

Voices to policy: Anandi Yuvaraj, International Community of Women Living with HIV (ICW)/Asia Pacific Regional Network (APN)

As a woman living with HIV representing our regional networks ICW (International Community of Women Living with HIV/AIDS) and APN (Asia Pacific Network), working with HIV prevention, care and treatment programs has provided me with many opportunities to interact, influence and mobilize people and systems in a range of settings and at many levels in India, regionally, and internationally. I have seen many women, particularly women living with HIV/AIDS, speaking up and taking an active role in mobilizing other HIV-positive women, educating them about the virus and imparting skills on how to cope. To me, this is a solid indicator of empowerment. Unfortunately, this empowerment is happening after the women are infected and not before – as it should. We should be empowering adolescents, giving young women and men a variety of HIV prevention tools, including life-skills education within gender- and rights-based framework. Unfortunately, women are not funded to share these best practices. I strongly advocate with member states to invest in women and girls as equal partners with legitimate experiences to learn from.

I happened to visit a group of women living with HIV in Cambodia Mekong river region and I was told they didn't have access to safe water despite the fact that the Mekong river is flowing only 1000 meters away. They said "We now have access to HIV treatment, but do not have access to safe water, so we suffer often due to water borne infections such as diarrhea. We all know how our governments and policy makers talk about the need for installing oil pipelines from one continent to another in the name of economic development undermining the health related development that meet the needs of women in the community."

We all know women deliver the world- now world needs to deliver for women!

I would like to bring up another burning issue from my regional perspective. Viral Hepatitis B and C infection are silent epidemic within HIV context and most people who inject drug use are already infected with Hep C. These can be effectively treated, but the treatment uptake is extremely low because its simply unavailable or prohibitively expensive and this is a direct impact of Intellectual Property Rights issue that our colleague from Third world network raised yesterday and today. People living with HIV from IDU community are dying of Hep C even if they are on HIV treatment. Evidence shows that providing integrated and patient oriented treatment services are effective and there is an urgent need to

scale up the capacity of service providers in the public health system to deliver these services.

I have also noticed that while we all work very hard to make wonderful commitments, statements and agreements among various stakeholders, a huge gap exists in translating these commitments and agreements into realistic and meaningful community-level programs. Often, we do not have the patience to implement our own policies. By the time we maximize the impact of one policy, by establishing concrete programs, we introduce new policies uninformed by on-the-ground realities. For example attempts at country level to criminalize the transmission of HIV, does not have any public health benefit and goes against a human rights framework. This way we bring everything to a standstill and cause confusion at ground level, preventing us from achieving the goals and objectives that we set for ourselves.

At other times, we do not have the courage just to scale up programs that work, or to challenge each other about whether policies and programs really make any difference in people's lives. We all know, for example, that direct engagement of those people most affected by the epidemic – sex workers, MSM, IDUs and people living with HIV/AIDS – in policy and program design, development and implementation improves success. Still, we have never developed indicators to measure their involvement, nor we have developed concrete country-

level plans to increase the engagement of at-risk and HIV-positive communities. If this situation continues, Universal access will just remain as a plan in our records and will never be achieved.

Many governments recognize that the face of HIV/AIDS is increasingly female as the epidemic matures. For example in the Asian context, over 40% infections occur among women and girls and over 60% in sub-saharan context. We do not need more data to demonstrate that we should scale up our work with women and girls. However despite these numbers few governments have had the courage to examine the social- and gender-based factors that put women (and men) at risk of HIV infection or other social epidemics, including violence. Everybody wants to find the 'magic bullet' that will reduce the rate of HIV infection among women, but without giving women real economic, social and political power and enabling them to take control over their lives. The effectiveness and uptake of all existing and new HIV prevention tools including and technologies depends and will continue to depend on how far we have integrated gender responses into strategies. Investing in women controlled tools and technologies such as microbicides and increasing female condoms are critical to meet the needs of women and girls and meet the MDGs.

In terms of funding in health related MDGs, success of one MDG depends on progress in all the others as indicated by the GFATM board statement: More money for health will translate into more health for the money. The forthcoming G8, G 20 and MDG summits will have to demonstrate real commitment backed with real money in real time. The Global Fund must be replenished!

There are great many emerging examples in terms of what works and how scaling up one response can increase the utilization of other services targeted through another vertical intervention. In line with my co-respondent Joanne's statement, For example in Haiti, GFATM funding was found to benefit health systems, vaccination among children increased as a result of this.

Success of treatment programmes in the HIV context depends on treatment adherence and literacy. The community of people living with HIV has provided the majority of the interventions around HIV treatment literacy through a peer approach and there is no mention of the need to prioritize treatment adherence and literacy in national strategic plans at country level. As such, there have not been resources allocated to the provision of treatment adherence and literacy programs in the India context.

Last, but not least I would like to leave you with this thought: We as civil society advocates have still not fully learned the lessons from various development

programmes to leverage on the momentum that we have to achieve the MGs goals and beyond. Let us share these lessons learned with each other to achieve a common goal, that is health and development for all. For us MDGs are a window of opportunity to hold everyone accountable including ourselves – both politically and financially.

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