

**Statement by Dr. Nafis Sadik
Special Envoy of the UN Secretary-General
for HIV/AIDS in Asia-Pacific**

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**WHO Working Group, HIV and TB: Special Role for
Women and Families**

**Opening presentation
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Thank you for inviting me to present at this important meeting. Understanding the interaction between TB and HIV, and acting on what we know, will be vital in turning back the interlinked epidemics of HIV and TB in Asia and the Pacific.

Almost 5 million people were living with HIV in Asia in 2007. But the trends vary by region and country. In many parts of Asia, HIV epidemics are concentrated in high-risk groups, such as sex workers and injection drug users. But in other countries, for example India, HIV has spread to the wider population, including women in stable unions, a group previously thought to be at low risk of infection.

More than half of the world's TB disease occurs in the Asia Pacific region. And despite being curable and preventable tuberculosis remains one of the commonest causes of illness and death among people living with HIV, causing almost 1 in 4 of all HIV deaths.

But there is good news. You have been hearing yesterday about the impressive scale up of an integrated TB/HIV response in many

countries in the region but I fear that the needs of women are not yet being fully addressed. As the UN Secretary General's Special Envoy for AIDS in Asia and the Pacific and former Executive Director of UNFPA I would like to champion the specific needs of women in relation to the co-epidemic of TB and HIV.

Women's vulnerability to TB and HIV is complex and varies in different settings. For physiological reasons women are more vulnerable than men to HIV infection. Social, economic and cultural factors can exacerbate their vulnerability to HIV infection and TB disease and create barriers to women accessing HIV and TB services. Delayed diagnosis and access to treatment can greatly increase the negative impact of these diseases on women and their families.

Poverty and malnutrition are strongly associated with tuberculosis. Migrancy, whether voluntary for economic reasons or forced due to trafficking, can further increase the vulnerability of women and their families to TB and HIV, and create particular challenges for continuity of care.

Stigma, attached to both diseases, can be particularly harmful for women. There are very real fears that HIV infection or TB disease will prevent them from being married; or lead to rejection by their husbands and social exclusion for themselves and their children. They are reluctant to seek testing or treatment because of what they might discover, or what people might think. In regions where women cannot travel alone, it may be difficult for them to persuade male relatives to take time off work to accompany them.

Gender issues although frequently discussed in the context of HIV prevention and treatment are seldom discussed in the context of TB control and most TB programmes, until recently, have not reported the outcome of treatment by age and sex, so we rarely know whether women on treatment have equal treatment outcomes to men.

While integrating the delivery of TB and HIV services we also need to make sure these services meet the specific needs of women. We need to explore the benefits of integrating TB and HIV services with sexual and reproductive health care services. Can home-based family counselling and testing for TB and HIV extend reach and increase uptake?

This region has a long history of women's and community activism. We must build on this to empower women socially and economically to take greater control of their own health and that of their families.

These difficult economic times call for determined leadership to ensure that the integrated TB/HIV approach meets the needs of women. But it is only through such determined leadership - specifically in favour of women's health, education and empowerment – that we will enable women to emerge from poverty, to stay healthy, to raise their families and guarantee the continued social and economic development of the region.