

HIV in Asia and the Pacific:

# GETTING TO ZERO



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JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

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WORLD BANK



**ZERO NEW HIV INFECTIONS**  
**ZERO DISCRIMINATION**  
**ZERO AIDS-RELATED DEATHS**

“Today, we have a chance to end this epidemic once and for all. That is our goal: Zero new HIV infections, Zero discrimination, and Zero AIDS-related deaths.”

**UNITED NATIONS SECRETARY-GENERAL BAN KI-MOON**  
AT THE UNITED NATIONS GENERAL ASSEMBLY HIGH LEVEL  
MEETING ON AIDS, JUNE 2011

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All data cited are from the *UNAIDS Report on the Global AIDS Epidemic 2010*, based on 2010 UNGASS Country Reports, unless otherwise referenced. Data graphs and country and regional information were sourced from the Data Hub ([www.aidsdatahub.org](http://www.aidsdatahub.org)).

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Designed by Daniel Feary

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## ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral treatment
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
FTA	Free trade agreement
HIV	Human immunodeficiency virus
ILO	International Labour Organization
MDG	Millennium Development Goal
NGO	Nongovernmental organization
OST	Opioid substitution therapy
PPTCT	Prevention of parent-to-child transmission
STI	Sexually transmitted infection
TB	Tuberculosis
TRIPS	Trade-related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary counseling and testing
WHO	World Health Organization



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## FOREWORD

Thirty years have passed since the syndrome, now known as AIDS, was first reported, and it is 10 years since the landmark adoption of the 2001 Declaration of Commitment on HIV/AIDS at the United Nations (UN) Special Session on HIV/AIDS.

In Asia and the Pacific, we mark 20 years since the creation of the AIDS Society of Asia and the Pacific (ASAP) and the convening of the 10th International Congress on HIV/AIDS in Asia and the Pacific (ICAAP).

Today, we are at a truly historic moment. We have a new vision, astounding new science, renewed political will and new regional results that give us hope for the AIDS response.

Our global vision is clear: Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths.

We have seen amazing new scientific advances. From solid evidence that antiretroviral therapy does more than treat HIV, it also prevents HIV—to the development of an effective microbicide and further evidence that male circumcision is effective in preventing HIV in men—science is opening new doors.

World leaders adopted a new Political Declaration at the 2011 UN General Assembly High Level Meeting on AIDS. Countries committed to reaching bold targets by 2015.

We understand the epidemics and the actions that can halt them better than ever. Asia and the Pacific have shown ample proof that HIV epidemics can be stopped, and that treatment and care can reach people who need it. Across the region, rates of HIV infections have dropped by 20% over 10 years. Increasingly, countries are focusing responses where they are most needed.



Throughout the entire region, civil society—including communities most affected by HIV—is transforming the response, holding Member States accountable and collaborating with governments to ensure that programmes are designed and implemented with key affected communities.

Progress in Asia and the Pacific is significant and is helping to lead and shape the global agenda on AIDS.

But gains are fragile. To sustain the AIDS response a new era of shared responsibility is fundamental. This requires stronger efforts from both domestic and international partners working together to ensure sustainable and innovative sources of financing.

I encourage all countries in Asia and the Pacific to review their programmes, targets and priorities to ensure they have the greatest impact.

We must seize this historic moment and all opportunities available—to reach our vision of ‘Getting to Zero’.

The beginning of the end of this epidemic is surely within our reach.

A handwritten signature in black ink, reading "Michel Sidibé", written over a diagonal line that extends from the bottom left towards the top right.

**MICHEL SIDIBÉ**  
UNAIDS EXECUTIVE DIRECTOR



## INTRODUCTION

Introduction	10
Global commitments & targets	12



## THE BIG PICTURE

The HIV situation in Asia and the Pacific at a glance and a selection of country profiles

At the crossroads	16
Country snapshots	24

# CONTENTS



## THE FEATURES

Perspectives and voices on key HIV issues for the region

HIV and young people at higher risk: a time to listen	38
Sex work and HIV programming: time for a make-over?	46
A tale of six cities	52
From the desk of	58
From the mouth of	60
Born free (of HIV)	62
Keeping treatment affordable	68
Community trailblazers	74
Gender and HIV: intersections	80
Making the law work for the AIDS response in Asia and the Pacific	88
Say what? Words of wisdom on HIV in 2011	104



## FACTS & FIGURES

Key HIV data and policy issues for the region

Tracking the HIV epidemics in Asia and the Pacific	110
Ending HIV infections among people who inject drugs	113
Ending HIV infections among men who have sex with men and transgender people	116
Ending HIV infections among people who buy and sell sex	118
Ending new HIV infections among children	121
Ending AIDS-related deaths	123
HIV services for people in the margins	127
Mitigating the impact of AIDS through social protection	129
Protecting rights and ending stigma and discrimination	131
Communities at the heart of the AIDS response	133
Investing in the AIDS response in Asia and the Pacific	135
Improving strategic information	137
References & notes	138

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## INTRODUCTION: A NEW PHASE FOR AIDS IN ASIA AND THE PACIFIC

This report, *HIV in Asia and the Pacific: Getting to Zero*, comes at a decisive point in the international and regional response to the HIV epidemic.

In June 2011, 192 Member States of the United Nations agreed to bold new targets and commitments that can make AIDS a thing of the past, including:

- reducing sexual transmission of HIV by 50%;
- halving HIV infection among people who inject drugs;
- eliminating new HIV infections among children;
- increasing in the number of people on life-saving treatment to 15 million; and
- closing the US\$ 6 billion global AIDS resource gap.

World leaders pledged to achieve these goals by 2015, which will move us closer towards the vision of Zero new HIV infections, Zero discrimination and Zero AIDS-related deaths.

'Getting to Zero' in Asia and the Pacific demands evidence-based responses that solidly focus on and involve key populations most at risk, are adequately resourced and grounded in human rights. Increasingly, countries are acting on this knowledge – and reaping the rewards. Tremendous progress has already been made, proving that the epidemic can be reversed, and that HIV treatment and care can be brought to those who need it.

Infection rates have dropped in most countries in the region and increasing HIV

prevention coverage is resulting in safer sexual and injecting behaviours. There are now over 740 000 people receiving treatment in the region—more than triple the 2006 numbers. The significance of that achievement is now magnified by recent evidence of the powerful effect of antiretroviral treatment on HIV transmission.

These life-saving gains must be consolidated, expanded and sustained.

Critical challenges remain.

There are still insufficient and inadequate HIV programmes for key populations most at risk including men who have sex with men, people who inject drugs, people who buy and sell sex, transgender people, young people at higher risk, and migrants.

Sixty percent of people eligible for antiretroviral treatment still do not receive it and coverage of services to prevent new infections among children needs to be rapidly increased.

Stigma and discrimination are widespread and present a forbidding barrier throughout Asia and the Pacific. Almost all countries in the region have laws, policies and practices that hamper the AIDS response and compromise the human rights of key affected communities.

All this occurs in a context where donor funding for AIDS is declining, and national funding remains meager in most places.

Countries in Asia and the Pacific are at a crossroads in the AIDS response.

In 2010, nearly two people were still newly infected for every person who started antiretroviral treatment. Countries cannot



shift the trajectory of the epidemic with a ‘business as usual’ approach.

AIDS funding needs to become a shared responsibility. More regional resources need to be invested to maintain the momentum that has been built, or we will lose the ground we have gained against the epidemic.

At this critical juncture in the region’s response, *HIV in Asia and the Pacific: Getting to Zero* features an update on the regional epidemic and response and aims to provide perspectives on the situations, opportunities and challenges currently at play—to build understanding, inform discussion and inspire ongoing commitment for actions that will halt HIV and get Asia and the Pacific ‘to Zero’.

### **INCREASING POLITICAL MOMENTUM IN THE REGION**

The Commission on AIDS in Asia (2008) and the Commission on AIDS in the Pacific (2009) helped elevate HIV on the national and regional agenda, and fostered a regional consensus across stakeholders on how to craft a more effective response.

In May 2010, the growing urgency around HIV led to the adoption of Resolution 66/10 by all 62 Members and Associate Members of the UN Economic and Social Commission for Asia and the Pacific (ESCAP).

In this intergovernmental negotiated text, the resolution notes that HIV epidemics in the region chiefly affect sex workers, men who have sex with men, and people who inject drugs, and that an effective response requires working closely with these populations. Resolution 66/10 identifies and calls for the removal of legal and political barriers to universal access, and pledges to promote dialogue between health and other sectors, including justice, law enforcement and drug control.

One year later, UN ESCAP Members and Associate Members unanimously adopted Resolution 67/9, which reinforces the previous year’s resolution by committing Member States to increase access to prevention and treatment services for key populations at higher risk, including transgender people, through nationally owned and funded strategic plans.

Impetus for Resolution 67/9 came from the Asia and the Pacific Regional Consultation on Universal Access (March 2011), which brought together policy makers from 30 countries and over 80 civil society and community representatives who jointly developed a text outlining actions to enable Asia and the Pacific to achieve Zero new HIV infections, Zero discrimination and Zero AIDS-related deaths.

## 2011 GLOBAL COMMITMENTS & TARGETS

A selection of the pledges made at the 2011 UN General Assembly High Level Meeting on AIDS.

<p>Halve sexual transmission of HIV</p>	<p>Reduce transmission of HIV among people who inject drugs by 50%</p>	<p>Close the global resource gap for AIDS and increase funding to between US\$ 22 billion and US\$ 24 billion per year through</p>
<p>Ensure that no children are born with HIV</p>	<p>In the 2011 Political Declaration on HIV/AIDS,* Member States commit, by 2015, to:</p>	<ul style="list-style-type: none"> <li>● Reaching a significant level of annual global expenditure on HIV and AIDS by increasing national ownership of AIDS responses through greater allocations from national resources and traditional sources of funding;</li> </ul>
<p>Increase universal access to antiretroviral therapy to get 15 million people on life-saving treatment</p>	<p>Reduce tuberculosis deaths in people living with HIV by 50%</p>	<ul style="list-style-type: none"> <li>● Urging developed countries to achieve the target of 0.7% of gross national product for official development assistance.</li> </ul>

\* The Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS



## NEW UN SECURITY COUNCIL RESOLUTION ON HIV AND PREVENTING SEXUAL VIOLENCE IN CONFLICT

On 7 June 2011, the day preceding the 2011 UN General Assembly High Level Meeting on AIDS, the UN Security Council adopted a new resolution calling for increased efforts by UN Member States to address HIV in peacekeeping missions. The resolution also calls for HIV prevention efforts among uniformed services to be aligned with efforts to end sexual violence in conflict and post-conflict settings.

Encourage and support the active involvement and leadership of young people, including those living with HIV, in the AIDS response

Engage people living with and affected by HIV in decision-making, and in planning, implementing and evaluating the response

Remove obstacles that limit the capacity of low-income and middle-income countries to provide affordable and effective HIV prevention and treatment products

Ensure national HIV and AIDS strategies that promote and protect human rights, including programmes aimed at eliminating stigma and discrimination

Also outlined in the 2011 Political Declaration on HIV/AIDS, were commitments to:

Eliminate gender inequalities and gender-based abuse and violence

Review laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes

Encourage member states to eliminate any remaining HIV-related restrictions on entry, stay and residence

Revise the recommended framework of core indicators that reflect present commitments by the end of 2012

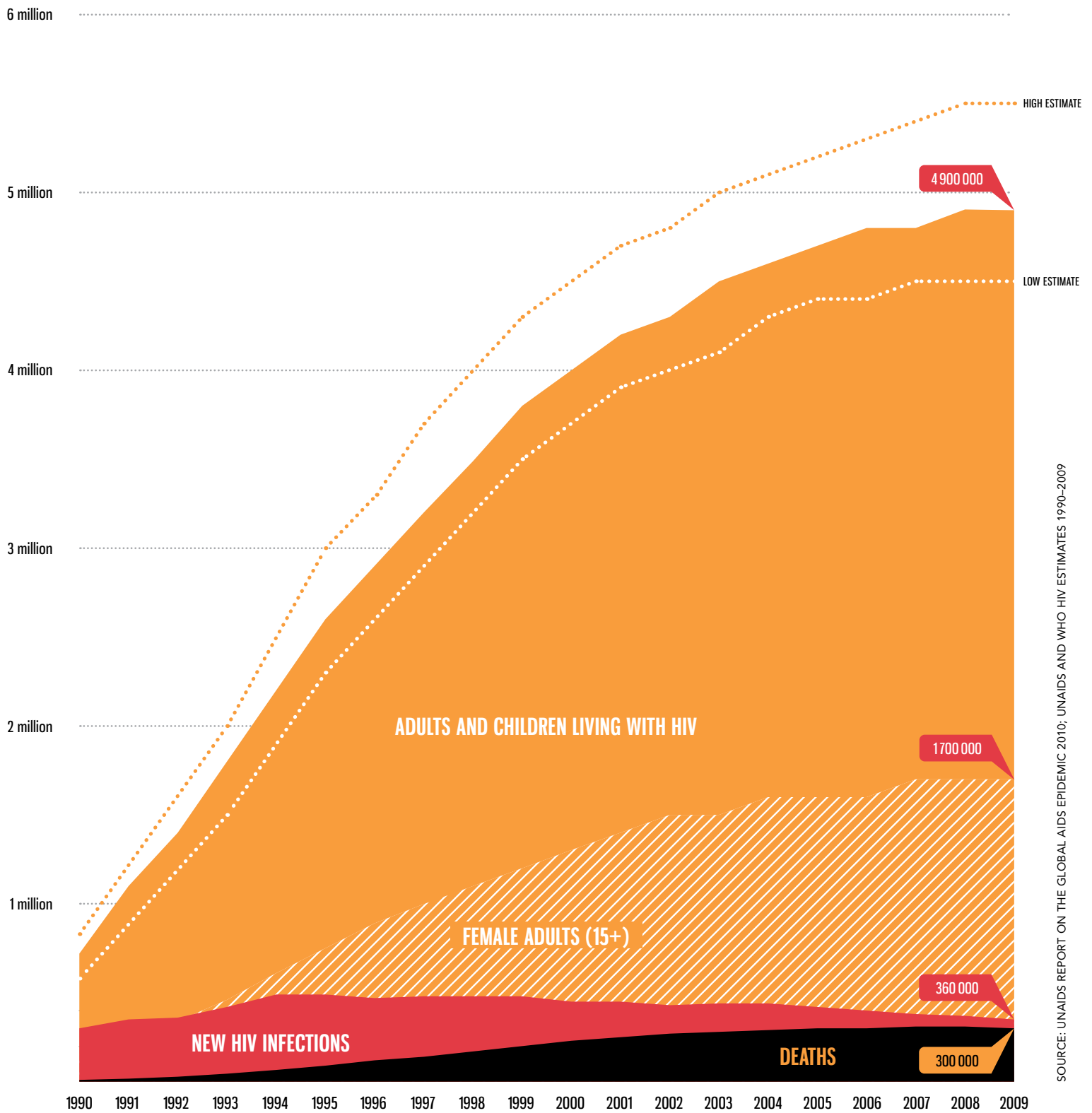




# THE BIG PICTURE

The HIV situation in Asia and  
the Pacific at a glance and  
a selection of country profiles

# HIV in Asia and the Pacific, 1990–2009



SOURCE: UNAIDS REPORT ON THE GLOBAL AIDS EPIDEMIC 2010; UNAIDS AND WHO HIV ESTIMATES 1990–2009



# AT THE CROSSROADS

## ASIA AND THE PACIFIC'S AIDS RESPONSE HAS REACHED A CRITICAL JUNCTURE.

- Although the region has seen impressive gains, including a 20% reduction in new HIV infections since 2001, the epidemic still outpaces the response—there are still almost two new HIV infections for every person who starts treatment.
- Expenditure on AIDS remains insufficient and international funding is declining.

## MORE PEOPLE THAN EVER BEFORE HAVE ACCESS TO HIV SERVICES ACROSS THE REGION, BUT MOST COUNTRIES ARE A LONG WAY FROM ACHIEVING UNIVERSAL ACCESS TARGETS FOR HIV PREVENTION, TREATMENT, CARE AND SUPPORT.

## FOR THE REGION TO REACH ZERO NEW HIV INFECTIONS, ZERO DISCRIMINATION AND ZERO AIDS-RELATED DEATHS, COUNTRIES MUST:

- Make high-impact HIV prevention a top priority.
- Speed up and sustain access to antiretroviral treatment.
- Advance human rights and gender equality.

## SUCCESS REQUIRES:

- Committed political leadership, strong national ownership, and partnerships that include people living with HIV and key affected populations.
- Increased and sustained resources for HIV, focused on key populations at higher risk.
- Expanded access to affordable drugs, diagnostics and prevention commodities.
- An end to laws, policies and practices that fuel stigma and discrimination, violate rights and hinder effective AIDS responses.

# EPIDEMICS ARE STILL DRIVEN BY SPECIFIC BEHAVIOURS THAT PUT PEOPLE AT HIGHER RISK OF HIV INFECTION

**AN ESTIMATED 4.9 MILLION (4.5–5.5 MILLION) PEOPLE WERE LIVING WITH HIV IN ASIA AND THE PACIFIC IN 2009—ROUGHLY THE SAME NUMBER AS IN 2005.**

- Between 2001 and 2009, there was a 20% decline in new HIV infections—from 450 000 (410 000–510 000) to 360 000 (300 000–440 000).
- An estimated 300 000 (260 000–340 000) people died from AIDS-related causes in 2009.
- In Asia and the Pacific, the vast majority of people living with HIV are in 11 countries: Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam. There are people living with HIV in almost all the other countries in the region, and epidemics can emerge even in countries where HIV levels were previously low (for example, the Philippines).
- New HIV infections remain concentrated among key populations at higher risk: people who buy and sell sex, people who inject drugs, men who have sex with men, and transgender people.
- In many countries in Asia, HIV epidemics start with the virus spreading rapidly among people who inject drugs and use non-sterile injecting equipment. Many may also buy and sell sex, allowing HIV to spread to larger networks of sex workers and their clients.
- HIV prevalence among people who inject drugs remains high even in countries with overall declining epidemics, and it is increasing in areas with expanding epidemics.
- The rapid growth of epidemics among men who have sex with men across the region, especially in cities, is a major source of new HIV infections.
- While there has been progress in preventing HIV among sex workers, the rate of new HIV infections in this population continues to increase in certain areas and settings.
- Male clients of sex workers—an estimated 75 million men across Asia and the Pacific—are key determinants in both the spread and magnitude of HIV epidemics in the region, since they are the biggest single group that transmits HIV to their regular intimate partners.

**DATA SUGGEST THAT A SIGNIFICANT PROPORTION OF NEW HIV INFECTIONS WITHIN KEY POPULATIONS AT HIGHER RISK ARE AMONG YOUNG PEOPLE UNDER THE AGE OF 25.**

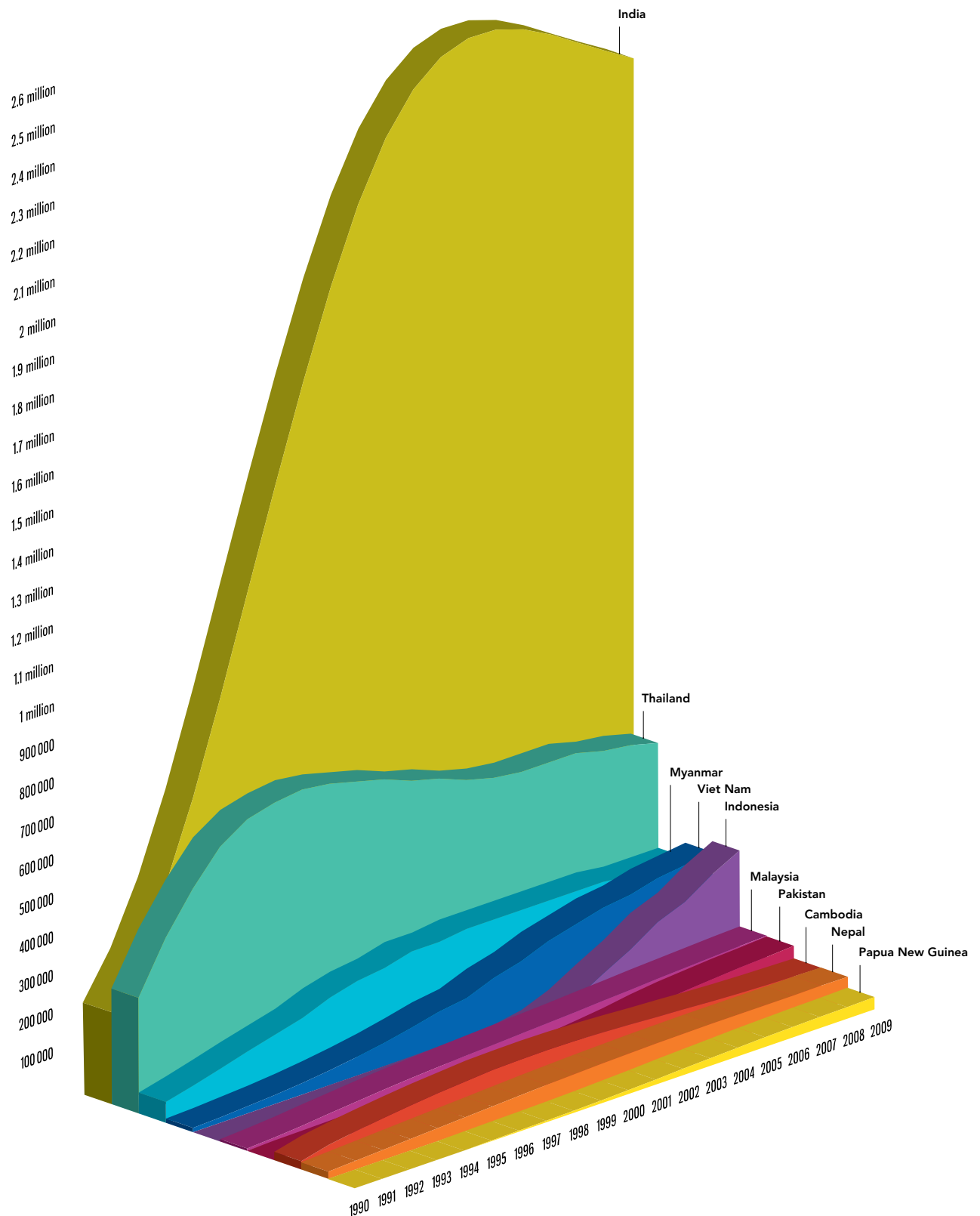
**WOMEN COMPRISE ABOUT 35% OF PEOPLE LIVING WITH HIV IN ASIA AND THE PACIFIC, A PROPORTION THAT HAS REMAINED STABLE IN THE PAST DECADE. THE MAJORITY OF WOMEN LIVING WITH HIV IN THE REGION WERE INFECTED BY THEIR INTIMATE PARTNERS.**

**ALTHOUGH DATA ARE SCARCE, INTERNAL AND INTERNATIONAL MIGRATION APPEAR TO BE SUBSTANTIAL FACTORS IN THE HIV EPIDEMICS IN A NUMBER OF COUNTRIES ACROSS THE REGION.**



People living with HIV in Asia and the Pacific, 1990–2009

SOURCES: UNAIDS REPORT ON THE GLOBAL AIDS EPIDEMIC 2010; UNAIDS AND WHO HIV ESTIMATES 1990–2009  
 NOTE: In China, the multifaceted epidemic with geographic and HIV variations among key affected populations, makes this type of trend assessment highly complex and it could not be included in the 2010 estimation round. The number of people living with HIV in China in 2009 was 740 000 (540 000–1 000 000).



# THERE HAS BEEN SIGNIFICANT PROGRESS...

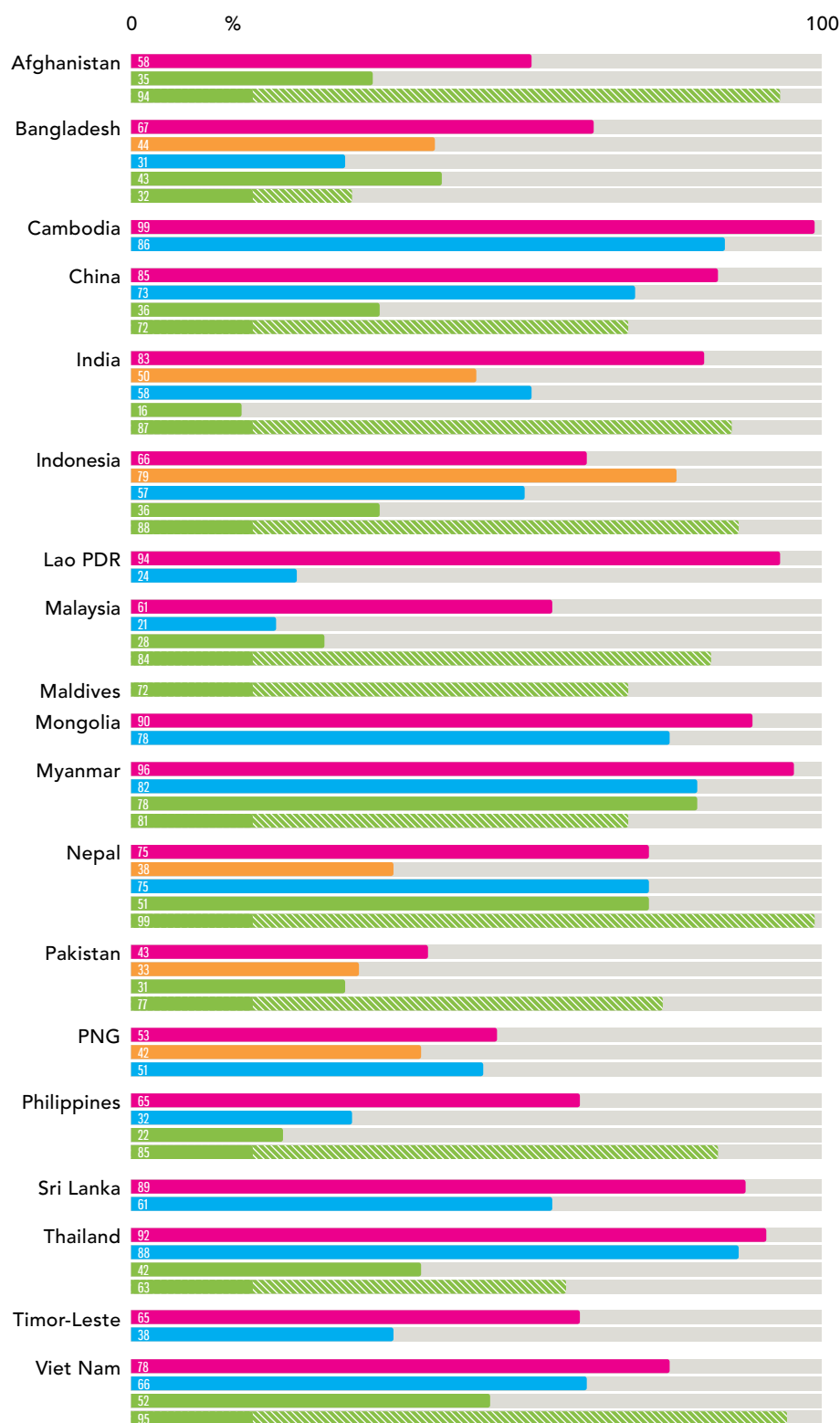
- Cambodia, India, Myanmar and Thailand have reduced their HIV infection rates with intensive, wide-reaching HIV prevention programmes among people who buy and sell sex.
- In many other countries, increasing HIV prevention coverage and trends toward safer sexual and injecting behaviours are being observed.
- Wider access to services that prevent new HIV infections among children has led to an overall 15% decrease in new HIV infections among children in Asia and the Pacific since 2006. Malaysia and Thailand are on track to eliminate new HIV infections among children.
- The number of people receiving antiretroviral treatment in the region has tripled since 2006, reaching some 740 000 people at the end of 2009. Cambodia is one of only eight countries in the world that provides antiretroviral therapy to more than 80% of the people eligible for it.
- There are courageous examples of legal and policy reforms aimed at reducing discrimination and stigma, and at building a more enabling environment for effective action against the epidemic.
- Evidence shows that the most successful HIV programmes, policies and plans in the region are those that meaningfully involve key populations at higher risk and people living with HIV in their design and implementation. Countries are increasingly responding to that evidence.
- China, Malaysia, Pakistan, Samoa and Thailand are funding the bulk of their response from domestic resources.

# ... BUT THE GAINS ARE UNEVEN AND FRAGILE

- The HIV epidemic continues to outpace the response—there are still nearly two new HIV infections for every person who starts antiretroviral treatment.
- Sex work is continually evolving. Many interventions are missing new categories of mobile and informal sex workers. Critically, prevention programmes seldom reach out to clients of sex workers.
- Most programmes to protect men who have sex with men, people who inject drugs and their intimate partners from HIV infection are inadequate in size and scale—despite the strong examples of programmes that can effectively protect those populations against HIV.
- Few specific HIV prevention programmes exist for young people among key populations at higher risk, transgender people, migrants and intimate partners of people who have unsafe sex or who inject drugs.
- Access to antiretroviral therapy and prevention of new HIV infections among children lags behind global averages. Less than one third of people who are eligible for these services were receiving them at the end of 2009; in South Asia, where the largest number of people in need live, coverage was lower than elsewhere in the region.
- Access to affordable drugs and diagnostics for antiretroviral therapy and prevention of new HIV infections among children could be affected by the terms of free trade agreement negotiations.
- Stigma and discrimination against people living with HIV and key populations at higher risk remains rife, including among health-care workers.
- Most (90%) countries in the region retain laws and policies or allow practices that effectively prevent people living with HIV, and key populations at higher risk, from accessing life-saving HIV services.
- At around US\$ 1.1 billion at the end of 2009, AIDS spending in Asia and the Pacific amounted to approximately one third of estimated funding needed to achieve universal access to HIV services.
- International funding for AIDS is declining, yet many countries in Asia and the Pacific depend heavily on foreign funding, particularly for provision of antiretroviral therapy.



### Safe behaviour in key populations at higher risk



Percentage of surveyed population who used a condom at last sex



Percentage of female sex workers reporting the use of a condom with their most recent client



Percentage of male sex workers reporting the use of a condom with their most recent client



Percentage of men who have sex with men reporting the use of a condom the last time they had anal sex with a male partner



Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse



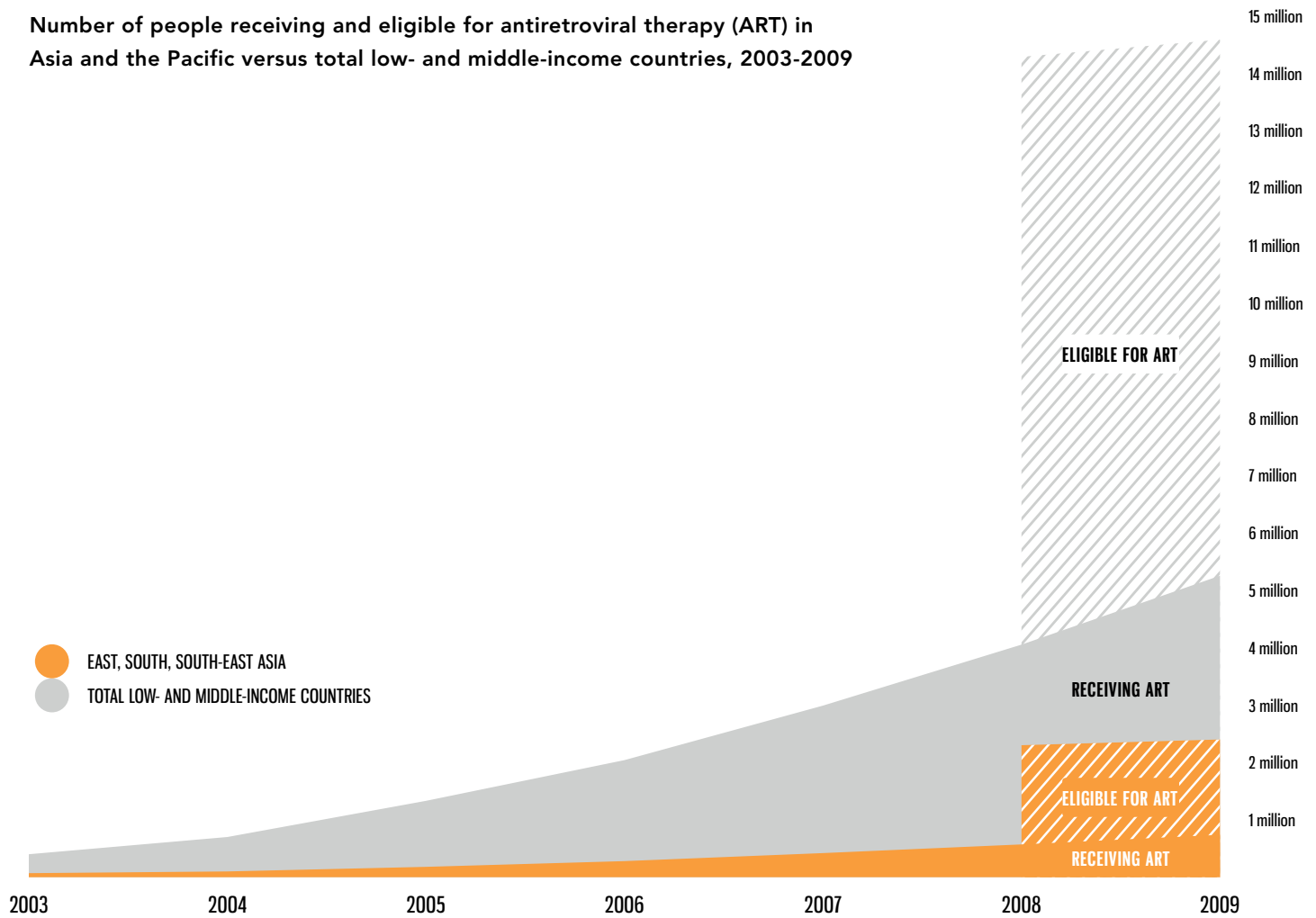
Percentage of people who inject drugs that used sterile injecting equipment at last use



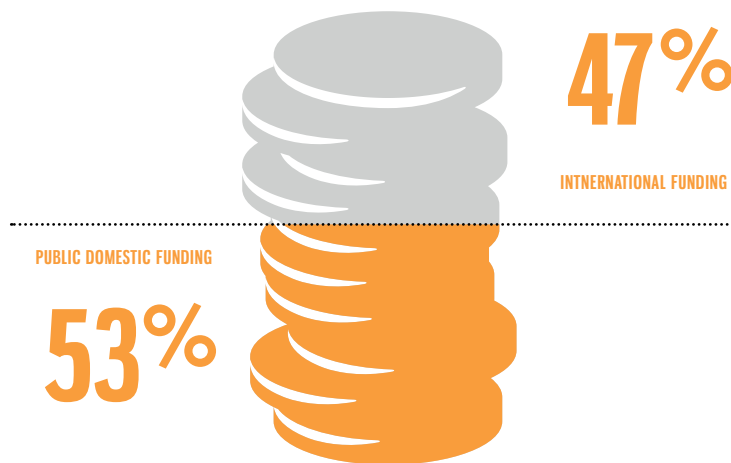
Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected

All data are as reported in the *UNAIDS Global Report on the AIDS Epidemic 2010*, based on 2010 UNGASS Country Reports. It should be noted that although countries generally cited data from surveys in 2009, some countries cited data from 2007 and 2008.

Number of people receiving and eligible for antiretroviral therapy (ART) in Asia and the Pacific versus total low- and middle-income countries, 2003-2009



Proportion of public domestic and international funding in Asia and the Pacific, low- and middle-income countries







# LEADERSHIP, OWNERSHIP AND PARTNERSHIP ARE NEEDED TO DRIVE AHEAD

- Bold political leadership, country ownership and broad partnerships are critical for successful AIDS responses.
- People living with HIV, and key populations at higher risk, need to be at the heart of responses.
- To halt new HIV infections, countries must urgently expand prevention efforts and resources that focus on key populations at higher risk.
- To end new HIV infections among children, comprehensive HIV prevention and treatment services need to be scaled up and use antiretroviral regimens as recommended in the 2010 WHO Guidelines.
- To end AIDS-related deaths, countries must accelerate the expansion of access to antiretroviral therapy.
- Recent developments provide countries with a unique opportunity to catalyze a new phase in antiretroviral treatment.
  - The Treatment 2.0 approach, which aims to make antiretroviral therapy simpler and more effective, is a critical opportunity to catalyze a new phase in AIDS treatment.
  - The 2010 World Health Organization (WHO) treatment guidelines recommend initiations of antiretroviral therapy and improved treatment regimens.
  - New evidence confirms that timely antiretroviral therapy greatly reduces HIV transmission.
- To seize these opportunities, decisive and urgent action is needed to secure and expand affordable access to antiretroviral drugs.
- Punitive and discriminatory laws, policies and practices that undermine the AIDS response and increase stigma must be removed. Services must be responsive to the needs of women, men and transgender people of all ages.
- AIDS funding is a shared responsibility, across the region and globally. Declines in international funding must be reversed, and all countries, in particular middle-income countries, in Asia and the Pacific need to increase domestic public funding for AIDS, as well as for health and social protection in general.

**AT THIS CROSSROADS IN THE RESPONSE IN ASIA AND THE PACIFIC, COMPLACENCY IS NOT AN OPTION. WITHOUT INTENSIFYING EFFORTS WHERE THEY ARE MOST NEEDED, THE IMPRESSIVE GAINS WILL BE LOST.**

**COUNTRIES IN ASIA AND THE PACIFIC HAVE THE CAPACITY TO LEAD THE WORLD TO ZERO NEW HIV INFECTIONS, ZERO DISCRIMINATION AND ZERO AIDS-RELATED DEATHS.**

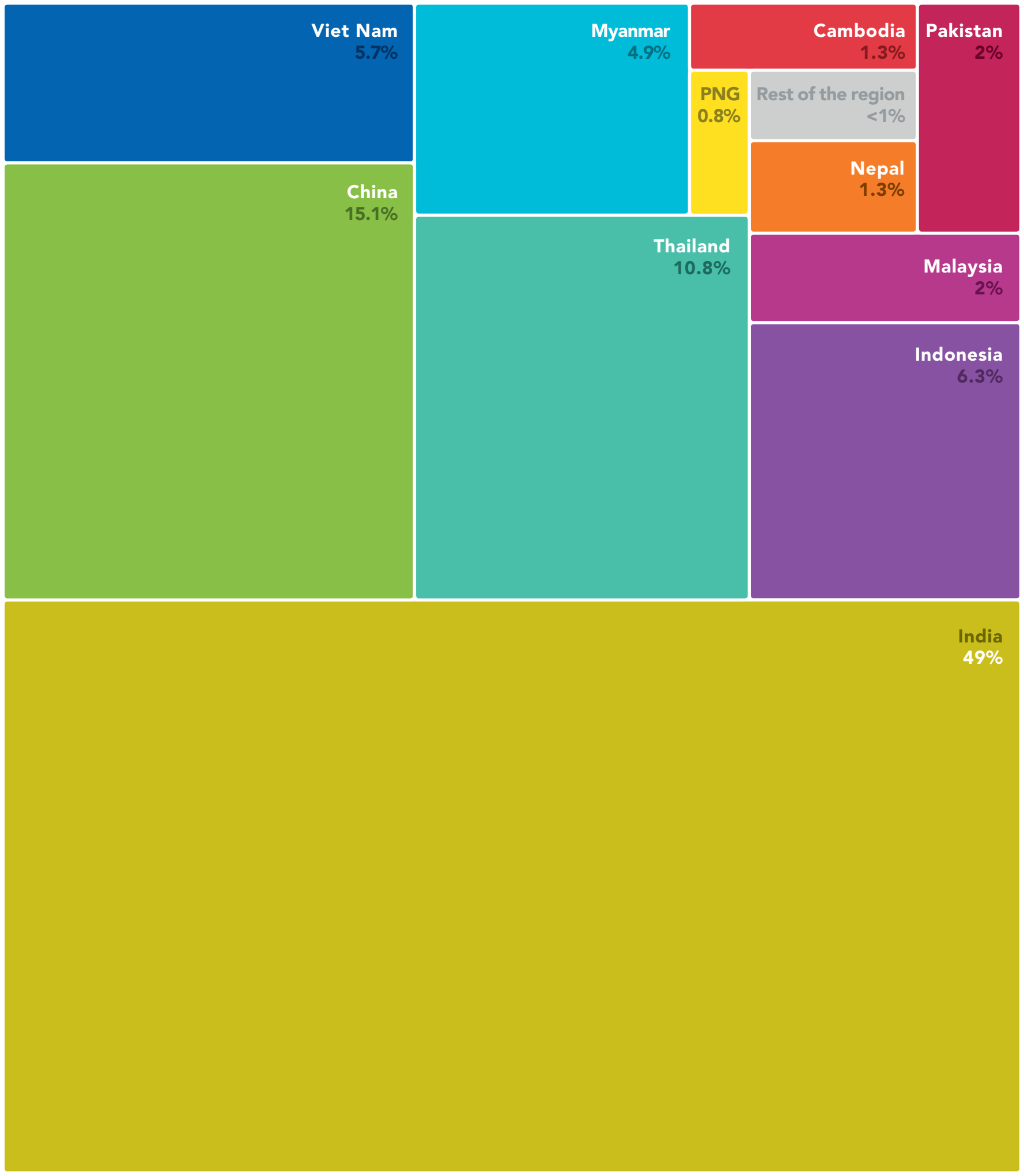
In Asia and the Pacific, the vast majority of people living with HIV are in 11 countries: Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Papua New Guinea, Thailand and Viet Nam. The next pages provide snapshots of the epidemics and responses in these countries.\*

HIV is a reality in all countries of the region and every country must ensure an evidence-informed, effective, rights-based and fully funded response.

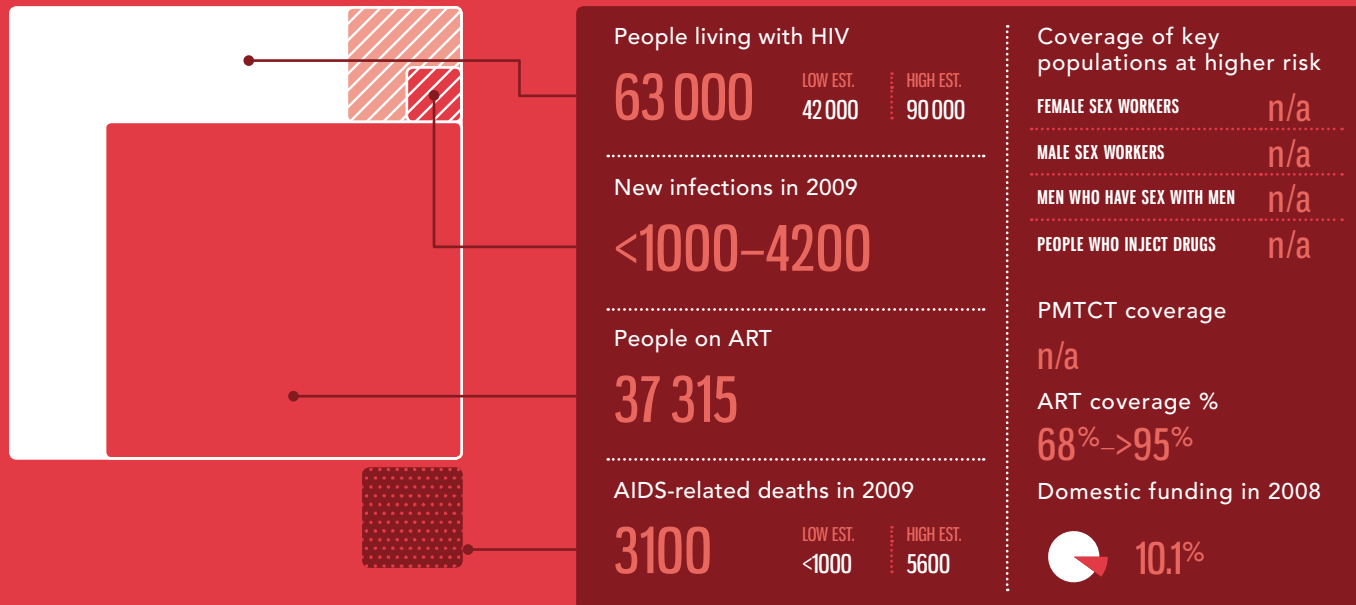
\*In line with the UNAIDS mandate to provide standardized global strategic information on HIV, all country data are drawn from the UNAIDS 2010 Report on the global AIDS epidemic, which was informed by the 2010 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) country reports.

The HIV estimates trends were produced by UNAIDS and WHO using data provided by countries and the "Estimates and Projections" modelling software developed by the UNAIDS Reference Group on HIV/AIDS Estimates, Modelling and Projections. These estimates do not necessarily reflect the latest official estimates used by national governments.

This report only includes 2009 coverage data for prevention of new HIV infections among children (UNGASS Indicator #4) for countries that did not use single dose nevirapine. Coverage Data for 2010 based on new WHO guidelines will be released later this year.



# Cambodia



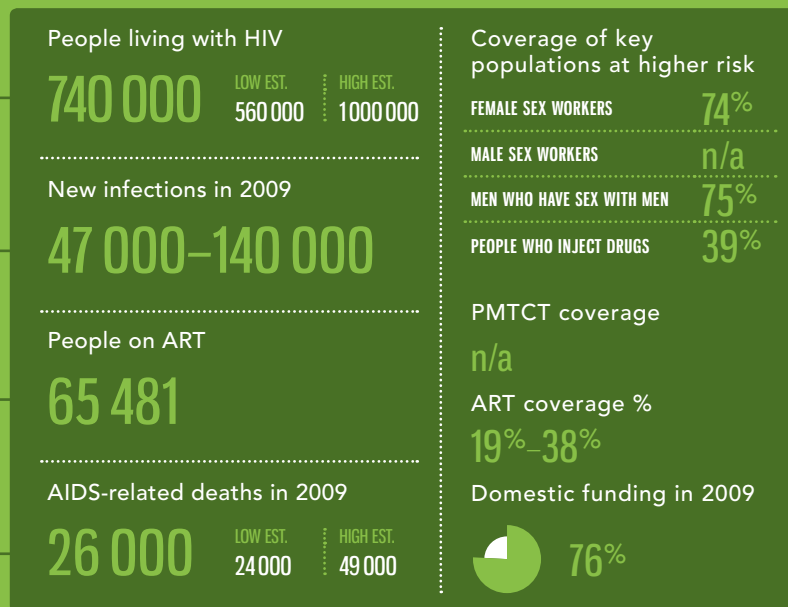
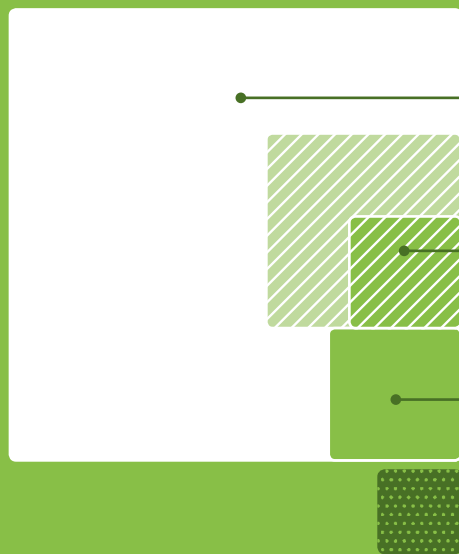
## EPIDEMIC SNAPSHOT

- There were 63 000 (42 000–90 000) people living with HIV, 1700 (<1000–4200) new HIV infections and 3100 (<1000–5600) AIDS-related deaths in 2009.
- HIV prevalence in the general population is down to 0.5% (0.4%–0.8%) in 2009, from a peak of 1.2% (0.8%–1.6%) in 2001.
- HIV prevalence is still high among people who inject drugs (24.4%), entertainment workers (14%) and men who have sex with men (4.5%).
- Antiretroviral therapy coverage ranged from 68%–95% in 2009, with 33 677 adults and 3638 children receiving treatment.

## RESPONSE HIGHLIGHTS

- Strong national leadership on HIV and wide social mobilization are key factors of success.
- Cambodia was presented with the MDG 6 award by the Millennium Development Goals (MDG) Awards Committee for succeeding in halting and reversing the epidemic.
- Cambodia is the only Asian country that has reached the universal access target for antiretroviral therapy according to the 2010 WHO guidelines.
- The continuum of HIV prevention to care and treatment approach for sex workers, men who have sex with men, and people who inject drugs is enabling scale-up of HIV prevention and linkages to other health and social services.
- The Most-At-Risk-Populations Community Partnership Initiative is designed to build safe spaces for key populations at higher risk to access and use services.
- Prevention of new HIV infections among children has been scaled up through linking HIV with sexual and reproductive health.

# China



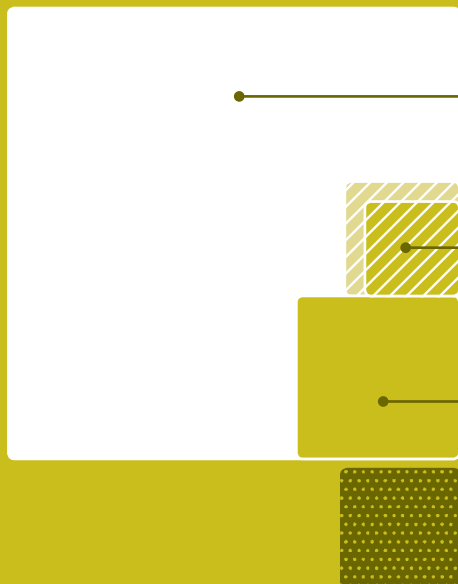
## EPIDEMIC SNAPSHOT

- There were 740 000 (560 000–1 000 000) people living with HIV, between 47 000 and 140 000 new HIV infections and 26 000 (24 000–49 000) AIDS-related deaths in 2009.
- Over 80% of the epidemic is concentrated in six provinces.
- Overall, sexual transmission accounts for three quarters of new HIV infections. Unsafe sex between men is a particular concern, and accounted for one third of new HIV infections in 2009.
- A survey of men who have sex with men conducted in 61 cities nationwide in 2008–2009 found an average HIV prevalence of 4.9%, varying from 4% to 20% in different regions.
- Prevalence among people who inject drugs remains high; it is estimated at 9.3% nationwide in 2009, and over 50% at sentinel sites in six provinces.
- Antiretroviral therapy coverage was between 19% and 38% in 2009, with 65 481 people receiving treatment.

## RESPONSE HIGHLIGHTS

- Top-level leadership has been a major catalyst for China's HIV response, more than three quarters of which is financed with domestic funding.
- The "Four Frees, One Care" policy has led to rapid expansion of HIV services, including antiretroviral therapy. It supports free HIV testing and counselling, free antiretroviral therapy, free services for prevention of new HIV infections among children, free education for children orphaned by AIDS, and care for people living with HIV.
- The national AIDS strategy is aligned to the UNAIDS strategic vision of 'Getting to Zero'.
- Methadone maintenance treatment is available to people who inject drugs, with 701 clinics operating and serving about 300 000 people who use drugs cumulatively by the end of 2010.
- China lifted its long-standing restrictions that prevented people living with HIV from travelling to China in April 2010.

# India



People living with HIV

**2 400 000** LOW EST. 2 100 000 HIGH EST. 2 800 000

New infections in 2009

**110 000–160 000**

People on ART

**320 074**

AIDS-related deaths in 2009

**170 000** LOW EST. 150 000 HIGH EST. 200 000

Coverage of key populations at higher risk

FEMALE SEX WORKERS **31%**

MALE SEX WORKERS **n/a**

MEN WHO HAVE SEX WITH MEN **18%**

PEOPLE WHO INJECT DRUGS **15%**

PMTCT coverage

**n/a**

ART coverage %

**23%–28%**

Domestic funding in 2008



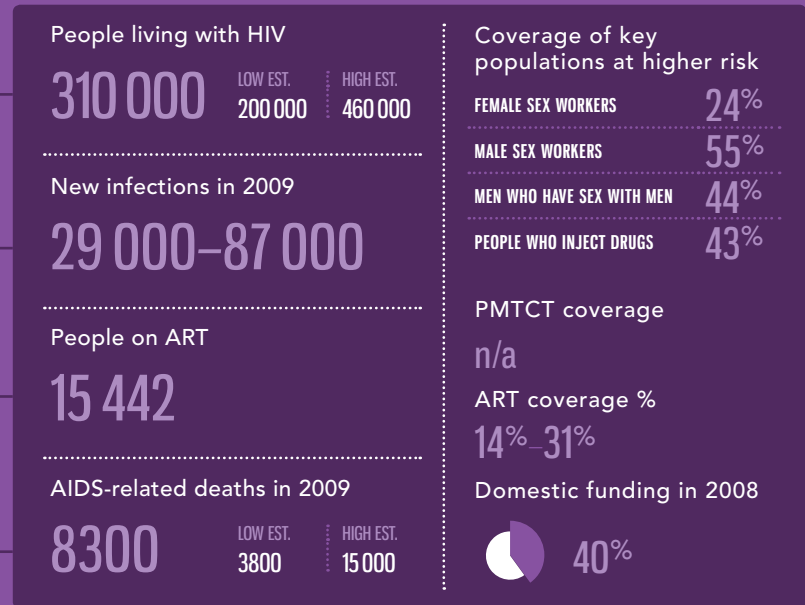
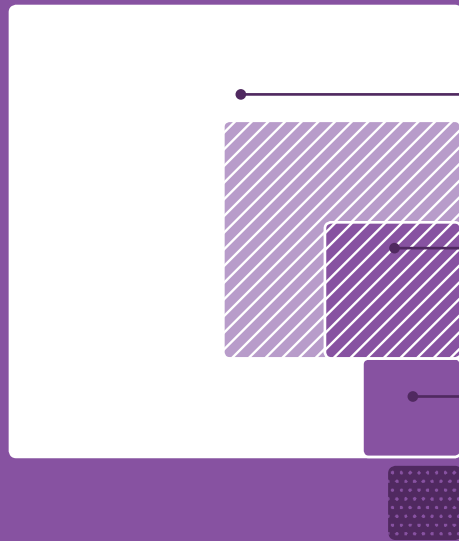
## EPIDEMIC SNAPSHOT

- India accounts for half of Asia's HIV epidemic, with 2.4 million (2.1–2.8 million) people living with HIV, 140 000 (110 000–160 000) new HIV infections, and 170 000 (150 000–200 000) AIDS-related deaths estimated in 2009.
- Women account for 39% of reported HIV cases.
- Incidence declined by 50% between 2000 and 2009 due to programmatic success in six high-prevalence states.
- There are 320 074 people receiving antiretroviral therapy—20% more than the National AIDS commissions, committees or councils (NACP) III target—but more needs to be done to reach all those in need.
- HIV prevalence among female sex workers declined to less than 5%. Prevalence remains high among men who have sex with men (7.3%) and people who inject drugs (9.2%).

## RESPONSE HIGHLIGHTS

- HIV investments are balanced over programme components.
- Investments increased from US\$ 99.6 million during NACP I (1992–1999) to US\$ 2.5 billion during NACP III (2007–2012). Domestic contribution increased to 25% (2011).
- There was significant scale up in coverage of focused programmes among key populations at higher risk.
- Consensual sex between adult men was decriminalized by the Delhi High Court, strengthening the protection of human rights for men who have sex with men.

# Indonesia



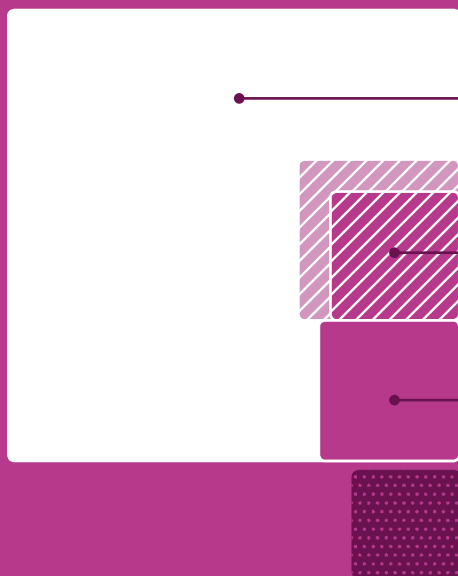
## EPIDEMIC SNAPSHOT

- There were 310 000 (200 000–460 000) people living with HIV, between 29 000 and 87 000 new HIV infections and 8300 (3800–15 000) AIDS-related deaths in 2009.
- There are 6 million people estimated to be at high risk of HIV infection.
- New HIV infections are stable, but HIV prevalence and AIDS deaths are increasing.
- Most new HIV infections are due to sexual transmission. HIV transmission through drug use will continue to be an important part of the epidemic in coming years.
- The Papuan provinces are a major concern, with more than 2.4% HIV prevalence in adults, and HIV infection rates up to 15 times higher than the rest of the country.  
Source: 2010 & 2008 UNGASS Country Reports.
- Antiretroviral therapy coverage was 21% (14%–31%) in 2009, with 15 442 people receiving treatment.

## RESPONSE HIGHLIGHTS

- There has been encouraging progress in coverage of prevention and treatment programmes. The government focuses on prevention through sexual transmission, including harm reduction for people who inject drugs, and people in prison settings.
- Government shows strong commitment, with district and provincial governments playing a stronger role in managing and funding HIV activities.
- There is an upward trend in domestic contribution to total HIV spending (from 40% in 2009 to 50% in 2010).

# Malaysia



<p>People living with HIV</p> <p><b>100 000</b> <small>LOW EST. 83 000 HIGH EST. 120 000</small></p>	<p>Coverage of key populations at higher risk</p> <p>FEMALE SEX WORKERS <b>12%</b></p> <p>MALE SEX WORKERS <b>n/a</b></p> <p>MEN WHO HAVE SEX WITH MEN <b>n/a</b></p> <p>PEOPLE WHO INJECT DRUGS <b>8%</b></p>
<p>New infections in 2009</p> <p><b>8400–13 000</b></p>	<p>PMTCT coverage <b>55%–&gt;95%</b></p> <p>ART coverage % <b>18%–29%</b></p>
<p>People on ART</p> <p><b>9962</b></p>	<p>Domestic funding in 2009</p> <p><b>98.4%</b></p>
<p>AIDS-related deaths in 2009</p> <p><b>5800</b> <small>LOW EST. 4500 HIGH EST. 7200</small></p>	

## EPIDEMIC SNAPSHOT

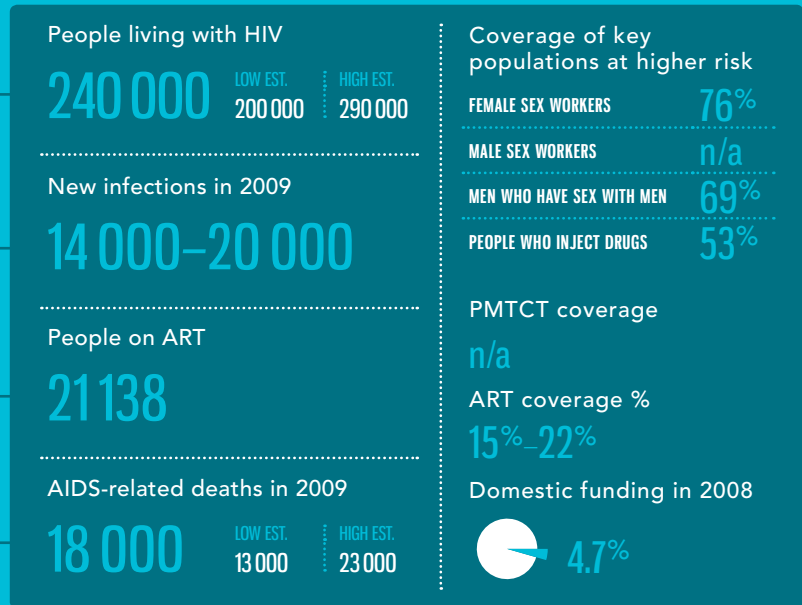
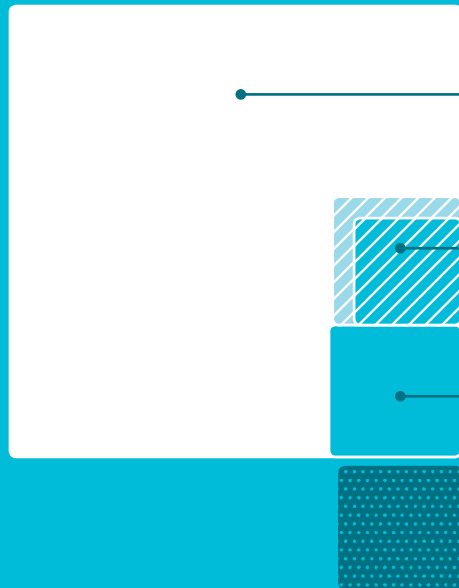
- There were 100 000 (83 000–120 000) people living with HIV, 10 000 (8400–13 000) new HIV infections and 5800 (4500–7200) AIDS-related deaths in 2009.
- New HIV infections are levelling off, but HIV prevalence is increasing and there is no decline in AIDS-related deaths.
- The epidemic is driven mainly by injecting drug use (22.1% prevalence), but sexual transmission of HIV is increasing.
- Antiretroviral therapy coverage was 23% (18%–29%) in 2009, with 9962 people receiving treatment.

## RESPONSE HIGHLIGHTS

- Strong advocacy has galvanized government commitment and maintained a solid focus on people who inject drugs.
- A countrywide rollout of needle and syringe programmes is underway and methadone maintenance therapy is available in prisons.
- Compulsory detention for people who use drugs has been abandoned, shifting to voluntary, non-conditional treatment (including methadone maintenance therapy) at 'Cure and Care' centres.
- First-line antiretroviral therapy is fully subsidized, second-line antiretroviral therapy is partially subsidized, and antiretroviral therapy is available in prisons.



# Myanmar



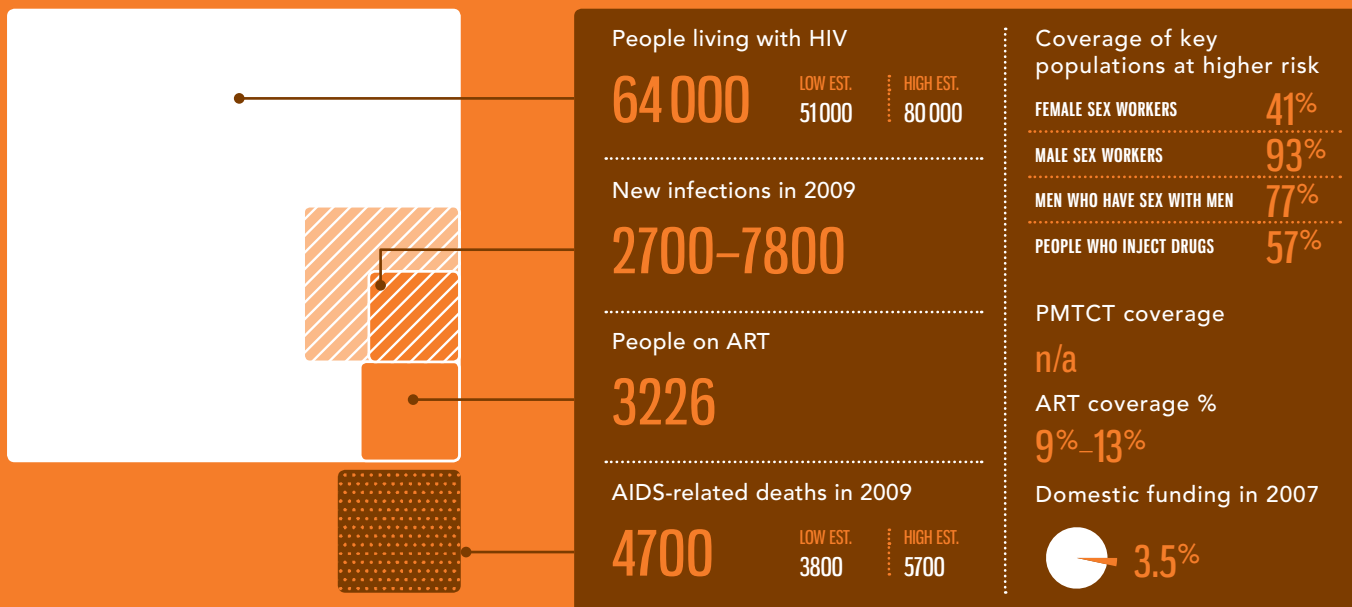
## EPIDEMIC SNAPSHOT

- There were 240 000 (200 000–290 000) people living with HIV, 17 000 (14 000–20 000) new HIV infections and 18 000 (13 000–23 000) AIDS-related deaths in 2009.
- New HIV infections are declining and the number of AIDS deaths is stable.
- The epidemic is largely concentrated among sex workers (HIV prevalence 18.1% in 2008) and their clients, men who have sex with men (28.8% prevalence in 2008) and people who inject drugs (36.3% in 2008).
- Antiretroviral therapy coverage was 18% (15%–22%) in 2009, with 21 138 people receiving treatment.

## RESPONSE HIGHLIGHTS

- Strong commitment and partnerships (between government, local and international nongovernmental organizations and the UN system) have driven impressive improvements in prevention coverage for female sex workers.
- Methadone maintenance therapy programmes for people who inject drugs are being introduced.
- Antiretroviral therapy access has grown rapidly (from fewer than 100 people in 2002).
- An integrated HIV care programme for tuberculosis patients has begun, and almost 7000 people started antiretroviral therapy through this programme since 2008. The same scheme has also successfully implemented provider-initiated HIV testing and counselling for tuberculosis patients.

# Nepal



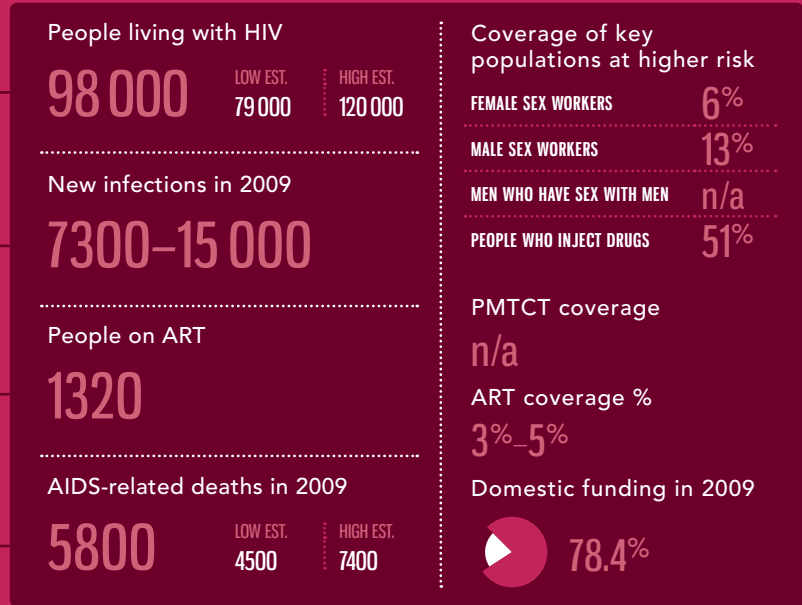
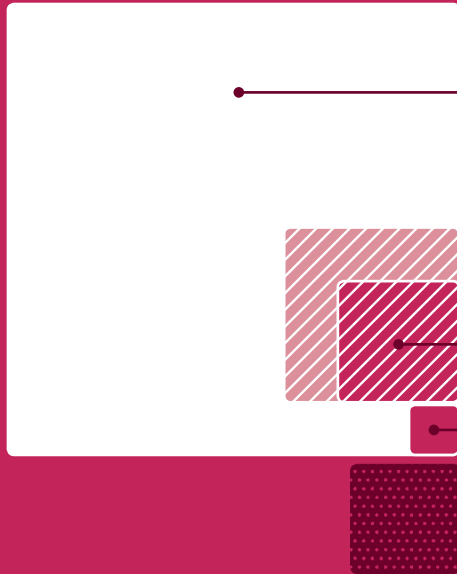
## EPIDEMIC SNAPSHOT

- It is estimated that there were 64 000 (51 000–80 000) people living with HIV, of whom 31% are women, and 4 800 (2 700–7 800) new HIV infections in 2009. Around 17 000 people living with HIV have been tested to confirm their HIV status.
- HIV prevalence is stabilizing and new HIV infections show a declining trend.
- There is an upward trend in prevalence in the Far and Mid West regions among seasonal migrants to India and their spouses. Migrants account for 29% of nationally estimated total HIV infections.
- There has been a steady decline in prevalence among people who inject drugs, and a nearly stable trend among men who have sex with men, and among female sex workers.
- Antiretroviral therapy was accessed by 3 226 people, which corresponds to 11% (9%–13%) coverage.

## RESPONSE HIGHLIGHTS

- Coverage of key populations at higher risk has been significantly expanded through focused interventions.
- Resource mobilization has been successful through The Global Fund Round 10 and from external development partners through the 2011–2016 National Health Sector Plan's pooled funding mechanism (World Bank, United Kingdom Department for International Development and the Australian Government Overseas Aid Program).
- Civil society organizations have played significant roles particularly in increasing access to HIV services for geographically and socially hard-to-reach populations.
- Revised AIDS policy has identified AIDS as a priority development issue, confirmed alignment with international commitments on HIV and human rights, adopted a gender-sensitive and inclusive policy and promoted a decentralized national response.

# Pakistan



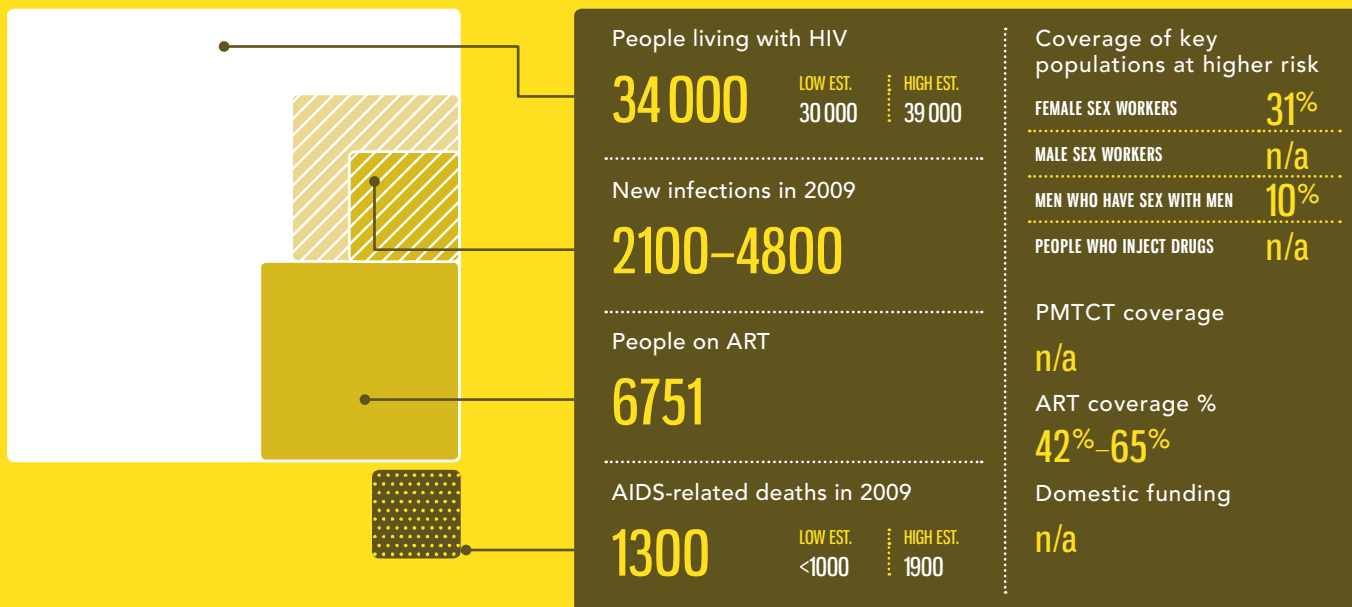
## EPIDEMIC SNAPSHOT

- There were 98 000 (79 000–120 000) people living with HIV, between 7300 and 15 000 new HIV infections and 5800 (4500–7400) AIDS-related deaths in 2009.
- The epidemic is concentrated in urban centres, with 20.8% HIV prevalence among people who inject drugs and an emerging epidemic among transgender people involved in sex work (6.1% prevalence).  
Source: 2010 UNGASS Country Report.

## RESPONSE HIGHLIGHTS

- Evidence on the HIV situation and response has been generated through four rounds of integrated bio-behavioural surveys (IBBS) since 2004–2005.
- Antiretroviral therapy coverage was 4% (3%–5%), with 1320 people receiving treatment in 2009.
- A model of community and home-based care led by civil society, including people living with HIV, is being implemented across the country.
- Civil rights of the transgender community was recognized in a Supreme Court decision in 2009.
- Faced with declines in external funds, a devolved AIDS response to the provinces has resulted in increased domestic resource allocation at the local level.

# Papua New Guinea



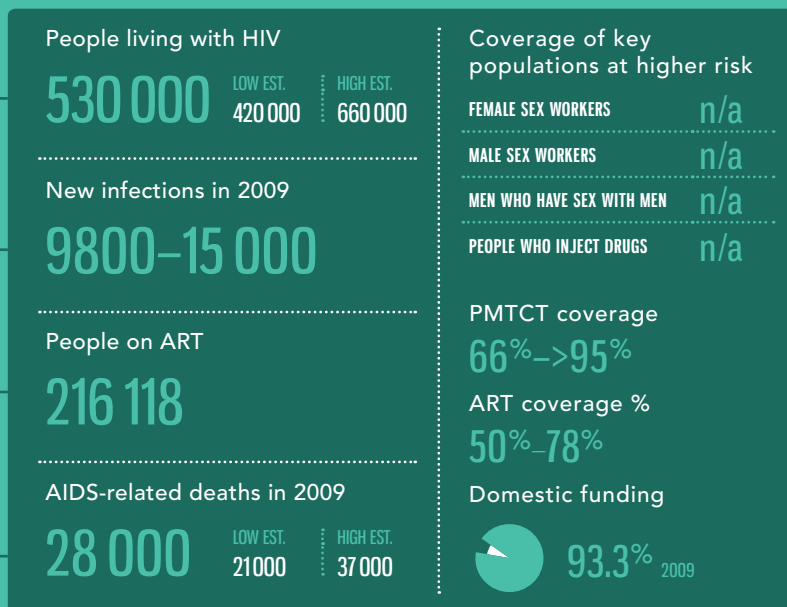
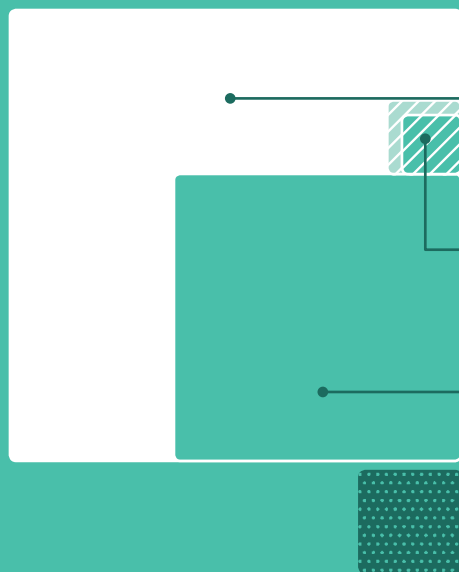
## EPIDEMIC SNAPSHOT

- There were 34 000 (30 000–39 000) people living with HIV, 3200 (2100–4800) new HIV infections and 1300 (<1000–1900) AIDS-related deaths in 2009.
- The epidemic grew rapidly in the decade up to 2005 then slowed.
- Most HIV infections were due to unprotected sex, including paid sex (17.8% unadjusted prevalence in sex workers in 2010 in Port Moresby, according to recent RDS survey) and sex between men (4.4% prevalence).
- Antiretroviral therapy coverage was 52% (42%–65%) in 2009, with 6751 people receiving treatment.

## RESPONSE HIGHLIGHTS

- Strong government commitment is leading to increased access to testing, treatment, care and support.
- Strategic information has improved (there are more sentinel surveillance sites and prevention of mother-to-child transmission testing sites), and collaboration between National AIDS Council and Department of Health is stronger.
- Partnerships with civil society, including faith-based groups and the private sector, are increasing.

# Thailand



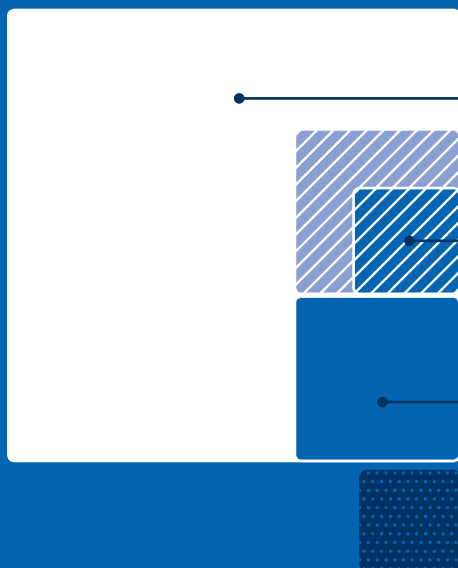
## EPIDEMIC SNAPSHOT

- There were 530 000 (420 000–660 000) people living with HIV, 12 000 (9800–15 000) new HIV infections and 28 000 (21 000–37 000) AIDS-related deaths in 2009.
- New HIV infections and AIDS deaths are declining, and there is a stable trend in HIV prevalence.
- Early success has been achieved, mainly through programmes focusing on sex work, followed with reinvigorated interventions in the 2000s.
- Injecting drug use (38.7% prevalence), sex work (2.8% prevalence among female sex workers), and unprotected sex between men (13.5% prevalence in 2009) are the main factors driving the epidemic.
- In Bangkok, HIV prevalence in cross-sectional surveys of men who have sex with men increased rapidly from 17% in 2003 to 31% in 2007, and 25% in 2009.
- Antiretroviral therapy coverage is 61% (50%–78%) in 2009, with 216 118 people receiving treatment and services to prevent mother-to-child transmission reach between 66% and over 95% of eligible women.

## RESPONSE HIGHLIGHTS

- A rapid, focused response among sex workers and clients reversed the epidemic in the 1990s.
- Meeting universal access targets for antiretroviral therapy and mother to child transmission prevention are on track.
- Subsidized health, introduced to care for previously uninsured citizens, has transformed access to health-care services including HIV services.
- The government funds more than 83% of the HIV response with domestic resources.

# Viet Nam



<p>People living with HIV</p> <p><b>280 000</b> <small>LOW EST. 220 000 HIGH EST. 350 000</small></p>	<p>Coverage of key populations at higher risk</p> <p>FEMALE SEX WORKERS <b>47%</b></p> <p>MALE SEX WORKERS <b>n/a</b></p> <p>MEN WHO HAVE SEX WITH MEN <b>24%</b></p> <p>PEOPLE WHO INJECT DRUGS <b>15%</b></p>
<p>New infections in 2009</p> <p><b>16 000–38 000</b></p>	<p>PMTCT coverage</p> <p><b>n/a</b></p>
<p>People on ART</p> <p><b>37 995</b></p>	<p>ART coverage %</p> <p><b>26%–45%</b></p>
<p>AIDS-related deaths in 2009</p> <p><b>14 000</b> <small>LOW EST. 9500 HIGH EST. 20 000</small></p>	<p>Domestic funding in 2009</p> <p><b>2.1%</b></p>

## EPIDEMIC SNAPSHOT

- There were 280 000 (220 000–350 000) people living with HIV, between 16 000 and 38 000 new HIV infections and 14 000 (9500–20 000) AIDS-related deaths in 2009.
- The HIV epidemic in Viet Nam is still in a concentrated stage (comprised of a number of local epidemics, with very specific dynamics). The highest HIV prevalence is with male injecting drugs users (18.4%), female sex workers (3.2%) and men who have sex with men (16.7%).
- Antiretroviral therapy coverage is 34% (26%–45%) in 2009, with 37 995 people receiving treatment.

## RESPONSE HIGHLIGHTS

- Rapid scale-up of prevention, treatment, care and support services have occurred over the last 10 years.
- Political commitment; collaboration between various government ministries under the leadership of the National Committee for HIV/AIDS, Drugs and Prostitution Prevention and Control; and involvement of people living with HIV have improved.
- Significant support has been received from the United States President's Emergency Plan for AIDS Relief, World Bank, United Kingdom Department for International Development, The Global Fund and other donors. However, Viet Nam's economy is growing rapidly and the total amount of donor funding is expected to significantly decrease over the next five years.
- A rights-based national HIV law has guided the response since 2006.
- Harm reduction programmes have expanded, including needle and syringe programmes, condom programmes and methadone maintenance therapy.

# THE FEATURES

Perspectives and voices on key  
HIV issues for the region

HIV and young people at higher risk:

# A TIME TO LISTEN





## ON THE DAY HE LEFT SAUDI ARABIA TO RETURN TO HIS HOME COUNTRY SRI LANKA, PALITHA WIJEBANDARA FOUND OUT WHY HE WAS BEING DEPORTED: THE ANNUAL COMPANY-STIPULATED BLOOD TEST HAD COME BACK, AND IT READ "HIV-POSITIVE".

Palitha was shocked and confused. He had been tested without his specific consent or counselling, as part of ‘company practice’, and he did not understand the implications of his test result.

At only 23 years old, he was alone. He did not know how to face his family back home in Sri Lanka. He feared the questions, “Why did you leave? What happened?” and he feared discovery of his serostatus and of the fact that he had been having relations with men—a deeply held secret of his. At his wits’ end, he contemplated suicide.

Determination and courage saw him through. Five years later, Palitha is ‘living positively’ with HIV and has become a well-known HIV activist in his country (see *Time to Lead*, page 45).

“Finding myself HIV-positive changed my life completely,” he reflects. “I had to change all my plans. Before I went to Saudi Arabia, I had this idea of earning money. I thought I would end up entering a heterosexual marriage, because that is what you do to have a family as a ‘normal’ man, to take care of my parents. I thought homosexuality was an illness,” he recalls. “I was very confused.”

Palitha is one of many thousands of young people in Asia and the Pacific who have become HIV-positive. Young people from key affected populations—young people who buy and sell sex, young men who have sex with men, adolescents who use drugs and young transgender people—face high risks of HIV infection.

Statistics show that 41% of people who have recently become HIV-positive are younger than 25 years. Although data on young people who are at higher risk of contracting HIV are sparse, the estimates that do exist are troubling. In some Asian countries, three out of five female sex workers, and almost half of all men who have sex with men, are younger than 25 years. In the Lao People’s Democratic Republic, 82% of sex workers and half of men who have sex with men are in that age group.

The same is true for people who inject drugs. In Nepal, half of all people who inject drugs start injecting in their late adolescence, when they are between 15 and 21 years old. By the time someone has been injecting for a year, there is a 33% chance that they will have acquired HIV.

Despite such high vulnerability, young people from key populations at higher risk find it difficult to obtain information on HIV, sterile injecting equipment, or other services such as HIV testing and support.

Stigma, the criminalization of certain behaviours and other legal hindrances, and funding shortages mean that young people from key populations at higher risk are often difficult to reach with services and information that can protect them (see *Why is it so Difficult to Reach Young People at Risk?*, page 44). Often, they are also robbed of the voice to describe, discuss and alter their realities.

The following pages feature personal stories from young people who are living with HIV or who are from key populations at higher risk. They discuss their fears, their aspirations and the need for their voices to be heard in the AIDS response. The feature also includes information and discussion on why young people at higher risk are difficult to reach in HIV programming and the importance of youth leadership for progress.

**"SOME THINGS ARE HARD TO SAY OPENLY"**

**XIAO CHEN\*** 21 CHINA

As a young gay man, one of the main problems to access health, HIV or STI [sexually transmitted infection] services is being too embarrassed. Some things are hard to say openly and you worry that if you say those things, people will discriminate against you.

The first time I wanted to get an HIV test, I had no idea where to get it and I was too scared to go to the hospital. I only found out where to go later from a friend who'd already been for a test. I am not HIV-positive.

I've been to free training classes [given] by some organizations which taught me the most important thing is each time you have sex, you need to use protection. Secondly, you shouldn't sleep around. These programmes are really useful. They not only teach you how to protect yourself, but also how to take care of your friends. We need to know about how treatment of HIV works and what testing involves, and we need materials to teach us about HIV.

There needs to be more awareness-raising work. The main problem is people in this group have too much casual sex and do not actively get tested on a regular basis. Also, some people are too concerned about losing face to stand up and make their voices heard.

Young people have plenty to say, but their voices aren't heard. Nowadays, the media never stop doing live reports on the newest, most exciting news, but they quickly lose interest when it is about HIV. I think if people paid more attention to HIV and strengthened the voice of the community a bit, more people would learn about HIV and understand the issues.

**"WORK WITH US, SIT WITH US, FEEL WITH US AND WE WILL BE ABLE TO REDUCE HIV TRANSMISSION"**

**LINDA JOHN** 27 PAPUA NEW GUINEA

I found out I was HIV-positive in 2004, at age 20 when I was pregnant and had to go to the clinic. It was a big challenge being a young person with HIV. Young people these days are more vulnerable to the HIV epidemic and yet people—especially parents—don't understand what we need.

I now represent people living with HIV as a national focal point for YouthLEAD (see the *Time to lead* side bar), as well as Igat Hope in Papua New Guinea, which is an affiliate of YouthLEAD. Together, we are a region-wide project that gives voice to adolescents in designing and shaping the response to the epidemic.

In Papua New Guinea, it is very difficult to talk about sex in the family, although young people have sex and use drugs and alcohol. A lot of them suffer sexual abuse and violence, and when you look at the statistics in our country, most of the people living with HIV are around 25 years old.

Lots of young sex workers in Papua New Guinea I know are dying of AIDS, because fear of stigma and discrimination stopped them from accessing the treatment, care and support they need.

We have lots of work to do. We need to be empowered and supported so that we can take ownership of AIDS. What I'm calling for is to work with us, sit with us, feel with us and we will be able to reduce HIV transmission.

\* Some names have been changed to protect the identities of the interviewees.

**PAYAL 18 NEPAL**

I started with cigarettes and hash at 14. By 15, I moved to 'brown sugar' [heroin]. At 17 I was injecting. I always had enough money to buy drugs, but my friends who didn't had to have sex with the dealer to get them.

As a young woman, it was difficult to get syringes from medical shops so I'd ask the boys to buy them for me. I had heard of organizations that give out needles, but many are far and they only target the boys. Besides, the syringes distributed are only 5 mL. When we mix the formula for injecting, it is more than 5 mL, so we had to use them twice despite getting abscesses and being in a lot of pain.

And if the police are suspicious, they body search you. If they find syringes, they harass and insult us, and take us [in] to custody. Sometimes they beat us up.

I've been clean for the past six or seven months, thanks to Positive Voice, which helped me to understand needles can also transmit HIV. Before this, I thought it was only transmitted sexually. Now I visit the centre regularly.

I'm scared of HIV but also not too scared because I know I should use clean needles and condoms. But some of my friends don't know this—there is not enough outreach for young women. Most NGOs [nongovernmental organizations] and programmes for people who use drugs target men.

# "YOUNG FEMALE DRUG USERS HAVE LESS INFORMATION ON HOW TO BE SAFE"

When I visited a VCT [voluntary counselling and testing] clinic, health personnel were not polite and immediately asked me if I was a sex worker. A doctor asked me outright, "Are you HIV-positive?" This discouraged me from going to the clinics.

Sex workers and female drug users find it hard to open up because it is not proper for a young woman to talk about sex and syringes. We have less information on how to be safe. To be honest, condoms are used more to prevent pregnancy than for HIV.

I am now working as a peer educator at Aavash Samuha, an NGO. I try to motivate young female drug users to come to the clinics and tell them my story. But there are also lots of users who do not want to change their behaviour and we have to also respect that. I just try to get them to visit the drop-in centres.

## "WITH COMMUNITY MOBILIZERS, I STARTED TO GO TO VCT"

MS FULMAYA 16 NEPAL

I started [working] in a guesthouse when I was 15. I was at school, but since my family situation was not good, some of my friends said if I wanted to earn some money I could try sex work.

My parents don't know what I do. They think I am going out with friends. I am not at school any more.

Community mobilizers came up to me one day during their outreach, and with them I started going to VCT clinics. If I had been alone I wouldn't go, but with them I felt comfortable. At the centres, I got information on condoms and that if a condom ruptures I should get tested. Before meeting them, I didn't know about HIV or STIs.

There are different types of clients. Some want to use condoms, but I don't know if that is due more to avoid pregnancy. A few don't want to use condoms. Some clients agree to use condoms in the beginning, but start bargaining or change their minds once we get into the room. If this happens, I try to negotiate.

I am afraid of getting HIV because I worry I might transmit it to my family and they might get discriminated [against] within the community.

I don't think prevention campaigns really work—they don't reach out to young female sex workers, as often we do not come out to access the information, and if we do it doesn't speak to us.

I am trying to help others, telling them how to use condoms properly and encouraging them to get tested and counselled.

I want the government to provide more opportunities for young people to work. I want to make a difference.

I am fed up with the police and I hate the clients' misbehaviour and violence. Governments and agencies should really try to address this. We have self respect and don't want others to hurt us.

## "IT IS CRITICAL TO END PREJUDICE AND FEAR AGAINST HIV AND AIDS"

POLARIS 23 REPUBLIC OF KOREA

I found out I had HIV while serving in the military, where testing is compulsory for all soldiers. Up to that time, I had avoided taking the test out of fear.

There have been several HIV campaigns in South Korea, but they are not well appreciated by the general public. The campaigns are one-day events—usually on World AIDS Day [1 December]. They are not conducted in an efficient or effective way, and are very superficial. That's one reason why the public lacks knowledge on HIV or simply does not care. Thus, I believe large-scale public relations campaigns targeting the general population are necessary elements to enhance their effectiveness.

Korean youths need pragmatic and accurate information to learn and understand about sex—I suggest a 'sexuality museum' could help do that. Basic information and awareness-raising should start at the elementary school level.

I would rather see zero discrimination and stigmatization than a zero HIV society. I believe it is critical to end prejudice and fear against HIV and AIDS in Korean society. Korean youth has not been much engaged in social movements or activities to promote human rights of marginalized people, because young people think HIV does not concern them. It is essential for people living with HIV and lesbian, gay, bisexual and transgender [people] and other marginalized groups to get together in workshops, discussions and seminars so they can discuss common issues, identify their different needs, and voice them through better advocacy.

# "I FEEL MORE ALONE NOW"

## BUGOI 16 PHILIPPINES

The youngest of five siblings, Bugoi—who is transgender—has been living in the alleys of Adriatico Malate in Manila, doing sex work in the evening and then sleeping on the street or in a friend's house in the morning. Bugoi started sex work at a very young age. Six months ago, she started smoking marijuana and taking methamphetamine (shabu), either orally or by snorting it, which she believed was safer than injecting. Her friends told her the drugs would boost her stamina during sex work.

"Sometime our clients offer us the drugs and if we perform well, they give us extra pay and a shabu for free. Clients often prefer to use shabu before we have sex. I feel numb every time I use shabu, I don't care about what people say anymore, I just want to do the things I want to do. My body is full of energy.

I've been arrested three times before because the police found marijuana on me. I was sent to prison for 16 days, where the adult inmates discriminated [against] me because I'm transgender.

People call me names like 'gay boy who use[s] drugs'. Whenever they say this I feel hurt inside. I still keep my poise and act normally, but I feel more alone now.

I'm afraid one day my family will find out about my sex work and drugs. But I have no choice as I need to help my mother earn another day's living.

I can't get the free HIV test because I don't want my mother to know what I'm doing and so I cannot provide the clinic with parental consent. So I have to go to Yafa—a youth NGO—to ask [for a] consent letter from the volunteers.

It's a hassle to do that when all I want is to know my HIV status and whether I have a sexually transmitted infection.

I hope someday things will change. I dream of travelling the world someday. I'm being trained to become a peer educator to other young transgender people in sex work who also use drugs. I came to realize how important it is to share my knowledge with my peers about HIV as well as about our rights as young people. In my own little way at least I know I helped."

## WHY IS IT SO DIFFICULT TO REACH YOUNG PEOPLE AT RISK?

**MISMATCHED FUNDING**—In Asia, an estimated 90% of HIV resources for young people are focused on people with low risks of HIV infection, even though they only represent a small proportion of total HIV infections. This leaves fewer resources for young people who are at higher risk of HIV infection.

**DATA SHORTAGE**—Data on the behaviour and HIV prevalence of young people who are at higher risk of HIV are in short supply. This is partly because young people at higher risk are not integrated into the current survey systems, partly because they are reluctant to participate in surveys, and partly due to various legal constraints (see below). There are few reliable estimates of the numbers of young sex workers, young people who inject drugs and young men who have sex with men in Asia and the Pacific. Some countries (such as Bhutan, Nepal and the Philippines) are making progress in gathering such data, but these changes are small in scale and there is still much to be done.

**LEGAL CONCERNS**—In many countries parental consent is an issue for people younger than 18 years when they try to access HIV services. In many countries, taking HIV tests and tests for sexually transmitted infections, going on HIV treatment, or using reproductive health or harm-reduction services requires the consent of a parent or guardian. This prevents many young people from knowing their HIV status and seeking treatment and care. In South-East Asia, only one of the seven countries that responded to a WHO survey had provisions that enabled minors to access contraceptives, HIV testing or harm-reduction services without parental consent.

**EASE OF ACCESS**—Many adolescents find sexually transmitted infection clinics and HIV clinics intimidating, and feel uncomfortable

talking about personal issues with clinical staff who are much older than them, and who can be judgmental. In addition, harm reduction programmes for people who inject drugs generally focus on adults, despite statistics that show some young people who inject drugs start injecting as early as 12 years old.

**SELF-IDENTIFICATION AND MISSED MESSAGES**—Many young people who have recently started engaging in higher risk behaviours, such as selling sex, or injecting drugs, do not identify themselves as ‘sex workers’ or ‘drug users’. So outreach programmes for those groups often fail to reach these young people—and when they do, their messages and approach are not necessarily appropriate.

**STIGMA AND DISCRIMINATION**—Stigma regarding HIV is compounded by the discrimination that surrounds higher risk behaviours. This causes young people to shun services that could protect them against HIV and other infections. Many are not only worried about how the community will perceive them; they also fear for the reputations of their families.

**LIMITED PEER OUTREACH PROGRAMMES**—Focused peer outreach programmes are the most effective ways to reach young people at risk of HIV infection, but they are insufficient in size and number. Young people from key populations at higher risk need to be more integrally involved in their design and implementation.

Sources: *Commission on AIDS in Asia. Redefining AIDS in Asia: Crafting an effective response.* New Delhi, Oxford University Press, 2008.

UNDP, ESCAP, UNAIDS & Global Commission on HIV and the Law. *Regional Issues brief 2: Rights of children and young people to access HIV-related services.* Bangkok, United Nations Development Programme, 2011 ([http://asia-pacific.undp.org/practices/hivaids/documents/aprd/IssuesBrief\\_Children.pdf](http://asia-pacific.undp.org/practices/hivaids/documents/aprd/IssuesBrief_Children.pdf), accessed 10 August 2011).

UNICEF, UNAIDS, UNESCO, UNFPA, ILO, WHO and The World Bank. *Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood.* New York, United Nations Children's Fund, 2011.

UNAIDS Inter-Agency Task Team on HIV and Young, UNFPA. *Guidance Brief: HIV interventions for most-at-risk young people.* New York, United Nations Population Fund, 2008.

## TIME TO LEAD

Young people from key populations at higher risk can play crucial roles in HIV programmes. Developing and harnessing that potential remains an important gap in the region's AIDS responses.

Palitha Wijebandara, the young Sri Lankan featured earlier in this article, drew strength from his involvement in peer support and from his efforts to promote the rights of young lesbian, gay, bisexual and transgender people. He is an example of the many young people in Asia and the Pacific who are ready and able to lead HIV activities.

Set up in May 2010, YouthLEAD is one initiative in the region beginning to harness the leadership potential of young people from key populations at higher risk. Initiated by Coalition of Asia Pacific Regional Networks on HIV/AIDS (also known as Seven Sisters), with support from the United Nations Population Fund (UNFPA), YouthLEAD is helping develop youth leadership in key populations at higher risk to strengthen their involvement in community, national and regional programmes.

In just over a year of operation, 30 YouthLEAD focal points from 15 countries have represented their young peers at high-level events across the region and globally, blending advocacy with artistic performances to underline their message, "Do you see me?"

YouthLEAD is launching the New Generation Leadership Initiative at the 10th International Congress on AIDS in Asia and the Pacific. This course-based initiative will build the leadership skills and capacity of young people representing or working closely with young key populations at higher risk. The course is designed and delivered by young people in collaboration with education, media and communication experts. It will be piloted during the Congress and will then become available elsewhere in the region in the following year.

Find out more: [www.youth-lead.org](http://www.youth-lead.org)



YouthLEAD performing at the 2011 Asia-Pacific Universal Access Consultation in Bangkok, Thailand.

SEX WORK

+ HIV

PROGRAMMING:

TIME FOR

A MAKE-OVER?



**IN THE ASIA AND THE PACIFIC AIDS RESPONSE, SEX WORK PROGRAMMING IS, IN MANY COUNTRIES, SEEN AS A GREAT SUCCESS STORY. COUNTRIES THAT HAVE REDUCED THEIR NATIONAL HIV INFECTION LEVELS ATTRIBUTE THE FEAT TO A DETERMINED DRIVE TO INCREASE CONDOM USE DURING PAID SEX. THE STORY, HOWEVER, IS MORE COMPLEX.**

Lower national HIV prevalence among sex workers often masks much higher rates of HIV infection in specific geographical areas. And, despite the recognition that sex work programmes have been critically important in the region's AIDS response, funding for sex work programming in most countries has been shrinking since 2007, according to analysis of UNGASS Country Data.

“While there has been real progress in addressing HIV in the context of sex work in the region, too often it is viewed as a battle that is almost won,” says Julia Cabassi, UNFPA Regional Adviser on HIV and Most-at-Risk Populations.

“In reality, the battle is far from over,” she warns. “Sex work is changing across the region, and HIV programmes are not adapting quickly enough.”

#### **TIMES OF CHANGE**

Sex work is an evolving phenomenon. Policy shifts, police 'crackdowns' and the ubiquitous presence of mobile phones and the Internet have enabled sex workers to shift away from brothels towards more indirect, mobile and flexible forms of sex work, including home-based work.

These changes have been occurring for at least a decade. In 2003, for example, 40% of surveyed beer promoters and 56% of karaoke singers in Cambodia reported selling sex in the previous year, according to a Ministry of Health report on HIV sentinel surveillance.

A study in India, *Reaching the un-reached: an exploratory study of hidden and difficult to reach sex workers in Tamil Nadu*, pointed to the existence of large numbers of “hidden and difficult to reach sex workers” who operate in various guises: small-time or 'side' actresses, escorts, masseuses, housewives, bar girls, dancers, students and more.

The *AIDS 2031 report on Asian economies in rapid transition: HIV now and through 2031* confirmed that changing social patterns, increased migration and mobility, greater economic uncertainty and the proliferation of networking opportunities (especially via mobile phones and Internet technology) are making sex more readily available and easier to sell.

A number of studies, including those mentioned previously, show that people who engage in sex work are also becoming more varied. Increasingly, young, educated, urban women are

supplementing their incomes by selling sex ‘on the side.’

Strategies for reaching the diverse range of people who sell sex with reliable and relevant HIV information have not kept up with the changing dynamics of the profession. The Tamil Nadu study noted that consistent condom use and awareness about proper condom use were low, and knowledge about sexually transmitted infections, HIV and treatment options were poor.

### LIMITS OF SUCCESS

Several countries in South-East and East Asia have implemented the 100% Condom Use Programme (100% CUP), an approach that is credited with reducing HIV among sex workers in the 1990s and early 2000s in Cambodia and Thailand, as well as several other countries in the region.

The programme aims to ensure that condoms are used 100% of the time during paid sex, and in other risky sexual encounters.

However, there are serious concerns that in some countries, the 100% CUP is misused by government authorities, resulting in severe, negative effects on sex workers’ rights and their ability to protect themselves from violence.

The 100% CUP relies on various ways to get sex establishments to comply with it. However, evidence suggests that enforcement mechanisms are often used to target and harass individual sex workers.

Clients of sex workers are not usually targeted in this approach. Instead, they are positioned as ‘informers’ of non-compliance via contact tracing that identifies

One of over 500 dolls dressed by sex workers across Asia and the Pacific in an art exercise organized through APNSW to underline the messages sex workers want the world to hear.

non-compliant establishments.

A 2008 investigative report by the Center for Advocacy on Stigma and Marginalization confirmed that the approach of the 100% CUP tends to “target sex workers as a core transmitter group”. By doing so, this approach reinforces the stereotype of sex workers as vectors of disease, and “perpetuates the stigma and discrimination that hinders sex workers’ ability to advocate their rights,” the report noted in its Executive Summary.

The study also claimed that some of those responsible for implementing the 100% CUP approach (including health-care providers and law enforcers) used coercive methods, such as forced HIV testing, deprivation of income and health care, and harassment and extortion.

“Police violence and the rule of law are the biggest challenges in addressing key issues of sex work and HIV,” says Andrew Hunter, Programme and Policy Director of the Asia Pacific Network of Sex Workers (APNSW).

“Involving police in ensuring compliance with 100% condom use leads to corruption ... it typically involves discretionary power—and therefore abuse,” he says.

Legal measures that criminalize sex workers (and the organizations that provide them with health and other services) exist in most countries in the region. These laws and regulations tend to cast a wide net, and can sanction action against anything, from people trafficking to public indecency. As discussed in the background report prepared for the 2010 Asia and the Pacific Regional Consultation on Sex Work and HIV, in practice, these laws and regulations also facilitate police crackdowns, institutionalized harassment, detention and extortion of sex workers.

“Police often use the possession of condoms as evidence of sex work,” says Kay Thi Win, Programme Manager of the Targeted Outreach Programme initiative in Myanmar, which provides peer-to-peer HIV prevention and support for sex workers. “So, to avoid arrest that can involve violence, rape and other trauma, many sex workers try to avoid things that may identify them as sex workers—like carrying condoms or visiting health clinics for check-ups.”

As numerous studies have noted, law enforcement agencies often end up in conflicting roles. They are expected to help enforce the availability of condoms in entertainment venues, but at the same the criminalization of sex work



sees them using the possession of condoms as evidence of 'prostitution'.

"We must reconcile conflicting approaches, where different arms of governments support efforts to address HIV among sex workers on one hand, and undermine such efforts on the other through police raids that drive sex work underground and make sex workers fearful to carry condoms," urges Cabassi.

### MAKE-OVER TIME

So how do HIV and sex work programmes adapt to the evolving world of sex work?

Dr Smarajit Jana, Chief advisor for the Durbar Mahila Samanwaya Committee (DMSC, otherwise well known as the sex-worker led 'Sonagachi project') stresses the need for "community-led, creative solutions", where sex workers have a say in the design and implementation of programmes that affect them.

"Sex workers know about sexual behaviour better than anyone and know about clients better than anyone," he says. "Governments and the UN agencies have to engage with sex workers for HIV programming. This is proven to be more effective and reach further."

Such approaches are becoming more common. Like the DMSC Sonagachi Project, Ashodhaya in India, and the Targeted Outreach Programme in Myanmar, are among others showing the benefits of sex workers taking leadership roles in the provision of services (see *Community Trailblazers*, page 74).

Meena Seshu, director of the Indian NGO Sangram, which works on sex work and HIV, stresses that now, more than ever, sex workers need to be involved in HIV programming.

"The sex worker no longer needs to be on the street or in a brothel," she explains. "Their networks are closed. No outsider will be able to easily access them, nor know where they go for health check-ups, where they access condoms, etc."

"Without [involvement of sex workers] a whole chunk of the sex worker community will be out of reach," she warns.

### WIDER APPROACHES, OPEN MINDS

Although condom use remains critical to HIV prevention, programmes must move beyond treating condoms as the »

### CHANGING WORLD

Kamathipura in Mumbai, the world's largest red-light district, brothels in Nippani, a small town in Karnataka in southern India—these were some of Shabana Kazi's work sites. Then the 40-year-old sex worker's life changed dramatically.

The Veshya AIDS Mukabla Parishad, a sex workers' collective with which she was affiliated, was attacked. The small space in Nippani where the sex workers held their weekly meetings and ran their HIV and STI awareness project became a combat zone. Shabana says local politicians and ruffians threatened, then forced, her and other women to stop their activities. When they sought police protection, they encountered abuse. Fearing for their lives, the women moved to neighbouring districts for work.

That was more than eight years ago. Today, Shabana is not bound by geography.

"I have a cell phone. I am known," she says. "When a lodge owner in some other district or state has a client and needs me, he calls me. Everything, including my travel expenses, is paid for. The client pays the lodge owner in advance. I pay the lodge owner some small amount—what we call 'chai paani'. There are many women who are like me."

Shabana's experience illustrates the changing world of sex work in Asia and the Pacific.

## SEX WORKERS SPEAK THEIR MINDS ABOUT STIGMA, DISCRIMINATION AND VIOLENCE

“Sex workers are still mostly seen as ‘disease spreaders’, instead of being accepted as workers who make their own healthy choices as long as we get the opportunity ... Programmes still don’t believe sex workers themselves can prevent HIV,” said a sex worker from Thailand, one of 140 who attended the first Asia-Pacific Regional Consultation on HIV and Sex Work, held in October 2010 in Pattaya, Thailand.

“We can’t tell our names and where we are from ... When seeking treatment for STIs, they require us to disclose our identity and our occupation and health-care workers discriminate against us,” complained a Chinese sex worker.

Akram Anwar and his colleagues who work with Ashodhaya, a community-based organization of sex workers in southern India, says that one of the biggest issues facing male sex workers is violence and a lack of community support.

“Unlike the ‘ordinary’ men who have sex [with] men, male sex workers are a visible group because they wear make-up,” he explains. “This leads to more discrimination. Typically, the police slap on petty charges to harass and humiliate them before their family. Police raids drive male sex workers underground. It makes the population who are already at risk invisible.”

» ‘magical’ factor. UNFPA’s Julia Cabassi says other factors must be taken into account.

“Peer education, access for sex workers to friendly sexual and reproductive health services (including for sexually transmitted infections), voluntary counselling and testing, and HIV treatment and care are all vital,” she says.

“But services alone are not enough,” she adds. “More attention is needed to ensure a supportive environment for access to services and for creating environments that support sex workers to negotiate condom use.”

To enable greater progress, governments need to reconcile conflicting law enforcement and public health approaches to ensure that HIV prevention efforts are supported and that the rights of sex workers are protected. Increased access to legal services and mechanisms for redress are critical so that sex workers can respond to rights violations.

“But we must work to prevent violence, not just provide redress once violence has occurred,” Cabassi believes.

In addition, according to Hunter, affordable, reliable and appropriate services “must be non-stigmatizing”.

“Sex workers often don’t go to STI and other health services because of stigma and discrimination,” he says.

“The very people paid to provide services to sex workers are often the most discriminatory. We need to address this and make sure all health services are accessible for all people, including sex workers.”

### WORK IT OUT

The International Labour Organization’s (ILO) recommendation concerning HIV and AIDS and the world of work, which was adopted by governments, employers and workers from around the world in mid-2010, lays the foundation for a shift in the way sex work is recognized.

Sex workers have campaigned for sex work to be recognized as work, and that working conditions in the sex industry be made safer through alignment with national and international standards on prevention and management in the workplace, occupational health and safety protections, and access to social security.

The recommendation is the first international labour standard on HIV and the world of work. It expresses the



Sex workers take to the streets in Zi Teng, Hong Kong to advocate "Sex work is work!"

principle of universal access to prevention, treatment, care and support services, and provides a scope of application that covers sex work (by using broad definitions of work and workers). According to the recommendation, sex workers are entitled to the same standards and protections in the workplace as workers in any other industry.

"This labour standard on HIV and AIDS provides an opportunity to call on the labour sector to take steps to address the basic human rights of sex workers, including protection from workplace violence, the need for safe working conditions and access to healthcare," says Richard Howard, ILO Senior Specialist on HIV and AIDS in Asia and the Pacific.

Policy-makers seem serious about the shift. At a regional consultation on sex work and HIV in Pattaya, Thailand in late 2010, the Deputy Permanent Secretary at Thailand's Ministry of Public Health, Dr Siriwat Tiptaradol, stressed that sex workers earn their living and often support family members with incomes from providing sexual services.

"Sex work is an income-generating activity or a form

of employment," he explained. "As such it can be considered along with other forms of economic activity."

#### LOOKING AHEAD

The new dynamics of sex work and HIV have also brought new opportunities. Sex workers are increasingly organized and are now much more involved in defending their rights and livelihoods.

HIV programmes have to adapt to these changes, and countries need to resolve their policy contradictions so that sex workers and their clients can be protected more effectively against HIV and other scourges.

A supportive environment for sex workers to negotiate condom use is critical. Policy-makers, clients, entertainment venue managers and sex workers all have important roles to play.

"HIV and sex work programmes have the opportunity not only to help protect sex workers from HIV, but also to contribute to their wider well-being and inclusion in society," believes Kay Thi Win from Myanmar. "There is a wealth of opportunity, but we have to stand firm and continue to battle hard to overcome the challenges." ■



# A TALE OF SIX CITIES

Promoting universal access to HIV services for men who have sex with men  
and transgender people in Asia's cities



Jethro Patalinghug first felt the impact of HIV personally when one of his friends tested HIV-positive.

“I saw first-hand what it’s like to live with HIV—the struggles and difficulties that people face in their everyday lives,” explains the 34-year-old Filipino film producer, who lives in Manila.

When he learnt of his friend’s diagnosis, Jethro had just launched a video campaign promoting the rights of lesbian, gay, bisexual and transgender people called *I am not immoral*, which was becoming very successful within many sectors, including business and government.

“Suddenly everything changed,” Jethro remembers, when his friend—who would later die of an AIDS-related illness—told him the news. “I recognized that through my widening network of connections from the video campaign, I may have the power to help my friends and others realize the importance of taking the [HIV] test.”

Across Asia and the Pacific, HIV epidemics among men who have sex with men are growing. Men who have sex with men in the region are nearly 20 times more likely to be HIV-positive than the general population, according to a 2007 expert study published in *PLoS Medicine*. Data now show a trend of increasing HIV cases among men who have sex with men in urban centres.

In parts of Myanmar, 29% of men who have sex with men have tested HIV-positive in surveys, as have 5% in Indonesia, and 7%–18% in parts of southern India. Other studies point to HIV prevalence exceeding 10% in some cities in China, Thailand and Viet Nam. According to the Silom Community Clinic cohort study on men who have sex with men, undertaken in Bangkok, HIV prevalence among men who have sex with men attending the clinic increased from 25% in 2005 to 35% in 2010 (see *HIV among men who have sex with men in the cities*, page 55).

Yet the percentage of men who have sex with men reached with services that can help prevent HIV infection remains extremely low. A recent United Nations Development Programme (UNDP) review estimated that HIV prevention services reached a mere 9%–20% of men who have sex with men in Asia.

“These kinds of figures are very troubling,” says Clifton Cortez, at UNDP’s Asia-Pacific Regional Centre in Bangkok.

In 2010, responding to growing numbers of new HIV infections in urban areas, city governments, UNDP, UNAIDS and the United States Agency for International Development and NGOs set up the *Men Who Have Sex with Men and Transgender Populations Multi-City HIV Initiative in six cities: Bangkok, Chengdu, Ho Chi Minh City, Jakarta, Manila and Yangon*. The scheme is also known as the ‘Six city Initiative’.

“The policy agenda is increasingly focusing on the need for targeted city based responses,” Cortez says.

## BEHIND THE HIV SURGE IN CITIES

Asian cities have large, growing populations that encompass burgeoning middle classes and many millions of people who live in poverty with little access to health or social welfare services. For many men who have sex with men, and transgender people, these cities also offer new freedom for expressing their sexual and gender identities. But city dwellers often also experience social dislocation, isolation and limited economic opportunities, all of which can deepen their vulnerability to exploitation, rights violations and HIV infection. This adds up to an urgent need for improved and more accessible city-based health and social services.

**“The policy agenda is increasingly focusing on the need for targeted city-based responses.”**

**CLIFTON CORTEZ**  
UNDP ASIA-PACIFIC  
REGIONAL CENTRE

### **SUCCESS STORIES IN SIX CITIES: NEW WAYS OF REACHING OUT**

Building on examples of proven and effective men who have sex with men programming from Hong Kong and Singapore, the ‘Six city Initiative’ sought to highlight innovative responses and underline that city-based action can have a critical impact on tackling HIV among men who have sex with men and transgender people.

Examples of good practice were showcased at a gathering of the ‘Six city Initiative’ representatives in Hong Kong in late 2010. One example was developed by Jethro Patalinghug, who used the success of his video campaign and widening networks of contacts to create “Take the Test”, a project that provides free and rapid HIV testing at big gatherings of men who have sex with men across the Philippines.

“The death of my friend from HIV and the diagnosis of others around me strengthened my resolve to bring the message of taking the HIV test to gay men in the Philippines,” he says.

The project has been hailed for reaching large number of city-dwelling men who have sex with men, and is now part of a new wave of savvy projects that try to protect men who have sex with men and transgender people from HIV.

**“If we are to reach gay teens and young people effectively,  
we need to provide them with something new.”**

**VITTAYA SAENG-ARON**  
FILM DIRECTOR, THAILAND

### **LET’S GO ONLINE**

The Internet has become central to the social lives of many men who have sex with men and transgender people. More and more men who have sex with men are using online social networking sites to date and network, which is not surprising in a region where Internet use has increased more than five-fold since 2000.

*Love auditions*, an online safe-sex mini-series, is tapping into these social trends. “If we are to reach gay teens and young people effectively, we need to provide them with something new,” says director Vittaya Saeng-Aroon, who produced the mini-series in collaboration with his production company, Cyberfish Media, as well as the Rainbow Sky Association of Thailand and the Thai Ministry of Health. The series focuses on gay teenagers and has attracted thousands of Thai viewers who follow the exploits of three gay characters.

### **SHOW SOME STYLE**

City environments enable community gatherings of large groups of men who have sex with men and transgender people and provide ideal opportunities to publicize HIV and human rights issues. *(continued on page 56)*

»





## HIV AMONG MEN WHO HAVE SEX WITH MEN IN THE CITIES

The most recent data from the six cities participating in the 'Six city Initiative' show alarmingly high rates of HIV among men who have sex with men:

**BANGKOK**—HIV prevalence in cross-sectional surveys of men who have sex with men increased rapidly from 17% in 2003 to 31% in 2010. HIV prevalence among men who have sex with men attending the Silom Community Clinic increased from 25% in 2005 to 35% in 2010. HIV incidence in a cohort study of men who have sex with men averaged 6% over four years. Incidence was highest among young men who have sex with men aged 18–21 years, 30% of whom acquired HIV in those four years.

**CHENGDU**—HIV prevalence among men who have sex with men in Chengdu was over 10% in 2011 according to the Government of China.

**HO CHI MINH CITY**—HIV prevalence among men who have sex with men almost tripled between 2006 and 2009, rising from 5.3% to 15%. In the same period, HIV prevalence among men who have sex with men in Hanoi increased from 9.4% to 17%.

**JAKARTA**—HIV prevalence among men who have sex with men in Jakarta increased fourfold from 2% in 2003 to 8.1% in 2007. Over the same period,

HIV prevalence among transgender people increased from 25% to 34%.

**MANILA**—Newly-reported HIV and AIDS cases among men who have sex with men more than quadrupled between 2006 and 2009, and men who have sex with men accounted for approximately 70% of all new HIV case reports in 2008–2009.

**YANGON**—In 2007, HIV prevalence among men who have sex with men in the HIV Sero-Surveillance Survey was 23.5%. In the 2009 survey, prevalence was 12.5%. A wider sample of men who have sex with men was surveyed in 2009, which may explain the lower prevalence. Intensifying prevention efforts needs to be continued.

Data from the following cities also supports these findings.

### HONG KONG, JAPAN, SINGAPORE AND

**TAIWAN**—Following rapid increases in newly diagnosed HIV infections among men who have sex with men in the early 2000s, new HIV case reports have leveled off in recent years.

Source: *Men Who Have Sex With Men and Transgender Populations Multi-City HIV Initiative in Six cities: Bangkok, Chengdu (China), Ho Chi Minh City, Jakarta, Manila, and Yangon.* United States Agency for International Development Asia, UNDP Asia-Pacific Regional Centre, Hong Kong Department of Health, UNAIDS, WHO, Asia Pacific Network of People Living with HIV, Asia Pacific Coalition on Male Sexual Health, Family Health International, 2011.



» In Yangon, Myanmar, the 2011 Sedona Township Transgender Fashion Contest thrilled thousands with its competitive heats held at shopping centres across the city. The events were used to promote public awareness of HIV and advocate greater acceptance of transgender people.

Demand for tickets to the grand finale was so high that they were touted on the black market at three times the cover price. Among the 1800 guests was the chief of the city's health department, who addressed the crowd and accepted a large donation for HIV services.

#### **POSITIVE PARTNERSHIPS**

In some Asian cities, partnerships between public health providers and community organizations are beginning to improve HIV and sexual health services for men who have sex with men and transgender people.

China's Chengdu Infectious Diseases Hospital has developed a partnership model for HIV treatment adherence counselling that relies on people living with HIV (many of whom are men who have sex with men) working as lay counsellors. The arrangement also refers patients to HIV support groups and community organizations led by men who have sex with men.

**“I recognized that... I may have the power to help my friends and others realize the importance of taking the [HIV] test”**

**JETHRO PATALINGHUG**

TAKE THE TEST CAMPAIGN, THE PHILIPPINES

In Bangkok, the Poz Home Centre, a small organization led by men who have sex with men and transgender people, has set up partnerships with primary clinic sites and the outpatient sections of major hospitals. The aim is to ensure continuity of treatment and care for men who have sex with men and transgender people once they leave the clinic or hospital.

#### **CHAMPIONS TO OVERCOME CHALLENGES**

The 'Six city Initiative' has shown that progress continues to be hampered by restrictive legal environments and policies, selective enforcement practices, and a lack of coordination between local health and law enforcement officials and community-based organizations.

Urban HIV services tend to work best when they have champions in city governments who support them. In Ho Chi Minh City, the local harm-reduction department is helping remove barriers while cultivating the support of higher



authorities. Alongside that, the Chengdu Centre for Disease Control and Prevention is supporting the coordination of medical and community-based HIV services for men who have sex with men. The centre is also helping to remove legislative hurdles that make it difficult for community organizations to assist with HIV counselling and testing.

#### UNSOLVED ISSUES

Despite such progress, significant challenges remain. Innovative activities are increasing, but they are still too few to halt the epidemic among men who have sex with men and transgender people.

**"The innovative projects we are seeing are encouraging; however, too often these are scattered."**

**SHIVANANDA KHAN**

CHAIR OF THE ASIA-PACIFIC COALITION ON MALE SEXUAL HEALTH

According to a recent UNDP report, *Towards universal access: examples of municipal HIV programming for men who have sex with men and transgender people in six Asian cities*, most community-generated actions are not adequately resourced to scale up their potentially valuable work.

Shivananda Khan, chair of the Asia-Pacific Coalition on Male Sexual Health, agrees: "the innovative projects we are seeing are encouraging; however, too often these are scattered with individual projects that are effective in small numbers".

"We need a more strategic approach," he believes.

Meanwhile, HIV services for transgender people remain scarce. HIV programming usually merges transgender people into programmes for men who have sex with men, often with little insight into their particular service-delivery needs.

The contradictions between policing practices and public health campaigns are another barrier to effective implementation.

Police often regard possession of condoms as evidence that a person sells sex. At the same time, local public health services are promoting and distributing condoms to prevent HIV and other sexually transmitted infections. Young men who have sex with men, and transgender people trying to access HIV services, can find the path blocked by age-of-consent requirements and the need to obtain parental consent for HIV testing.

"There seems to be resistance to new ideas and innovations that [may] threaten long-established approaches," warns Jethro Patalinghug. "But determination and collaboration can get past those obstacles," he adds. ■



# FROM THE DESK OF

After a day's work in mid-June 2011, the desk of a regional Asia and the Pacific focal point for HIV and people who use drugs tells some interesting stories—snapshots of some of the challenges and opportunities currently at play within efforts to promote harm reduction and HIV services for people who use drugs.

**MEMO**

Hi J...

Pls look at new commitments from the UN General Assembly High Level Meeting versus current state of affairs in region. Need a few key points for mts tomorrow. Tks.

There is limited data for numbers of people who inject drugs on ART. A global review found that fewer than 10 in 100 people who inject drugs living with HIV were receiving ART in a number of countries in Asia and the Pacific.

WHO, UNODC and UNAIDS recommendation for evidence-informed treatment of opioid dependence is clear. But countries still implement approaches that are not supported by evidence and may actually do more harm; for example, herbal medicines, crackdowns, detentions.

Global Commission on Drug Policy Study  
June 2011 - important development

## Drugs war 'a failure' - Commission

LED BY HIGH-PROFILE MEMBERS INCLUDING SEVERAL FORMER Presidents, the Global Commission on Drug Policy's report found that the repressive "war on drugs" has achieved the opposite of its goal: driving drug use rates up for the profit of black market cartels. People who inject drugs (such as heroin) also run a much higher risk of getting infected with HIV if they live in a "100% repression" country, such as Thailand or Russia.



## The comprehensive package

Interventions for HIV prevention, treatment and care among people who inject drugs

- Needle and syringe programmes (NSPs)
- Opioid substitution therapy (OST) and other drug dependence treatment
- HIV Testing and counseling
- Antiretroviral therapy (ART)
- Prevention and treatment of STIs

Opioid substitution therapy programmes are increasing rapidly in the region, but opioid substitution therapy coverage is only at 5%.

Lack of sustained \$\$ = huge increase in needle sharing (eg. Nepal, Bangladesh)

Approximately 309 000 people who use drugs are detained in compulsory detention centres.

## Draft drugs law calls for two-year detentions

A draft drug law that calls for drug users to be subjected to up to two years of involuntary rehabilitation is expected to be finalised at the end of the month, officials said earlier this week.

system of compulsory drug treatment violates international human rights law and is not supported by either scientific evidence or international medical practice.



Prevalence of hepatitis C among people who inject drugs is as high as 90% in some countries. But diagnosis and treatment of hepatitis C is lacking for most.

"Sometimes I get clean needles, sometimes I don't. Particularly during office holidays."

"The funny thing is, in our country, the Ministry of Health distributes needles and syringes but then the Ministry of Home Affairs arrests us for carrying them."



**Bijay Pandey**  
A leader of an organization for people who inject drugs in Nepal

Read more from Bijay Pandey over the page—Ed

Programmes designed and implemented by communities work best. Creation of Asian Network of People who Use Drugs has strengthened the meaningful participation and involvement of people who use drugs in developing policy and programmes.

Source: WHO, UNODC and UNAIDS. Technical guide 2009

China - 700 methadone maintenance treatment clinics and over 200 medication places in 27 provinces, attended by 130000 frequent patients

- Condom programmes for IDUs and their sexual partners
- Targetted information, education and communication for IDUs and their sexual partners
- Vaccination, diagnosis and treatment of viral hepatitis
- Prevention, diagnosis and treatment of TB

Australia is at the forefront of harm reduction since 1985.



The recommended level of coverage of needle and syringe (NSP) programmes is 60% of people who inject drugs. But only 14% of people who inject drugs in Asia are being reached with needle NSP.

Needle and syringe programmes prevent HIV transmission. Between 2000-2009, investment in needle and syringe programmes in Australia resulted in:  
- prevention of estimated 96 667 HIV infections  
- substantial health-care cost savings to government related to hepatitis C and HIV.

Malaysia Has moved away from compulsory drug detention centres, progress in harm reduction, especially in scaling up methadone maintenance treatment.

Sources:  
WHO, UNODC and UNAIDS. Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization, 2009.  
Mathers BM et al. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet*, 2010, 375:1014-1028.  
Anne Bergstrom. UNODC Regional Centre for East Asia and the Pacific, personal communication, June 2011.  
Cook C & Kanaef N. *Global State of Harm Reduction, 2008*. London, International Harm Reduction Association, 2008.

NSP continue to be questioned and services shut down.

### Methadone, clean needles reduce HIV infections

Harm reduction has been surrounded by controversy since the mid 1980s when needle exchanges and substitution treatments were first introduced in Western Europe. Social and political attitudes on how to tackle drug use differ greatly, but all governments promote drug use prevention through supply and

when the message should be abstinence from drugs. Substitution drug treatment is a difficult concept for many to accept; critics argue that this prolongs drug addiction or provides users with drugs to sell on the street to fund further drug use. Although outreach work in the

National Centre in HIV Epidemiology and Clinical Research, University of New South Wales. *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia*. Canberra, Commonwealth of Australia Department of Health and Aging, 2009.  
WHO (WPRO) & Ministry of Health of Malaysia. *Good Practices in Asia: effective paradigm shifts towards an improved national response to drugs and HIV/AIDS: scale-up of harm reduction in Malaysia*. Manila, World Health Organization, 2011.

# FROM THE MOUTH OF “WE NEED POLICY REFORM TO MAKE POSSIBILITIES INTO REALITIES”



BIJAY PANDEY IS FROM NEPAL AND LEADS **NAYA GORETO**, AN ORGANIZATION RUN BY AND FOR PEOPLE WHO USE DRUGS, AND WHICH ADVOCATES FOR THE RIGHTS OF THE DRUG-USING POPULATION. BIJAY PREVIOUSLY WORKED FOR MANY YEARS WITH YOUTH VISION, WHICH HAS BEEN PROVIDING SERVICES TO PEOPLE WHO USE DRUGS FOR MORE THAN TWO DECADES AND IS ONE OF THE KEY HARM-REDUCTION SERVICE PROVIDERS IN NEPAL. BIJAY IS ALSO THE VICE-CHAIR OF THE ASIAN NETWORK OF PEOPLE WHO USE DRUGS.



### What are the key issues facing people who use drugs in your country?

For us, universal access seems a distant dream. It is very difficult to access the services I need. Sometimes I get clean needles, sometimes I don't—particularly during office holidays. I often have to wait in very long queues, or have to follow up many times before I am able to get access to opioid substitution therapy (OST).

Due to the existing laws of the land, I am often treated as criminal. The funny thing is that in our country, the Ministry of Health distributes syringes, but then the Ministry of Home Affairs (the cops) arrests us for carrying them.

We need proper medical care and emergency responses. This includes having shelter available for people who need health care. We need prompt availability of services—we drug users are often not accommodated even when we seek services. I think economic stability is the most essential component for drug users, which has not been focused on much. We also need essential care: detox, OST, treatment over the long term. Currently, this is definitely inadequate. And for all of this, we need policy reform—to make these possibilities into realities.

**"THE FUNNY THING IS THAT IN OUR COUNTRY, THE MINISTRY OF HEALTH DISTRIBUTES SYRINGES, BUT THEN THE MINISTRY OF HOME AFFAIRS (THE COPS) ARRESTS US FOR CARRYING THEM."**

### What do you think is needed for people who use drugs to be empowered to protect themselves from HIV?

Firstly, people who use drugs should not be punished or criminalized for their use of drugs. Secondly, they need comprehensive harm-reduction services along with enough information. And last but not least, we need employment opportunities.

Proper information and education can help lead to safer injecting, safer sex, knowledge on potential risk of HIV during drug use and related phenomena. People who inject drugs absolutely need availability of adequate amounts of injecting equipment and availability of condoms to help protect ourselves from HIV. ■

A woman with long dark hair, wearing a pink and white patterned shirt, is sitting on the left side of the frame, looking towards a young girl. The girl is standing on the right, wearing a white sleeveless top with a red ribbon and blue jeans. They are in a brightly lit, colorful environment with wooden beams and flags in the background. The text "BORN FREE (OF HIV)" is overlaid in the center, with "BORN FREE" in large white letters and "(OF HIV)" in smaller white letters to the right. The text is set against a semi-transparent grid of white dots.

**BORN  
FREE** (OF HIV)





## PROVIDING PREGNANT WOMEN LIVING WITH HIV WITH ANTIRETROVIRAL PREVENTION AND TREATMENT REDUCES THE RISK OF A CHILD BECOMING INFECTED WITH HIV TO LESS THAN 5% — AND KEEPS THE MOTHERS ALIVE.

UNAIDS Executive Director Michel Sidibé issued a bold call in early 2009: end new HIV infections among infants by 2015.

Two years later, the 192 Member States of the United Nations unanimously agreed to eliminate new HIV infections among children by 2015 when they signed the Political Declaration at the UN General Assembly High Level Meeting on AIDS in June 2011. World leaders also launched the Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive (2011–2015).

“We believe that by 2015, children everywhere can be born free of HIV and that their mothers can remain healthy,” said Mr Sidibé at the launch of the plan. “This new global plan is realistic, it is achievable and it is driven by the most affected countries.” The Global Plan was developed by a multistakeholder group which included representation of more than 30 countries.

Achieving the target will contribute to reach MDG 6 (Halt and begin to reverse the HIV epidemic), as well as MDGs 3 (Promote gender equality and empower women), 4 (Reduce child mortality) and 5 (Improve maternal health).

### ASIA AND THE PACIFIC RISING TO THE CHALLENGE

At a November 2010 meeting in the Lao People’s Democratic Republic, government, civil society and UN representatives from the region agreed that the goal of eliminating new HIV among children was achievable in Asia and the Pacific. A regional framework was adopted

to guide countries in accelerating their efforts to prevent mother-to-child transmission of HIV.

Malaysia and Thailand have already moved significantly towards the 2015 goal, with coverage rates exceeding 80%. However, regional coverage lags the global average, with the biggest coverage gap being in South Asia, mainly India.

As Asia and the Pacific gears up towards the target of eliminating new HIV infections among children, here we outline a selection of programmes and initiatives in the region that are helping countries close in on the ultimate goal of zero new HIV infections.

### THE ‘LINKED RESPONSE’ IN CAMBODIA

Until 2007, prevention of mother-to-child transmission programmes were improving relatively slowly, compared to other maternal and child health, and HIV-related areas. A year later, however, the National AIDS Committee and the National Maternal and Child Health Centre introduced a new, collaborative strategy: the ‘Linked Response’.

Piloted in five health districts, the strategy reached its third-year goal of 80% HIV testing coverage within the first year. This was achieved by closely linking HIV, maternal and newborn health, and sexual reproductive health services. This approach ensured that pregnant women had access to a package of services, while enabling effective communication and referrals between services to reach all women at risk.

In addition to government and development partners,

community-based organizations played a pivotal role in the scheme's success. By coordinating district AIDS and maternal and child health administrators and health workers, and by using HIV resources to equip public health facilities, the scheme has led to broad improvements in Cambodia's public health system.

The success of 'Linked Response' led to its country-wide application in 2009. This approach has since been used to expand the provision of quality and comprehensive services across Cambodia.

#### **INCREASED POLITICAL COMMITMENT OF INDIA**

Addressing the UN General Assembly in June 2011, India's Minister of Health and Family Welfare declared his country's commitment to "convert the 27 million annual

pregnancies into institutional deliveries for efficacious preventive interventions through better detection of HIV positivity amongst pregnant women".

"From a paltry 700 000 institutional deliveries in 2006, the number of institutional deliveries has increased to over 10 million in 2010," he said. In India, an estimated 65 000 women living with HIV get pregnant and 19 500 infants are becoming infected with HIV each year. That makes India the country with the largest burden of new paediatric HIV infections in the region, and ranks it among the 10 countries globally with the highest number of women and children in need of antiretroviral therapy.

India's National AIDS Control Programme III (2007–2012) shifted the country's strategy from a state-based to a district-based response. All 609 districts are now categorized based on HIV prevalence, and a specific strategy

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## **THE FOUR PRONG STRATEGY**

A comprehensive approach to preventing new HIV infections among children and keeping their mothers alive consists of four prongs:

- Providing comprehensive HIV prevention services to women of reproductive age within reproductive and maternal health services such as antenatal care, postpartum and postnatal care, and other health and HIV services, including through involvement of male partners and working with community structures.
- Providing appropriate counselling and support and contraceptives to women living with HIV to meet their need for family planning and spacing of births, and to optimize health outcomes for them and their children.
- For pregnant women living with HIV, ensuring HIV testing and counselling and access to the antiretroviral drugs needed to prevent HIV infection from being passed on to their babies during pregnancy, delivery and breastfeeding.
- Providing HIV care, treatment and support for women and children living with HIV and their families.

Each of these four prongs is key for preventing HIV infections in children and improving maternal and child survival in the context of HIV. Progress on prong 3 (preventing transmission of HIV from mothers to babies) alone will not be enough to reach the goal of eliminating new HIV infections among children. The Global Plan emphasizes the need to also intensify efforts to reduce new HIV infections among women. This will require scale-up of HIV prevention among key populations at highest risk, as well as from HIV positive men to their female intimate partners. The recent trial results demonstrating that timely and effective antiretroviral therapy greatly reduces HIV transmission among sero-discordant partners or in sero-discordant couples firmly places antiretroviral therapy in the package of HIV prevention options. Early access to treatment to protect their intimate partners will encourage people to be tested for HIV, disclose their status, and access essential HIV services.



for preventing new HIV infections among children has been defined for each category.

In the past decade, India has launched other programmes to strengthen its response to prevent new HIV infections among children. For example, it has merged its centres for voluntary counselling, and testing and prevention of mother-to-child transmission, to form Integrated Counselling and Testing Centres. India has initiated community-based HIV screening through frontline health workers. It has also adopted a phased approach to scale up services, prioritizing the geographical areas with highest HIV burden.

Meanwhile, India has planned to start the gradual phasing out of single dose nevirapine in favour of the ARV regimens recommended in the 2010 WHO Guidelines from September 2011 on, starting with the high prevalence districts. »



In the past decade, India has launched a number of programmes to strengthen its response to prevent new HIV infections among children.

## TOWARDS ZERO NEW HIV INFECTIONS AMONG CHILDREN BY 2015 IN ASIA AND THE PACIFIC

The Regional Framework for the Elimination of New Paediatric HIV Infections and Congenital Syphilis in Asia and the Pacific 2011-2015 proposes targets, strategies, a costing tool and a monitoring and evaluation framework to assist countries in developing and implementing their national action plans. Progress in the following areas will be particularly critical in the region:

- Strengthening sexual and reproductive health, and maternal, newborn and child services by increasing investments in human resources, infrastructure and equipment.
- Integrating and linking HIV prevention, treatment, care and support services with sexual and reproductive health and maternal, newborn and child services, including data generation and use.
- Involving networks of HIV-positive women and women from key populations at higher risk in service delivery and referrals to reduce stigma and improve service access, quality, efficiency and sustainability.
- Using new technologies to improve referrals, avoid loss to follow-up and manage data across the various services.

Note: In Asia, many women are infected by their spouses or intimate partners. To reflect HIV transmission dynamics and emphasize the need to involve men more in HIV and related health services, countries in Asia and the Pacific have adopted the 'prevention of parent-to-child transmission' (PPTCT) terminology. This shift was discussed and agreed in the past two Asia-Pacific UN Prevention of Parent-to-Child Transmission Task Force Meetings held in Chennai, 2009 and Vientiane, 2010.

» **COMMUNITY-BASED APPROACH IN NEPAL**

In Nepal, intimate partners of seasonal workers who leave and return to rural areas after work stints in urban centres are believed to be more at risk of HIV infection than the general population—mainly due to the sexual behaviour of their husbands. This increases the likelihood of HIV in newborns in rural areas.

The National Centre for AIDS and STD Control and its partners (United Nations Children’s Fund (UNICEF), United States Agency for International Development and Family Health International) launched a community-based project in the Achham district in April 2009. The main objective of the project was to assess the feasibility of delivering prevention of mother-to-child transmission services through community health centres, rather than strictly via district hospitals.

All men and women of reproductive age in the district now receive information on HIV, and all pregnant women are counselled and referred for testing at the community level. In line with the National Safe Motherhood and Newborn Health Strategy, pregnant women are encouraged to have all the recommended antenatal check-ups and

deliver their babies at one of the 10 birthing centres in the district. HIV-positive pregnant women who deliver at home with a skilled birth attendant receive an antiretroviral drug for use during and immediately following delivery to prevent their child from becoming infected with HIV.

The project capitalizes on the government’s maternity scheme, which provides pregnant women with transportation costs for delivery. Home-based care teams provide follow-up support to ensure that HIV is diagnosed early in infants and that all confirmed cases initiate antiretroviral therapy.

**THAILAND: GENERATING DATA FOR POLICY ADVOCACY AND EFFECTIVE PROGRAMMING**

The Government of Thailand has been making significant progress building a database on prevention of mother-to-child transmission that supports a full continuum of services. Supported by the UN system and other development partners, the approach covers pregnant women who access antenatal care services, newborns who require early diagnosis of HIV, and follow-up to ensure that children and women remain on antiretroviral therapy.

Thailand was well positioned to strengthen the generation of data (research, surveillance and estimates) for prevention of mother-to-child transmission policy formulation, and programme planning and implementation. This has enabled steady improvement of its programmes to prevent new HIV infections among children. The national monitoring and evaluation database also provided information for improving the quality of interventions and for more effective advocacy with policy-makers and health administrators.

Further improvements would include mechanisms to track AIDS orphans’ access to education and health-care services, legal protection of children rights, and the status of social transfers to orphans and vulnerable children (including those affected by AIDS). In addition, a gap analysis has identified the absence of a national database and systematic data-collection mechanisms from the provincial to the national levels. The analysis also indicated that data quality can be strengthened further. ■



Thailand is making significant progress building a database on prevention of mother-to-child transmission.



**“I was so happy when I found out I could deliver a baby without HIV. I knew about the precautions I would need to take. But my husband and mother-in-law did not believe this and said that if I didn’t abort the pregnancy they would abandon me.”**

**RITIKA INDIA**

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### COMMUNITY SURVEY HIGHLIGHTS CHALLENGES FOR HIV-POSITIVE WOMEN’S ACCESS TO KEY SERVICES

The Women’s Programme of the Asia Pacific Network of People Living with HIV, in collaboration with the Regional Treatment Working Group and UNAIDS, recently conducted a survey in Bangladesh, Cambodia, India, Indonesia, Nepal and Viet Nam on access to HIV, and sexual and reproductive, maternal, newborn and child health-care services for women living with HIV.

The Women’s Programme of the Asia Pacific Network of People Living with HIV interviewed a total of 757 currently or recently pregnant women living with HIV. Key findings included:

- Pregnancy-control: condoms were found to be the most known (88%), available (83%), used (79%) and preferred (64%) method. Male partners made decisions on pregnancy or the contraceptive method in most cases, not the woman. Up to 37% of pregnancies were not desired by the mother.
- Antiretroviral therapy: almost two thirds (64%) of the HIV-positive women were receiving antiretroviral therapy. Half of them had started antiretroviral therapy before their most recent pregnancy, but in India only 24% had done so.
- Prevention of mother-to-child transmission services: more than half (55%) of the women said that these services were available, and 52% said they had used those services. Availability of prevention of mother-to-child transmission services ranged from 73% in Cambodia and 62% in Indonesia, to 48% in India and 36% in Bangladesh.
- Infant testing for HIV: among women with previous live births, 53% said the infants had been tested for HIV (ranging from 13% in Bangladesh to 83% in Cambodia).
- Sterilization and medical termination: among the 29% of the women who had been encouraged to undergo sterilization, almost 40% were not provided with any other option (although it was not clear in how many cases this advice was linked to HIV status, rather than to a high number of existing children and a low socioeconomic status). Approximately 5% of pregnancies were ended through medical terminations, of which two thirds occurred specifically because of the mother’s HIV status.

The survey also highlighted several opportunities for additional research and action. It was clear that women’s knowledge of sexual and reproductive health was low and many were unable to make informed health-related decisions. The survey also highlighted major challenges in the quality of health-service delivery, such as stigma and lack of confidentiality, incorrect application of guidelines and lack of stocks of medications.

The full report of the survey, *Access to reproductive and maternal health care for women living with HIV in Asia*, is available on the Asia Pacific Network of People Living with HIV/AIDS web site (<http://www.apnplus.org>).



**KEEPING  
TREATMENT  
AFFORDABLE**



## ENSURING SUSTAINED ACCESS TO AFFORDABLE QUALITY DRUGS IN LOW- AND MIDDLE-INCOME COUNTRIES WILL BE KEY TO ACHIEVING UNIVERSAL ACCESS TO ANTIRETROVIRAL TREATMENT AND THE GOAL TO GET 15 MILLION ON TREATMENT BY 2015.

Over the past decade, more than 6 million people have received antiretroviral therapy in developing countries. Researchers from UNAIDS, WHO and the United States-based Futures Institute estimate that antiretroviral therapy has resulted in gains of about 14.4 million life-years among adults globally between 1995 and 2009.

Antiretroviral drugs “changed the way in which HIV is viewed—from a death sentence to a chronic illness,” says Sarah Zaidi, Executive Director of the International Treatment Preparedness Coalition. That achievement was propelled by a surge in donor funding and by the drastic reduction of the cost of first-line antiretroviral regimens from around US\$ 10 000 to US\$ 67 per person per year over the past decade.

At the UN General Assembly High Level Meeting on AIDS in New York in June 2011, governments from around the world made a pledge to get an additional 9 million people living with HIV on treatment by 2015. The target of 15 million people receiving treatment by 2015 represents 80% of those who will be in need of treatment by then.

**“We need a system that works for health and not only for commerce.”**

**MEDECINS SANS FRONTIERES**

## **TREATMENT 2.0**

Learning from the progress and challenges so far, reaching and sustaining universal access to antiretroviral therapy will require a paradigm shift. To catalyse this process, UNAIDS and WHO have developed the Treatment 2.0 initiative. The aim is to achieve a simpler, more effective and sustainable approach to HIV treatment, building on five core elements:

- creating better pills and diagnostics
- making HIV testing more accessible and simple
- reducing costs at all levels
- simplifying service delivery
- strengthening community involvement.

The 2010 WHO antiretroviral therapy guidelines for adults and adolescents, recommend starting antiretroviral therapy earlier, at a CD4 count of 350. This would result in a 20% additional reduction of HIV-related mortality by 2015. The guidelines also recommend the use of less toxic treatment regimens, which will increase treatment adherence and thus limit the emergence of drug resistance.

Treatment 2.0 got a further boost in May 2011, when the United States National Institutes of Health announced that clinical trials had confirmed the enormous preventive effect of antiretroviral therapy. The study found that if people living with HIV receive treatment before their CD4 count reaches 350, the risk of transmitting the virus to an uninfected sexual partner could be reduced by as much as 96%.

“This breakthrough is a serious game-changer, and will drive the prevention revolution forward,” said UNAIDS Executive Director Michel Sidibé. “It makes HIV treatment a new priority prevention option.” The challenge now, he said, was to ensure that sero-discordant couples had the option to choose and use treatment for HIV prevention.

## **MAKING ANTIRETROVIRAL DRUGS AFFORDABLE**

In 2001, World Trade Organization (WTO) members agreed to the Doha Declaration, which affirmed that the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) can and should be interpreted and implemented in a manner supportive of WTO Member States’ right to protect public health.

Around this time, the governments of Brazil and Thailand started local production of antiretroviral drugs, while Indian generic companies offered first-line antiretroviral drugs at rock-bottom prices to the developing world.





All voices count in the activist call for affordable treatment.



Antiretroviral drugs "changed the way in which HIV is viewed."

Taking advantage of the lack of patents, generic companies were also able to manufacture fixed-dose combinations of first-line antiretroviral drugs that led to the simplification and scale-up of treatment across the developing world. India has emerged as the 'pharmacy of the developing world', accounting for more than 80% of the donor-funded developing country market for antiretroviral drugs and 91% of the volume of paediatric antiretroviral drugs in 2008.

Several developing countries have used the TRIPS flexibilities in pursuit of public health goals. In 2003, for example, Malaysia became the first country in Asia to issue a government-use licence for importing generic antiretroviral drugs. The move reduced the average cost of antiretroviral drugs for the Malaysian Ministry of Health from us\$ 315 to us\$ 58 per patient per month. In 2005, the Indian Government introduced several health safeguards while changing its patent law to comply with the TRIPS agreement, including stricter rules for granting patents and to allow health groups to challenge patents. In 2007, Thailand used compulsory licences to provide access to efavirenz and lopinavir/ritonavir as part of its universal access health programme.

#### COMPLEXITIES

These positive developments could now be affected.

"In recent years, we see increasing pressure for developing countries to adopt clauses on intellectual property aimed at limiting the use of TRIPS flexibilities that have so far allowed countries to restrict patenting of life-saving medicines and produce or import them in generic forms," says Sarah Zaidi from the International Treatment Preparedness Coalition (ITPC). Known as "TRIPS-plus provisions", these measures require countries to change their laws to provide intellectual property protection and enforcement far in excess of what they agreed to under the TRIPS agreement.

The primary vehicles for adopting these TRIPS-plus measures are free trade agreements (FTA). The European Union (EU) – India FTA, under negotiation since 2007, is among the most keenly monitored of these deals, since a large share of generic medicines are produced in India.

Médecins Sans Frontières (MSF), for example, sources more than 80% of the antiretroviral drugs for its projects from India. "If Indian companies can no longer supply low-cost generic medicines, most countries will be left with no choice but to buy high-priced medicines from originator companies," warns Paul Cawthorne, of MSF's Campaign for Access to Essential Medicines.

Activists point to evidence of the impact of previous FTAs that the United States signed with several developing countries. The imposition of data exclusivity through the United States – Jordan FTA resulted in an increase in medicine prices by 20% between 2002 and 2006.

A study of the impact of the United States – Central American FTA in Guatemala found 15 years of data exclusivity had been granted on

lopinavir/ritonavir and had resulted in the removal of a generic version of this medicine.

India recently announced that it would not accept data exclusivity or other provisions beyond the TRIPS agreement or its own domestic law.

Activists have warned of other dangers as well. “The EU – India FTA negotiations,” says Kajal Bhardwaj, a lawyer working in India on HIV, health and human rights, “have highlighted the dangers of TRIPS-plus provisions not only in chapters on intellectual property, but also in the so-called ‘investment chapter’. This would allow companies to use private international arbitration to challenge government health policies that are aimed at making medicines affordable.”

### **CLEARING THE OBSTACLES**

These concerns have sparked a broad-based movement among networks of people living with HIV across the region and globally.

“Since 2009, networks of people living with HIV, like the Delhi Network of HIV Positive People and others, have been urging the Indian Government to resist the inclusion of such clauses in the free trade agreement with the European Union,” says Shiba Phurailatpam of the Asia Pacific Network of People Living with HIV (APN+). However, “while street activism has been very effective, it is not enough. With more people needing to shift to second-line regimens and the need to provide treatment for co-infection like hepatitis C, strong action from a broader coalition, including international agencies, has become necessary.”

In March 2011, UNAIDS, WHO and UNDP issued a joint policy brief to help guide countries in using the intellectual property and trade flexibilities set out in the TRIPS agreement and the Doha Declaration, to reduce the price of HIV medicines and expand access.

The three agencies expressed their serious concern about antiretroviral therapy sustainability in the current economic climate, and pledged to help countries increase access to treatment and provide technical assistance to implement the TRIPS flexibilities to scale up access to antiretroviral medicines.

Soon afterwards, the final statement of 200 government and civil society participants at the March 2011 Asia-Pacific Regional Consultation on Universal Access to HIV Prevention, Treatment, Care and Support in Bangkok requested governments to avoid accepting FTA provisions that could hinder access to affordable medicines, diagnostics and vaccines, and to promote the use of the public health-related provisions in TRIPS.

The statement also called on the UN to facilitate the development of global mechanisms through which pharmaceutical companies and all other stakeholders would jointly ensure and secure access to affordable diagnostics and medicines, as well as the development of new products.

In May 2011, more than 50 Asian, African, American and European activists, meeting in Bangkok, once again flagged the threats posed by free trade

**“Strong action from a broader coalition, including international agencies, has become necessary.”**

**APN+**



Over the past decade, more than 6 million people have received antiretroviral therapy in developing countries.

Sources: Waning B, Diedrichsen E, Moon S. A lifeline to treatment: the role of Indian generic manufacturers in supplying antiretroviral medicines to developing countries. *J Int AIDS Soc*, 2010, 13:35.

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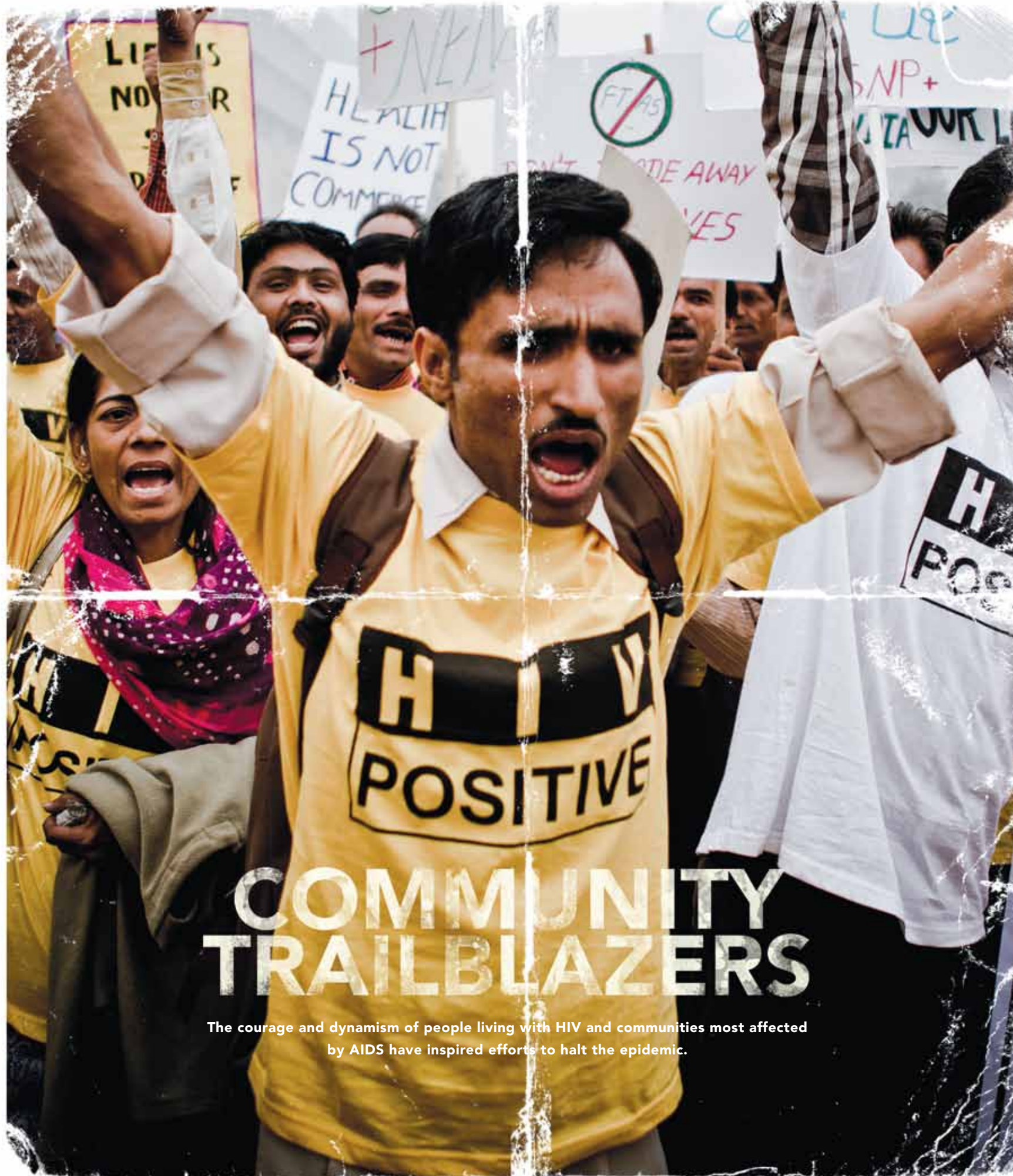
agreements to affordable HIV treatment in the *Bangkok Declaration on Free Trade Agreements and Access to Medicines*, particularly since the negotiations are wrapped in secrecy and are not subject to public scrutiny. Calling on developed countries to immediately remove all TRIPS-plus provisions from free trade agreement negotiations, the declaration also called on national governments in the global south to “band together and refuse to accept any further restrictions on production, registration, supply, import or export of generic medicines; to launch South-South collaboration on an urgent basis to put in place a sustainable, affordable pipeline of generic medicines for future generations; and call for an immediate review of TRIPS and its impact on access to medicines in developing and least developed countries”.

In June 2011, the 192 UN Member States endorsed the 2011 Political Declaration on HIV/AIDS, which committed to remove before 2015 obstacles that limit the capacity of low-income and middle-income countries to provide affordable and effective HIV prevention and treatment products. The Declaration also committed to reduce costs through the use of TRIPS flexibilities and “ensure that intellectual property provisions in trade agreements do not undermine these existing flexibilities, as confirmed by the Doha Declaration” (paragraph 7).

Networks of people living with HIV and their allies hope The Global Fund, UN agencies and donors will not only back countries when they try to use the TRIPS flexibilities, but proactively provide technical and other support to countries to encourage the use of these mechanisms. They also want countries to join efforts to produce cheap drugs, and feel that government officials and parliamentarians should be made more aware of the likely impact of FTAs on public health.

But the issue, say analysts, also needs to be addressed in a more sustained manner. In 2008, governments at the World Health Assembly adopted the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (the Global Strategy). Apart from encouraging the extensive use of TRIPS flexibilities and encouraging local production, the Global Strategy outlined several mechanisms such as patent pools, prize funds and the consideration of a global treaty on research and development. “The current system is not only failing to deliver affordable medicines, but also the medicines and diagnostics that are most needed in developing countries. For people living with HIV, better TB [tuberculosis] diagnostics and TB medicines are crucial. Better adapted HIV medicines and simplified CD4 and viral load tests as people are moved on to improved HIV treatment are the need of the hour,” says MSF’s Paul Cawthorne. “We need a system that works for health and not only for commerce.”

“We now have a unique chance to reduce both new HIV cases and AIDS deaths by offering timely ART for all in need,” says Shiba Phurailatpam from APN+. “We can’t let barriers to affordable drugs come in the way of this!” ■



# COMMUNITY TRAILBLAZERS

The courage and dynamism of people living with HIV and communities most affected by AIDS have inspired efforts to halt the epidemic.



Speaking in June 2011, UN Secretary-General Ban Ki-moon lauded activist efforts in the AIDS response, saying they had “blazed a new trail”. “You organized and rallied and worked until governments—and multilateral organizations like the UN—changed the way we do business.”

Since the earliest days of the AIDS epidemic, the courage and dynamism of people living with HIV and communities most affected by AIDS have inspired efforts to halt the epidemic. Persistence and determination, often in the face of adversity, have helped shift global health and development agendas to recognize the impact that affected communities can have in designing and implementing AIDS responses. Civil society has been critical in catalyzing and shaping global, regional and national action, and in mobilizing the support of politicians and donors.

People living with HIV and other civil society actors provide essential HIV prevention, treatment, care and support services, sometimes in the absence of an adequate response from government and the international community, and frequently with minimal resources.

#### **ASIA AND THE PACIFIC: INFLUENCE, IMPACT**

“In Asia and the Pacific, we have some of the most organized and effective examples of community leadership and unity in the world,” says Steven Kraus, UNAIDS Director of the Regional Support Team for Asia and the Pacific.

“People living with HIV, sex workers, men who have sex with men, people who use drugs, and transgender people are consistently stepping forward, speaking out with one voice, driving the agenda and pushing the boundaries to ensure inclusion and equity.”

In a region where most countries impose at least some restraints on freedom of expression and civil society action, and where key populations at higher risk are often criminalized and harassed, it is not easy to build activist networks. Yet united action, say activists, has made the difference and has helped achieve networks strong enough to have an impact. “The community of people living with and affected by HIV in the region has never been more united,” says Shiba Phurailatpam of the Asia Pacific Network of People Living with HIV/AIDS. “We have proven again and again that we can achieve a lot if we take collective action—nothing is impossible.”

Key affected populations have played a great role in helping to strengthen Asia and the Pacific’s AIDS response. In recognition of this work, here we shine the spotlight on some of the initiatives that are making a difference across the region.

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## THE POWER OF NETWORKING

Asia and the Pacific's civil society and community organizations are organized well via a number of dynamic and dedicated regional networks. Below are a few examples.

**The Coalition of Asia Pacific Regional Networks on HIV/AIDS (the Seven Sisters)** was set up in 2001. Based in Bangkok, it is a broad-based alliance that brings together five regional networks representing key populations at higher risk:

- Asia Pacific Transgender Network (APTN)
- Asia Pacific Network of People Living with HIV (APN+)
- Asia Pacific Network of Sex Workers (APNSW)
- Asian Network of People who Use Drugs (ANPUD)
- Coordination of Action Research on AIDS and Mobility (CARAM ASIA).

Seven Sisters also has other strategic partners and strong collaboration with other regional networks (such as the Asia Pacific Council of AIDS Service Organizations and the AIDS Society of Asia Pacific).

In March 2011, Seven Sisters brought together 80 community representatives in a regional universal access consultation that has managed to influence regional and global political agendas. Earlier, in 2010, Seven Sisters set up YouthLEAD, a project that encourages the voice and involvement of young people living with HIV and those from key populations at higher risk.

**The Asia Pacific Network of People Living with HIV (APN+)**, established in 1994, is the regional network of people living with HIV. Also based in Bangkok, it has 30 country members, which are represented either by national networks or smaller organizations of people living with HIV.

APN+ provides a collective voice for people living with HIV in the region, and links their regional communities with the Global Network of People Living with HIV (GNP+) and other networks, such as the International Treatment Preparedness Coalition, around the world. It also has a women's arm, the Women's Programme of the Asia Pacific Network of People Living with HIV (WAPN+). Along with its partner organizations, APN+ engineered the first successful effort by a network of people living with HIV to access funds from The Global Fund to Fight AIDS, Tuberculosis and Malaria.

**The Asian Network for People who Use Drugs (ANPUD)** advocates comprehensive, locally driven harm-reduction

approaches that include access to voluntary drug treatment and related health-care services, and access to HIV and hepatitis treatment. ANPUD campaigns for decriminalization, the reduction of stigmatization and increased funding for harm-reduction services. It also supports the establishment of peer networks at the country level and provides a forum to develop a common voice to influence policy processes.

**The Asia Pacific Coalition on Male Sexual Health (APCOM)** is a regional coalition that brings together men who have sex with men and HIV community-based organizations with government-sector representatives, donors, technical experts and the UN. APCOM advocates for stronger political support, along with increased investment and coverage of HIV services in Asia and the Pacific for transgender people and men who have sex with men. It also promotes principles of good practice and lessons learnt by bringing together representatives from diverse groups in an effort to share experience, knowledge and expertise.

**The Asia Pacific Network of Sex Workers (APNSW)** is led by sex workers, and has more than 50 member organizations in 17 countries. Members include national sex workers networks and organizations. APNSW's human rights-centered, cultural approach uses films, posters, literature, artwork and music to help cultivate sex worker alliances and build awareness of policy positions.

**The Coordination of Action Research on AIDS and Mobility (CARAM)** Asia branch, has been working on issues of migrants' rights and health since 1997. With a secretariat based in Kuala Lumpur, CARAM is a regional network of 37 members in 18 origin and destination countries that span Asia and the Middle East. The network channels its work through three task forces: Migration Health and HIV; Migrant Labour Rights; and Migration, Globalization and Development. The task forces carry out participatory action research and advocacy on issues related to migrants' health and well-being, ranging from HIV to migrant workers' rights.

**The Asia Pacific Transgender Network (APTN)** is an emerging regional network representing the transgender community and issues in various fora, meetings and platforms. APTN's aim is to provide a platform whereby transgender community members will be better represented at meetings, workshops, advocacy development and programme planning, implementation, monitoring and evaluation among governments, development partners and civil society. At the time of writing, the organizational structure is under development and there are efforts to develop a governance mechanism and draft work plan through consultation with stakeholders.



**“Our peer researchers are trusted by other women living with HIV. The quality of information [women living with HIV] can get cannot be matched.”**

**KIRENJIT KAUR**  
COORDINATOR, WOMEN'S PROGRAMME OF THE ASIA PACIFIC NETWORK OF PEOPLE LIVING WITH HIV

## SHARPENING UNDERSTANDINGS OF THE EPIDEMIC

People living with HIV have been playing a strategic role in gathering information that can inform the design of community-appropriate services, as well as guiding the planning of national AIDS strategies.

A 2011 study conducted by the women's programme of APN+ (WAPN+) examined access to maternal, sexual and reproductive, and child services among women living with the HIV in Asia. The study was designed and run by women living with HIV in six Asian countries. Two women living with HIV from each country, identified as leaders in their communities, were trained in peer-based qualitative and quantitative research methods. The findings from this and other peer-driven studies are informing policies and programmes that can address to the most pressing priorities of people living with HIV.

The *People Living with HIV Stigma Index* is a joint initiative by the Global Network of People Living with HIV (GNP+), the International Community of Women Living with HIV (ICW), the International Planned Parenthood Federation (IPPF) and UNAIDS. Implemented by teams of people living with HIV at the country level, the Stigma Index collects evidence about stigma, discrimination and rights abuses experienced by people living with HIV to facilitate increased awareness possible remedies to address stigma. In Asia and the Pacific, Stigma Index reporting has been taken up in fourteen countries with evidence collection already completed in nine. A regional analysis, collating all evidence collected so far, was completed in August 2011. This is the first large-scale regional comparison of standardized HIV-related stigma indicators of its kind.

## INNOVATIVE PRACTICES IN COMMUNITY-DRIVEN DELIVERY OF TREATMENT AND SERVICES

AIDS Care China, an NGO, has set up Red Ribbon Centres to support government-run antiretroviral therapy programmes in China. Located at hospitals or clinics, these centres assist patients who access antiretroviral therapy at linked facilities, and help them adhere to their treatment.

Staffed mainly by people living with HIV, the centres track and manage patients, provide patient counselling and education, and can link patients with medical providers.

The organization has also established shelters for people living with HIV who travel to access treatment and need short-term housing. Treatment outcomes have improved at the Red Ribbon Centre sites, with both the numbers of antiretroviral therapy patients and those with CD4 counts higher than 350 rising, and rates of loss-to-follow-up falling.



**“The model was developed based on the belief that doctors have their areas of expertise [and] community members and people living with HIV have ours... we are here to complement each other's work.”**

**THOMAS CAI**  
DIRECTOR OF AIDS CARE CHINA

## CREATING A SAFE SPACE FOR SEX WORKERS AFFECTED BY HIV

Having contracted HIV as a sex worker in Yangon, Thida Win decided not to turn to Myanmar's faltering health service. Instead, she sought the help of peers, in the form of the Targeted Outreach Programme (TOP).

Run almost entirely by sex workers, TOP provided her with treatment, shielded her against the double stigma of her profession and her HIV status, and landed her a job.

TOP founder and director, Habib Rahman, feels the biggest priority is to enable peers to share their experiences, concerns and solutions without fear or discrimination. TOP also focuses on men who have sex with men, many of whom face similar problems.

Since it was created in 2004, the programme has established 19 drop-in centres across the country and has reached close to 50 000 sex workers (as of April 2011).

TOP follows a self-perpetuating model. It trains sex workers in management and other skills so that more centres can be set up across the country. The centres provide peer support, a space for socializing and entertainment, free condoms and a host of clinical services, including HIV testing and antiretroviral therapy. TOP plans to have drop-in centres operating in 29 cities (some with HIV testing facilities) and to reach out to clients of sex workers, as well as female partners of men who have sex with men.



**“When I was diagnosed I was pregnant and they [TOP] told me how to find a safe way for the baby. So the child is [HIV] negative and I am so happy ... I am now a health worker for my community and I can forget I am [HIV] positive. I am so proud to work for the programmes, I will work for them for my whole life.”**

**THIDA WIN TOP**

## NEW WAYS TO BOOST CONDOM USE

Service Workers in Groups (SWING) is a Bangkok-based community organization that set up a revolving condom fund aimed at increasing condom distribution to transgender sex workers and men who have sex with men, in a partnership between civil society and the private sector.

Another example of community-generated action, SWING liaised with sex venue owners and managers, and a local condom manufacturer. It forged an arrangement in which the manufacturer provided condoms at cost, while community workers marketed the condoms inside sex venues at the lowest possible prices.

The revolving condom fund now has an annual budget of US\$ 13 300. By mid-2009, the fund was distributing condoms to 64 establishments in Bangkok and 12 across Chiang Mai, Korat and Nonthaburi, as well as via Thailand's Sexual Diversity Network.

Other community organizations in Thailand plan to adopt this model of condom distribution and modify it to local needs. The programme has also been adopted by Thailand's Global Fund-backed HIV programme, with roll-out expected in 14 provinces across the country.







## A UNIQUE IMPACT FOR PEOPLE WHO USE DRUGS

The Society for Service to Urban Poverty (also known as 'SHARAN') is an NGO based in New Delhi, India. The society has been providing a range of unique drug treatment and HIV prevention services for people who use drugs since 1993—with impressive impact at all levels. The society's early programmes focused on opening a drop-in centre that provided a non-judgmental and safe environment, in a slum colony badly affected by high levels of drug dependence and a burgeoning epidemic of injecting drug use. As well as being able to access opioid substitution therapy, free sterile needles and syringes, and detoxification and rehabilitation programmes, people visiting the drop-in centre could also benefit from comprehensive services including HIV prevention education on safer sex and drug-use practices, HIV pretest and post-test counselling, free condoms, recreational facilities and peer-educator sessions. Results were impressive, including evidence of frequency of injecting, decrease in number of clients presenting injecting-generated abscesses, and solid retention averages.

“The initiatives were so effective that, in just few years, the society's model was scaled up across the country and adopted into the national AIDS plan in 2008. Then, as now, all the programmes were at least 80% conceptualized, managed and implemented by people who currently or previously used drugs, and the regional services evolved into the Indian Harm Reduction Network Society for Service to Urban Poverty. Initiatives continue to provide needle and syringe programmes, opioid substitution therapy detoxification and employment programmes covering more than 2000 people who inject drugs in Delhi.

## USING MULTIMEDIA FOR HIV PREVENTION AND AGAINST STIGMA

In the Pacific, people living with HIV are using multimedia approaches to communicate HIV-prevention messages to island communities. One example is the Pacific Islands AIDS Foundation's *Positive Lives* series, which began in 1999 with the documentary *Maire*, a film about the foundation's founder who was one of the first HIV-positive people in the Pacific to make her status publicly known. Since then, the foundation has produced six documentaries (most in multiple languages) featuring Pacific Islanders who are living with HIV. ■



## A RECIPE FOR SUCCESS

The Ashodaya Samithi (Dawn of Hope Collective) was founded in 2004 in Mysore, India as a sex worker empowerment network. Struggling to win hearts and minds to fight stigma, Ashodaya opted for an alternative route: the stomach.

Using a World Bank loan, Ashodaya members opened a small hotel and restaurant (Hotel Ashodaya) in central Mysore on World AIDS Day 2008. At first, the idea was to provide sex workers with affordable food. Gradually, a larger clientele grew. The restaurant is now a bustling enterprise that is run by 14 male, female and transgender sex workers.

“We started the venture with apprehension,” says Prakash, one of the restaurant's founders. “People abused us and some even threatened us. But today, Ashodaya has become popular even with foreign tourists.”

The eatery closes around 6 pm so the staff—most of whom are sex workers—can go to work on the streets of Mysore. Profits have enabled the collective to expand its reach: it now also funds an AIDS hospice, pays for funerals, runs an orphanage and arranges regular clinics where sex workers learn more about HIV and are provided with condoms.

Ashodaya operates in several districts in Karnataka. Other examples of their programmes include the Ashraya (a shelter and care home for sex workers living with HIV) and the Ashodaya Academy (a community-to-community learning centre), as well as other government-supported sex work interventions.

GENDER & HIV:

# INTERSECTIONS

How do gender identity, sexuality and HIV interact in Asia and the Pacific?



## WHAT DO THE WIFE OF A MIGRANT WORKER IN INDIA, A MAN WHO HAS SEX WITH MEN IN MALAYSIA, A NURSE IN PAPUA NEW GUINEA AND A YOUNG TRANSGENDER PERSON IN NEPAL HAVE IN COMMON? THEY ARE VULNERABLE TO HIV BECAUSE OF THEIR GENDER IDENTITY OR THEIR SEXUAL ORIENTATION.

“The balance of power in heterosexual, homosexual or other relationships determines how sex is negotiated, how gender roles in intimate relations are defined, and how individual human rights are exercised,” explains a UNICEF / UNAIDS / International Center for Research on Women paper on gender-based violence, sexual abuse and increased risks to HIV (*Issues Paper 4*, page 8).

Gender norms in Asia and the Pacific differ from culture to culture, but they dictate how individual vulnerability to HIV is defined and they also shape access to treatment, care and support for those living with HIV.

As recommended in the UNAIDS *Agenda on woman and girls*, gender-aware AIDS strategies, that are alert to these realities can have a powerful impact on the epidemic.

But how exactly do gender inequalities and HIV interact? This feature presents the stories of men, women and transgender people from all corners of the region whose experiences illustrate some of the ways in which gender, sexuality and power intersect.

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*“When he goes to work, he forgets me and doesn’t even bother to write a letter”*

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Studies in Asia indicate that gender inequality, in combination with migration, can render migrants and their spouses or intimate partners more vulnerable to HIV.

Prevailing notions of masculinity sanction migrant men’s indulgence in risky, casual sex with multiple partners. The men then return to their households and risk passing on sexually



transmitted infections to their spouses and intimate partners.

Women's economic dependence on their male partners, particularly in countries where there are few income-earning activities for women with low educational attainment, deepens their vulnerability.

Suhasini's story illustrates those risks.

Suhasini became responsible for her family when her husband migrated to a city in West India in search of work.

"At that time, I sought help from a distant uncle-in-law," she recalls. "Although I knew that he would take advantage of my situation, I had no option but to ask his help for all the work outside home."

"Many times he tried to sexually abuse me. I used to escape. I told this to my husband when he came home. My husband never bothered about it and scolded me saying that, 'It is you who can't control your desire; you should remain within your control rather than seeking help from such men.'"

"I used to cry always," she says. "My husband used to come twice in a year and stay for few days. When he goes to work, he forgets me and doesn't even bother to write a letter. He also reduced [the] frequency in sending money and says whatever he is sending I have to adjust within that. I started depending more on the uncle-in-law for much of the household work."

"There are no social support services for women like me in the villages and many of us are either dependent on other relatives or friends in the neighbourhood. And men take advantage of this," she laments.

"After six years, my husband came back home with ill-health. I took care of him initially. He became severely ill and went to a hospital."

Suhasini and her husband did not use condoms, so health workers at



the hospital suggested she should get tested. It transpired that she, too, was HIV-positive. “I was angry with my husband for giving me AIDS,” she says. “Now there is no one to take care of me when I have become sick.”

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*“I would rather stand up and say I am positive, and keep quiet about my sexual identity”*

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Men who have sex with men tend to live in a culture of secrecy. They maintain the façade of being heterosexual because of intense social pressures to conform to the dominant norms of masculinity. Unable to disclose their true sexuality, they tend to shun services that could help them protect themselves and their intimate partners against HIV and other infectious diseases.

“Men who have sex with men are not fully open, especially in the Asian context,” explains Andrew Tan, President of myPlus, the Malaysian Positive Network. “So if a married man who has sex with men walks into a treatment centre, he is likely to be perceived as a heterosexual male rather than a man who has sex with men—and this is something he may not try to correct.”

People who fail to conform to dominant gender roles risk encountering powerful stigma, as do people who reveal that they are HIV-positive. It can add up to an unbearable burden, says Andrew Tan. “To say you are [HIV] positive as well as gay is almost a fate worse than death in some of the contexts in Asia. I would rather stand up and say I am positive, and keep quiet about my sexual identity.”

“This is the way a lot of men who have sex with men think,” he explains. “You know how Asian families talk about family, morality, etc. Our mothers know; intuitively they know, but they remain silent. It’s not talked about. All these issues contribute and trickle down to how we seek care, how services are or are not provided, in the context of AIDS.”

“It comes from that one place, where people are just not able to accept that the other person is coming from a different place—different norm, different identity, different way of being.”

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*“In our culture they blame the woman, whatever happens”*

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Gender norms influence the ability of people living with HIV to access prevention, treatment and support services. Women who are living with HIV are often denied basic reproductive rights, such as the right to choose to have children. In some cases, they are encouraged, or forced, to undergo sterilization or abortion. »

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#### HUMAN RIGHTS VICTORY AT THE UN

In a historic decision, the UN Human Rights Council passed its first-ever resolution on sexual orientation and gender identity in June 2011 (Resolution of the Human Rights Council Resolution (Human Rights, sexual orientation and gender identity) A/HRC/17/L.9/Rev.1 2011).

The breakthrough resolution was presented by South Africa, along with Brazil and 39 other cosponsors from all regions of the world. It affirms the universality of human rights, and declares concern about acts of violence and discrimination based on sexual orientation and gender identity.

## MEN LESS LIKELY TO ACCESS VOLUNTARY TESTING

The adage that men do not like to visit the doctor is corroborated by evidence. Men are, on average, less likely to seek medical services, particularly for sexually related infections or concerns. According to the *People Living with HIV Stigma Index: Asia Pacific Regional Analysis 2011*, several of the surveyed countries recorded notable gender disparities in relation to voluntary testing. In Bangladesh, for example, some 49% of women volunteered for HIV tests compared with only 25% of men.



» Most traditional gender stereotypes reinforce women’s inferior status in society, and entrench unequal power dynamics in their intimate relationships and marriages that make it very difficult to control their sexual lives. Cultural norms that condone domestic violence make matters even worse—as the following story illustrates. It is drawn from *Diamonds*, a collection of stories from Asia and the Pacific, published by the Asia Pacific Network of People Living with HIV/AIDS and the United Nations Development Fund for Women (UNIFEM, now the United Nations Entity for Gender Equality and the Empowerment of Women [UNWOMEN]) in 2009.

Maura, from Port Moresby, Papua New Guinea, was a young woman when her family forced her to marry a man named Max. She quickly suspected he was not well. “I asked him to go and get it checked out, but he refused, saying it had been like that for a long time,” she remembers.

Soon, though, Maura was pregnant. “I went to the antenatal centre and they didn’t tell me that they were going to test me for HIV, but when I came back for the next visit, I saw a red dot on my card and ... the doctor just told me they had tested my blood and it was HIV-positive.”

Without giving Maura any more information on HIV, the doctor told her to return with her husband two weeks later for further tests.

“Both our results came back [HIV] positive,” she says. “From that moment, Max was so angry. At first he was in denial and he said it wasn’t his blood. Within a week, his habits changed and he was drinking and coming home late, at one or two in the morning, and then he started becoming violent.”

Maura’s first child was very weak and died at three months. But she was soon pregnant again. “Max kept forcing me to have sex with him and whenever I refused he would bash me up.”

Maura gave birth to a boy. Then she became pregnant yet again.

“Max wouldn’t wear condoms,” she says, “and I wasn’t using any contraception, because I was afraid of the side-effects of hormonal contraceptives on HIV. I didn’t have any information about how they would affect my HIV and I had no doctor monitoring me ... In our culture, they blame the woman whatever happens—it is my responsibility if I get pregnant, and if I refuse to have sex with my husband, people say I deserve to get beaten up, because I didn’t do my proper duty as a wife.”

Maura saw a doctor to enquire about an abortion. “The doctor told me, ‘We can terminate your pregnancy under one condition.’ I asked, ‘What’s the condition?’ And she said, ‘That you are sterilized.’”

“I told her, ‘I don’t want to be sterilized. I just don’t want this pregnancy—I’m not ready for it.’ But I felt I was caught in between, so I said, ‘Okay.’ They told me to bring Max to the clinic, so I did. Max didn’t want to sign the consent form, and they replied, ‘Well if you say no, we can’t terminate the pregnancy, so you better just sign it.’ So he did, and I went through the termination of pregnancy and sterilization.”



Maura's other baby died soon after, at the age of nine months.

"I was angry and I regretted that I had been forced to get sterilized. I was surrounded by people who were celebrating Christmas, but for me, I had no reason to celebrate."

Since then, Maura has become involved with the National AIDS Council and the APN+, raising awareness in Papuan towns and further afield.

A recent Asia and the Pacific regional analysis of the *People Living with HIV Stigma Index* report notes that up to 79% of women living with HIV say that a health professional has advised them not to have children. In some cases, provision of antiretroviral therapy had been made conditional on the use of contraceptives.

*"Because the organization is run by transgender people, I felt very comfortable"*

Data on transgender people and HIV in Asia and the Pacific are scarce, but country estimations suggest there are substantial numbers of these people in the region.

Transgender people are frequently arrested or harassed under laws relating »

### 2011 POLITICAL DECLARATION ON HIV/AIDS PRIORITIZES ACTION ON GENDER

In June 2011, in their Political Declaration on HIV/AIDS endorsed at the High Level Meeting on AIDS, the UN General Assembly reiterated earlier pledges to "eliminate gender inequalities and gender-based abuse and violence," and to ensure "that national responses to HIV and AIDS meet the specific needs of women and girls ... for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV through the elimination of all forms of discrimination."

- » to sex work, loitering or vagrancy. Several studies have reported significant health risks due to their socially marginalized status and lack of access to public health services, which often forces transgender people to use informal health services or to self-medicate.

Sabin, an 18-year-old Nepalese transgender person, has become increasingly involved in peer HIV-prevention activities. She recounts some of the incidents and issues that have shaped her life.

“Since I was 8 or 9, I would borrow my sisters’ make-up, use their lipsticks, and help them cooking and cleaning,” Sabin recalls. “When I was about 14, I realized I was attracted to boys. I had sex for the first time when I was 16, without condoms.”

“Transgender people are highly stigmatized in Nepal,” she says, “so I have only shared my true identity to my sex partners and a few friends—not with my family. If there was more protection for people like me, I would open up and live as a transgender woman.”

“The first time I decided to go to the transgender group, an outreach educator inspired me to go for voluntary counselling and testing. There were no restrictions for age at all and because the organization was run by transgender people, I felt very comfortable,” she says. “In other medical centres and hospitals, parents collect the reports, so I couldn’t go to them.”

“I went for a check-up and after the session with the pre-counsellor, I found out after 15 minutes that I was not [HIV] positive. This was good news, and the counselling really helped me to understand HIV and the preventive measures I needed to take.”

“I only knew a few bits of information about HIV, through general books and ads, but I didn’t have correct knowledge about condom use. After the counselling and the interactions with the NGO, I knew more about correct and consistent use of condoms and lubricants, and this really helps for transgender people,” she says.

“Now I am able to teach this to my peers, to inspire them to get counselling and to motivate others.”

“At one point in my life, sex was a way to get food and pay for my studies. I would have sex for less than a dollar. But then I realized I should not do these things without knowing. Now, I want to speak out to and for young, 18 and under transgender people who don’t usually have a voice.” ■





## TAKING GENDER SERIOUSLY IN NATIONAL RESPONSES TO HIV

If programmes are to address the needs of all people affected by HIV, national AIDS strategies need to tackle issues of gender and sexual identity. Some countries in Asia and the Pacific are showing how this can be done.

In 2010, Viet Nam organized a gender analysis of its national AIDS response to inform a new national AIDS strategy. The analysis revealed that greater focus was needed on gender dynamics of the epidemic and especially its effect on women. The concerns of men and norms of masculinity also had to be addressed. More robust data were needed, as were sex-disaggregated indicators for monitoring and evaluation, and stronger capacity to undertake gender analysis, programming and monitoring.

A multi-partner gender assessment of Myanmar's national AIDS plan ensured wide ownership of the process and greater commitment to adopt the findings.

In Cambodia, a gender caucus that included civil society and UN representation helped make the new National Strategic Plan on HIV/AIDS 2011 more gender inclusive in its approach to programming, monitoring and budgeting.

"Such initiatives are very encouraging," says Nazneen Damji, Programme Manager on Gender Equality and HIV/AIDS from UNWOMEN, who was part of the UNAIDS delegation that supported Viet Nam in its 2011 gender analysis initiative. "It shows that gains in gender [awareness] can be made when multiple actors come together—and it proves that gender must be on everyone's agenda."

### THE ART OF DEMYSTIFICATION

In the attempt to help demystify the complex issues of gender and HIV and make them easier to understand, new methods are being initiated—including the use of art and cartoon. In one example, Australian cartoonist Judy Horacek has teamed up with UNAIDS Regional Support Team for Asia and the Pacific to develop a series of cartoon-based messages aiming to underline the complexities of the gender and HIV debate. The cartoons will be used for advocacy and training to help better define and explain key aspects of gender and HIV.



# MAKING THE LAW WORK FOR THE AIDS RESPONSE IN ASIA AND THE PACIFIC

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**“In the Asia-Pacific Region, and across the world, there are too many examples of countries with laws, policies and practices that punish, rather than protect, people in need of HIV services. Where the law does not advance justice, it stalls progress.”**

**MICHEL SIDIBÉ  
UNAIDS EXECUTIVE DIRECTOR, 2011**



**H**uman rights violations increase the risk of HIV infection and aggravate its impact. Promoting and protecting human rights is therefore critically important if the region's AIDS responses are to succeed.

Rights violations are commonplace in many parts of the region, and include discrimination against people living with HIV, women and members of vulnerable groups such as sex workers, people who inject drugs, men who have sex with men and transgender people.

Law and law enforcement are means by which to protect human rights in the context of HIV but about 90% of countries in Asia and the Pacific are reported to have at least one form of punitive law or practice that hampers access to HIV services.

A few countries have recognized these problems and are adopting laws and policies aimed at removing such hurdles. Some of the laws are intended to protect people living with HIV, while others are meant to create an enabling environment for key affected populations to access HIV services.

The following pages present a snapshot of the legal and policy landscape in Asia and the Pacific in relation to HIV.

The examples catalogue the protective HIV-related laws and policies adopted by countries, as well as punitive laws and practices—such as laws that restrict entry, stay or residence of people living with HIV on the basis of their HIV status; laws that specifically criminalize HIV transmission or exposure; laws that criminalize consensual same-sex sexual relations between adults; laws and policies that mandate compulsory detention of people who use drugs; and laws that allow for the application of the death penalty for drug-related offences.

## LIMITATIONS AND DISCLAIMER

In this report, the Asia and the Pacific region refers to countries in Asia, the Pacific and Oceania, and is not limited to countries covered by the UNAIDS Regional Support Team for Asia and the Pacific. The countries covered are Afghanistan, Bangladesh, Bhutan, Brunei Darussalam, Cambodia, China, Democratic People's Republic of Korea, India, Indonesia, Japan, Lao People's Democratic Republic, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Republic of Korea, Singapore, Sri Lanka, Thailand, Timor-Leste and Viet Nam (Asia); and Australia, Fiji, Kiribati, Marshall Islands, Micronesia, Nauru, New Zealand, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu (Pacific and Oceania).

The information and data herein are based on research by the Global Network of People Living with HIV, the International Harm Reduction Association, the International Lesbian and Gay Association, the International Planned Parenthood Federation and UNAIDS. The research was compiled in the publication *Making the law work for the AIDS response: a snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support* (2010). Details about the methodologies and possible limitations of the research can be found on the organizations' various websites. Updated information (as of June 2011) from these organizations was used to supplement the data drawn from that report. Where information on a specific country, territory or area was not available, other sources were consulted, as indicated.

The designations used and the presentation of the material in this document do not imply the expression of any opinion whatsoever on the part of the United Nations, the UNAIDS Secretariat, or any of the UNAIDS Cosponsors concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

19

OUT OF 38  
COUNTRIES IN  
THE REGION

**CRIMINALIZE  
SAME-SEX  
RELATIONS**

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29

OUT OF 38  
COUNTRIES IN  
THE REGION

**CRIMINALIZE SOME  
ASPECTS OF SEX  
WORK**

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15

OUT OF 38  
COUNTRIES IN  
THE REGION

**IMPOSE SOME FORM OF  
RESTRICTION ON THE ENTRY,  
STAY AND RESIDENCE OF PEOPLE  
LIVING WITH HIV BASED ON  
THEIR HIV STATUS**

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8

OUT OF 38  
COUNTRIES IN  
THE REGION

**MAINTAIN COMPULSORY  
DETENTION CENTRES FOR  
PEOPLE WHO USE DRUGS**

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11

OUT OF 38  
COUNTRIES IN  
THE REGION

**PROVIDE FOR THE  
DEATH PENALTY FOR  
DRUG-RELATED OFFENCES**

Source: GNP+, IHRA, ILGA, IPPF and UNAIDS. *Making the law work for the HIV response: A snapshot of selected laws that support or block universal access to HIV prevention, treatment, care and support.* Geneva, Joint United Nations Programme ON HIV/AIDS, 2010, and latest information available as of June 2011.  
([http://data.unaids.org/pub/BaseDocument/2010/20100728\\_hr\\_poster\\_en.pdf](http://data.unaids.org/pub/BaseDocument/2010/20100728_hr_poster_en.pdf))



# Afghanistan



## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	<b>NO</b>	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	<b>YES</b>
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	<b>YES</b>	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	⊖	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	<b>YES</b>		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	<b>YES</b>	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	<b>YES</b>	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	⊖

## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	<b>NO</b>	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	<b>NO</b>
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	<b>YES</b>	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	<b>NO</b>	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	<b>NO</b>		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	<b>YES</b>	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	<b>YES</b>	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	<b>NO</b>	DEATH PENALTY FOR DRUG OFFENCES	<b>YES</b>



# Bangladesh

## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	⊖	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	⊖
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	⊖	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	⊖	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	<b>NO</b>		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	<b>YES</b>	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	⊖	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	⊖



# Bhutan

## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	<b>NO</b>	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	<b>NO</b>
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	<b>YES</b>	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	<b>YES</b>	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	<b>NO</b>		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	<b>YES</b>	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	<b>YES</b>	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	<b>YES</b>



# Brunei Darussalam

PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	YES		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	YES	DEATH PENALTY FOR DRUG OFFENCES	YES

# Cambodia



PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	—		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	YES	DEATH PENALTY FOR DRUG OFFENCES	YES

# China



**LIFTING HIV-RELATED TRAVEL RESTRICTIONS**

The Government of China lifted its long-standing travel ban for people living with HIV in April 2010. There is no evidence indicating that the application of HIV-related travel restrictions benefits public health: on the contrary, these restrictions are discriminatory, threaten public health and are overly broad in terms of avoiding potential costs.

**STRENGTHENING PROTECTION FROM DISCRIMINATION**

To strengthen HIV prevention and treatment, in 2010, China issued a notice to the State Council to strengthen rights protection for, and end discrimination against, people living with HIV and their families. According to a 2011 International Labour Organization report, such laws can address the discrimination faced by people living with HIV in health-care settings in a positive manner.

However, the report also noted several challenges, including poor implementation, low awareness of HIV and occupational-protection measures, confusion about hospitals' responsibilities, and concerns about health workers' exposure to infection.

Source: International Labor Organization, the National Center for STD and AIDS Prevention and Control (NCAIDS). China (2011) Discrimination against people living with HIV within healthcare settings in China.

PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	—	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	—
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PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	—	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	YES	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	—		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	—	DEATH PENALTY FOR DRUG OFFENCES	YES

# Democratic People's Republic of Korea





# India



## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	NO		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	NO	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	YES

## 📌 ANNULMENT OF SECTION 377 OF THE PENAL CODE OF INDIA

On 2 July 2009, the Delhi High Court annulled a 150-year-old law criminalizing “carnal intercourse against the order of nature”, commonly known as Section 377 of the Indian Penal Code. In the affidavit it put before the judges, India’s National AIDS Control Organization contended that Section 377 hampered HIV-prevention efforts. The National AIDS Control Organization noted that only 6% of men who have sex with men had access to HIV prevention, treatment, care and support services. Many were reluctant to reveal their same-sex behaviour due to fear of police extortion, harassment and violence.

In 2011 India’s Supreme Court began deliberations to evaluate the High Court’s decision to see if and how the annulment could be replicated in other states and across the country.

## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	NO	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	NO		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	YES

# Indonesia



## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	NO
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	⊖		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	⊖

# Japan



PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	NO	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	NO	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	⊖		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	YES	DEATH PENALTY FOR DRUG OFFENCES	YES

# Lao

People's Democratic Republic



PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	NO	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	YES	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	NO		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	YES	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	NO	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	YES	DEATH PENALTY FOR DRUG OFFENCES	YES

# Malaysia



**HARM-REDUCTION FOR PEOPLE WHO USE DRUGS**

Although some compulsory drug detention centres still exist in Malaysia, a dramatic turnaround in favour of harm reduction has occurred. In response to a MDG report suggesting that the country was lagging behind in this area, the government took quick action. After reviewing its policy of using compulsory detention as the chief response to injecting drug use, the cabinet endorsed a switch to harm reduction and voluntary treatment in November 2005. In

2007, the Malaysian National Anti-Drug Agency, collaborating with the University of Malaya Medical Centre, introduced methadone maintenance for clients of after-care centres, which were intended for people who use drugs who were being discharged from compulsory detention. In 2010, the National Anti-Drug Agency transformed five compulsory detention centres for people who use drugs into 'Cure and Care' centres, which are voluntary outpatient-treatment facilities offering a range of treatment options. The new approach is based on the principle of addressing the needs

of people who use drugs through a wide range of treatment options, and to allow them to choose, instead of imposing a uniform programme on all people who use drugs. Malaysia's initiatives are now being showcased in the region to show that the move from a punitive approach into a health and client-centred approach is possible if there is leadership and political commitment.

Source: *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles*. Geneva, World Health Organization, 2009 ([http://www.idpc.net/sites/default/files/library/WHO\\_Asia\\_Compulsory\\_Treatment.pdf](http://www.idpc.net/sites/default/files/library/WHO_Asia_Compulsory_Treatment.pdf), accessed 14 August 2011).

PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	NO	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	NO
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PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	⊖		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	YES	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	⊖

# Maldives







## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	NO
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	YES	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	⊖		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	⊖

# Mongolia



## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	NO	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	NO		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	YES	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	YES

# Myanmar



## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	NO
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	⊖		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	⊖

# Nepal



## RIGHTS FOR LESBIAN, GAY, BISEXUAL AND TRANSGENDER PEOPLE

In November 2008, Nepal's Supreme Court ruled in favour of guaranteeing full rights to lesbian, gay, bisexual and transgender people as 'natural persons' under the law. This includes the right to marry. Despite this positive development and the absence of laws against sex work and drug use, sex workers, people who use drugs and transgender people in Nepal still experience harassment, extortion and beatings.

### PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	<b>NO</b>	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	<b>NO</b>
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### PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	<b>YES</b>	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	<b>NO</b>	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	⊖		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	<b>YES</b>	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	<b>YES</b>	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	<b>YES</b>

# Pakistan



### THIRD GENDER RECOGNIZED

In 2009, Pakistan's Supreme Court issued an Order recognizing the civil rights of transgender persons by including them in population registration under the status of a third gender. Transgender persons can now have national identity cards showing 'transgender' as their identity and the changes give hope for enhanced protection of the fundamental rights and citizen entitlements including improvement in access to employment, health care, education and social welfare nets accessible to other populations. Nevertheless, there are significant challenges relating to the implementation of this measure that need to be addressed if concrete benefits are to be generated, particularly due to the fact that same sex sexual relations are still prohibited in Pakistan.

### PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	<b>YES</b>	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	<b>YES</b>
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### PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	<b>YES</b>	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	<b>NO</b>	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	<b>NO</b>		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	<b>NO</b>	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	<b>YES</b>	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	⊖

# Philippines



### PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	⊖	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	⊖
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### PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	⊖	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	<b>YES</b>	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	⊖		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	<b>NO</b>	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	<b>YES</b>	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	<b>YES</b>

# Republic of Korea





# Singapore



## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	NO	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	NO
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	YES	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	YES		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	YES	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	NO	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	YES	DEATH PENALTY FOR DRUG OFFENCES	YES

## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	NO	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	NO		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	YES	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	YES



# Sri Lanka

## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	⊖		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	YES	DEATH PENALTY FOR DRUG OFFENCES	YES



# Thailand

## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	NO	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	⊖	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	⊖		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	NO	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	⊖



# Timor-Leste

# Viet Nam



## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	NO	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	YES		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	YES	DEATH PENALTY FOR DRUG OFFENCES	YES

### Political commitment for legal reform

In Resolutions 66/10 and 67/9 (adopted in May 2010 and May 2011, respectively), 62 Members and Associate Members of ESCAP urged a review of national laws, policies and practices to enable the full achievement of universal access targets with a view to eliminating all forms of discrimination against people living with HIV.

Building on those resolutions, UN Member States attending the June 2011 UN General Assembly High Level Meeting in New York committed to “review, as appropriate, laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people

living with and affected by HIV, and consider their review in accordance with relevant national review frameworks and time frames,” through the United Nations General Assembly, Political Declaration on HIV/AIDS.

### Fostering dialogue on HIV and the law in Asia and the Pacific

The Global Commission on HIV and the Law, an independent body launched by UNDP and UNAIDS, held the first of a series of seven regional dialogues in Bangkok in February 2011.

The dialogue brought together some 150 policy-makers and community advocates from 22 countries to generate policy discussions on important HIV-related human rights and legal issues in the Asia and the Pacific

region. It was an opportunity for civil society, people living with HIV, representatives of key populations at higher risk (including sex workers, people who use drugs, women who have sex with women, men who have sex with men, and transgender people) to engage with government representatives and HIV programme implementers on the legal, policy and other hindrances to HIV services.

The commission comprises

some of the world’s most respected figures in legal, human rights and HIV health and policy areas. It is expected to conclude its work in December 2011, and will make practical, evidence-informed and human rights-based recommendations for effective HIV responses that protect and promote the rights of people living with HIV and other key affected communities.



# Australia



## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	CONTRADICTION	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	CONTRADICTION		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	NO	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	⊖

### COMPREHENSIVE HARM-REDUCTION WORKS

When Australia made harm reduction its official policy in 1985, it was one of the first countries anywhere to do so. Its needle and syringe exchange programmes are considered the most comprehensive in the world. Harm reduction is credited with having helped maintain relatively low HIV prevalence at 1% (in 1999–2008) among people attending needle and syringe exchange programmes in the country. Civil society, community-based organizations and representatives of people who use drugs are key players in the implementation of harm-reduction efforts in Australia.

## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	NO
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## PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	YES	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	YES	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	NO		
LAWS THAT CRIMINALIZE SAME SEX SEXUAL ACTIVITIES BETWEEN CONSENTING ADULTS	NO	LAWS THAT DEEM SEX WORK ('PROSTITUTION') TO BE ILLEGAL	YES	COMPULSORY TREATMENT FOR PEOPLE WHO USE DRUGS	⊖	DEATH PENALTY FOR DRUG OFFENCES	⊖

# Fiji



### DECRIMINALIZING SEX BETWEEN MEN

Fiji became the first Pacific Island nation with colonial-era sodomy laws to formally decriminalize sex between men when it passed the Fiji National Crimes Decree in February 2010. Fiji is currently reviewing its national HIV legislation with the specific intention of eliminating all punitive laws.

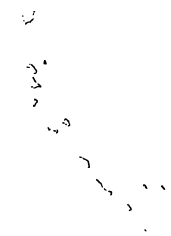
### PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	⊖	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	⊖
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### PUNITIVE LAWS

LAWS THAT PRESENT OBSTACLES TO ACCESS TO HIV SERVICES FOR VULNERABLE SUBPOPULATIONS	⊖	HIV-SPECIFIC RESTRICTIONS ON ENTRY, STAY OR RESIDENCE	⊖	LAWS THAT SPECIFICALLY CRIMINALIZE HIV TRANSMISSION OR EXPOSURE	NO		
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# Kiribati



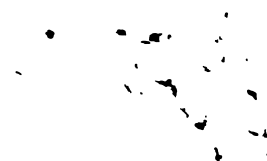
### PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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# Marshall Islands



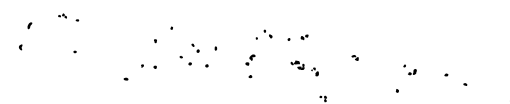
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# Federated States of Micronesia



### PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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# Nauru





## PROTECTIVE LAWS

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# New Zealand



### DECRIMINALIZATION OF SEX WORK

In 2003, the Parliament of New Zealand adopted the Prostitution Reform Act 2003, which decriminalizes sex work. The Act has been hailed by health and human rights experts for protecting sex workers against harassment and violence from clients and police, as well as for ensuring access to HIV prevention, treatment, care and support services for sex workers and their clients. Implementation of the Act led to the development of occupational safety and health guidelines by the New Zealand Government Department of Labour, in consultation with sex workers and their organizations.

## PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	NO
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# Palau



### PACIFIC POLICE PROGRAMME

The Pacific Islands Chiefs of Police, which comprises more than 75 000 serving police officers, has made HIV and human rights a central consideration in their professional conduct.

Working with various stakeholders, including the New Zealand Aid

Programme and UNAIDS, the Pacific Islands Chiefs of Police conducted a successful HIV and human rights project in the region from 2008 to 2010. A survey of police officers in Papua New Guinea, the Marshall Islands and Samoa examined attitudes, behaviours and interpersonal relationships with regards to violence,

law enforcement and other HIV and human rights-related issues. In Samoa, the survey recommendations have led to significant changes in HIV training programmes for police. Other achievements include HIV policy training for police officers, and basic research training on HIV and youth in the Pacific.

### PROTECTIVE LAWS

LAWS THAT PROTECT PEOPLE LIVING WITH HIV AGAINST DISCRIMINATION	YES	LAWS THAT SPECIFY PROTECTIONS FOR VULNERABLE POPULATIONS	YES
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# Papua New Guinea



### PREVENTION ACT 2003

Papua New Guinea's HIV/AIDS Management and Prevention Act 2003 is aimed at protecting several HIV-related rights, including the rights to non-discrimination and confidentiality for people living with HIV. However, laws that prohibit same-sex sexual relations and sex work remain on the statute books, and pose serious obstacles to HIV prevention, treatment and care.

### REVIEW OF LAWS THAT CRIMINALIZES POPULATIONS AT HIGHER RISK

In May 2011, Papua New Guinea conducted a national dialogue on HIV and the law, bringing together law makers, the police, the judiciary, AIDS activists, religious leaders, men who have sex with men, transgender people, people living with HIV, and sex workers. The occasion provided a first opportunity for stakeholders to openly discuss the challenges faced by populations at higher risk in Papua New Guinea in accessing HIV services due to laws that criminalizes them.

### PROTECTIVE LAWS

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# Samoa



### PROTECTIVE LAWS

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# Solomon Islands







# Tonga

## PROTECTIVE LAWS

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# Tuvalu

## PROTECTIVE LAWS

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# Vanuatu

# SAY WHAT? WORDS OF WISDOM ON HIV IN 2011— FROM THE REGION AND BEYOND

BAN KI-MOON, SECRETARY-GENERAL OF THE UNITED NATIONS

**"From its birth, the campaign against AIDS was much more than a battle against disease. It was a cry for human rights. It was a call for gender equality. It was a fight to end discrimination based on sexual orientation. And it was a demand for the equal treatment of all people."**

MICHEL SIDIBÉ, EXECUTIVE DIRECTOR, UNAIDS

**"The AIDS response must be the catalyst for improving maternal health and child health, for reducing infant mortality, stopping TB [tuberculosis] deaths among people with HIV and strengthening health systems."**

NAFIS SADIK, UNITED NATIONS SECRETARY-GENERAL SPECIAL ENVOY ON AIDS IN ASIA AND THE PACIFIC

**"It is important to bring the urgency faced by the AIDS crisis to as many people as possible."**

AGUNG LAKSONO, MINISTER FOR PEOPLE'S WELFARE OF INDONESIA

**"Within the global community we know what works. The question is, do we have the will? Do we have the courage? Are we willing to prioritize and replicate what we know works?"**

TRUONG VINH TRONG,  
DEPUTY PRIME MINISTER OF  
VIET NAM

**"Prevention is the best cure. It is imperative to undertake comprehensive preventive measures. Harm-reduction interventions, counselling and improvement of diagnostic capacity are essential to efforts towards the goal of zero new HIV infections. This requires strong involvement of people from all walks of life and social segments, as well as the leadership of governments."**

LOK CHUMTEAV BUN RANY  
HUN SEN, FIRST LADY OF  
CAMBODIA

**"Bold decisions are needed to dramatically reshape the response and achieve the UNAIDS vision of Zero new HIV infections, Zero discrimination and Zero AIDS-related deaths. Cambodia is committed to playing its part in a global movement that can and will make AIDS a thing of the past."**



VIRENDAR SEHWAG, CRICKETER

**"I think that too many people stigmatize people living with HIV, but they are no different from anybody else and we need to eliminate discrimination against those living with the disease from society. There also needs to be more awareness of what it means to be living with HIV."**

RATU EPELI NAILATIKAU, PRESIDENT OF FIJI

**"In the Pacific, in the area of legislation and reform, much work has been done—legislations have been reviewed. However, progress towards legislative amendments has been slow because HIV-related law reform can be a monumental challenge, given the punitive approach, and the high levels of stigma and discrimination."**

PRIETY ZINTA, UNAIDS GOODWILL AMBASSADOR

**"In this day and age in our country, we must stand up and say HIV-related stigma and discrimination is unacceptable. It is wrong to discriminate against anyone because of HIV. The starting-point is information and knowledge! If we take action today, together we can reach zero new HIV infections."**

KEVIN RUDD, MINISTER OF FOREIGN AFFAIRS OF AUSTRALIA

**"Full equality for women and girls, including protecting the right to be free from violence, is essential. Damaging gender stereotypes—for men, women and transgender people—inhibit an effective HIV response. Responses that seek to remove the dignity of those most at risk of HIV infection degrade us all."**

LYN KOK, PRESIDENT & CEO, STANDARD CHARTERED BANK (SCB), THAILAND, AND AMBASSADOR FOR SCB'S HIV INITIATIVE

**"Time and time again people living with HIV say to me that stigma and discrimination is worse than being infected and death. Education, knowledge and non-discrimination policies are the key to having a society that is more informed and tolerant thus enabling those living with HIV to maximize their full potential and strongly contribute to the society they live in."**

URSULA SCHAEFER-PREUSS, VICE-PRESIDENT, ASIAN DEVELOPMENT BANK

**"Given the tremendous growth in recent decades, the Asia and Pacific region should be able to extend more adequate and effective services and programmes to key affected populations, particularly the poor and vulnerable. However, many countries are spending too little on public health systems and national AIDS programmes, leaving key populations exposed to threats that could have been avoided."**

KUMAR SANGAKARRA, CRICKETER

**"As a Think Wise champion and cricketer, I want to help educate people on how to protect themselves from HIV. It is important that young people around the world have access to the right information to help them make informed decisions and break down stigma and discrimination."**

PAIJIT WARACHIT, PERMANENT SECRETARY, MINISTRY OF HEALTH OF THAILAND

**"It has become clear that the TRIPS flexibilities help to ensure that people living with HIV around the world have access to care and treatment. This is a crucial understanding for the international community to have in order for us to achieve fully the goals of zero AIDS-related deaths and zero new [HIV] infections."**

TUITAMA LEAO TALALELEI TUITAMA, MINISTER OF HEALTH OF SAMOA

**"Improving communication, gender power relations, overcoming traditional, cultural and religious barriers, upholding equity, maintaining respect for human rights and strengthening of health systems [all this] must be prioritized to ensure a more encompassing and engaged response."**

IGOR MOCORRO, PHILIPPINES YOUTH COALITION FOR SEXUAL AND REPRODUCTIVE RIGHTS AND MEMBER OF YOUTHLEAD

**"Young people need to make informed choices. Sexual education in and out of schools is a tool for the freedom of choice to understand that HIV prevention is everyone's responsibility. We have the passion for change and it's time for leaders to take young people seriously as equal partners and key actors in society who can make a difference."**

NELSON EDUARDO SOARES MARTINS, MINISTER OF HEALTH AND PRESIDENT OF NATIONAL AIDS COMMISSION OF TIMOR-LESTE

**"Efforts to combat HIV and AIDS must be linked to campaigns against sexual violence and for the rights of women. We must act together as one global nation in order to protect the lives of our global people and future generations."**

PARK IN-KOOK, PERMANENT REPRESENTATIVE OF THE REPUBLIC OF KOREA TO THE UNITED NATIONS

**"Entire societies need to participate proactively and foster HIV-free environments without any stigma and discrimination. Health and social investment to vulnerable groups, including sex workers, drug users and men who have sex with men must be scaled up. Punitive regulations and restricted access to health services, from which people suffer, have backfired on efforts to eliminate HIV/AIDS."**

RAZA BASHIR TARAR, DEPUTY PERMANENT REPRESENTATIVE OF PAKISTAN TO THE UNITED NATIONS

**"The problem of HIV/AIDS cannot be dealt with as a health issue alone. It, indeed, is a development issue, as well, since poverty is directly contributing to the spread of HIV/AIDS."**



TEIMA ONORIO,  
VICE-PRESIDENT OF KIRIBATI

**"The creation of an enabling environment which avoids or prevents prejudice, stigma, discrimination and criminalization remains the major challenge towards our response."**

BERNADETTE CAVANAGH, CHARGÉE D'AFFAIRES AI,  
NEW ZEALAND PERMANENT MISSION TO THE  
UNITED NATIONS

**"Young people are seldom involved as full and meaningful partners in decision-making regarding HIV policies and programmes. We call for an inclusive approach in HIV programming and service delivery which also encompasses those with disabilities."**

MECHAI VIRAVAIIDYA, POPULATION AND COMMUNITY  
DEVELOPMENT ASSOCIATION (PDA), THAILAND, AND  
COMMISSIONER ON THE UNAIDS HIGH LEVEL COMMISSION  
ON HIV PREVENTION

**"Leaders are not leaders at all unless they act to prevent people from dying. Every prime minister, every president would lead the drive against new HIV infections because we have lost more people to HIV than all the soldiers killed on both sides during World War II. HIV is a major problem and we have to solve it. Every leader in the world must be involved."**

DAVID LOZADA, JR, UNDERSECRETARY,  
DEPARTMENT OF HEALTH OF THE  
PHILIPPINES

**"It is paramount that a zero strategy is sound and realistic, given the evolving epidemiology of the disease, the emergence of new technology to halt its spread, as well as the collective effort of nations and organizations to end the epidemic."**

VINCE CRISOSTOMO, COORDINATOR OF THE  
COALITION OF ASIA PACIFIC REGIONAL NETWORKS  
ON HIV/AIDS (THE SEVEN SISTERS)

**"The High Level Meeting was an important event for 2011 and there are many opportunities for advocacy coming from the declaration. But we still have mixed feelings and concerns about some of the issues captured within it and will be working to further address this. For [the] Asia-Pacific, the ESCAP 67/9 Resolution is extremely significant and in line with what civil society wants. Using these political declarations, and momentum, the important thing is that all stakeholders come together to ensure universal access for all who need it by 2015."**

JAMES CHAU,  
UNAIDS GOODWILL AMBASSADOR

**"Thirty years and counting, we need to let the world know that AIDS isn't over. It is unacceptable that more than 7400 every day are still getting infected. It is an outrage that we still haven't turned a fundamental tide against both stigma and also discrimination. And it defies the heart that our brother and sisters living with HIV are still not living with equal access to treatment. This is their right, this is our responsibility, but together we have every reason to hope."**



# FACTS & FIGURES

Key HIV data and policy issues  
for the region

Unless referenced otherwise, all data are drawn from the UNAIDS 2010 *Report on the global AIDS epidemic*, which was informed by the 2010 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) country reports.

This section only reviews data from low- and middle-income countries in Asia and the Pacific.

# TRACKING THE HIV EPIDEMICS IN ASIA AND THE PACIFIC

## Overall, the regional epidemic is stabilizing, new infections are declining and AIDS deaths are levelling off

- An estimated 4.9 million (4.5–5.5 million) people were living with HIV in Asia and the Pacific in 2009: 4.8 million (4.3–5.3 million) adults and 160 000 (110 000–210 000) children younger than 15 years.<sup>1</sup> The number of people living with HIV has not changed substantially over the past five years.
- The number of people newly infected with HIV was estimated at 360 000 in 2009 (300 000–430 000), 20% fewer than the 450 000 (410 000–510 000) new infections estimated to have occurred in 2001.
  - An estimated 22 000 (15 000–31 000) children under 15 years were newly infected with HIV in 2009—a 15% drop from the 1999 estimate of 26 000 (18 000–38 000).
- Approximately 300 000 (260 000–340 000) people died from AIDS-related causes in 2009. This figure has remained stable in recent years and there are no signs of a decline.
  - AIDS-related deaths among children declined from 18 000 (11 000–25 000) in 2004 to 15 000 (9 000–22 000) in 2009—a decrease of 15%.
- Seven countries reported an estimated 100 000 or more people living with HIV: India, China, Thailand, Indonesia, Viet Nam, Myanmar and Malaysia (ranked by the number of people living with HIV in each country).
  - Over 90% of people living with HIV in Asia and the Pacific live in those countries, with India alone accounting for about half (49%) of the HIV burden in the entire region.
  - In the Pacific region, Papua New Guinea has the largest epidemic, with an estimated 34 000 (30 000–39 000) people living with HIV in 2009.
  - Controlling the epidemics in these countries is essential if the regional epidemic is to be reversed.

Countries with the highest burden of HIV in Asia Pacific, 2009

COUNTRY	NUMBER LIVING WITH HIV	LOW ESTIMATE	HIGH ESTIMATE	NUMBER OF NEW HIV INFECTIONS	LOW ESTIMATE	HIGH ESTIMATE
India	2 400 000	2 100 000	2 800 000	140 000	110 000	160 000
China	740 000	540 000	1 000 000	–	47 000	140 000
Thailand	530 000	420 000	660 000	12 000	9 800	15 000
Indonesia	310 000	200 000	460 000	–	29 000	87 000
Viet Nam	280 000	220 000	350 000	–	16 000	38 000
Myanmar	240 000	200 000	290 000	17 000	14 000	20 000
Malaysia	100 000	83 000	120 000	10 000	8 400	13 000
Pakistan	98 000	79 000	120 000	–	7 300	15 000
Nepal	64 000	51 000	80 000	4 800	2 700	7 800
Cambodia	63 000	42 000	90 000	1 700	<1000	4 200
PNG	34 000	30 000	39 000	3 200	2 400	4 800

Source: *Report on the Global AIDS Epidemic*. Geneva, Joint United Nations Programme on HIV/AIDS, 2010.

Note: New infection point estimates were not published for countries where there was a lack of agreement between the UNAIDS and country estimate

### CAUTION: EMERGING EPIDEMICS

Tracking HIV risk behaviours and ensuring HIV prevention, even in low prevalence countries, cannot be neglected. After more than 20 years of being a 'low and slow' epidemic, the Philippines now has an expanding epidemic among people who inject drugs (from 0.6% to 53% prevalence between 2009-2011 in Cebu) and men who have sex with men (5% prevalence in Manila and Cebu).





## The epidemics vary significantly between and within countries

- The combination of HIV transmission dynamics and varying coverage levels of essential HIV services make it possible to distinguish five country epidemic profiles.
  - **Profile 1:** Declining new HIV infections and numbers of people living with HIV, but AIDS-related deaths remain stable or are declining (Cambodia, Thailand and India, three of the oldest epidemics in the region).
  - **Profile 2:** Declining new infections, but the number of people living with HIV and the number of AIDS-related deaths are stable (Myanmar, Nepal and Papua New Guinea).
  - **Profile 3:** New infections are stable or declining, but the number of people living with HIV and the number of AIDS-related deaths are increasing (Indonesia, Malaysia, Pakistan and Viet Nam).
  - **Profile 4:** New infections and the number of people living with HIV are increasing, and AIDS-related deaths remain low (the emerging epidemics in Bangladesh, Lao People's Democratic Republic and the Philippines).
  - **Profile 5:** Low-prevalence countries with 1000 or fewer new HIV infections each year, and where the numbers of people living with HIV are low (Bhutan, Fiji, Mongolia, Maldives, Sri Lanka, Timor-Leste and several Pacific islands).
- National trends hide varying epidemic patterns and diverse trends within countries, especially in large countries such as China, India and Indonesia.
  - This highlights the need to closely monitor subnational epidemic patterns, and customize responses to local HIV transmission dynamics.

## Transmission happens through unsafe injecting drug use, unsafe sex between men and unsafe sex work in most of the region

- In many countries, HIV epidemics start with the virus spreading very rapidly among people who inject drugs or men who have sex with men, since non-sterile injecting equipment and unprotected anal sex are efficient ways of transmitting the virus.

- As a result, in most countries, HIV prevalence is highest among people who inject drugs, men who have sex with men, and sex workers and their clients.
- HIV spreads from these key populations to their intimate partners. In the absence of adequate prevention programmes, men who buy sex are the single largest key population, and will play the largest role in spreading HIV to low-risk women and their infants.
- The HIV epidemics in Papua New Guinea and in Indonesia's Papua and West Papua provinces appear to have developed without being triggered by HIV transmission among people who inject drugs. Instead, HIV has spread mainly through unprotected heterosexual intercourse among concurrent partners, including paid sex.

## A significant proportion of young people from key populations at higher risk are infected with HIV

- Young people below the age of 25 years constitute a significant percentage of the key populations at higher risk in Asia and the Pacific.
  - In some Asian countries, over 60% of female sex workers are younger than 25 years, as are close to half of men who have sex with men.
- HIV surveys have found that prevalence among young people at risk can be as high as among older cohorts. This means that young people at risk are becoming infected early, and that prevention programmes are not reaching them sufficiently.
  - HIV prevalence is 42%<sup>2</sup> among young people who inject drugs in Indonesia, 28% among their peers in Myanmar, 23% in Pakistan, and 8% in China.
  - Among female sex workers, those younger than 25 years are at least as likely as their older counterparts to be HIV-positive in Indonesia (10.4% compared to 10.1% in a 2007 study), Papua New Guinea (7.2% compared to 4.8% in 2009) and Pakistan (2.4% compared to 2.3% in 2008).<sup>3</sup>

# TRACKING THE HIV EPIDEMICS IN ASIA AND THE PACIFIC

## The proportion of HIV infections in women is stable at around 35%

- An estimated 1.7 million (1.6–2 million) women in Asia and the Pacific were living with HIV in 2009.
- The proportion of women living with HIV increased from 21% in 1990 to 36% of all adults in 2002. Since then, it has stabilized at about 35%, substantially below the global average of 52%.
  - A large proportion of these women acquired HIV through unprotected sex with their regular male partners who were infected with HIV through injecting drug use or sexual risk behaviours.
  - This underlines the need for HIV prevention programmes among serodiscordant couples, as well as the need to meet women's treatment needs and prevent vertical transmission of HIV to children.
  - More attention should be devoted to promoting gender equity, and ensuring male responsibility for the sexual and reproductive health of their spouses, other intimate partners and families.

### THE EPIDEMICS IN ASIA AND THE PACIFIC TEND TO DEVELOP IN DISTINCT PHASES

As demonstrated by the Commission on AIDS in Asia in its 2008 report,<sup>4</sup> HIV epidemics in the region generally follow a fairly predictable pattern through the following phases.

In the initial latent epidemic phase, national HIV prevalence is low. Most new infections are among people who inject drugs and men who have sex with men, and sex workers account for a small number of new infections. Rapid scale-up of high-impact prevention coverage, focused and effective harm reduction programmes among people who inject drugs, and wide-scale consistent condom use among men who have sex with men and in sex work will avert a large-scale epidemic.

If an epidemic is not controlled in the early latent phase, HIV prevalence starts rising among sex workers and their clients due to overlapping sexual and injecting drug use networks. In this expanding epidemic phase, HIV infections can grow to significant proportions. In addition to maintaining harm reduction programmes and safer sex between men, immediate and effective prevention efforts to promote consistent condom use during sex work are essential. Programmes to prevent HIV transmission through unprotected sex between the large proportion of Asian men who buy sex and their intimate partners also need to be initiated.

In maturing epidemics, HIV prevalence has been rising for several years among sex workers and their clients. Most new HIV infections occur among clients of sex workers, but onward transmission to the sexual partners of those people becomes an important source of new infections. The same package of programmes is required as in the expanding phase.

In declining epidemics, HIV prevalence is falling due to successful sex work-related prevention programmes, but a major epidemic in men who have sex with men looms if programmes in this group have been neglected. Achieving safer sex between men will yield the largest reduction in new infections. High rates of consistent condom use during sex work must be sustained, but it is essential to have interventions that prevent the steady HIV transmission from HIV-positive men to their intimate partners, and to maintain effective harm reduction efforts to prevent resurgence of an epidemic among people who inject drugs.



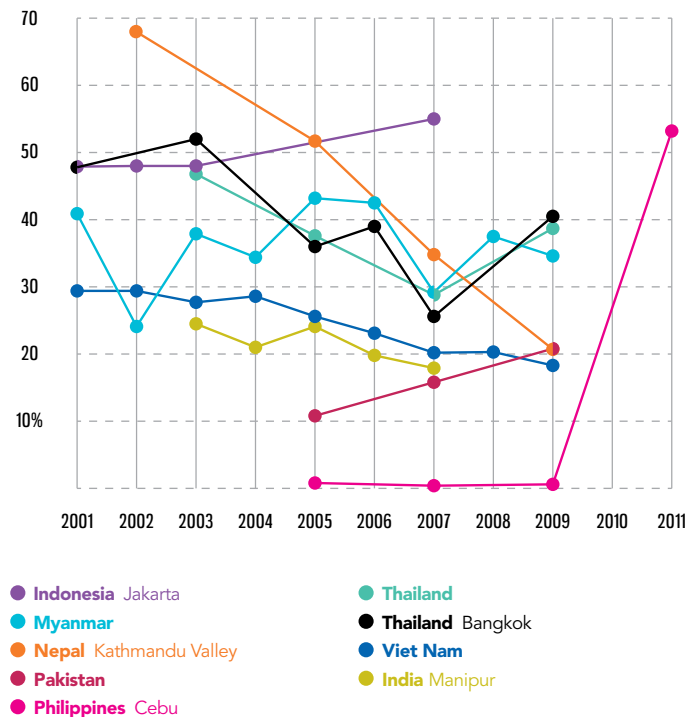
## Prevalence remains high in several countries

- Asia includes 7 of the 15 countries globally where over 100 000 people inject drugs and where HIV prevalence among them exceeds 10%. These countries are China, India, Indonesia, Malaysia, Pakistan, Thailand and Viet Nam.
  - An estimated one in six people who inject drugs in Asia is infected with HIV.<sup>5</sup> More than one in three people who inject drugs surveyed in Indonesia, Myanmar, and Thailand are HIV-positive, one in four in Cambodia and one in five in Nepal, Pakistan and Viet Nam.
  - In Pakistan, HIV prevalence almost doubled from 11% in 2005 to 21% in 2008,<sup>6</sup> and in Bangladesh, prevalence among people who inject drugs in Dhaka rose from 1.4% in 2000 to 7% in 2007 (the latest available data).<sup>7</sup>
  - The Philippines is experiencing a rapidly growing epidemic. In Cebu, HIV prevalence in people who inject drugs increased from 0.6% to 53% in 2009–2011.<sup>8</sup> In nearby Mandaue, 3.6% of people who inject drugs are HIV-positive.
  - The overlap between injecting drug use and sex work means that HIV epidemics in people who inject drugs invariably spread to other population groups until effective prevention efforts take hold.
  - An emerging concern is the increasing use of amphetamine-type stimulants (ATS). Data from the UNODC *World drug report 2011* suggest that between 4 million and 38 million people (0.2%–1.4% of people in Asia aged 15–64) have used ATS at least once in the past year. Although only 11% of users become dependent, some studies have associated ATS use with risky sexual behaviour.<sup>9,10</sup>

## Support for a public health approach is broadening...

- An increasing number of countries in the region that have embraced the principle of harm reduction, and have initiated or are expanding HIV prevention and treatment programmes for people who inject drugs.
- Meanwhile, despite the increase in the number of service delivery sites, access to and use of needle and syringe programmes and opioid substitution programmes remain low in most countries.
  - The number of needle and syringe programme sites in Asia has increased seven-fold—from 291 in 2006 to 2200 in 2010—mainly due to scale-up in Bangladesh, China, Indonesia and Viet Nam.<sup>11</sup> However, only Bangladesh and Viet Nam reported distributing more than 100 needles and syringes per user per year in 2009

HIV prevalence among people who inject drugs, where data is available, 2001–2011



(considered “medium availability”). In Indonesia and Malaysia—countries with significant HIV epidemics among people who inject drugs—15 or fewer clean needles and syringes were distributed per injecting drug user per year.

- Among 11 countries reporting UNGASS data in 2010, the regional median prevention programme coverage for people who inject drugs was 17%, compared with a global median of 32%. None of the countries in the region reported coverage higher than 60% for people who inject drugs. Programme data indicate that coverage of needle and syringe programmes in Asia in 2010 was only 14%, albeit up from 1% in 2006.<sup>12</sup>
- Over 80% of people who inject drugs reported using a sterile needle and syringe at last injection (UNGASS indicator 21) in 8 of the 13 countries in Asia that reported those data for 2009. However, other sources<sup>13</sup> report that use of non-sterile injecting

# ENDING HIV INFECTIONS AMONG PEOPLE WHO INJECT DRUGS

equipment remains common, suggesting that levels of consistent safe behaviour are lower.

- Opioid substitution programmes were available at 1182 sites in 2010, up from 341 in 2006. Bangladesh and Cambodia introduced opioid substitution therapy for the first time in 2010. However, only 5% of the estimated 4 million people who inject drugs in Asia and the Pacific were being reached with these programmes in 2010.<sup>14</sup>
- Considering the overlap between injecting drug use and paid sex, and the high prevalence of HIV among people who inject drugs, condom promotion is essential to prevent the spread of HIV from people who inject drugs to sex workers and their sexual partners. Reported condom use among people who inject drugs is lower than the use of sterile injecting equipment. Among 12 countries reporting data, the median percentage of people who inject drugs reporting condom use at last sex (UNGASS indicator 20) was 36% (ranging from 16% in India to 78% in Myanmar).

## ... but law enforcement approaches still prevail

- A 'war on drugs' approach still dominates in several countries in the region.
  - Law enforcement authorities continue to criminalize the possession of needles and syringes, and mount 'crackdowns' against people who use drugs, even when they are in treatment or visiting drop-in centres for clean needles and syringes or other services.
  - Criminalization of drug use drives people who inject drugs away from health and HIV services operated by government and nongovernmental agencies. Stigma and discrimination in health-care settings have the same effect.
  - Several countries (Cambodia, China, Lao People's Democratic Republic, Malaysia, Myanmar, Sri Lanka, Thailand and Viet Nam) still detain people who use drugs in compulsory centres.
  - An estimated 309 000 people who inject drugs (almost 8% of the estimated 4 million people who inject drugs in the region) are detained in approximately 1000 compulsory centres for people who use drugs in East and South-East Asia.
  - A few countries are beginning to shift away from the compulsory centre approach, including Malaysia, which is transforming its compulsory centres into voluntary 'Cure and Care' clinics.

## Towards consistent harm reduction strategies throughout the region

- Legal and policy barriers to HIV prevention and treatment for people who inject drugs must be removed.
  - Stronger collaboration is needed between drug control and law enforcement officials and the health sector.
  - Compulsory centres for people who use drugs need to be replaced with voluntary and community-based treatment approaches that offer a wide range of options for treatment and care for drug dependence, including expanding services to those in prisons.
- In 2010, WHO, UNODC, UNAIDS, the Global Fund and the Asian Network of People who Use Drugs (ANPUD) outlined a new, three-pronged strategy for controlling HIV among people who inject drugs:
  - Create a favourable enabling environment for harm reduction, especially by strengthening policy coordination and harmonization between public health and public security ministries, and by removing policy and punitive legal barriers.
  - Provide technical support to governments to scale up community-based harm reduction programmes and to build capacity for developing public health evidence based approaches for users of amphetamine-type stimulants.<sup>15</sup>
  - Ensure the availability of quality strategic information to develop and budget for effective national responses to drug use.<sup>16</sup>
- The recent report of the Global Commission on Drug Policy made a call for humane and effective drug policies.<sup>17</sup>
  - The report states that drug policies be evidence- informed and based on human rights and public health principles, and be implemented by involving families, schools, public health specialists and civil society leaders in partnership with law enforcement agencies and other relevant governmental bodies.
  - It recommends governments to promote policies that effectively reduce consumption and that prevent and reduce harm; to invest in evidence-informed prevention, with a special focus on young people; and focus repressive measures on organized crime and drug traffickers in order to reduce the harm associated with the illicit drug use market.



### CONCERNS ASSOCIATED WITH COMPULSORY CENTRES FOR DRUG USERS

1. In most cases, effective and evidence-informed treatment options for drug dependence (such as opioid substitution therapy) and for other health conditions are not available for drug users in compulsory centres.<sup>18</sup>
2. As these centres usually do not provide HIV prevention commodities (such as condoms and sterile injection equipment), detainees are at risk of contracting HIV and other bloodborne diseases. There are reports that people who are living with HIV in compulsory centres, including people co-infected with tuberculosis or hepatitis C, often do not have access to treatment.<sup>19</sup>
3. A number of countries have reported high relapse rates following release from the centres, ranging from 60% to close to 100%.<sup>20</sup>
4. Concerns have been raised regarding forced, often unpaid labour, of drug users in compulsory centres. UN Special Rapporteur on the Right to Health, Mr Anand Grover, stated in his 2010 report that “forced labour, solitary confinement and experimental treatments administered without consent in compulsory centres violate international human rights law and are illegitimate substitutes for evidence-informed measures such as substitution therapy, psychological interventions and other forms of treatment given with full, informed consent”.
5. Most compulsory centre systems lack mechanisms allowing residents to file complaints related to arbitrary detention, forced labour, abuse or other grievances.

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We commit to working towards reducing transmission of HIV among people who inject drugs by 50 percent by 2015

FROM THE 2011 POLITICAL DECLARATION ON HIV/AIDS,  
ADOPTED BY THE UNITED NATIONS GENERAL ASSEMBLY  
ON 10 JUNE 2011

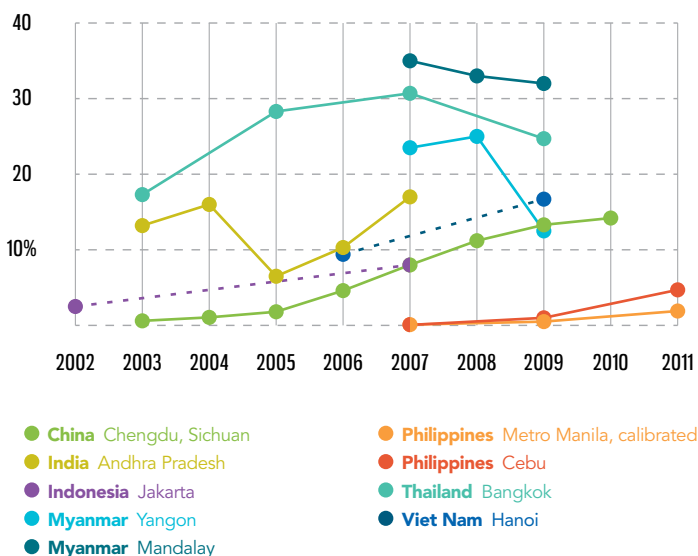
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# ENDING HIV INFECTIONS AMONG MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE

## The latest wave of HIV epidemics in the region

- Serious epidemics among men who have sex with men are underway across the region, especially among young people and in cities.
  - Very high infection levels—between 13% and 32%—are being found in surveyed men who have sex with men in cities in China, India, Myanmar and Viet Nam.<sup>21</sup>
  - In Thailand, the epidemic among men who have sex with men was largely ignored until a study uncovered 17% prevalence in Bangkok in 2003. Subsequent studies found infection levels had risen to 31% by 2007, but were a little lower (25%) in 2009.<sup>22,23</sup>
  - In the Philippines, epidemics have erupted in metropolitan Manila and Cebu (5% HIV prevalence), and several other cities (1%–2% prevalence). Other data reveal a doubling of HIV transmission among men who have sex with men throughout the country.<sup>24</sup>
- Unless prevention measures are improved, by 2020 up to 50% of new HIV infections in the region could be among men who have sex with men, according to modelling done by the Commission on AIDS in Asia in 2008.

**Trends in HIV prevalence among men who have sex with men in selected cities with prevalence over 5%, 2002–2011**



## Recent progress

- Advocacy, capacity support and resource mobilization are improving, especially at the regional level.
  - Community-based organizations have led successful multicountry Global Fund proposals to address HIV among men who have sex with men and transgender people, covering 11 countries and totalling over US\$ 50 million.<sup>25</sup>
  - An example is the creation of the Asia Pacific Coalition on Male Sexual Health (APCOM), a regional advocacy body of men who have sex with men and HIV community-based organizations, the government sector, donors, technical experts and the UN system.
- Many national AIDS programmes now identify HIV responses among men who have sex with men and transgender people as priorities, even though the legal and social environments remain restrictive.
  - Health departments in 22 countries have identified men who have sex with men and transgender people as priority populations for HIV prevention. Four countries have specific men who have sex with men and HIV strategic plans or action plans (Cambodia, China, India and Indonesia).
- Nevertheless, progress is not yet widely evident in service coverage for men who have sex with men and transgender communities.
  - In 2009, in the 10 reporting countries in the region, median service coverage for men who have sex with men was 49% (compared to 57% globally). Reported coverage for men who have sex with men exceeded 60% in four countries: China (75%), Mongolia (77%), Myanmar (69%) and Nepal (77%). No country in the region shared recent coverage data for prevention for transgender people in their 2010 UNGASS reports.
  - Median reported condom use at last sex was 60% in the 16 countries that reported those data. In Cambodia, China, Mongolia, Myanmar, Nepal and Thailand, at least 70% of surveyed men who have sex with men said they had used a condom the last time they had sex, but 50% or fewer did so in Lao People's Democratic Republic, Malaysia, Papua New Guinea, the Philippines, Singapore and Timor-Leste.
- Young men who have sex with men and transgender people are at significant risk for HIV infection.<sup>26</sup>
  - HIV programmes are not ensuring that young men who have sex with men understand their HIV risks and the severity of the epidemics among their communities.



## Important gaps and challenges remain

- Programmes are too dispersed, and too few of them accurately focus on key 'hot spots' of high HIV prevalence. Many current prevention activities focus on men who have sex with men and transgender people tend to be generic and fail to gain their attention and respect.
- Stigma and discrimination in health-care settings are major impediments.
  - Few public health sector services have been sensitized to the needs of men who have sex with men and transgender people. Studies show that discrimination, breach of confidentiality and lack of counselling when using HIV services cause people to avoid health facilities.<sup>27</sup>
- Harassment and violence at the hands of law enforcement personnel (often facilitated by laws and ordinances) add even more barriers.
  - In many places, the police still treat the possession of condoms as evidence of prostitution.
  - Men who have sex with men and transgender sex workers are especially vulnerable to sexual assault and extortion, particularly from the police.

## Scaling up HIV prevention among men who have sex with men and transgender people is a regional priority

- Effective HIV interventions must reach at least 80% of men who have sex with men and transgender people if they are to reverse the HIV epidemics in these populations.
- A comprehensive, rights-based approach to HIV prevention for men who have sex with men and transgender people should include at least the following elements:
  - national strategic plans and programmes with initiatives that promote safe environments for men who have sex with men and transgender people;
  - partnerships with law enforcement authorities (particularly at the local level), and provision of human rights training to reduce harassment and abuse;
  - access for men who have sex with men and transgender people to legal assistance and other means for seeking redress if their rights are violated;
  - greater support for the efforts of men who have sex with men and transgender people to organize themselves collectively;

– meaningful involvement of organizations representing men who have sex with men and transgender people in the design, implementation and assessment of programmes that are meant to benefit them.

- The recently released guidelines, *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people*, provide clear recommendations for a public health approach that should be adopted to respond to these epidemics in the region.<sup>28</sup>
- Comprehensive programmes for men who have sex with men and their sexual partners in large cities are an urgent priority in the region.
  - The Men Who Have Sex with Men and Transgender Populations—Multi-City Initiative was launched in 2010. It includes the Six Cities Project, which supports the expansion of effective, comprehensive and rights-based AIDS responses in the targeted cities: Bangkok (Thailand), Chengdu (China), Ho Chi Minh City (Viet Nam), Jakarta (Indonesia), Manila (Philippines) and Yangon (Myanmar).
  - Early feedback indicates that strategic information, policies and guidance are now increasingly being translated into locally focused programmes.
  - Projects are trying to strike a balance between stern and light-hearted messages, and various forms of engagement. There is more use of the Internet and other social media, and interactive education (such as mobile theatre and 'edutainment') is more prominent. Protected outreach and peer education are being attempted to avoid police harassment, and the information needs of HIV-positive and HIV-negative men are being linked.

We note that many national HIV prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men, people who inject drugs and sex workers

FROM THE 2011 POLITICAL DECLARATION ON HIV/AIDS, ADOPTED BY THE UNITED NATIONS GENERAL ASSEMBLY ON 10 JUNE 2011

Noting with concern the continuing barriers to access to HIV prevention, treatment, care and support faced by key affected populations, particularly sex workers, injecting drug users, men who have sex with men and transgender populations

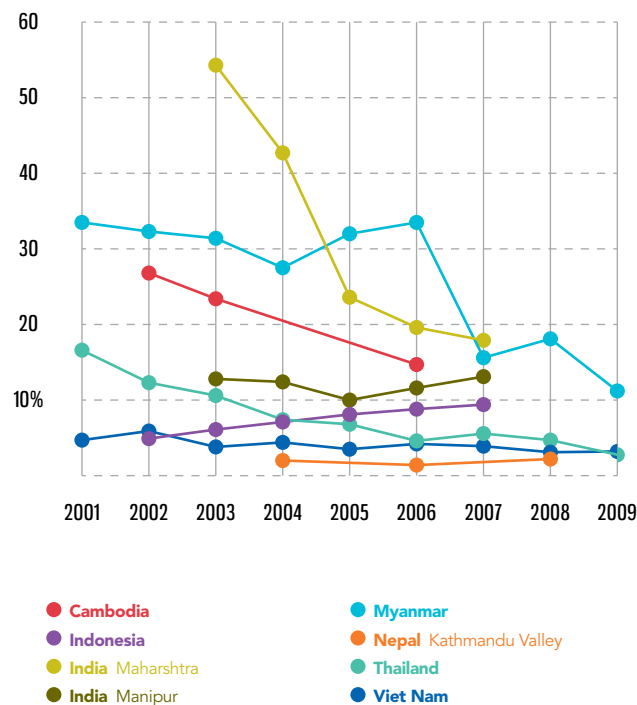
FROM RESOLUTION 67/9 ADOPTED BY THE COMMISSION OF THE ECONOMIC AND SOCIAL COUNCIL FOR ASIA AND THE PACIFIC ON 19–25 MAY 2011

# ENDING HIV INFECTIONS AMONG PEOPLE WHO BUY AND SELL SEX

## Significant overall HIV declines are offset by high prevalence in some areas

- There has been progress in reducing HIV infections among female sex workers across the region. National HIV prevalence in this group has declined in the early epidemics of Cambodia, India and Thailand, or has been kept low in countries such as China and Nepal. Nevertheless, hotspots of high prevalence continue to occur.
  - Surveys of female sex workers show HIV prevalence of 18% in Maharashtra<sup>29</sup> and 41% in Pune (India).<sup>30</sup> In Viet Nam, HIV prevalence reported in 2010 was 3.2% but, in Hai Phong, 23% prevalence has been found among street-based sex workers.<sup>31</sup>
  - As HIV transmission expands from people who inject drugs to people who buy and sell sex, infections are increasing in Indonesia, as well as in low-prevalence countries such as Pakistan and the Philippines.<sup>32</sup>
- Data for male and transgender sex workers are scarce, but show very high HIV prevalence.
  - 10%–25% of surveyed male sex workers in Indonesia and Thailand, for example, have tested HIV-positive in surveys, as have 34% of transgender (hijra) sex workers in Jakarta and 16% of their peers in Mumbai.<sup>33</sup> In Cambodia, HIV prevalence among transgender people was almost two times higher than among men who have sex with men (9.8% compared to 5%).<sup>34</sup> In Pakistan, the 6.1% prevalence among transgender sex workers was much higher than the 0.9% and 2.2% prevalence found among other male sex workers and female sex workers, respectively.<sup>35</sup>
- Clients of sex workers make up the largest HIV-affected population group in Asia and the Pacific.
  - Depending on the country, between 0.5% and 15% of adult males in the region buy sex.<sup>36</sup>

HIV prevalence among female sex workers, countries where data is available, 2001–2009







## Programme coverage and rates of condom use are increasing but remain below targets in many countries

- Fifteen countries in Asia reported 2009 data on coverage of HIV prevention services for female sex workers. Median reported coverage in the region was 40% (58% globally). For male sex workers, among five reporting countries, median reported coverage was 13% (range 9%–93%).
- UNGASS reported coverage for female sex workers was more than 60% in four countries: China (74%, up from 46% in 2007); Lao People's Democratic Republic (70%); Mongolia (74%); and Myanmar (76%). Only Nepal reported coverage of more than 80% for male sex workers.
- Condom use during sex work is increasing but remains below the 80% target.
  - About half the countries in the region reported that at least 80% of female sex workers used a condom with their most recent client in 2009. But levels of consistent condom use are lower, and condom use with regular partners is much lower. In Indonesia, for example, only 34% of female sex workers said they consistently used condoms during paid sex,<sup>37</sup> as did 33% of their peers in a study of five urban communities in China.<sup>38</sup>
  - Reported condom use among male sex workers is lower than among female sex workers. Only a few countries reported these data in 2010. In Bangladesh, Indonesia, Nepal, Pakistan and Papua New Guinea, 35%–45% of male sex workers said they used condoms the last time they had paid sex, as did almost 80% in Indonesia.
  - Reported condom use rates among transgender and hijra sex workers are generally high. Reported condom use rates at last sex for transgender sex workers in 2009 was 67% in Bangladesh, 90% in Cambodia, 93% in India and 94% in Malaysia, but only 33% in Pakistan.
  - Reported high rates of condom use among surveyed sex workers do not necessarily reflect the complex realities on the ground. Surveys seldom capture hidden and highly vulnerable sex workers who are not well covered by HIV services and programmes.

## A lack of enabling environments and comprehensive programmes

- Crackdowns, detention and various forms of physical, sexual and emotional abuse at the hands of the police occur in many countries and impede efforts to halt HIV transmission in paid sex.
  - In many places, police regard the possession of condoms as evidence of 'prostitution'. Sex workers are especially vulnerable to rape and abuse, not only by clients, but also by the police.<sup>39</sup>
  - The 100% Condom Use Programmes are credited with reducing HIV infections in sex work. But there are serious concerns regarding compulsory HIV testing, lack of confidentiality, police harassment and various punitive practices.<sup>40</sup>
- Stigma and discrimination in health-care facilities are major impediments.
  - Studies in India,<sup>41</sup> Nepal<sup>42</sup> and Viet Nam<sup>43</sup> show that significant proportions of female and transgender sex workers shun health facilities because of discrimination, breach of confidentiality and lack of counselling when accessing HIV testing.
- Fewer than half the countries in the region currently provide a comprehensive package of services for sex work programmes.<sup>44</sup>
  - Most programmes focus on condom provision and treatment of sexually transmitted infections, with little emphasis on consistent and proper use of condoms, and on improving access to other sexual and reproductive health services and to HIV testing, treatment, care and support.
  - Few programmes currently embrace a multisectoral response that includes cooperation with relevant ministries and other partners to train and sensitize police and entertainment venue managers to address violence, harassment, stigma and discrimination.
  - Clients of sex workers are rarely reached with prevention programmes.
  - Often missing is the meaningful involvement and mobilization of sex worker communities, despite evidence that programmes that are led by sex workers are among the most effective in the region.<sup>45</sup>

# ENDING HIV INFECTIONS AMONG PEOPLE WHO BUY AND SELL SEX

## Towards a new generation of sex work programmes

- **Addressing and changing punitive laws and regulations related to sex work and ending police violence and harassment are vital if prevention programmes are to be successful.**
- **Anti-trafficking laws and efforts should focus on people who were forced into sex work and should never violate the human rights of sex workers who freely choose to engage in sex work.**
- **Health-care providers need to be trained and supported to combat stigma and discrimination in health care, and to provide services that are responsive to the needs of key populations at higher risk, such as sex workers.**
- **A comprehensive, rights-based, multisectoral and multipartner approach is needed. It should feature:**
  - sex workers' meaningful involvement in the design, implementation and assessment of programmes that are intended to benefit them;
  - support for sex workers' attempts to organize themselves collectively;
  - partnerships with law enforcement authorities (particularly at a local level), and human rights training to reduce violence and harassment;
  - access for sex workers to legal assistance and other means to seek redress if their rights are violated;
  - programmes that promote safe working conditions for sex workers and access to social security through the workplace;
  - prevention programmes that include sexual reproductive health services, quality counselling and testing; treatment of HIV, and other sexually transmitted and opportunistic infections; and access to alcohol and drug-related harm reduction, including needle and syringe programmes and opioid substitution;
  - programmes to identify and reach men who buy sex, and greater effort to promote male responsibility for the sexual and reproductive health of their spouses, other intimate partners and families.

### THE CHANGING WORLDS OF SEX WORK

Sex work is diversifying away from brothel-based venues to karaoke rooms, massage parlours, bars and other entertainment venues, and the sex industry is becoming bigger and more diffuse.

A recent study in India, for example, encountered large, hidden networks of men and women who sold sex in various guises (as escorts, masseuses, bar girls and dancers, or call boys and girls). HIV prevention awareness among these sex workers was very poor; and consistent, correct condom use rates were extremely low.<sup>46</sup>

This new generation of highly mobile and hidden sex workers is not yet benefiting sufficiently from HIV services and programmes. Programmes and surveillance must be adapted to these realities, and the improved data must be used to design more effective HIV prevention programmes.



## A global goal

- The goal of eliminating new HIV infections among children by 2015 is a key component of the UNAIDS Strategy 2011-2015 and was endorsed by all UN Member States in the June 2011 UN General Assembly Political Declaration on HIV/AIDS.
- Eliminating new HIV infections in children and keeping their mothers alive contribute toward achieving Millennium Development Goal (MDG) 6, as well as MDG 3 (promoting gender equality and empowering women), MDG 4 (reducing child mortality) and MDG 5 (improving maternal health).
- A comprehensive approach to the elimination of new HIV infections among children consists of four prongs:
  - Preventing HIV among women of reproductive age;
  - Providing appropriate counselling and support and contraceptives, to women living with HIV;
  - For pregnant women living with HIV, ensuring HIV testing and counselling and access to the antiretroviral drugs needed to prevent HIV infection from being passed on to their babies during pregnancy, delivery and breastfeeding;
  - Providing HIV care, treatment and support for women, children living with HIV and their families.

## Progress everywhere and some success stories, but insufficient service coverage overall

- In Asia and the Pacific, a relatively stable proportion of 35% of people living with HIV are women. In 2008, there were an estimated 85 000 women living with HIV among an estimated 69 million pregnant women in the region, a proportion of just over 1 per 1000.<sup>47</sup>
  - Without intervention, up to 45% of infants born to women living with HIV are at risk of becoming infected with HIV. Appropriate services can reduce this risk to less than 5%.
  - In 2009, an estimated 22 000 children (15 000–31 000) in Asia and the Pacific were newly infected with HIV.
  - Without access to care and treatment, about one third of children with HIV die before their first birthday, 50% die before reaching two years of age, and 80% die before they are five years old.
  - In Asia, the majority of women living with HIV are infected by their intimate partners. To reflect this and to emphasize the need

to involve men more in HIV and related health services, countries in Asia and the Pacific have adopted the 'prevention of parent-to-child transmission' terminology.<sup>48</sup>

- Only 17% of pregnant women in Asia and the Pacific received an HIV test in 2009 — a big increase from the 2% in 2005, but still below the average of 26% for low-income and middle-income countries globally.<sup>49</sup>
  - HIV testing coverage was below 50% in 14 of 18 reporting countries in 2009, and below 5% in Bangladesh, Indonesia, Lao People's Democratic Republic, Pakistan, the Philippines, Sri Lanka and Timor-Leste.
- Coverage for preventing mother-to-child transmission in Asia and the Pacific has improved, but the regional average still trails well behind the global average.<sup>50</sup>
  - Thailand (with over 90% coverage) and Malaysia (over 80%) are on track to reach the goal of eliminating new HIV infections among children.<sup>51</sup>
  - The largest unmet need is in India. It is the only Asian country in the 22 countries globally that are home to about 90% of women living with HIV who need services for preventing new HIV infections among their children.<sup>52</sup>
- The 2010 revised WHO guidelines for prevention of mother-to-child transmission recommend dual or triple antiretroviral combinations, instead of single-dose nevirapine (which is less effective, involves an increased risk of viral resistance, and does not provide protection during breastfeeding).
  - Most countries in Asia and the Pacific have moved to these more efficacious regimens, or are in the process of doing so. However, at the end of 2010, single-dose nevirapine was still being used in China, Fiji, Kiribati, Mongolia and Viet Nam, and was the only regimen used in India.
- In the Asia-Pacific region, 32% of infants born to women living with HIV received antiretroviral prophylaxis, which was only slightly below the global average coverage of 35% and a large increase from 7% in 2005.
  - Reported coverage levels varied widely, from over 85% in Bhutan and Thailand, to between 45% and 54% in Cambodia, China, Malaysia, Myanmar and Viet Nam, and below 20% in Lao People's Democratic Republic, Nepal, Pakistan and Papua New Guinea.<sup>53</sup>
- In Malaysia and Thailand, less than 5% of children born to women living with HIV acquire HIV, which demonstrates that the goal of eliminating mother-to-child transmission is feasible.
  - However, in Papua New Guinea, 41% of children born to HIV-positive mothers acquire HIV, as do between 22% and 31% in Cambodia, China, Mongolia, Myanmar, Pakistan and Sri Lanka.<sup>54</sup>

# ENDING NEW HIV INFECTIONS AMONG CHILDREN

- Early HIV diagnosis is critical for prompt initiation of antiretroviral therapy in HIV-positive children, which WHO now recommends for all children younger than 12 months who are HIV-positive.<sup>55</sup>
  - Very few infants born to women living with HIV are currently provided with a virological test within two months of birth<sup>56</sup> because of a lack of affordable rapid tests that can be done at service delivery points. As a result, most HIV-positive infants do not receive antiretroviral therapy as early as they need it.
- At a regional meeting organized by the Regional Task Force on Prevention of Parent-to-Child Transmission in Asia and the Pacific in late 2010, country teams committed to the dual goal of eliminating new HIV infections and congenital syphilis in children. A regional framework, which is informed by the region's good practices and proposes precise targets for each prong, has been developed to guide those efforts.<sup>60</sup> Progress on four fronts will be particularly critical:

- strengthening sexual and reproductive health, and maternal, newborn and child health services, including through increased funding;
- integrating and linking HIV services with those services;
- involving networks of women living with HIV and women from key populations at higher risk in service delivery to improve service access, quality, efficiency and sustainability;
- using new technologies to avoid loss to follow-up and to manage data across various services, particularly after delivery.

## Main barriers to increasing service coverage for preventing new HIV infections among children

- Lack of access to quality antenatal care and assisted delivery services is a major barrier to increasing coverage for preventing new infections among children in the region, particularly in low-income countries (including Bangladesh, Cambodia, Lao People's Democratic Republic, Myanmar, Nepal), but also in India.
- There is significant loss to follow-up at every step of the cascade of services — from testing pregnant women and providing them and their babies with adequate antiretroviral regimens, to testing infants and providing antiretroviral therapy to women and babies in need.
- Stigma and discrimination continue to hinder access of women living with HIV to maternal and neonatal health services.<sup>57</sup> Barriers to services are even higher for sex workers and women who inject drugs.<sup>58</sup>

## Towards eliminating new HIV infections among children

- In June 2011, world leaders launched the Global Plan towards the Elimination of New HIV Infections Among Children and Keeping Their Mothers Alive.<sup>59</sup> The plan lays out programmes, targets and a detailed timetable for action at community, national, regional and global levels. At its hub are four key principles:
  - women living with HIV at the centre of the response;
  - country ownership;
  - leveraging synergies, linkages and integration for improved sustainability;
  - shared responsibility and specific accountability.



## Universal access to treatment: now more than ever

- The case for providing timely universal access to antiretroviral therapy is now stronger than ever. There is ample evidence of the human and economic benefits of antiretroviral therapy for HIV-positive people. In China, it is estimated that the provision of free antiretroviral therapy has led to a 64% drop in AIDS-related mortality.<sup>61</sup>
- Moreover, recent trial results show that when HIV-positive people receive timely and effective antiretroviral therapy, the risk of transmitting the virus to their uninfected sexual partners can be reduced by as much as 96%.<sup>62</sup> This places ‘treatment for prevention’ firmly in the package of HIV prevention options. Early access to treatment will encourage people to be tested for HIV, disclose their status and access essential HIV services.
- The sooner access to treatment increases, the bigger the impact on HIV incidence and on AIDS morbidity and mortality. The scale-up will require additional investments in the short term, but will save costs eventually by reducing the number of new infections and deaths, as well as medical costs and loss of productivity among people living with HIV.

## Most people living with HIV still do not know they are infected

- Many people living with HIV only discover their serostatus when they are already seriously ill and the efficacy of antiretroviral therapy treatment is greatly reduced.<sup>63</sup> Late diagnosis also increases the period in which a person unwittingly could be transmitting the virus to others.
- In most countries, the proportions of key populations at higher risk who know their serostatus are especially low.<sup>64</sup> The few data available show that HIV testing rates among clients of sex workers are also very low, which highlights the lack of interventions reaching out to this population.<sup>65</sup>
- Greater access to HIV testing services is crucial to achieve the goals of Zero new infections and Zero AIDS-related deaths.
  - The introduction of provider-initiated testing and counselling at sexually transmitted infection clinics, antenatal care facilities and tuberculosis services can increase the number of people who have HIV tests.
  - Generalization of rapid point-of-care testing and strengthening linkages between counselling and testing, and treatment and care services will reduce loss to follow-up.

- There should be particular attention on removing barriers to testing for key populations at higher risk, particularly young people.<sup>66 67 68 69</sup> To effectively reach marginalized and vulnerable populations, community-based testing services need to be expanded.

## Access to antiretroviral therapy is improving, but too slowly

- Of the 14 million (13.5–15.8 million) people estimated to be in need of antiretroviral therapy in low-income and middle-income countries worldwide at the end of 2009, 2.4 million lived in Asia and the Pacific.
  - Six countries account for over 90% of the regional treatment burden: China, India, Indonesia, Myanmar, Thailand and Viet Nam.
- The number of people receiving antiretroviral therapy in the region almost tripled in recent years (from 280 000 in 2006 to 739 000 in 2009), but the increase was slower than in low-income and middle-income countries overall.
  - By end 2009, there are still almost two new cases of HIV infection for every person put on treatment (360 000 new infections and 168 000 people starting antiretroviral therapy) in Asia and the Pacific. The gap is narrowing as HIV incidence slows and antiretroviral therapy provision expands, but the need for treatment still outpaces provision.
- Overall antiretroviral therapy coverage in the region is 31% (29%–33%), lower than the global average for low-income and middle-income countries of 36% (33%–39%). In south Asia, which accounts for more than half of the people eligible for in Asia and the Pacific, antiretroviral therapy coverage is only 25% (15%–50%).
  - Cambodia, with 94% (68%–95%) coverage, is one of eight countries worldwide that has achieved universal access under the 2010 WHO treatment guidelines criteria. The Lao People’s Democratic Republic, Papua New Guinea and Thailand have reached coverage levels higher than 50%.
- In most reporting countries, coverage for men is lower than for women—by a considerable margin in Mongolia and Sri Lanka—while men were more likely than women to benefit from antiretroviral therapy in Pakistan and Papua New Guinea.
- Paediatric antiretroviral therapy coverage, at 44%, exceeds adult coverage and is higher than the global average of 28%. This is largely due to the 80% and higher coverage achieved in Cambodia, Malaysia and Thailand.

# ENDING AIDS-RELATED DEATHS

- Key populations at higher risk frequently face stigma, discrimination, official harassment and punitive legislation, all of which hinder their access to health services.<sup>70 71 72 73</sup>
  - Removing those barriers to testing and treatment is essential for achieving universal access. In particular, health-care provider training is needed to increase confidentiality and reduce discrimination against key populations at higher risk and people living with HIV.
- Treatment adherence is essential to prevent the development of HIV drug resistance and maintain the effectiveness of more affordable first-line antiretroviral regimens.
  - Average adherence at 12 months (UNGASS indicator 24) in Asia and the Pacific in 2009 was higher than the global average of 82%.
  - For adherence at 2–5 years of antiretroviral therapy, the few reporting countries generally follow the global pattern in which attrition is highest during the first year, after which adherence stabilizes at about 75%.
- In most countries in the region, first-line antiretroviral therapy and treatment for opportunistic infections are being offered free of charge or at low costs.<sup>77 78 79 80 81</sup>
  - Other medical costs are often not covered and patients usually bear transportation costs to health facilities.<sup>82 83</sup>
  - Nongovernmental organizations and home-based care teams provide support in some areas, but not all. In a 2008 study in Nanning, China, expenses were up to three times the average annual income of an urban resident, and 12 times that of a rural resident.<sup>84 85</sup>
  - Linkages to services and access to social security through the workplace present opportunities to alleviate many direct and indirect financial costs of HIV care and treatment.

## Access to affordable drugs is under threat

We commit by 2015 to address factors that limit treatment uptake and contribute to treatment stock-outs ... and delays in drug production and delivery, inadequate storage of medicines, patient drop-out, including inadequate and inaccessible transportation to clinical sites, lack of accessibility of information, resources and sites.

FROM THE 2011 POLITICAL DECLARATION ON HIV/AIDS, ADOPTED BY THE UNITED NATIONS GENERAL ASSEMBLY ON 10 JUNE 2011

## Treatment quality and affordability are major challenges

- More than 95% of patients on antiretroviral therapy are currently taking first-line treatment regimens.<sup>74</sup> Given the lack of routine viral load monitoring in most countries and limited availability of second-line antiretroviral drugs, it is likely that a significant proportion of patients eligible for a second-line regimen are being maintained on failing first-line therapy.<sup>75 76</sup>
- Reducing or at least controlling the cost of antiretroviral therapy commodities and service delivery is vital if universal access to treatment is to be achieved and sustained.
  - The cost of the most commonly used first-line antiretroviral drugs decreased from over US\$ 10 000 to less than US\$ 67 per patient per year between 2000 and 2010—mainly due to competition from producers of generic forms of the medicines.<sup>86</sup>
  - As drug resistance increases over time, more patients will require second-line and third-line medicines. But patented fixed-dose combinations, paediatric drugs and second-line and third-line regimens remain 10–20 times more expensive than generic versions.
- The flexibilities contained in the TRIPS agreement—and reaffirmed in the 2001 Doha Declaration on the TRIPS agreement and Public Health<sup>87</sup>—provide important opportunities for World Trade Organization members to reduce the prices of HIV medicines.
  - There have been attempts to restrict the use of those flexibilities during negotiations for bilateral and regional free trade agreements. If adopted, such clauses would limit access to affordable drugs and threaten antiretroviral therapy scale-up and sustainability.
  - Various high-level declarations, including the June 2011 Political Declaration on HIV/AIDS, adopted by the UN General Assembly, have reaffirmed the rights of low-income and middle-income countries to fully use these provisions, and encouraged them to do so. All governments should ensure that free trade agreements involving low-income or middle-income countries comply with the principles of the Doha Declaration.



- International organizations should support their national partners in the use of these flexibilities and in all other actions consistent with the TRIPS agreement to promote access to antiretroviral drugs, other HIV medicines and technologies related to HIV treatment.
  - Beyond that, all stakeholders should join efforts to develop mechanisms to limit the price of medicines for low-income and middle-income countries.
    - This could include pooled procurement mechanisms, the expansion of local production, support to the voluntary Medicines Patent Pool, and stimulating pharmaceutical investment through advance market commitments.
- 
- We commit to remove before 2015, where feasible, obstacles that limit the capacity of low- and middle-income countries to provide affordable and effective HIV prevention and treatment products, diagnostics, medicines and commodities ... including by amending national laws and regulations, as deemed appropriate by respective Governments, so as to optimize the use, to the full, of existing flexibilities under the Trade-Related Aspects of Intellectual Property Rights Agreement ... promote generic competition in order to help reduce costs associated with life-long chronic care ... and encourage the voluntary use, where appropriate, of new mechanisms... to help reduce treatment costs and encourage development of new HIV treatment formulations, including HIV medicines and point-of-care diagnostics, in particular for children.
- Less than one fifth of TB patients were tested for HIV in Asia and the Pacific in 2009—the lowest rate of testing worldwide. The countries with the highest HIV prevalence among TB patients are Thailand (17%), Myanmar (9.2%), India (6.4%) and Cambodia (6.4%).<sup>89</sup>
  - Among the TB patients who tested positive for HIV, 52% received antiretroviral therapy in WHO's South-East Asia region and 16% did so in the Western Pacific region. Encouragingly, coverage of co-trimoxazole preventive therapy in Asia and the Pacific was higher (75% in South-East Asia, and 64% in the Western Pacific).
  - HIV–TB coinfection management aims to:
    - prevent and reduce HIV morbidity and mortality among people with TB through HIV prevention education, testing and counselling, co-trimoxazole preventive therapy, antiretroviral therapy and AIDS care and support;
    - decrease the burden of TB among people living with HIV by rapidly scaling up the 'Three I's' for prevention of TB (intensified TB case-finding among people living with HIV, isoniazid preventive therapy for people without active TB, and infection control for TB), and by providing combined antiretroviral therapy and TB treatment for people living with HIV who have active TB.
  - TB screening and isoniazid prophylaxis coverage among people living with HIV is very low in Asia and the Pacific. Median coverage for combined antiretroviral therapy – TB treatment for people estimated to be living with HIV–TB coinfection (UNGASS indicator 6) was 17% for all low-income and middle-income countries, but only 11% in Asia and the Pacific.
  - Strengthening collaboration between HIV and TB programmes, including on data reporting and analysis, is a regional priority.
    - Governments and donors must significantly increase their investments in TB control programmes and research. New opportunities, such as a new genetic diagnostic test, can improve the speed and accuracy of TB diagnosis in people living with HIV, as well as diagnosis of drug-resistant TB.

FROM THE 2011 POLITICAL DECLARATION ON HIV/AIDS,  
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ON 10 JUNE 2011

## Coverage of HIV–tuberculosis services is unacceptably low

- Asia accounts for 18% (216 000) of HIV-positive tuberculosis (TB) cases globally, with 60% (130 000) of them living in India.<sup>88</sup>

# ENDING AIDS-RELATED DEATHS

## THE DEADLY COMBINATION OF TB AND HIV

TB is the most common cause of death in HIV-positive people globally, causing 20% to 25% of AIDS-related deaths. An estimated one third of people living with HIV worldwide are also infected with TB, and are at high risk of developing TB disease.

HIV infection is the most potent risk factor for converting latent TB infection into active TB disease, and TB bacteria accelerate the progression of HIV infection to AIDS. Many people living with HIV in low-income and middle-income countries develop TB as the first manifestation of AIDS. The two diseases form a deadly combination:

- TB is harder to diagnose and progresses faster in people living with HIV.
- TB in people living with HIV is almost certain to be rapidly fatal if undiagnosed or left untreated.
- People living with HIV are particularly vulnerable to the emergence of multi-drug-resistant TB. This is essentially untreatable in many parts of the world and constitutes a major threat to the global AIDS response.

## HIV coinfection with hepatitis C virus is being neglected

- **Hepatitis C virus and HIV coinfection is particularly prevalent among people who inject drugs.**
  - The few available data suggest that 60%–90% of HIV-positive people who use drugs in Asia and the Pacific also have hepatitis C virus.<sup>90 91 92</sup>
  - Because people living with HIV are living longer with antiretroviral therapy, they are increasingly facing the effects of other chronic diseases such as hepatitis C.<sup>93</sup>
- **The lack of international guidelines for the clinical management of HIV–hepatitis C virus coinfection, and the cost of hepatitis C drugs, strongly limit access to hepatitis C treatment for people with HIV.<sup>94</sup>**
- **Hepatitis C virus and HIV prevention and treatment services for people who inject drugs need to be offered jointly and should be scaled up.**

**We commit by 2015 to work towards reducing tuberculosis deaths in people living with HIV by 50 per cent.**

**FROM THE 2011 POLITICAL DECLARATION ON HIV/AIDS, ADOPTED BY THE UNITED NATIONS GENERAL ASSEMBLY ON 10 JUNE 2011**

## TREATMENT 2.0

Ending AIDS-related deaths will require a rapid shift to a new phase in treatment for HIV and opportunistic infections. To that end, UNAIDS and WHO have launched the Treatment 2.0 initiative, which promotes a radically simplified HIV treatment platform that rests on five connected pillars:

- developing better drugs for simpler and less toxic treatment regimens that allow improved adherence and reduced viral resistance;
- providing point-of-care diagnostics for early and rapid diagnosis, and cheaper treatment monitoring;
- reducing drug and non-drug costs of treatment;
- adapting delivery systems to facilitate decentralization and the continuum of care;
- mobilizing communities to improve treatment access, delivery and adherence.

Together, these strategies aim to address the main barriers and bottlenecks to antiretroviral therapy access and sustainability. In many countries, networks of people living with HIV are proving to be linchpins for strong treatment adherence and for boosting the reach and effectiveness of antiretroviral therapy programmes.<sup>95</sup>

Several countries in the region, including China and Viet Nam, are preparing to pilot the Treatment 2.0 approach in selected sites, with close collaboration between government and communities of people living with HIV, and with support from the UN and other international development actors.<sup>96</sup>





## Migration is widespread and growing

- There are an estimated 50 million people in Asia and the Pacific who do not live in their country of birth. In addition, hundreds of millions of people migrate internally. An increasing proportion of migrants both between and within countries are women.
  - Migration per se is not a risk factor for HIV, but the circumstances that lead people to migrate and the conditions they encounter as migrants can increase their vulnerability.
  - Migration appears to be a substantial factor in the HIV epidemic. In Nepal, nearly 30% of all HIV new infections in 2009 were in migrants.<sup>97</sup>
  - Survey data from 2009 showed internal male migrants in five states in India were much more likely to buy sex than were men in the wider population (16%–88% of surveyed migrants reported visiting sex workers, compared to 2.2%–15% of men in the general population).<sup>98</sup>
  - In Bangladesh, married men who had lived apart from their wives or abroad were 5–6 times more likely to report extramarital sex, compared with their counterparts who had not lived apart.<sup>99</sup>
- Harmonize national HIV and migration policies, and force collaboration between ministries of health, labour and foreign affairs; trade unions; and civil society organizations in countries of origin and destination.
  - Enforce regulations to protect migrants from mandatory HIV testing and to ensure adherence to generally accepted testing standards.
  - Standardize pre-departure training on HIV vulnerability and prevention.
  - Establish minimum labour standards and health rights for migrant workers in the region, including access to health service and insurance schemes.
  - Mobilize human and financial resources for work on HIV and migration.

## Responses are timid

- All countries in the region include migrants, refugees and mobile populations as vulnerable groups in their HIV national plans, but in general they continue to have poor access to information and health services. In particular, access to antiretroviral therapy and services for prevention of mother-to-child transmission remains a huge unmet need.
- Despite the economic contribution that migrant workers make to both their home countries and the countries where they live and work, insufficient financial resources are allocated to ensure that they can access basic health and HIV services throughout the migration cycle (i.e. at source, transit and destination sites, and when they return).

## Comprehensive cross-border strategies are needed

- Protecting migrants' rights and health requires a multi-prong approach that involves various actors in the countries of origin and destination:

### MIGRANTS' RIGHTS AND HIV IN ASIA AND THE PACIFIC

Migrants across the region continue to face mandatory HIV testing. Countries of origin, such as Bangladesh, India, Indonesia, Nepal and Philippines have clear national policies against mandatory HIV testing of their citizens. But no Asian nation applies comprehensive monitoring and enforcement to ensure HIV-testing standards of consent, counselling and confidentiality are met at private and government-approved testing centres. Very often, prospective migrant workers agree to being tested in order to meet the requirements for an employment opportunity abroad.<sup>100</sup> The workers are not usually informed of their test results.

# HIV SERVICES FOR PEOPLE IN THE MARGINS

## HIV services for refugees

- Refugee populations living in camps in Bangladesh, Nepal and Thailand, and in refugee villages in Iran and Pakistan, exhibit similar HIV epidemiological patterns and have comparable needs in relation to HIV prevention, care, support and treatment as the host populations in those countries.
- In addition, significant numbers of refugees live in large cities in the region (including, Delhi and Kuala Lumpur). Their vulnerability to HIV is similar to that of migrants.
- National HIV plans in an increasing number of countries regard refugees, along with migrants and mobile populations, as vulnerable groups. But generally, refugees continue to have poor access to HIV information and health services.
  - Access to antiretroviral therapy remains a huge challenge for refugees (both in camps and urban settings).
  - In a context of competing demands on limited resources, there is a risk that refugees will be among the first affected by budget cutbacks.
- The needs of refugees should be integrated into national AIDS programmes and must be adequately funded. This should be assessed systematically when submitting or reviewing funding proposals.

## HIV services in humanitarian crises

- Asia and the Pacific is prone to natural disasters and has had several violent conflicts. HIV services are not yet considered a priority for populations affected by emergencies. However, they can include people living with HIV who are in need of continued care, treatment and support. Key populations such as people who buy and sell sex, men who have sex with men, transgender people, and people who inject drugs are also among the people affected and will continue require essential prevention services.
- In general, relief workers lack awareness about the minimal HIV interventions that should be undertaken in the early periods of emergencies. A minimum set of HIV prevention and treatment based on Inter-Agency Standing Committee guidelines<sup>101</sup> should be delivered consistently to people affected by humanitarian crises.



## Important needs are not being met

- The social and economic impact of AIDS on individuals and households in Asia and the Pacific is considerable. Women and children are disproportionately affected.
  - The biggest impact of AIDS in the region is felt by households.<sup>102</sup> Income and household assets are reduced as employment opportunities diminish due to illness, discrimination or care-giving duties, while health expenditures increase.
  - Poor households are especially affected. As a result, HIV-affected households are often pushed (further) into poverty, as shown in socioeconomic impact studies of households in Cambodia, China, India, Indonesia and Viet Nam.<sup>103</sup>
  - Most care for people living with HIV is provided in the home, and women and girls are usually the primary care-givers.
  - It is estimated that more than one million children in the region have been orphaned by AIDS. But children's vulnerability in the context of HIV is multidimensional.<sup>104</sup>
  - The impact experienced by children includes stigma and discrimination (both in communities and from service providers), reduced access to education and poor school performance, poor nutritional status and a need for psychosocial care.
  - Street children or those growing up in contexts of drug use, sex work or exploitation are particularly vulnerable and in need of protection.
- The need for social protection to soften the impact of HIV is not being adequately met in Asia and the Pacific.
  - There is increasing recognition of the need for appropriate forms of social protection to reduce the household impact of HIV, but actual service provision varies considerably.<sup>105 106 107</sup>
  - Various forms of cash transfers, insurance, pension schemes, nutritional support, educational support and legal empowerment initiatives to assist HIV-affected households exist. Some countries have made good progress on this front, while others are just starting to develop such programmes.<sup>108</sup>
- Many existing social protection instruments are not sensitive enough to the reality of HIV.
  - They do not meet the needs of HIV-affected households, or do not reach them at all.
  - AIDS-related illnesses are still excluded from many health insurance schemes, and other insurance types often exclude people living with HIV.

- Inadequate resources and insufficient data on children affected by HIV hamper the design of child-sensitive and HIV-sensitive social protection.
- Several other common challenges also affect the suitability of social protection schemes for HIV impact mitigation.
  - Schemes are often fragmented and lack coordination. Social protection tends to be delivered in the form of projects or emergency interventions by nongovernmental organizations and donor agencies, and is not integrated into government systems.
  - Social protection tends to be limited to cash transfers and other types of social assistance (such as food or transportation vouchers), and is not comprehensive enough to address broader social welfare needs.
  - Social insurance is mainly restricted to the formal sector, while social assistance programmes focus mostly on impoverished communities. The large sections of populations that work in the informal sector are often missed by both forms of assistance.

## Towards HIV-sensitive social protection as a core HIV intervention

- Social protection has emerged as an important strategy for pro-poor development in the region. Making social protection HIV-sensitive, where relevant, offers tremendous scope for addressing the impact of HIV on households.
- However, countries and partners need to avoid creating HIV-specific social protection schemes that entail parallel structures, unsustainable financial requirements, and which are potentially stigmatizing. Successful HIV-sensitive social protection should:
  - *Aim for HIV-sensitive social protection rather than HIV-specific social protection*—This will be beneficial for reasons of sustainability, coverage, involvement of multiple sectors and the opportunities for mainstreaming HIV into national and decentralized development plans.
  - *Involve multiple sectors and partners*—HIV-sensitive social protection requires the involvement of different ministries, the private sector, civil society and communities. Their involvement and partnership is required at every stage, from planning to implementation. This is also important for sustainability.
  - *Engage affected individuals, networks and communities, especially key populations at higher risk*—HIV-sensitive social protection programmes should be designed in inclusive and participatory ways to ensure that they address the specific needs and concerns of the affected populations.

# MITIGATING THE IMPACT OF AIDS THROUGH SOCIAL PROTECTION

- *Protect and enhance human rights*—While implementing HIV-sensitive social protection schemes, special attention must be paid to ensure that the human rights of the participants are not violated, but are strengthened. Issues of concern include mandatory HIV testing, disclosure of beneficiary details, breach of confidentiality and involuntary confinement.
- *Take sustainability into account*—As in the case of antiretroviral therapy, HIV-sensitive social protection requires long-term political and financial commitment. Hence, sustainability should be an integral part of the planning process.<sup>109</sup>
- **Existing social protection measures must be systematically assessed for their sensitivities towards HIV, gender and children. New instruments must ensure that they are sensitive to these issues, following the principles above.**
  - Guidance on HIV-sensitive social protection, country-level assessment tools and good practices should be developed to assist in the design of HIV-sensitive social protection schemes.<sup>110</sup>
  - Recognition of the gender dimensions of poverty and vulnerability is vital if HIV-sensitive social protection programmes are to effectively address the impact of HIV.
  - Children affected by HIV must be integrated into child protection instruments and should be covered by programmes for orphans and vulnerable children, while taking into account any HIV-specific needs.

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We commit to ... improve access to quality, affordable primary health care, comprehensive care and support services, including those which address physical, spiritual, psychosocial, socio-economic, and legal aspects of living with HIV;

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We commit to strengthen national social and child protection systems and care and support programmes for children, in particular for the girl child, and adolescents affected by and vulnerable to HIV, as well as their families and caregivers;

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We commit to mitigate the impact of the epidemic on workers, their families, their dependants, workplaces and economies.

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FROM THE 2011 POLITICAL DECLARATION ON HIV/AIDS,  
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## A challenging environment for AIDS responses

- Despite the epidemiological evidence, too many countries in Asia and the Pacific still seem reluctant to fully support programmes that can end the HIV epidemics among key populations at higher risk.
  - The political will and policy space is restricted by prejudice, stigma and gender inequality, much of which is institutionally embedded in laws, policies and work practices.
- Stigma and discrimination against key populations at higher risk and people living with HIV continue to undermine effective AIDS responses.
  - They discourage people from seeking information and using services that can prevent HIV infection, hinder them from knowing whether they are infected, and impede access to treatment, care and support.
  - Stigma and discrimination deny employment opportunities to people living with HIV, which increases the financial burdens of ill health on individuals and families.
- The nine country *Stigma Index*<sup>111</sup> of people living with HIV regional analysis report found that one third of respondents used health-care services less often because of HIV-related stigma, and many had been denied family planning and sexual and reproductive services. The index also revealed that HIV significantly affects people's ability to secure and retain employment, as well as their employment or career progression, with 97% of those that experienced HIV-related discrimination in the workplace reporting no avenue for recourse.
- Gender inequality and gender-based violence continue to undermine efforts to manage and overcome the HIV epidemic.
- Numerous laws fuel stigma and discrimination against key populations and hamper programme development and effectiveness.
  - At least 29 out of 38 countries in the region criminalize some aspects of sex work. Numerous other laws and practices aimed at preventing sex work also undermine HIV programming.
  - Sex between men is criminalized in 19 out of 38 countries in the region. Laws against sodomy are often used to harass male and transgender sex workers.
  - All governments in Asia, and most in the Pacific, treat drug use as a criminal activity.
  - Laws in eight countries require compulsory detention of people who use drugs at drug detention centres, where medical services are frequently lacking.<sup>112</sup>
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- The provision of clean needles and syringes is prohibited in Bangladesh, Bhutan, Japan, Lao People's Democratic Republic, the Philippines, Sri Lanka and Thailand. Laws in many countries restrict access to substitution drugs like buprenorphine and methadone.
- In 15 out of 38 countries in the region, some form of restriction on the entry, stay and residence of people living with HIV is imposed, based on their HIV status.

## There has been some progress

- More countries are starting to shift towards a rights-based approach in their AIDS responses.
  - Eighteen countries have laws meant to shield people with HIV against discrimination, and 17 claim to provide certain forms of protection for key populations.
  - A number of countries in the region are moving away from an exclusively punitive approach to drug use.
- In most places, though, AIDS responses are undermined by conflicting approaches. On the one hand, public health efforts seek to promote access to HIV services. On the other hand, a law enforcement approach keeps sex workers, people who use drugs, men who have sex with men and transgender people from accessing services, and prevents service providers from doing their work.
  - Tensions between policy and legal changes at the national level, and the practices of authorities at local level are major impediments.
- The UNDP and UNAIDS Global Commission on HIV and the Law, launched in mid-2010, is analysing the most critical HIV-related legal and human rights challenges, and will recommend remedial policies.
  - The first regional dialogue in Asia and the Pacific in early 2011 helped shape strategies that were reflected in ESCAP Resolution 67/9. This informed the Political Declaration on HIV/AIDS, which the United Nations General Assembly adopted in June 2011.
- Some national HIV programmes are stepping up efforts to address stigma and discrimination, including among health-care and law enforcement officials. Some are also removing legal barriers and enacting laws to protect people living with HIV against discrimination.
  - India has a draft legal framework to address stigma and discrimination, and its national policy has been altered to allow access to opioid substitution therapy for people who inject drugs.
  - Viet Nam has a law on HIV and a legal framework that protects the rights of people living with and affected by HIV, and Fiji's

# PROTECTING RIGHTS AND ENDING STIGMA AND DISCRIMINATION

- cabinet has approved a similar decree. Papua New Guinea is reviewing outdated legislative frameworks.
- China has lifted travel restrictions for people living with HIV.
- **Commitment to address gender inequality as part of the AIDS response is growing.**
  - Various regional commitments, such as ESCAP Resolution 67/9, recognize the need to prevent and manage the consequences of gender-based violence as part of the AIDS response.
  - Bangladesh, Cambodia, China, Indonesia, Myanmar, Nepal and Viet Nam are examples of countries that are developing more comprehensive approaches to gender and HIV, including attempts to address the risk of HIV transmission in long-term intimate partnerships.
  - The UNAIDS *Agenda for Women and Girls* has been initiated to some extent across the region. It focuses on gender-based violence, sexual and reproductive health services, and the disproportionate burden of care that befalls women and girls.
- **Human rights and other public interest groups should closely monitor and publicize instances of HIV-related discrimination and rights abuses. They should use that evidence to advocate law and policy reform and programmatic strategies that can address stigma and discrimination.**
  - Systems for redress are being established in some countries, but they are still limited in capacity and impact, need to become more affordable, and should be publicized more effectively.
- **A gender-sensitive response must confront the broader social barriers to health and rights, and should do so with the meaningful participation of women and girls (including those living with HIV and those who belong to key populations at higher risk).**

## Towards rights-based and gender-sensitive AIDS responses

- **Governments should remove or revise laws that fuel HIV-related discrimination, especially those that regulate the labour market, the workplace and access to medical and other forms of insurance, health care and social services.**
- **Changing laws or regulations is a necessary but lengthy process. Localized safe spaces are also needed, where HIV activities can occur while larger scale legal and other changes are being pursued.**
- **Governments should enact laws that protect people living with HIV and key populations at higher risk against discrimination.**
- **Unless backed with intensive, hands-on support, favourable laws and policies run the risk of being negated by contrary practices and inappropriate law enforcement at local levels.**
  - There is an urgent need to sensitize law enforcement and other authorities (including the judiciary and health professionals) to the need to adapt to HIV-friendly laws and routines.
- **Remedies to counter stigma and discrimination need to be incorporated into national HIV policies and comprehensive, focused and funded programmes.**

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We commit to review, as appropriate, laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV, and consider their review in accordance with relevant national review frameworks and time frames and encourage Member States to consider identifying and reviewing any remaining HIV-related restrictions on entry, stay and residence so as to eliminate them.

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We pledge to eliminate gender inequalities and gender-based abuse and violence.

FROM THE 2011 POLITICAL DECLARATION ON HIV/AIDS  
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## Communities working for communities

- Community-based organizations have played a critical role over the past three decades. They have been key providers of prevention, treatment, care and support services, and have worked to create the social, political, legal and financial environments needed to respond effectively to the epidemic.
  - In many countries and contexts, community organizations are the only entities able to reach members of key populations at higher risk (such as people who inject drugs, men who have sex with men and sex workers) and other affected groups (such as migrants).
  - Community involvement also improves the quality, sustainability and accountability of HIV programmes. Community organizations are engaged in a wide variety of activities: they raise awareness in communities, deliver prevention services to key populations, support treatment programmes, report on drug stock-outs and other service quality problems, monitor rights violations, and campaign for treatment access and affordability.

## Support for community participation is growing...

- More international partners and donors are supporting civil society participation, and long-term support for civil society participation is showing encouraging results.
  - For example, core funding from the Australian Agency for International Development (AusAID) has enabled the Asia Pacific Network of People Living with HIV/AIDS (APN+) and the Coalition of Asia Pacific Regional Networks on HIV/AIDS (the 'Seven Sisters') to become dynamic actors in the regional AIDS response, and help build community sector capacity to participate in universal access processes.
  - APN+ has capably led the community in Asia and the Pacific in marshalling national and international campaigns for affordable access to essential HIV medicines.
- Young people from key populations at higher risk are beginning to assume leadership roles at national and regional levels.
- The Global Fund now channels funding through both government and public-private partnerships that comprise government and nongovernment stakeholders. It has also enhanced civil society involvement in national planning and in service delivery by including it in country coordinating mechanisms.

- Studies are confirming the effectiveness of peer outreach activities, including in places where conventional state-run activities have failed.
  - Sex workers who participated in a support group in the Indian state of Andhra Pradesh were four times more likely to report consistent condom use than those who did not belong to such groups.
  - Treatment support groups have become essential for increasing the reach and effectiveness of antiretroviral therapy programmes in many countries, including India, Nepal, Papua New Guinea and Viet Nam.

## ... but it is still an uphill struggle in many countries

- These gains are valuable, but civil society organizations still face important challenges.
  - Many community organizations face chronic resource constraints that limit the extent and scope of the work they perform. They also often lack support that can enable them to increase staff skills and capacities.
  - In many countries, community organizations still face legal and administrative constraints.

## Community involvement is critical

- AIDS activism for a rights-based approach that challenges prejudice and discriminatory practices against marginalized communities remains as crucial as ever.
- Governments need to fully recognize the value of involving community and grassroots organizations in the design, implementation and oversight of HIV programmes.
- Nongovernmental and community organizations must be able to acquire the legal status necessary for accessing financial, technical and organizational development assistance.
- Financial support for community organizations needs to broaden beyond project-based funding and should encompass core funding.
- Community systems strengthening—helping build the skills and capacities of local civil society groups—should be an integral part of countries' AIDS responses.

# COMMUNITIES AT THE HEART OF THE AIDS RESPONSE

## TECHNICAL SUPPORT FOR CIVIL SOCIETY ORGANIZATIONS

Several actors currently provide technical support to community organizations in the region, including the two technical support facilities set up by UNAIDS, and the technical support hubs established by the International HIV/AIDS Alliance and the Civil Society Action Team.<sup>113</sup>

In the Pacific, technical support to the Pacific Islands AIDS Foundation helped it strengthen its financial management systems, redefine its vision and devise a new five-year strategic plan with a resource mobilization strategy.

The Indian People's Alliance for Combating HIV and AIDS received support in organizing consultative meetings to contribute to the development of the country's national AIDS control programme.

In Bhutan, similar support enabled the national network of people living with HIV to receive organizational strengthening from an experienced community consultant working for the Nepal Network of Positive People.

In recent years, technical support has widened to include expertise related to Global Fund programmes—including proposal development, principal and subrecipient management, strengthening civil society engagement within country coordinating mechanisms and, increasingly, grant implementation.

Overall, these technical support mechanisms have become useful assets for community systems support in the region.

Recognize that close cooperation with people living with HIV and populations at higher risk of HIV infection will facilitate the achievement of a more effective HIV and AIDS response

Commit to continue engaging people living with and affected by HIV in decision-making, and planning, implementing and evaluating the response

**FROM THE 2011 POLITICAL DECLARATION ON HIV/AIDS, ADOPTED BY THE UNITED NATIONS GENERAL ASSEMBLY ON 10 JUNE 2011**





## An underfunded response

- The AIDS response in Asia and the Pacific is underfunded.
  - According to the Commission on AIDS in Asia's estimates, US\$ 3.1 billion is needed annually to fund a focused response in the region. This figure does not include additional investments needed to implement the 2010 WHO treatment guidelines.
  - Total HIV public expenditure in 2009 was US\$ 1.07 billion in the 30 countries in Asia and the Pacific that reported expenditure data.<sup>114</sup>
- Funding cutbacks threaten the past decade's progress against AIDS.
  - In 2009, international funding for the global AIDS response levelled off for the first time in a decade, and in 2010 it decreased slightly.
- Too little is being invested to protect key populations against HIV.
  - The Commission on AIDS in Asia recommended that 40% of AIDS funding should go to high-impact prevention among key populations at higher risk, and 10% to creating an enabling environment.
  - Among countries reporting detailed expenditure data in 2010, only 8% of total AIDS spending in south Asia and 20% in south-east Asia focused prevention in key populations at higher risk.<sup>115</sup> Meanwhile, high-cost, low-impact programmes (such as blood safety and standard precautions) received at least one third of HIV funding in those subregions.
- Among reporting countries, only Pakistan spent more than 50% of prevention funding on key populations at higher risk. Cambodia, Indonesia, Lao People's Democratic Republic and Sri Lanka spent under 25% of prevention funding in 2009 on protecting key populations, and Fiji, the Philippines and Thailand spent less than 10%.
  - The proportion of HIV funding spent on prevention programmes for key populations at higher risk decreased between 2007 and 2009 in several countries.

## Most countries rely mainly on donor funding

- The region depends heavily on international funding for its AIDS response.
  - Domestic public funding accounted for 53% of total reported HIV expenditure in Asia and the Pacific overall in 2009. China, Malaysia, Pakistan, Samoa fund the bulk of their national responses from public domestic sources.

- However, international funding represented more than 50% of total AIDS spending in three quarters of countries reporting in 2010, including most lower middle-income countries, and 95% of AIDS spending in the low-income countries.
- Antiretroviral therapy programmes are (almost) entirely funded by international funds in all but a few middle-income countries. This threatens the scale-up and sustainability of antiretroviral therapy in a majority of countries in the region.

## Adequately funded AIDS responses are a shared responsibility

- To address the double challenge of boosting HIV funding in the context of decreasing international funding, countries must combine four strategies:
  - Develop five-year plans to secure adequate funding for their AIDS responses from both international and domestic sources.
  - Increase investment of domestic resources, particularly in middle-income countries. Based on the Commission on AIDS in Asia 2008 estimates, middle-income countries in the region need less than 0.5% of their gross national income to fund focused responses that can reverse their epidemics.<sup>116</sup>
  - Enhance the cost-effectiveness of AIDS responses by allocating HIV funding to high-impact interventions—prevention programmes for key populations at higher risk and access to services for prevention of mother-to-child transmission and antiretroviral therapy. Low-impact prevention programmes should be funded from countries' overall health budgets.
  - Reduce programme costs through a variety of measures, including expanding community-based services and securing access to affordable drugs.
- At the global level, support for—and from—international funding mechanisms, such as the Global Fund, must be maintained. Larger domestic investment from middle-income countries would free up more international funding for low-income countries.

# INVESTING IN THE AIDS RESPONSE IN ASIA AND THE PACIFIC

## A NEW GLOBAL FRAMEWORK FOR FUNDING THE AIDS RESPONSE

A new strategic investment framework unveiled in June 2011 proposes a comprehensive roadmap for funding the world's AIDS responses.<sup>117</sup> It estimates that achieving universal access to HIV prevention, treatment, care and support globally by 2015 will cost US\$ 22–24 billion annually.

The new approach incorporates major efficiency gains that can be made through community mobilization, stronger coordination between programme elements, and the preventive benefits that can derive from expanded provision of antiretroviral therapy.

Immediate introduction of the framework will see resource needs decline after 2015, for three main reasons:

- coverage would have reached the target levels and could then be kept stable;
- efficiency gains would keep growing, particularly through cost savings in treatment commodities, simplification of laboratory monitoring and a shift to community-based approaches in treatment and testing;
- fewer new HIV infections would begin to reduce the need for services for people living with HIV.

Medium-term savings in treatment costs alone would offset almost all of the additional proposed investment.

Implementation of the new framework would avert an estimated 12.2 million new HIV infections and 7.4 million AIDS-related deaths between 2011 and 2020 (compared with a continuation of current approaches). It would result in a gain of 29.4 million life-years.

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We commit to working towards closing the global HIV and AIDS resource gap by 2015, currently estimated by the Joint United Nations Programme on HIV/AIDS to be US\$ 6 billion annually.

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We commit by 2015, through a series of incremental steps and through our shared responsibility, to reach a significant level of annual global expenditure on HIV and AIDS, while recognizing that the overall target estimated by the Joint United Nations Programme on HIV/AIDS is between US\$ 22 billion and US\$ 24 billion in low and middle-income countries, by increasing national ownership of HIV and AIDS responses through greater allocations from national resources and traditional sources of funding, including official development assistance.

FROM THE 2011 POLITICAL DECLARATION ON HIV/AIDS,  
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## Quality surveillance and programme data critical

Effective AIDS responses require quality surveillance and programme data. Asia and the Pacific is a region that generates a lot of data, but these data are still insufficiently used to inform decision-making.

## Surveillance and population size estimates

- HIV surveillance in Asia and the Pacific has evolved from case reporting, to sentinel surveillance,<sup>118</sup> to non-facility-based HIV and behavioural surveys among key populations at higher risk. AIDS case reporting is being complemented with routine monitoring data from counselling and testing centres.
- The improvements are generating new challenges. As new components of surveillance are added, resources and technical supervision are being spread more thinly. The resulting compromises can affect the quality of the data obtained and undermine their accurate use and interpretation.
- Size estimates of key populations are crucial for understanding the epidemic and for planning, costing, implementing and monitoring programmes.
  - Few countries have sufficiently reliable national and local-level size estimates for all relevant key population groups, although more countries are developing such estimates.
  - This is a resource-intensive undertaking, and countries need strategies for optimizing and integrating size estimations with other periodic surveys.
- Surveys and size estimations of key populations have been done in an ad hoc manner, instead of as part of national plans.
  - They are often led by donors to plan or evaluate programmes they are funding and are therefore not done regularly enough to detect trends.

## Programme monitoring and evaluation

- In most countries, national monitoring and evaluation (M&E) systems have been strengthened considerably in recent years, largely due to UNGASS, Universal Access and Global Fund reporting requirements.

- A remaining challenge is to establish coordinated systems to collect, maintain, analyse and use quality data across the various programmes and levels.
- Even though survey-based UNGASS data on key population prevention programmes are rarely nationally representative, they are often used as default national average figures.
  - For a more accurate understanding of coverage at the national and subnational levels, UNGASS indicator data need to be analysed in combination with programme coverage data. A number of countries are making good progress on this front.
- Only a few countries have conducted programme-level outcome evaluations. Evidence-informed examples to guide scaling-up of prevention programmes are therefore often lacking.
- An increasing number of countries are developing their capacities to track HIV expenditures, but the data are not used sufficiently to improve resource allocations and needs estimates. Capacities to analyse programme unit costs, efficiency and cost-effectiveness are still lacking in most countries.

## Towards functional strategic information systems

- Countries need to improve the prioritization, planning and streamlining of surveillance and M&E activities, with a focus on generating useful and quality data at regular intervals.
  - Countries need to develop costed national strategic information plans that are linked to their national strategic and operational plans.
  - Those plans need to include investments in human and system capacity at national and local levels, including for civil society organizations.
  - National strategic information plans should balance the need for a national perspective of the HIV epidemic and response, with the need for ownership and use of the data at subnational levels.
  - Coordination or even gradual integration between surveillance and programme M&E units should be pursued.
  - Spending for strategic information must comprise at least 5% of total HIV expenditure.
- Regular expert reviews and integrated analysis of epidemiology, programme and expenditure data need to become routine at national and subnational levels, especially in large countries with diverse epidemic patterns. This would inform necessary adjustments in programmes, resource allocations and data generation systems.

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- 102 Due to the concentrated nature of the epidemic in the region, an impact at macro-economic or sector level is unlikely. However, given the population size of many Asian countries, even low national prevalence means that millions of people are affected.
- 103 *The socio-economic impact of HIV at the household level in Asia: a regional analysis*. Geneva, United Nations Development Programme, 2011. The studies were conducted between 2005 and 2010.
- 104 Children are vulnerable because they are HIV-positive, at risk of HIV infection, or affected by the impact of HIV, and thus need different types of protection. See *Children and AIDS: fifth stocktaking report, 2010*. New York, Geneva, Paris, United Nations Children’s Fund, Joint United Nations Programme on HIV/AIDS, World Health Organization, United Nations Population Fund, United Nations Educational, Scientific and Cultural Organization, 2010 ; Edström J and Khan N. in Horn R (Ed.). *Report: protection and care for children faced with HIV and AIDS in East Asia and the Pacific: Issues, priorities and responses in the region*. Brighton, Institute of Development Studies and United Nations Children’s Fund, 2009; *Children affected by HIV/AIDS in South Asia: a synthesis of current global, regional and national thinking and research*. Kathmandu, United Nations Children’s Fund, Regional Office for South Asia, 2007.
- 105 *HIV-sensitive social protection for impact mitigation in Asia and the Pacific, Siem Reap, 27–29 April 2011: report on the high level consultation*. Geneva, United Nations Development Programme,



Joint United Nations Programme on HIV/AIDS, United Nations Children's Fund, International Labour Organization, 2011.

- 106** On average, countries in the region spend 5% of gross domestic product on health and social protection, with around 57% of the poor (by national poverty standards) receiving some form of social protection. See *Social protection index for committed poverty reduction. Volume 2: Asia*. Manila, Asian Development Bank, 2008.
- 107** Social protection has four dimensions, which are all relevant for HIV impact mitigation: (1) protective, providing relief from deprivation; (2) preventive, seeking to avert deprivation; (3) promotive, aimed at enhancing real incomes and capabilities; and (4) transformative, addressing social equity and exclusion. See Devereux S, Sabates-Wheeler R. *Transformative social protection. Institute of Development Studies working paper 232*. Brighton, Institute of Development Studies, 2004.
- 108** The following are some examples from the region: in India, there is a high level of political commitment to HIV-sensitive social protection, and a number of schemes benefitting people living with HIV and HIV-affected households have been developed. Some are HIV-sensitive, others are HIV-specific. There is, for example, a monthly pension scheme for elderly people, disabled people, widows (including widows of people living with HIV) or any person living with HIV, irrespective of age, marital status, sex or economic status. Poor households also benefit from schemes for people living below the poverty line, irrespective of HIV status. In Cambodia, there are home-based care programmes, intervention packages for orphans and vulnerable children (including educational assistance), programmes in the areas of housing and income generation as well as nutritional support. The new National Social Protection Strategy aims towards a cohesive national social protection system with expanded coverage. In Thailand, the National Social Protection Programme includes interventions for people living with HIV and children affected by HIV. Further, the Universal Coverage Scheme provides access to health services for all, and includes HIV-related health-care costs. For more detailed documentation and other examples of HIV-sensitive social protection in the region, see *HIV-sensitive social protection for impact mitigation in Asia and the Pacific* (op. cit.). For recent developments in social protection initiatives in Cambodia, China, India and Thailand, see *Sharing innovative experiences: successful social protection floor initiatives*. New York, United Nations Development Programme, 2011.
- 109** Ibid.
- 110** Ibid.
- 111** The survey was done in Bangladesh, Cambodia, China, Fiji, Myanmar, Pakistan, Philippines, Sri Lanka and Thailand. *People living with HIV stigma index Asia-Pacific -- regional report*. Bangkok, Global Network of People Living with HIV, International Community of Women Living with HIV/AIDS, International Planned Parenthood Foundation and Joint United Nations Programme on HIV/AIDS, 2011.
- 112** Call for compulsory drug detention centres to be closed [press release]. World Medical Association and International Federation of Health and Human Rights Organisations, 17 May 2011 ([http://www.wma.net/en/40news/20archives/2011/2011\\_11/index.html](http://www.wma.net/en/40news/20archives/2011/2011_11/index.html), accessed 18 July 2011). See also: Wolfe D, Carrieri MP, Shepard D. Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward. *Lancet*, 2010, 376:355–366. See also: *Human rights abuses in the name of drug treatment: reports from the field*. New York, Open Society Institute, 2009 ([http://www.soros.org/initiatives/health/focus/ihrd/articles\\_publications/publications/treatmentabuse\\_20090318/treatmentabuse\\_20090309.pdf](http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/treatmentabuse_20090318/treatmentabuse_20090309.pdf), accessed 18 July 2011). See also: Joint position statement on detention centres for 'drug treatment' [web site]. Global Network of People Living with HIV and International Network of People who use Drugs, 2010 (<http://www.eatg.org/eatg/Global-HIV-News/Prevention/Joint-position-statement-on-detention-centres-for-drug-treatment>, accessed 18 July 2011). See also: Cohen JE, Amon JJ. Health and human rights concerns of drug users in detention in Guangxi Province, China. *PLoS Medicine*, 2008, 5(12) (<http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050234>, accessed 18 July 2011). See also: *"Skin on the cable": the illegal arrest, arbitrary detention and torture of people who use drugs in Cambodia*. New York, Human Rights Watch, 2010 (<http://www.hrw.org/node/87692>, accessed 18 July 2011). See also: *"Where darkness knows no limits": incarceration, ill-treatment and forced labor as drug rehabilitation in China*. New York, Human Rights Watch, 2010 (<http://www.hrw.org/en/reports/2010/01/07/where-darkness-knows-no-limits-0>, accessed 18 July 2011).
- 113** The Civil Society Action Team (CSAT) is a global initiative of ICASO and its regional partners to empower civil society engagement in the Global Fund (by providing strategic information that strengthens capacity and supports access to technical assistance for civil society at local, regional and global levels (<http://www.csactionteam.org/>, accessed 18 July 2011).
- 114** US\$ 1.2 billion of extra-budgetary donor spending in India is included.
- 115** These data are not available for China, India and Viet Nam.
- 116** Increases in domestic HIV funding should be combined with overall increases in government funding for health, including the establishment or development of social health insurance schemes covering essential HIV services. Asia and the Pacific scores lower than global averages on government funding for health, and highest on out-of-pocket expenditures.
- 117** Schwartländer B et al. Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet*, 2011, 377:2031-2041.
- 118** Defined as surveys to measure HIV prevalence carried out at regular intervals (yearly or every two years) at specific and consistent facilities and geographic sites.

**UNAIDS**

Regional Support for Asia and the Pacific

9th floor, Block A

United Nations Building

Rajadamnern Nok Avenue

Bangkok 10200

Thailand

[unaids.org](http://unaids.org)