this region constitute the poorest of the poor people. High-risk behaviour patterns get aggravated by poverty, lack of education and economic inability to access RH services. HIV /AIDS is driven by attitudes related to gender roles. The estimated number of females living with HIV/AIDS in India is double that of males in the 15-24 year age group (Table 4).

Table 4. Estimated No. of young people living with HIV/AIDS end-2001

Countries in South Asia	Estimated young people 15-24 yrs [low]	
	FEMALE	MALE
Bangladesh	980	1100
Bhutan	-	-
India	430,000	220,000
Maldives	-	-
Nepal	4000	4100
Pakistan	4600	5800
Sri Lanka	490	400

Source: [32]

Millions of women and girls because of their subordinate position in societies and economic dependence cannot insist on fidelity, demand condom use, or refuse sex to their partner even when they suspect he is already infected. Abuse and violence against women, and lack of recourse measures and of legal and social protection, increase this vulnerability. Cultural beliefs and expectations about 'manhood' often encourage risky sexual and drug taking behaviour in men. This puts them and their partners at heightened risk.

3.3 HIV policies and strategic plans in SAWA & UNFPA focus areas

Most countries in SAWA [except Bhutan & Afghanistan] have an articulated final or draft HIV/AIDS policy and/or strategic plan. Brief extracts from the documents from the available seven SAWA countries vis-à-vis inclusion of UNFPA focus areas in HIV/AIDS is given below:

- **Pakistan:** The National HIV/AIDS Strategic framework 2000 identifies 'vulnerability of young people to HIV/AIDS' as a priority area/goal. Condom programming figures as a behavioural objective 'use of condoms with non regular sexual partners' in the Enhanced HIV/AIDS Control Program July 2002 document.
- **Nepal:** The final draft [July 2002] Nepal's national HIV/AIDS strategy includes a separate section on young people where detailed strategies for creating a supportive environment, BCC, youth friendly services are mentioned. The paper also mentions prevention of mother to child transmission though the important first prong of primary prevention in pregnancy is mission in the strategy. 100% condom use and female condom is included for social marketing in high risk populations.
- **Maldives:** The Strategic Plan for prevention and control of HIV/AIDS 2002-2006 mentions the target group of young people for knowledge and life skills. Social marketing and current limited access to condoms is also mentioned in the document.
- **India:** The National AIDS prevention and control policy in its objectives mentions " To promote better understanding of HIV infection among people, especially students and youth..."Under the strategies 'Promotion of condom use as a preventive measure" is mentioned in the document and specific strategies for the same in terms of social marketing, CBD and many others are articulated.
- **Iran:** As informed a new strategic HIV plan is under preparation in Iran. However, the review of the earlier plan [2000] shows inclusion of a specific section on young people including awareness education in schools, through NGOs and others. The document mentions a constraint of 'sensitivity on condom use' and articulates 'importance of using condoms during temporary marriage relationships'.
- **Bangladesh:** The priority strategies in the 1997-2002 draft strategic plan reviewed include both the UNFPA focus areas –"accessibility and use of quality condoms and promoting responsible sexual behaviour of young people both in and out of school.

- **Sri Lanka:** National Strategic Plan 2001-2005 mentions 'youth' which constitute a substantial proportion of the population as a program target group as well as school children. The strategy articulates special emphasis on the use of condoms. The Sri Lanka plan includes PMTCT.
- **Bhutan:** Though Bhutan does not have a formal policy document yet, the recent UN system desk review document in its various recommendations articulates need for addressing out of school young people and strengthening condom programming including social marketing.

The above policy/strategy analysis from SAWA countries on the articulation of the UNFPA focus areas shows that all of the policy strategic plans include the two aspects of prevention in young people and condom programming in targeted interventions in the strategies thus reiterating the Fund's programmes in countries in the region to develop strategic support in these focus areas. Prevention in pregnancy is not mentioned per se in any document though PMTCT finds inclusion in strategic plans in Nepal, Bhutan. India is the only country implementing a PMTCT programme in the region. However, there are no examples of operationalising the PMTCT first prong of primary prevention in the region and demonstration project for scaling up would be an area for the Fund's support.

4. HIV Prevention in UNFPA CPs in the region

The December 2002 UNAIDS report mentions that the window of opportunity for bringing the HIV epidemic under control is narrowing rapidly in Asia. This section examines UNFPA's response to HIV prevention in the region in (1) the on going country programmes (2) New country programmes being developed this year and (3) Supportive regional/inter-country initiatives.

4.1 HIV prevention in UNFPA CPs⁶

This section provides a brief on UNFPA activities in on-going HIV/AIDS programmes in the countries. The compilation of the reported activities has been done the three UNFPA focus areas - young people, condom programming and primary prevention in women.

(i) Preventing HIV infections in young people

The regional EC/RHI project in Sri Lanka through six national NGOs established counseling centers, trained community leaders as counselors, and developed IEC material on adolescent health including HIV/AIDS. The Sri Lanka project report that 228 service delivery point were established and 98,000 young people between the ages of 10-24 counselled. RHI in Nepal also includes youth friendly services through a NGO. In Bangladesh the population and reproductive health education projects for primary, secondary and technical/vocational systems during 2001 built national capacities through training of master and core trainers, teachers and inter-country study visits. *Telephone counseling* component was strengthened in India

⁶ This includes inputs from UNFPA country office reports on HIV/AIDS prevention activities during 2001.

through training of telephone counsellors and operationalising of telephone counselling as well as online AIDS counselling. Lessons learnt from Bangladesh and India articulate that family life education needs to address sensitive subjects including gender and need for skill building of adolescents and counseling. The non-formal, family life education project in Bangladesh with the primary and mass education division of the Ministry of education during 2001 supported training, materials/manuals and reaching out to young people through NGO sub-contracts for training in village education centers.

(ii) Condom programming for HIV/STI prevention

Specific activities in countries ranged from support to condom vending machines, commodity, programming through community based distribution [CBD]. In India district projects in Rajasthan and Orissa through an innovative CBD project supported condom programming. Activities during 2001 included training of voluntary couples, establishing depot holders in targeted villages and condom distribution for both family planning and STI /HIV prevention. In Nepal UNFPA provided support to NGOs for 'Condom Day' advocacy as well as supply of condoms. Technical assistance was also provided for monitoring condom needs and logistics under the UNFPA supported project. In Maldives, UNFPA provided commodity support for 4391 condoms in 2001 for dual protection-both FP and HIV. In Sri Lanka, UNFPA supported 73 condom vending machines to civil society organizations, the armed forces and various family planning NGOs. To support condom promotion UNFPA supported development/design of a condom promotion folder in Sinhala and Tamil.

(iii) Preventing HIV infections in women/pregnant women

In Bangladesh through a national RTI/STI case management project training was provided to different levels of health professionals and availability of services at Upazillas. STI case management services were also supported in the UNFPA India integrated population and development projects at district level. In Nepal, HIV/AIDS components were incorporated in revised training manuals for MCH workers for counseling at the community level. The Maldives program also reports that IEC activities on STI/HIV have been integrated into the RH service project. Community coordinators and volunteers received basic training in RH issues including STI/HIV. The Maldives program also supported a clinical and laboratory based study on RTI/STI prevalence.

(iv) Advocacy and enabling environment

In Nepal, about a dozen programmes were broadcast on HIV/AIDS, male responsibility through national radio channels. In collaboration with UNAIDS Nepal, UNFPA supported National AIDS day led by the Prime Minister of Nepal. Funds and technical assistance was provided towards revision of the National HIV/AIDS Strategy. In Sri Lanka, support for RH /HIV advocacy was provided to the Women's Bureau through training in public speaking and advocacy. The Bureau trained a cadre of personnel who in turn helped in developing the advocacy skills of 475 women's society leaders and members to sensitize the women in their

community. In Bhutan, Her Majesty the Queen , UNFPA Goodwill Ambassador has advocated for HIV/AIDS prevention in various forums. In Bangladesh two projects with religious leaders and garment workers integrated HIV/STI messages as well as services in the latter.

(v) Miscellaneous Country level initiatives: In Pakistan UNFPA provided ad-hoc support through UNAIDS amounting to US\$10,000. HIV/AIDS rapid testing kits and provisions necessary to prevent HIV transmission were included in emergency kits provided by UNFPA HQ to war affected populations within each country and among refugee camps [Sri Lanka, Afghan refugee camps]. In Sri Lanka auxiliary health workers were also trained in HIV/AIDS prevention and inclusion of HIV in the training manual under the conflict areas project. In India a multi-centric study on sexual behaviour was completed.

3.3 HIV Prevention in new country programmes in SAWA

Annex 1 provides a matrix of analysis on HIV prevention in the five new country programme outline documents from this sub-region for next five years. As can be seen from the analysis table, HIV/AIDS finds inclusion in the reproductive health programmes as integrated activities with maternal health, RH services, RTI/STI training. Adolescent reproductive health/young people are mentioned in all five new CPs as focus areas. However HIV is mentioned as integrated with ASRH services in three of the five. Contraceptive programming, procurement and logistics find mention in all five documents in various ways. However specific condom programming for HIV prevention is not articulated. The Sri Lanka programme mentions PMTCT support in the CP including antenatal screening. The UNFPA component of primary prevention in pregnancy is not articulate as a strategy in any of the documents. The country programmes when developing project documents need to examine inclusion to specific HIV prevention activities and indicators to ensure results in this area at the end of the programming cycle.

3.4 Regional Initiatives

The regional initiatives related to HIV programming in SAWA include the UNAIDS inter-country UBW programmes in countries in the region: Nepal [young people]; India [VCT], Bangladesh [needs assessment tool for condom programming for HIV], sex workers [Sri Lanka]. These related to demonstration/pilot initiatives on VCT and condom programming. A regional review on condom programming for HIV prevention was developed to identify policy and program issues to strengthen condom programming in the region. A specific South Asia review paper on the female condom was developed to support programming in this new area in the region. Advocacy initiatives include a symposium was organized at the ICAAP at Melbourne where UNFPA goodwill ambassadors from India and Bhutan participated. Regional partnerships with UNICEF ROSA and UNDP established in the region with collaboration in HIV/AIDS workshops on young people and PMTCT.

As can be seen from the above reported activities from the region, varied initiatives of support to HIV/AIDS have been reported from countries and regional projects integrated with other activities. Unfortunately, there is no report available on contributions to any HIV prevention results due to paucity and limited use of monitoring indicators related to HIV/AIDS as well as impact evaluations of country programmes in this sector. In January 2002 UNFPA conducted a global thematic evaluation of its support to HIV/AIDS in which one country from SAWA-Bangladesh- was also included. The evaluation report has provides a strategic assessment on the Fund's support and pointers for strengthening programming for HIV prevention. This is discussed in the next section.

5. Evaluating UNFPA's support for HIV prevention

The recent 2002 global thematic evaluation on HIV/AIDS addresses three questions: *Is UNFPA doing the right things? Are we doing things right? And is the Fund's support making a difference?*

The evaluation reports that the Fund has made broad progress in integrating HIV in country programmes that it supports. However, a relatively small amount of the programmes resources were spent in targeting interventions to those most at risk. Some findings from the evaluation of relevance to South Asia include:

- HIV prevention activities were scattered in among various projects, reaching different groups in disparate locations and circumstances.
- The country offices visited did not have sufficient technical and managerial capacity to ensure that the HIV interventions they support are of good quality.
- Interventions supported by UNFPA were in the case studies not based on a clear process of problem identification and analysis on HIV/AIDS, did not identify specific results to be achieved in terms of behaviour change or services and lacked indicators for monitoring.
- There were successful innovative interventions such as with religious leaders in Bangladesh, although the HIV/AIDS content was small.
- The evaluation found that the results of the Fund's STI and HIV related interventions at the country level were not very visible, particularly at public health facilities and schools.
- Accurate expenditures for HIV/AIDS activities are difficult to calculate due to the integrated nature of most interventions.
- Efforts to prevent HIV/AIDS are too small in each country to have a measurable impact on the HIV/AIDS pandemic.

Also, there is limited rigorous documentation of project experiences resulting in paucity to showcase the same. For example, the recent UNFPA HQ publication on the region " Asia and Pacific- A region in Transition" in its chapter on HIV/AIDS reports on one experience from SAWA Maldives [given in box below]. For

meaningful knowledge sharing and advocacy there is need for more examples of specific HIV/AIDS interventions and results from the region.

“In Maldives, Friday Sermons broadcast live on radio are powerful channels for reproductive health and advocacy. Radio and television spots dealing with family planning, adolescent health, HIV/AIDS prevention, under age brides and early pregnancy have also become common in Maldives, Bangladesh.....” Asia and Pacific- A region in Transition” UNFPA August 2002

6. To conclude:

As mentioned in the section [2.2] above, the Fund now has corporate strategic directions for HIV programming. However, in translating this global framework and for country level programming there are several aspects which would need further and contextual analysis particularly with shrinking UNFPA country programming funds, competing priorities for limited funds, expectations of concrete results including related to HIV prevention, issues related to integrating HIV prevention in on going supported activities, support to scaling up and/or piloting demonstration interventions, need for clarity on the Fund’s HIV support vis-à-vis other cosponsors [for example in the area of young people] and avoiding duplication and adhoc support for one time activities, how to provide value added support in the priority areas when there are already substantial available and programmed funds in countries [such as through World bank loans] which are having difficulty in spending in countries [For example in Bangladesh].

Some suggestions for strengthening HIV programming in SAWA countries:

- **Focused HIV Prevention in UNFPA CPs:** This review as well as the global evaluation inform of many scattered HIV activities in different projects even in small country programmes. UNFPA CPs in the region are recommended to focus their limited funds in HIV prevention programming in one-two critical country focus areas only rather than spreading over many projects. This would be useful for visibility, results as well as technical capacity building. Prevention in young people and condom programming for HIV prevention are included in all national strategic plans and policies from SAWA and it would be useful for country programmes to focus attention to these two areas and develop partnerships with the National AIDS organisations in the region.

- **Strategic selection of HIV prevention activities:** The selection of specific HIV interventions as part of country programme needs to be a *strategic* process: by examining the pattern of the epidemic, the evidence of what works best in the country situation, the comparative strengths and weaknesses of the country office and potential implementing agencies and support of other donors taking into consideration the issues raised in the above section. There emerges a need for sharing of experiences on how UNFPA country programmes have or have not been able to grapple with the issues in the first paragraph of this

section for use in future programming and development of a program guidance tool based on field experiences.

- **Strengthening HIV indicators & monitoring of this component in CPs:** The approval of the Fund's support to HIV/AIDS prevention needs to be more rigorous as well as the monitoring and evaluation through accepted, proven and measurable indicators⁷ specifically for HIV. For example ASRH integrated programme support envisaged in the new CPs to include indicators on HIV prevention. Documentation of experiences in the HIV prevention programming needs to be strengthened and budget earmarked for the same.
- **Global Fund and UNFPA:** An area where UNFPA is suggested to support countries and governments [as part of the UNAIDS co-sponsors] would be in support in the proposal development /operationalisation related to the Global Fund, particularly in the UNFPA focus areas. This would require institutional capacity building for strategic programming in the area of HIV/AIDS which is also envisaged as part of the Fund's global /regional efforts.
- **Developing linkages between global UBW, regional inter-country and country HIV/AIDS programming:** Regional and inter-country projects are currently developing tools, guidelines and supporting demonstration activities in HIV prevention from the current UNAIDS Unified Budget and Work plan [UBW]. There is need to establish linkages and synergy between these and country programme activities so that the regional initiatives are value-added for country programming. For this inter-country initiatives need to be developed in close discussion with the field for effective utilisation of the tools and products. Documentation and mechanisms for experience sharing of the regional /inter-country UBW initiatives need strengthening for the Fund's visibility also in this sector as a strong co-sponsor.

⁷ UNAIDS- National AIDS programmes: A guide to monitoring and evaluation June 2000

ANNEXURE 1. Analysis of HIV/AIDS in new CP outline documents – SAWA

Country	Nepal	SriLanka	Bhutan	Bangladesh	India
Programme cycle	Fifth 2002-2006	Sixth 2002-2006	Fourth 2002-2006	Sixth 2003-6	Sixth 2003-2008
Version/ date	14 Dec 01	17 August 01	13 Aug 01	November 01 Draft	Feb 2002
HIV national Prevalence	0.5%	<0.1 %	< 0.1 %	<0.1 %	0.8 %
Resources Regular [R] Multi/bi [MB]	\$ 17.5 million -R \$ 18 million-MB	\$ 5 million-R \$ 2 million-MB	\$ 4 million-R \$ 1 million-MB	\$ 21 million-R \$ 4 million-MB	\$ 60 million-R \$ 15 million-MB
HIV/AIDS in Sub-programme outputs					
RH sub-programme	Output includes HIV information and counseling	Mentioned as part of maternal health/ Mgt of RTIs	Outputs include HIV/AIDS information	Mentioned as part of maternal morbidity/women's health	Mentions integration of HIV in RH services
PDS sub-programme	No mention of HIV/AIDS related outputs/strategies	No sub programme mentioned	Includes advocacy on HIV/AIDS	No mention of HIV/AIDS related outputs/strategies	No mention of HIV/AIDS related outputs/strategies
Advocacy sub programme	No sub-programme	Advocacy for RH includes HIV	No sub programme	No mention of HIV/AIDS related outputs/strategies	Advocacy section includes HIV
HIV/AIDS programming & UNFPA Priority areas					
Young people	Adolescent programming but no mention specifically X**	Adolescent programming but no mention specifically Of HIV/AIDS prevention X	Mentions HIV/STI integrated with RH for Young people	In women's health section, young people are mentioned as focus for HIV information	Adolescent programming indicator on HIV included
Condom Programming	Contraceptive procurement and logistics	Contraceptive procurement/logistics mentioned but not condom programming for HIV	Support to contraceptives including condoms	Pilot testing for female condom. No condom programming for HIV/dual protection	Expanding contraceptive mix, CBD and social marketing support.
Prevention in Pregnant women	X**	Antenatal screening for HIV *** PMTCT IEC	Training in STI	X	Meeting needs of women who have competed childbearing X

** Nepal- though the CP document does not mention any of the UNFPA priority areas for HIV/AIDS programming the RH sub-programme document and log frame has included a specific output related to HIV/AIDS which includes focus on adolescents and condom programming.

*** SriLanka CP outline specifically mentions UNFPA support to 'antenatal screening for HIV in a high risk area of the country'. This is the only CP to move into programming in this area in the region