

HIV in Asia and the Pacific

UNAIDS report 2013

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Data sources: Unless otherwise referenced, all data cited are from UNAIDS 2012 Estimates, Global report: UNAIDS report on the global AIDS epidemic 2013 based on the 2013 Global AIDS Response Progress Reporting (GARPR), reports from national mid-term reviews of progress towards the targets and commitments for 2015 that were established in the United Nations General Assembly 2011 Political Declaration on HIV and AIDS conducted in 2013 by countries and submitted to UNAIDS, AIDSInfo (www.aidsinfoonline.org), the 2012 Global AIDS Response Progress Reports and National Commitments and Policy Instrument (NCPI) reports. Synthesis of country data from aforementioned sources and also from national surveillance and other reports, and its analysis into a regional overview was conducted by the Data Team at HIV and AIDS Data Hub for Asia and the Pacific (www.aidsdatahub.org).

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UNAIDS / JC2558

ISBN 978-92-9253-049-5

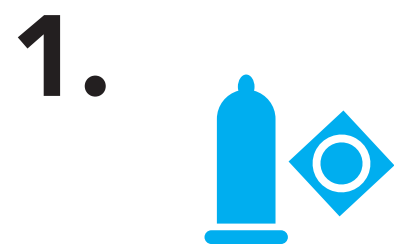
HIV in Asia and the Pacific

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10 targets

United Nations General Assembly 2011 Political Declaration on HIV and AIDS: Targets and elimination commitments

In June 2011, world leaders came together at the 2011 UN General Assembly High Level Meeting on AIDS in New York. They reviewed progress and adopted the Political Declaration on HIV and AIDS that includes new commitments and ten bold targets for the global AIDS response. With the overall goal of achieving universal access to HIV prevention, treatment, care and support by 2015, achievement of the ten targets will be a critical step towards the vision of Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths.



Reduce sexual transmission of HIV by 50% by 2015



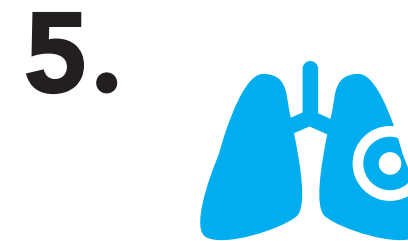
Reduce transmission of HIV among people who inject drugs by 50% by 2015



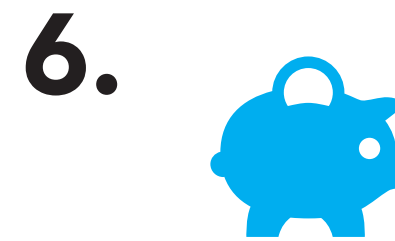
Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths



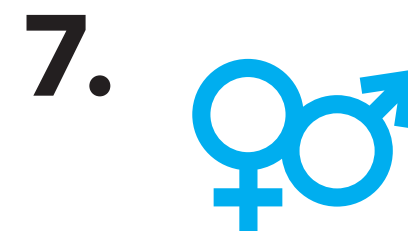
Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015



Reduce tuberculosis deaths in people living with HIV by 50% by 2015



Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22–24 billion in low- and middle-income countries



Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV



Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms



Eliminate HIV-related restrictions on entry, stay and residence



Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

Foreword

The AIDS response in Asia and the Pacific has seen some of the world’s greatest successes. HIV infection rates have fallen in countries across the region in the past decade—significantly in some; a growing number of people are receiving life-saving HIV treatment; domestic financing for AIDS has risen; and, governments across the region are increasingly addressing stigma and discrimination related to HIV and key populations at highest risk.

One of the reasons for this success has been the effective community leadership on HIV in Asia and the Pacific—some of the most organized and dynamic in the world. Across the region, people living with HIV, sex workers, men who have sex with men, people who use drugs and transgender people have boldly stepped forward to advance the agenda for the AIDS response, and are leading in the implementation of successful programmes.

As this report shows, however, there are signs that the progress in Asia and the Pacific may be at risk of stagnating. In some countries, there are new HIV epidemics in local geographic areas and among key populations at higher risk—particularly men who have sex with men. More than half the people eligible for HIV treatment do not have access. Despite progress, stigma and discrimination are a continuing challenge across the region and laws and practices continue to hamper AIDS responses in all countries.

The pace of progress needs to be redoubled to sustain past achievements, drive results and meet global AIDS targets by the end of 2015. Efforts should be more focused on targeted investments in the right places and on programmes to reach the people in greatest need, to generate biggest impact for limited resources. Communities of people living with HIV and key populations at higher risk must continue to be central to the AIDS response in the region—not as passive beneficiaries but as agents of change.

Countries in Asia and the Pacific should leverage their growing economic power to strengthen their commitment to domestic responsibility and global solidarity. Following the positive leadership from countries such as China, India, Malaysia and Thailand, an increasing number of countries in the region should prioritize funding for the national AIDS response from domestic resources.

The elimination of stigma, discrimination and injustice against people affected by HIV remains one of the most important and challenging milestones to reach the end of AIDS. Countries in the region must continue to actively engage in policy reform to stamp out stigma and discrimination and to uphold human rights.

With this enhanced focus and renewed commitment, countries can help ensure that Asia and the Pacific is on-track to reach our shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths.

With less than 800 days to reach the targets and commitments of the Millennium Development Goals and the 2011 United Nations General Assembly Political Declaration on HIV and AIDS, there is no time to lose. Let’s ensure that the strength, experience, resources and political will of Asia and the Pacific combine and focus to make every single day count—not only for the region, but for the entire global response.

Michel Sidibé
UNAIDS Executive Director

Introduction

Over 30 years since the discovery of HIV, Asia and the Pacific has kept AIDS high on the regional agenda, rallying around global and regional commitments and goals to address and turn the tide on HIV.

Building upon commitments such as the Millennium Development Goals and the United Nations (UN) General Assembly 2011 Political Declaration on HIV and AIDS, the vision of getting to zero new HIV infections, zero discrimination and zero AIDS-related deaths introduced by UNAIDS in 2011 has resonated across the region. A number of countries and regional bodies have developed their national and regional AIDS strategies around ‘Getting to Zero’.

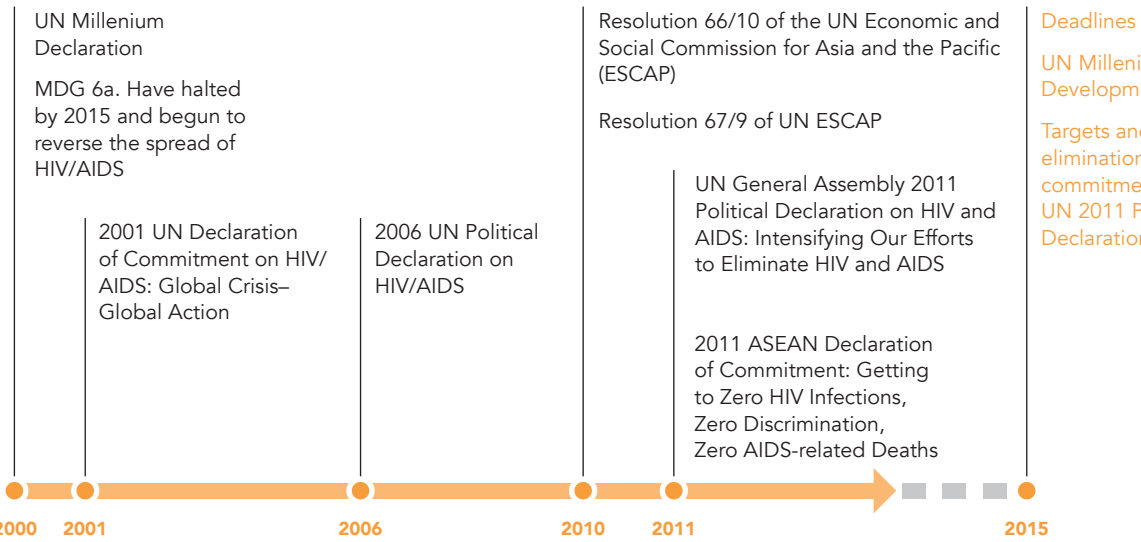
A significant milestone towards the eventual realization of this vision is the achievement of the 10 targets and elimination commitments as endorsed in the UN 2011 Political Declaration. Six of the 10 targets are specifically to be reached by 2015.

Efforts and energies of countries across the region are being channelled into striving reach these ambitious targets. In 2013 some countries in the region have already met some of the targets; others report they are on schedule to reach the targets by 2015.

Nevertheless, the course of the HIV epidemic in this region shows that current efforts need to be re-focused to ensure that the 10 targets are met in all countries. The overall rate of programme and service scale-up in the region needs to increase and efforts and investment need to be directed to where they are going to have most impact.

This report provides an overview of the epidemic and the response in Asia and the Pacific as well as focus on critical progress and challenges in the achievement of the 10 targets, towards getting Asia and the Pacific to zero new infections, zero discrimination and zero AIDS deaths. The report draws primarily on sources listed at the first page of this publication.

Figure 1
Global and regional commitments on HIV



Within the broad regional overview and the targets section, a forward-looking component is included, drawing primarily from mid-term reviews, highlighting commitments that countries have made to expand the reach of key services, improve service efficiency and enhance domestic investment. Snapshots of important developments and issues in specific countries, as well as voices from key figures within the regional response, are also included.

The annexes provides country-by-country data on the epidemic, the response and stigma and discrimination issues, and summarize achievements, challenges and future actions as recorded by countries in their 2013 mid-term reviews.

Mid-term reviews of UN 2011 Political Declaration targets and elimination commitments

With support from UNAIDS country and regional offices, Member States conducted a mid-term review to take stock of progress towards meeting the 10 targets and elimination commitments endorsed through the UN 2011 Political Declaration.

Mid-term reviews were intended to consist of a formal stock-taking exercise, as well as results from national consultation of stakeholders including people living with HIV, to review progress and chart future directions. UNAIDS asked that countries submit a report summarizing key findings from the mid-term review, as well as a matrix of responses to specific questions posed for each target.

In Asia and the Pacific, 21 countries conducted mid-term reviews of national progress in relation to the 10 targets. These reviews provide an invaluable insight into countries’ view of their progress and opportunities for strengthened responses in the coming years.

Overall, the mid-term reviews from Asia and the Pacific region bear a tone of cautious optimism. This report has drawn on the findings of the review process to identify the issues of most concern to the region.

Table of contents

Foreword	4
Introduction	5
HIV in Asia and the Pacific: Time to focus	8
The big picture	9
Special feature: HIV among men who have sex with men in Asia and the Pacific: a matter of urgency	33
10 targets	42
Target 1: Sexual transmission	43
Target 2: People who inject drugs	49
Target 3: HIV infection among children and keeping their mothers alive	52
Target 4: Treatment	57
Target 5: Tuberculosis and HIV	64
Target 6: Resources and spending	67
Target 7: Gender and the HIV response	71
Target 8: Stigma, discrimination and the law	75
Target 9: Eliminating restrictions on entry, stay and residence	80
Target 10: Integration	83
References	86
Annex	90

Asia and the Pacific's AIDS response is showing mixed results.

- Despite important progress, such as a 26% reduction in new HIV infections since 2001 and significantly increased domestic financing for AIDS, the epidemic still outpaces the response and half of people eligible for antiretroviral treatment are not accessing it.
- There are growing epidemics in some geographical areas and within key populations at higher risk, notably among men who have sex with men, in many countries.
- Not enough people from key populations at higher risk know their HIV status. This is hampering increased access to treatment.
- Evidence across the region shows that involving affected communities and networks at all stages of the AIDS response—from planning to delivery and monitoring—leads to greater success.
- Domestic financing for HIV has increased considerably in the region but HIV expenditure remains insufficient and international funding is shrinking.
- Despite some progress and legislative change in some countries, all countries in the region have laws, policies and practices that drive stigma and discrimination and hamper access to HIV services.

Reaching the internationally-agreed AIDS targets, towards the vision of Asia and the Pacific with zero new HIV infections, zero discrimination and zero AIDS deaths, requires:

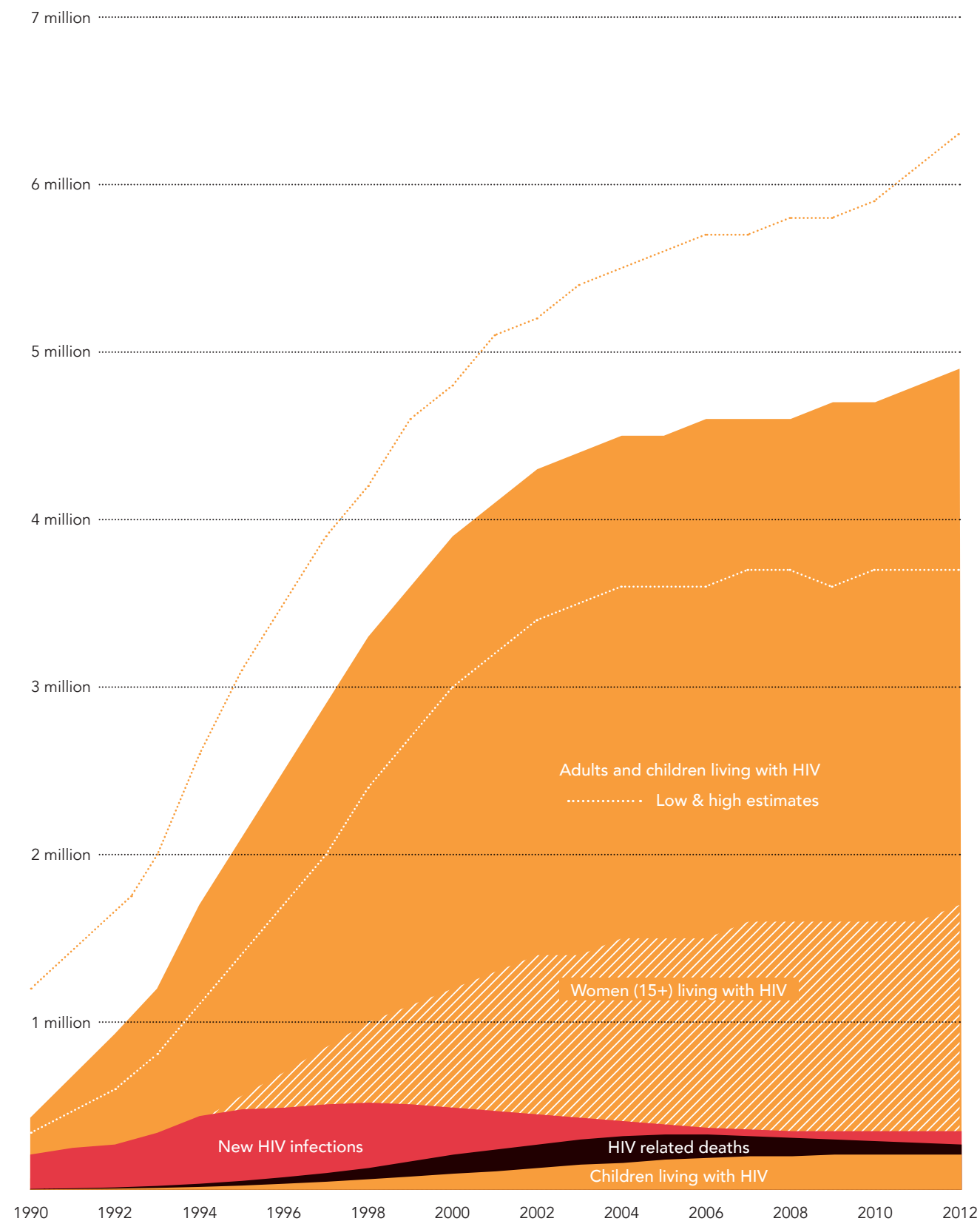
- strengthening political leadership and national ownership, as well as fully involving people living with HIV and key populations at all stages of the AIDS response;
- enhancing HIV prevention efforts, with particular focus on key populations at highest risk and geographical hotspots within countries;
- speeding up, expanding and sustaining HIV testing and counselling and access to antiretroviral treatment, including community-based HIV testing;
- continuing and augmenting efforts to procure affordable medicines, diagnostics and prevention commodities for the region and beyond;
- advancing human rights and gender equality through the removal of laws, policies and practices that fuel stigma and discrimination, violate rights and hamper the AIDS response; and
- increasing and sustaining domestic resources for HIV and ensuring funding is directed to where it will have the greatest impact.

The big picture

An overview of the HIV epidemic and response in Asia and the Pacific

Figure 2

HIV in Asia and the Pacific, 1990–2012



Source: UNAIDS HIV estimates 2012

There were an estimated 350 000 (220 000–550 000) new HIV infections in Asia and the Pacific in 2012, a decline of 26% since 2001. More people than ever are accessing treatment—1.25 million in 2012. Under the 2010 World Health Organization (WHO) guidelines,¹ overall treatment coverage is 51% [43–63%] in Asia and the Pacific: a 46% increase since 2009. AIDS-related deaths across the region have declined 18% since 2005 to an estimated 270 000 [190 000–360 000] in 2012. As a result, for many of the 4.9 million [3.7–6.3 million] people living with HIV, the disease is no longer a death sentence, but a manageable chronic condition (Figure 2).

According to the latest (2012) UNAIDS estimates, 12 countries account for more than 90% of people living with HIV and more than 90% of new HIV infections in Asia and the Pacific: Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Papua New Guinea, the Philippines, Thailand and Viet Nam (Figure 3).

The overall national prevalence of HIV in most countries in Asia and the Pacific remains low. However, the size of the regional population means low prevalence translates into large numbers of people living with HIV. Low national prevalence also masks higher HIV prevalence and incidence rates in certain geographical areas and among key populations at higher risk.

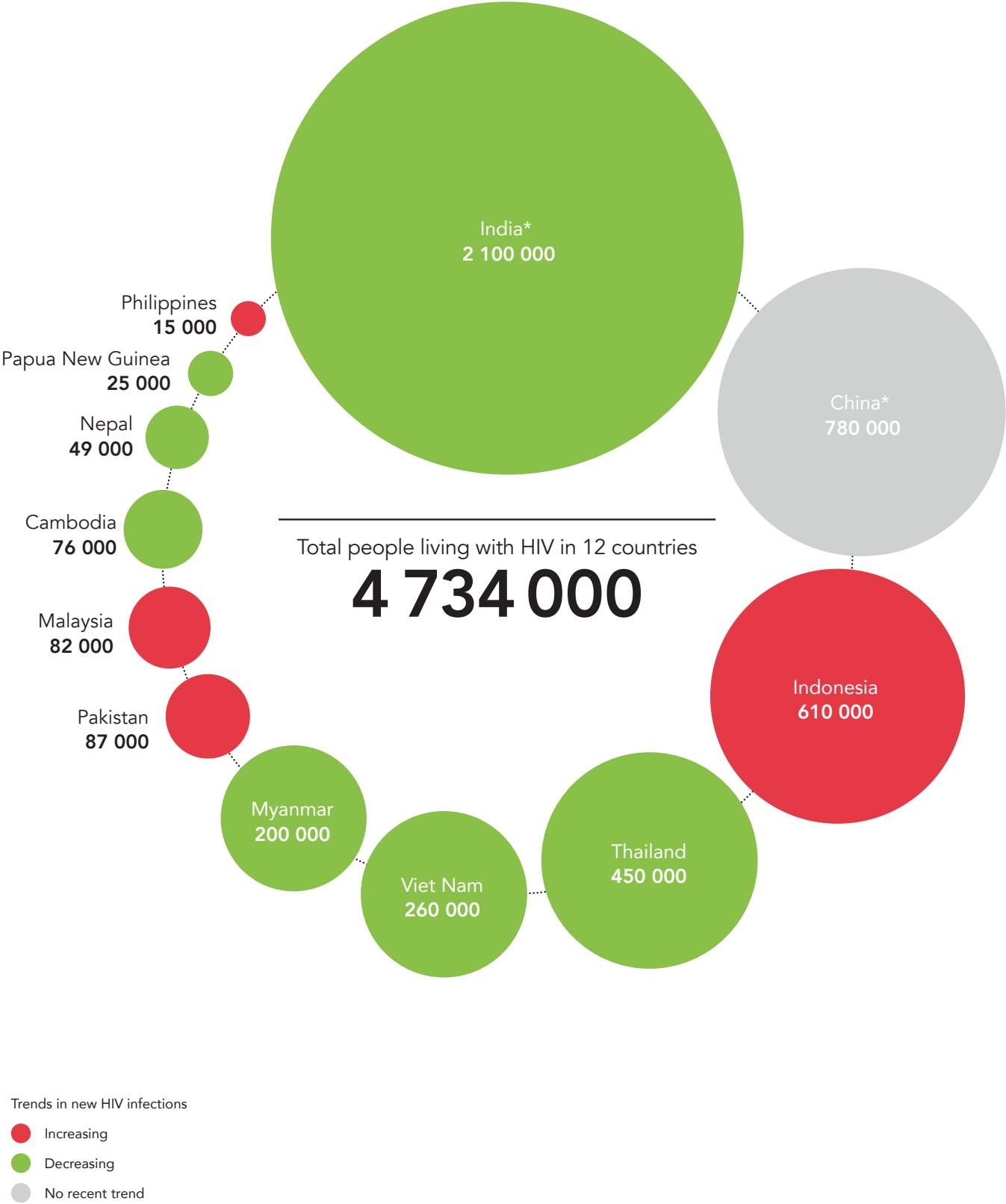
There are significant variations in HIV epidemics between and within countries. New HIV infections are concentrated among key populations at higher risk, which include people who inject drugs, female and male sex workers and their clients, men who have sex with men and transgender people. Other vulnerable populations include migrants, prisoners, intimate partners of key populations at higher risk and people working in certain industries such as mining, construction, transport services.

In 2012, there were an estimated 1.7 million [1.3–2.1 million] women living with HIV in the region. Women continue to account for about one third of people living with HIV, at 36% of the total, versus 35% in 2011.

There were 210 000 [180 000–280 000] children living with HIV in the region in 2012. New infections among children have declined by 28% to 23 000 [17 000–34 000] since 2001.

Figure 3

Twelve countries with highest HIV burden and new HIV infection trends



Source: UNAIDS HIV estimates 2012.
*Estimates for China and India are based on 2011 national data

Fewer new HIV infections overall, but instances of rising trends

The region-wide 26% reduction in new infections since 2001 has included some notable successes. Several countries have at least halved the number of new infections since 2001, including India (57%), Myanmar (72%), Nepal (87%), Papua New Guinea (79%) and Thailand (63%).

In the past five years, however, the overall numbers of new infections have remained largely unchanged. Emerging epidemics are becoming evident in a number of countries. For example, between 2001 and 2012, new HIV infections increased 2.6 times in Indonesia; Pakistan has seen an eight-fold increase and new infections in the Philippines have more than doubled (Figure 4).

Significantly, even in countries that have successfully reduced overall incidence, nationwide progress belies concentrated epidemics (more than 5% prevalence) in specific geographical locations and among specific population groups at higher HIV risk or vulnerable.

Directly measuring new HIV infections is difficult—hence most countries in Asia and the Pacific are not monitoring them directly. Passive case reporting systems are often weak. Trends and focus areas for the response to reduce new infections are therefore most often deduced from prevalence measures and analysis of risk behaviours.

HIV remains concentrated among key populations and in cities

The fastest-growing epidemics in the region are among men who have sex with men; these epidemics are typically concentrated in major cities. Estimates based on country information indicate that the regional population of men who have sex with men who are at risk of HIV infection ranges from 10.5–27 million. HIV prevalence among men who have sex with men is more than 10% in at least 10 major urban centres.³ For example, the national prevalence for men who have sex with men in Thailand is estimated to be 7.1%; in Bangkok, levels are estimated to be 24.7%.⁴ See the special feature on the issue of men who have sex with men and HIV (page 33).

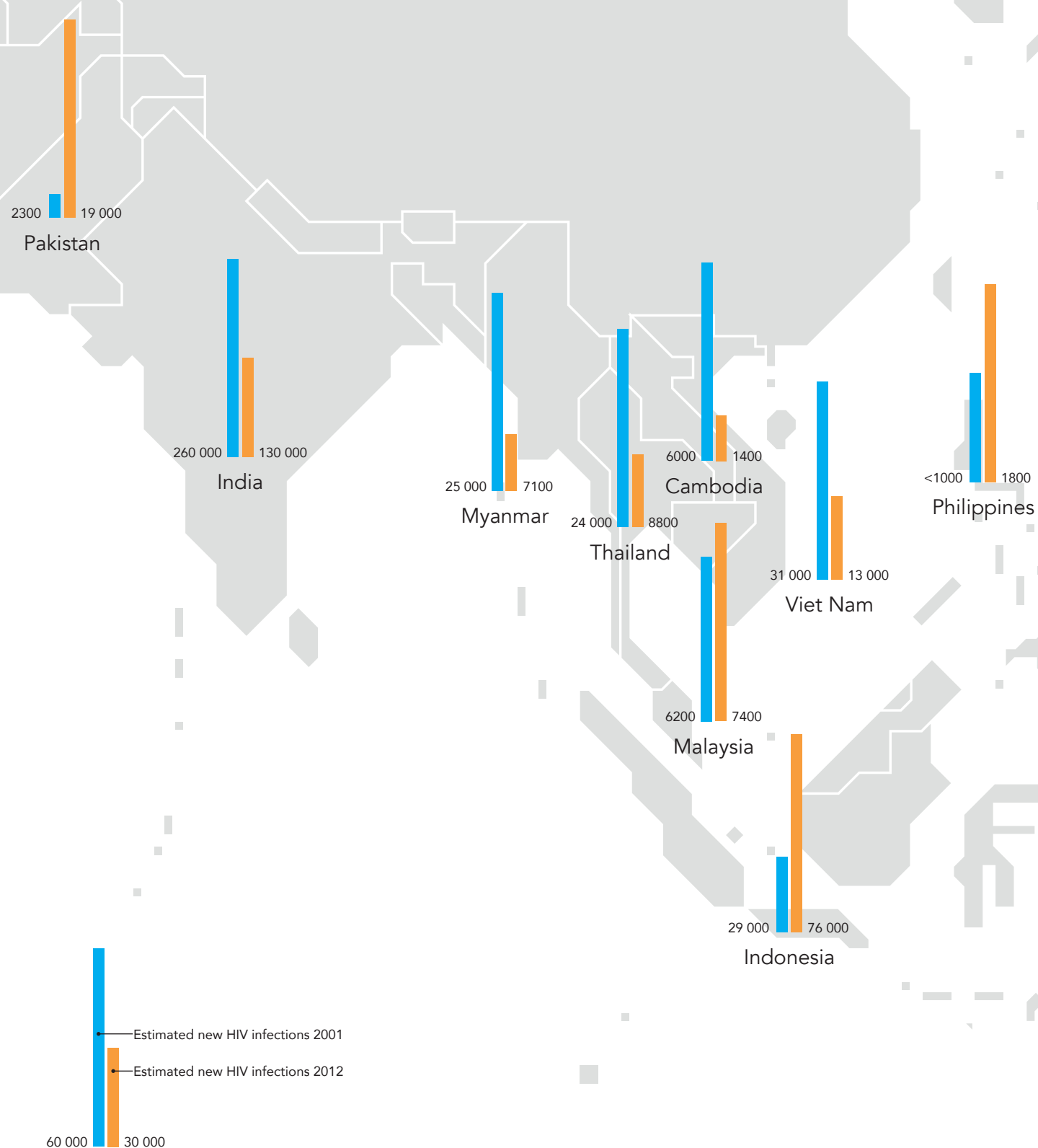
An estimated 3–4 million people living in Asia inject drugs. In three countries with expanding epidemics—Indonesia, Pakistan and the Philippines—injecting drug use has been a significant factor in the spread of HIV. In 2012, HIV prevalence among people who inject drugs was 36.4% in Indonesia, 27.2% in Pakistan and 13.6% in the Philippines.⁵

National trends sometimes mask significant geographical variations in HIV prevalence among injecting drug users. In the Philippine province of Cebu, prevalence among people who inject drugs was estimated at 53.8% in 2011 compared with 13.6% nationally.⁶ In the province of Thai Nguyen in Viet Nam, the prevalence among this group was reported to be 38.8% in 2012, compared with national prevalence of 11.6%.⁷

There has been progress in reducing new HIV infections among female sex workers across the region. National prevalence has declined in the early

Figure 4

Numbers of new HIV infections 2001 and 2012 in selected countries



Source: UNAIDS HIV estimates 2012, GARPR 2013.

*Estimates for India are based on national data

epidemics of Cambodia, India, Myanmar and Thailand, and has been kept low in some countries including China, Nepal and the Philippines.

Nevertheless, challenges remain. Based on a global systematic review in low- and middle-income countries, the burden of HIV infection was disproportionately high among female sex workers, who are 13.5 times more likely to acquire HIV than the rest of the adult female population. The highest was observed among female sex workers in Asia and the Pacific, with a 29-fold increase in odds of living with HIV compared with all women of reproductive age.⁸

As observed with other key populations, there are geographical areas with higher HIV prevalence—for example Hanoi, where prevalence among female sex workers was 22.5% in 2012⁹ or Jayawijaya, Indonesia,¹⁰ with 25% prevalence the same year. Even when national HIV prevalence trends among female sex workers have declined, for example in India and Myanmar, there are specific high-prevalence areas; 22% of female sex workers surveyed in Mumbai, India, and 15% surveyed in Patheingyi, Myanmar, were living with HIV.^{11,12}

Data on male and transgender sex workers are scarce, but where available demonstrate high HIV prevalence. For example, 18% of surveyed male sex workers in Indonesia and Thailand tested HIV-positive,¹³ as did 31% of transgender (*waria*) sex workers in Jakarta¹⁴ and 19% in Maharashtra.¹⁵ This underscores both the need for better data regarding male and transgender sex workers and for HIV programmes that address the needs of female, male and transgender sex workers.

Clients of sex workers are the largest population at risk of HIV infection in Asia and the Pacific. According to population-based surveys, 0.5%¹⁶–15%¹⁷ of men in the region bought sex in the previous year. This population's risk behaviour determines the extent of the spread of HIV, but there are limited data available on prevalence trends among clients of sex workers, and they are underserved by current HIV programmes. This emphasizes the need for more prevention efforts among key populations and reaching the female partners of men at higher risk both through key population programming and mainstreaming sexual and reproductive health services.

While evidence indicates that the majority of women in the region are acquiring HIV through their partners who engage in high-risk behaviour (including as sex work clients, through male-to-male sex or injecting drug use), policies and programmes to address intimate partner transmission are limited.^{18,19,20}

Research conducted in Asia and the Pacific suggests that the transgender population in the region is around 9–9.5 million, made up predominantly of transgender women.²¹ Little research has been done on their specific risk factors and data on HIV prevalence among transgender people is limited regionally, but global studies have found that transgender women are 50 times more likely to acquire HIV than adult males and females of reproductive age. The available data for the region indicate high HIV prevalence among transgender women in cities: 30.8% in Jakarta,²² 23.7% in Port Moresby²³ and 18.8% in Maharashtra, India (2010–2011 data).²⁴

Table 1

Geographical focus: National and local HIV prevalence levels (%) among key populations at higher risk, based on latest comparable national and local data, in selected countries with highest burden

	Men who have sex with men	People who inject drugs	Female sex workers
China	National 6.7	National 6.3	National 0.3
	Chengdu 16.3	Akesu 54.7	Kaiyuan 15.9
India	National 4.4	National 7.2	National 2.8
	Raipur 15.0	Delhi 18.3	Mumbai 10.0
Indonesia	National 8.5	National 36.4	National 7.0
	Jakarta 17.2	Jakarta 56.4	Jayapura 16.0
Myanmar	National 8.9	National 18.0	National 7.1
	Pathein 21.3	Myitkyina 29.0	Myitkyina 12.4
Pakistan		National 27.2	National 0.6
		Karachi 42.2	Karachi 1.9
Papua New Guinea	Port Moresby 4.4		Port Moresby 19.0
Philippines	National 1.7	National 13.6	National 0.3
	Quezon 5.6	Cebu 53.8	Cebu 5.5
Thailand	National 7.1	National 16.0	National ^a 1.7
	Bangkok 24.7	Bangkok 18.5	Bangkok ^a 6.0
Vietnam	National 4.0	National 11.6	National 2.7
	Ho Chi Minh City 14.0	Thai Nguyen 38.8	Hanoi 22.5

^a Indirect sex workers

Source: National HIV surveillance and IBBS 2009–2012

More young people aged 15–24 live in Asia and the Pacific than in any other region. ²⁵ In 2012, an estimated 690 000 young people were living with HIV (among which 46% are female).²⁶ The epidemic in this age group is driven mainly by unprotected sex and injecting drug use, as it is among adult populations. ²⁷

Although there has been a 28% reduction of new HIV infections among children since 2001, recent rates of decline appear to be slowing. Between 2010 and 2012, infections among children decreased by 8%.

Scale up and shifts needed in HIV prevention coverage and strategies

It is well understood that key populations at higher risk are central to the epidemic in Asia and the Pacific, yet they are insufficiently reached by prevention programmes. Modeling shows that only by reaching 80% prevention programme coverage among key populations can there be a significant impact on behaviours and new HIV infections. ^{28, 29} Reports conducted by countries in the region show that median coverage of men who have sex with men and male and female sex workers by HIV prevention programmes in the region (i.e. those who knew where to get a HIV test and received condoms in the previous year) is less than 60%. ³⁰

The way that HIV prevention programmes are focused also needs to reflect changing demographic and behavioural patterns. For example, HIV prevention programme median coverage in the region among different key populations at higher risk is about the same. However, while female sex workers reported a median of 80% condom use at last sex with clients, usage rates among male sex workers are half this number³¹ and two thirds of men who have sex with men reported using condoms at last sex. This indicates that the programmes for men are not as effective in leading to adopting protective sexual behaviours; new and more innovative approaches are needed.

In many countries, consistent condom use (i.e. using a condom for every sex act in the previous week or months) is reported to be much lower than last time use. Countries where female sex workers report high levels of consistent condoms use (for example: more than 80% since 2001 in Cambodia; more than 90% since 2004 in Thailand) have turned their epidemics around. Consistent condom use among sex workers and men who have sex with men is much lower in most other countries and at current levels is unlikely to have definitive impact on preventing new infections. This is clearly evident in China: prevalence rose to 6.7% in 2012 from less than 2% in 2005, while consistent condom use stagnated at approximately 40%.

Despite overwhelming evidence that harm reduction measures decrease new infections among people who inject drugs, access to these services is inadequate in most countries. Regional 2012 data show the median distribution of needles and syringes was just more than 100 syringes per person who injects drugs per year—half the level recommended level of 200.³² The proportion of people who inject drugs reporting safe injection practices declined slightly from 83% in 2010 to 80% in 2013 (in 11 countries reporting consistently over those years).³³

Data on opiate substitution therapy were reported by 13 countries; more than 297 000 people were in programmes.³⁴ Among the six countries providing coverage estimates for opioid substitution therapy, coverage ranged from less than 20% (considered a low coverage level) among people who inject drugs in Afghanistan, India, Myanmar, Sri Lanka and Viet Nam to 26% (a medium coverage level) in Malaysia.³⁵

While people who inject drugs are accessing safe injection equipment and information, safe sex messages are absent. Risk behaviour surveys show that a median of less than half of respondents used a condom at last sex (11 countries reporting consistently since 2010), less than among female sex workers and men who have sex with men.

Mixed progress on eliminating new HIV infections among children

Coverage of effective antiretroviral regimens for preventing new HIV infections among children remains low at 18% (14–25%) in south and south-east Asia, 26% (17–42%) in east Asia and 49% [38–63%] in Oceania, well below the 62% average for low- and middle-income countries worldwide.

In 2012, 14 523 pregnant women living with HIV received antiretroviral treatment to prevent their children from being infected in low- and middle-income countries in the region (excluding India). Some countries have achieved more than 50% coverage, notably Cambodia, Malaysia, Myanmar and Thailand.³⁶ By contrast, coverage estimates for south Asian countries such as Pakistan, Nepal and Sri Lanka are much lower (below 30%).

The largest unmet need for effective regimens is in India. In 2012 out of 12 702 pregnant women in India who received antiretroviral treatment to prevent their children from being infected, 8% received the recommended maternal triple antiretroviral treatment prophylaxis while 92% received single dose nevirapine.³⁷

Early infant diagnosis of HIV varies widely across the region, from single digit figures in some countries (Lao People’s Democratic Republic, Myanmar, the Philippines) to 100% in Malaysia and Mongolia.

Accelerate access to HIV testing, counselling, prevention, treatment and care to reduce AIDS-related deaths

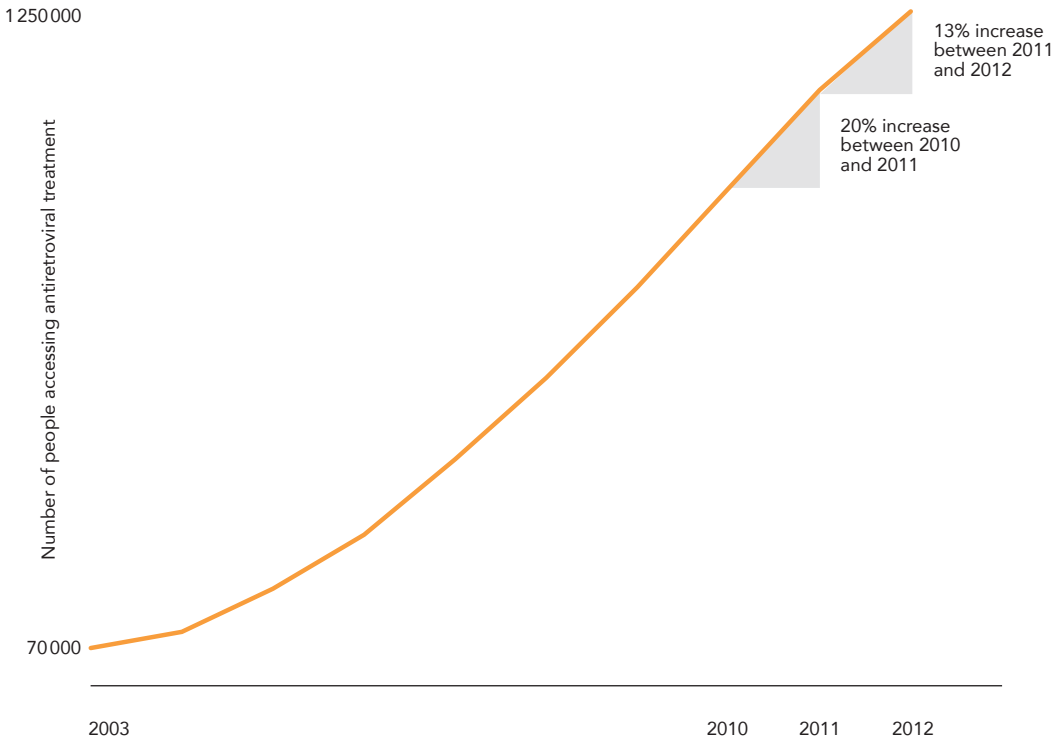
Between 2011 and 2012, the number of people accessing antiretroviral treatment increased by 150 000. However, under the 2010 WHO guidelines,³⁸ the region’s treatment coverage rate of 51% [43–63%] of eligible people lags behind the global coverage rate of 61% [57–66%]. Consequently, AIDS-related deaths have not reduced at the same rate as other regions (-20% compared to -30% globally since 2005) and benefits of the prevention impact of antiretroviral therapy are not being fully maximized. In terms of treatment adherence, the region has done well, with estimated 87% median adherence in 2012.³⁹

Certain countries (such as China, India, Myanmar, Thailand and Viet Nam) have made great strides in scaling up access to treatment, each with a rapid scale up to more than 10 000–60 000 in number of people accessing antiretroviral treatment in 2012. However, the slowdown in the pace of scale-up is of concern: the number of people on antiretroviral treatment increased by 13% in 2011–2012, compared to 20% in 2010–2011 (Figure 5, 6).

In 2012, more than 59 000 children in Asia and the Pacific were accessing antiretroviral treatment—a rate of 42% [37–55%]. This is well above the global child treatment coverage rate of 34% [31–39%].⁴⁰

Figure 5

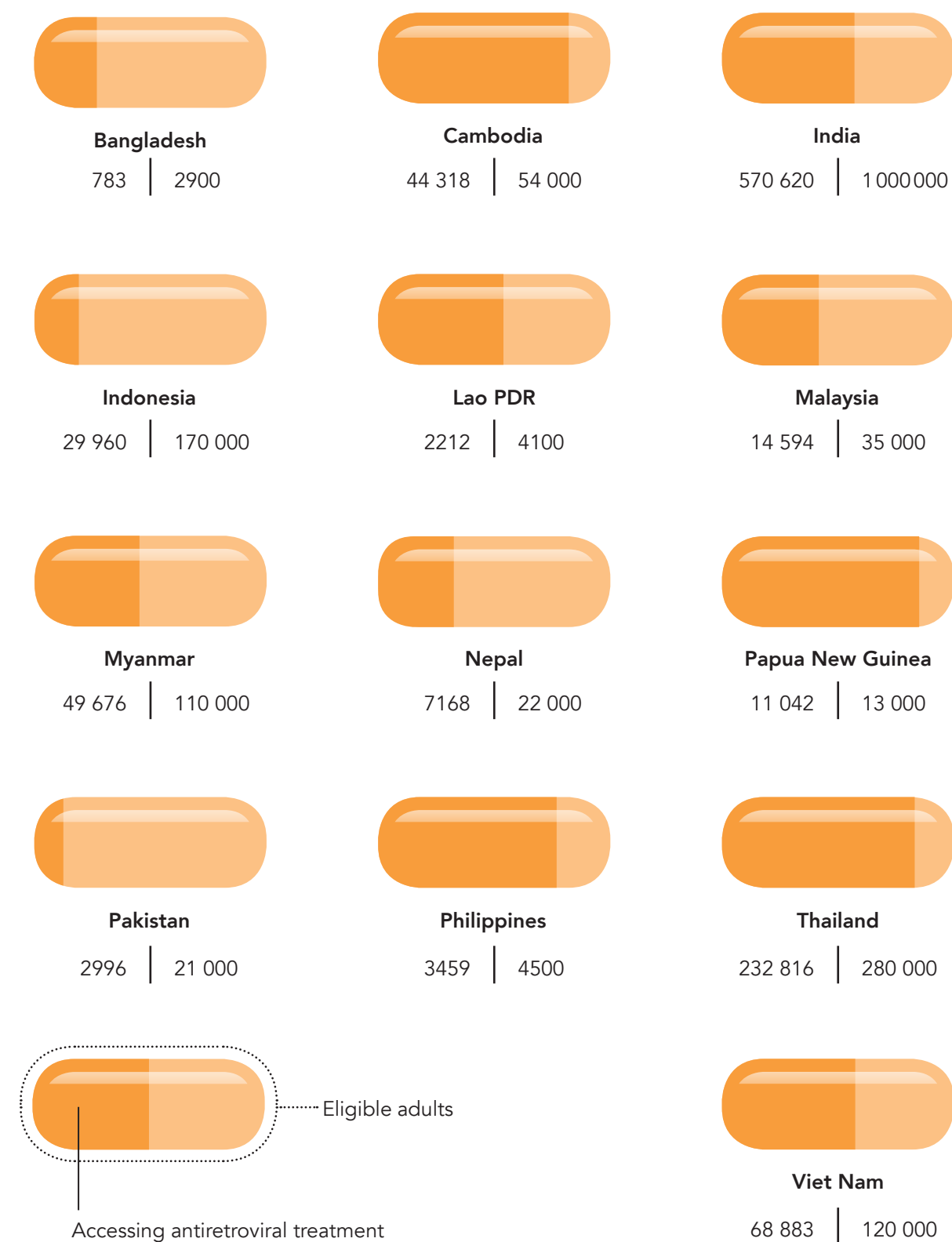
Number of people accessing antiretroviral treatment 2003–2012



Source: www.aidsinfoonline.org

Figure 6

Estimated number of adults eligible for* and accessing antiretroviral treatment in 2012



Source: UNAIDS estimates 2012 and GARPR 2013.

*Under 2010 WHO HIV treatment guidelines.

Early diagnosis and treatment are crucial

Regional data and projections show that most people living with HIV in the region do not know their status and only find out when they are already seriously ill, which greatly reduces the efficacy of antiretroviral treatment. The impact of late diagnosis due to the lack of access to HIV testing and counselling is severe: one in four people who start on antiretroviral therapy in low-income countries globally have CD4 cell counts under 100, putting them at high risk of AIDS-related illness and death.⁴¹

Helping people living with HIV to find out about their status as early as possible and linking them successfully to HIV prevention, care and treatment services gets more people onto treatment and maximizes the prevention benefits of treatment. In Asia and the Pacific, more than two thirds of men who have sex with men and people who inject drugs—and more than half of female sex workers—do not know their HIV status.

Effective national HIV responses require a significant expansion of HIV testing and counselling to expand access to prevention and care. Facility-based HIV testing and counselling, while essential, is unlikely to reach key populations at higher risk of HIV.

A recent systematic review and meta-analysis of community-based approaches has shown that community-based testing and counselling achieve high rates of uptake, reach people with high CD4 counts and link people to care. Community-based approaches also obtain a lower HIV rate relative to facility-based ones.⁴²

Enabling people living with HIV to find out about their status early requires: scaling up both facility and community-based HIV testing and counselling across the region; identifying the role of community in creation of demand for testing and counselling; and effective linkages to HIV prevention, care and treatment services.

WHO 2013 HIV treatment guidelines: new recommendations boost regional response

WHO's 2013 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*⁴³ represent an important opportunity for countries in Asia and the Pacific to increase the efficiency, impact and long-term sustainability of treatment programmes towards reaching the 10 targets and beyond.

These guidelines comprise a number of significant new recommendations for the regional response, including community-based HIV testing and counselling for key populations, with linkage to prevention, care and treatment services, in addition to provider-initiated testing and counselling—in all HIV epidemic settings.

With regards to starting antiretroviral treatment among people living with HIV, the guidelines recommend that antiretroviral treatment be initiated in all individuals with a CD4 count of 500 and below. They also state that antiretroviral treatment should be initiated for all people living with HIV regardless of WHO clinical stage of CD4 count in the following situations:

- individuals with HIV and active tuberculosis;
- individuals coinfectd with HIV and Hepatitis B with evidence of severe chronic liver disease; and
- people living with HIV in serodiscordant couples should be offered antiretroviral treatment to reduce risk of HIV transmission to their partners.

Speed, focus, innovation for results

To catalyse progress towards universal access to HIV treatment and the achievement of the 2015 treatment target, UNAIDS, WHO, the United States President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and other partners launched the Treatment 2015 initiative in July 2013.

This initiative emphasizes three critical elements of success:

- **Speed.** Rapid scale-up will modify the epidemic, reducing deaths and maximizing potential to reduce new HIV infections in communities.
- **Focus.** Using available data to identify key geographical settings and populations with high HIV prevalence and disproportionate unmet needs for HIV treatment.

- **Innovation.** Enabling new approaches to translate scientific advances into concrete action in countries more swiftly, including the reconceptualization of HIV testing and counselling, linking individuals' treatment and care at an early stage of HIV infection and strengthening community systems.

A number of countries—including Cambodia, China, Indonesia, Myanmar and Thailand—are moving towards the strategic use of antiretroviral treatment and the expansion of HIV testing and counselling, as outlined in the Treatment 2015 initiative.

Ensuring affordable access to treatment is an ongoing challenge for countries in Asia and the Pacific. Indonesia, Malaysia and Thailand have issued compulsory licenses or Government use orders for more affordable antiretroviral medicines.

Other countries have taken steps to use flexibilities under the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and/or to protect the right to exercise TRIPS flexibilities through laws, policies and programmes with key stakeholders such as parliamentarians, judges and patent examiners. Wider use of TRIPS flexibilities is needed in the region. Moreover, attention and leadership are paramount to ensure that free-trade agreements currently negotiated by a number of countries do not include provisions that may reduce low- and middle-income countries' access to affordable medicines.

A more widespread implementation of the 2013 WHO guidelines,⁴⁴ which recommend that eligible patients receive a simplified, daily, single-pill regimen where possible, should help maintain high levels of adherence.

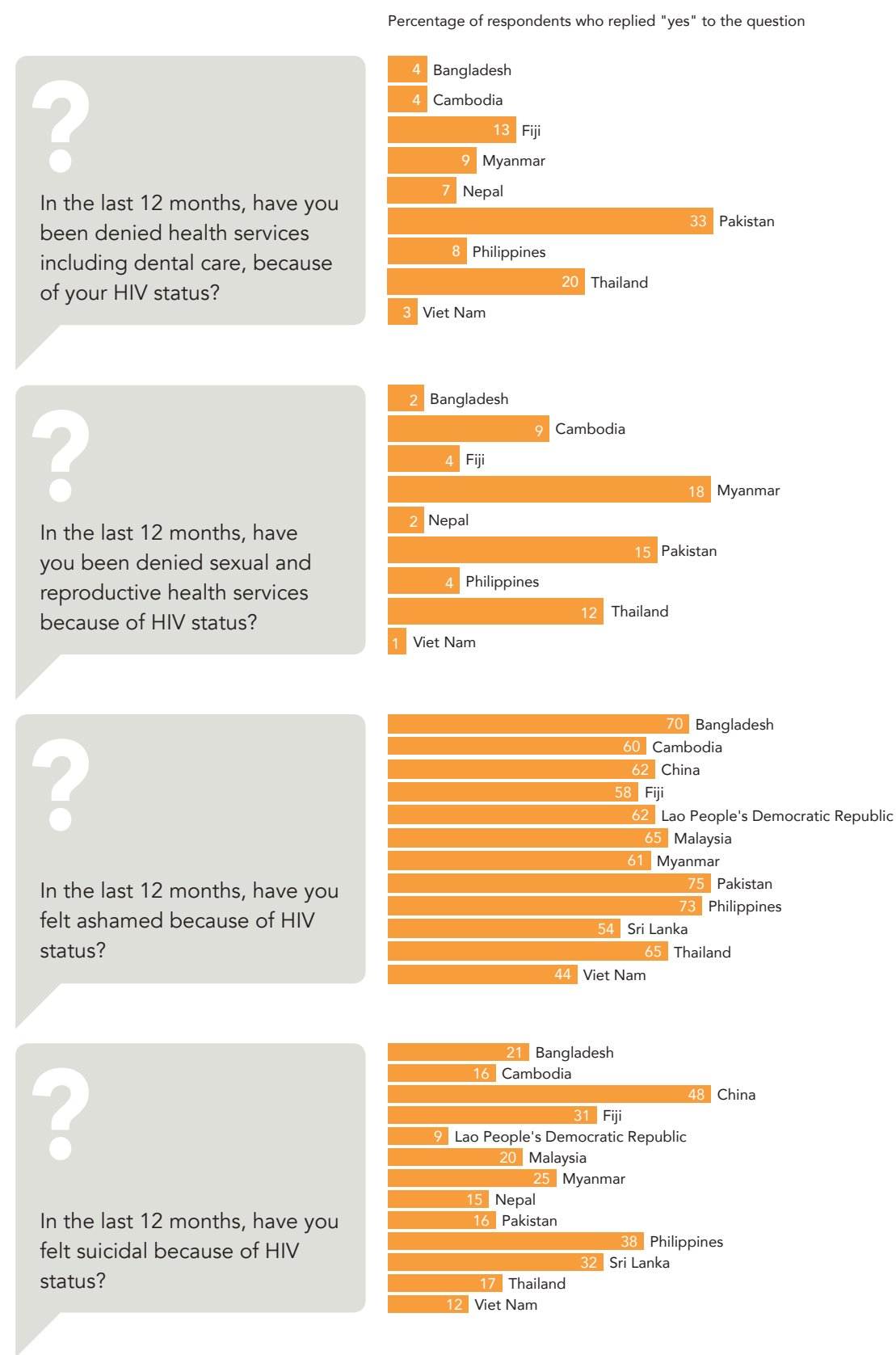
Tuberculosis: significant steps made but more efforts needed

Asia accounts for one in six HIV-positive tuberculosis cases worldwide and south-east Asia has the highest tuberculosis burden in the world (15% of the global total). Among the world's 41 high HIV/tuberculosis burden countries, seven are from Asia and the Pacific: Cambodia, China, India, Indonesia, Myanmar, Thailand and Viet Nam.⁴⁵

Between 2006–2011, more than 1.1 million tuberculosis patients in the region were screened for HIV and more than 630 000 people living with HIV were screened for tuberculosis coinfection. However, more efforts are needed to ensure antiretroviral treatment is initiated in all tuberculosis patients living with HIV, irrespective of CD4 cell count.

Figure 7

Results from the People Living with HIV Stigma Index surveys, 2008–2012



People Living with HIV Stigma Index data collected in 2008-2012: Bangladesh 2008, Cambodia 2010, China 2009, Fiji 2009, Lao People's Democratic Republic 2012, Malaysia 2010-11, Myanmar 2009, Nepal 2011, Pakistan 2009-10, Philippines 2009, Sri Lanka 2009-10, Thailand 2009, Viet Nam 2011.

Stigma and discrimination: progress made, but significant barriers remain

There has been some progress in addressing stigma, discrimination and punitive laws that undermine AIDS responses in the region. This has included significantly improved strategic information on stigma and legal and policy barriers the implementation of key programmes that reduce stigma and discrimination and increase access to justice; and reform of laws and policies that impede effective responses.

Despite progress, stigma and discrimination continue to be serious obstacles to effective and sustainable investments in the AIDS response. Governments in Asia and the Pacific have acknowledged in their mid-term reviews that HIV-related stigma and punitive legal environments are holding back progress on achieving zero new infections and zero AIDS related-deaths. Significantly, in countries where punitive laws, policies and practices prevail, there is evidence of slower progress on other targets.

Studies in diverse settings across the globe have linked HIV-related stigma with delayed HIV testing and counselling, non-disclosure to partners and poor engagement with HIV services.⁴⁶ Asia and the Pacific regional averages of the People Living with HIV Stigma Index data collected in 2008–2012⁴⁷ make for sobering reading: on average, 22% of respondents avoided going to a local clinic for medical care, 17% avoided going to hospital and 11% were denied health services (including dental care) because of their HIV status (Figure 7).

Levels of self-stigma were also high: 61% reported feeling ashamed because of their HIV status and 23% had felt suicidal because they were living with HIV. Fourteen countries in the region now have data from the Stigma Index, which should enable better targeting of policies, programmes and advocacy to remove this barrier to access to and uptake of HIV services.

Legal and policy reform

Current progress in tackling stigma and discrimination through removing punitive laws hindering HIV responses in the region indicates growing national political commitment.

In 2010, Fiji decriminalized sex between men and in 2011 eliminated specific criminalization of HIV transmission or exposure in recognition that, as prosecutions could occur under general criminal laws, there was no need to provide an HIV-specific offence. In 2012, Viet Nam amended laws in order to bring an end to compulsory detention of sex workers. In 2013, Mongolia eliminated HIV-related restrictions on entry, stay and residence and other punitive laws including criminalization of non-disclosure of HIV status. In Guangdong, China, restrictions preventing people living with HIV from being employed as teachers were removed in 2013.

In terms of protective laws, eight countries in the region had enacted omnibus national HIV laws by 2012, all of which include some protection against HIV-related discrimination.⁴⁸

Pakistan and the Philippines also recently passed subnational HIV or anti-discrimination laws that provide additional protection against discrimination on the grounds of HIV status and, in some cases also, on the grounds of sexual orientation and gender identity.

Seven countries (Cambodia,⁴⁹ the Federated States of Micronesia, Fiji, Lao People’s Democratic Republic, the Marshall Islands, Papua New Guinea and Viet Nam) have enacted laws allowing young people to consent independently to an HIV test in certain circumstances, despite the fact that they have not yet reached the age of legal majority.⁵⁰ These reforms are in concordance with the Convention on the Rights of the Child principles of recognizing the best interests and evolving capacity of the child and remove some of the legal barriers that make young people vulnerable to HIV.

Aside from legislative reforms, constitutional rights have been used to enforce human rights protections for people living with HIV and key populations in at least seven jurisdictions (Bangladesh, Fiji, India, the Hong Kong Special Administrative Region of China, Nepal, Pakistan, Philippines) in the region, illustrating the important role of the judiciary in the HIV response.⁵¹

Addressing punitive legal environments

Despite progress, stigma and punitive legal environments in most countries continue to have a negative impact on the rights of key populations at higher risk and other vulnerable groups, including access to HIV services.

Some 37 countries in the region are known to criminalize some aspects of sex work, 18 criminalize same sex behavior and 11 incarcerate people who inject drugs in compulsory drug detention centres—all measures that hinder people from accessing HIV services. Eleven countries, territories and areas in Asia and Pacific still have in place some type of HIV-related restriction on entry, stay and residence (Table 2).

In follow-up to regional and global commitments,⁵² as well as the Global Commission on HIV and the Law,⁵³ at least 15 countries in the region conducted national reviews and/or multisectoral and participatory consultations on legal and policy barriers to access to HIV services in 2012 and 2013. Implementing the recommendations from these processes, which address laws, law enforcement practices and access to justice, will bring countries significantly closer to achieving zero discrimination.

In addition to reviewing and reforming laws, countries are implementing other key programmes to create more enabling environments, including HIV-related rights awareness programmes with policy-makers, judges and law enforcement, and in workplaces and in health care settings.

For example, national human rights institutions in the region have become increasingly engaged in addressing HIV-related human rights issues. Bangladesh, India, Indonesia, Mongolia, Nepal, Pakistan, the Philippines, Sri Lanka and

Table 2

Punitive laws hindering the HIV response in Asia and the Pacific

	<div><div></div>Has punitive law</div> <div><div></div>Contradictory information</div> <div><div></div>Does not have punitive law</div> <div><div></div>Not illegal*</div> <div><div></div>No information available</div>	MEN WHO HAVE SEX WITH MEN	SEX WORKERS		PEOPLE WHO USE DRUGS		PEOPLE LIVING WITH HIV	
		Reported to criminalize same-sex sexual activities between consenting adult males	Reported to criminalize sex work in private	Reported to criminalize soliciting	Reported to maintain compulsory detention centres for people who use drugs	Reported to impose the death penalty for drug-related offences	Reported to impose some form of restriction on entry, stay and residence based on HIV status	Reported to specifically criminalize HIV transmission or exposure
South and south-west Asia	Afghanistan							
	Bangladesh							
	Bhutan							
	India							
	Maldives							
	Nepal							
	Pakistan							
	Sri Lanka							
	China							
East and north-east Asia	Japan							
	Mongolia							
	DPR Korea							
	Republic of Korea							
	Brunei Darussalam							
South-east Asia	Cambodia							
	Indonesia							
	Lao PDR							
	Malaysia							
	Myanmar							
	Philippines							
	Singapore							
	Thailand							
	Timor-Leste							
	Viet Nam							
	Australia							
Pacific	Fiji							
	Kiribati							
	Marshall Islands							
	Micronesia							
	Nauru							
	New Zealand							
	Palau							
	Papua New Guinea							
	Samoa							
	Solomon Islands							
	Tonga							
	Tuvalu							
	Vanuatu							
	Totals (of 38 Member States)	18	18	33	11	15	11	9

*Generally not prohibited but exceptions apply

Sources and limitations:

The information and data in this table 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. Refer to page 89 of HIV in Asia and the Pacific: Getting to Zero (UNAIDS, 2011) for the list of countries included.

The information and data herein are based on research by Amnesty International, the Global Network of People Living with HIV, the International Harm Reduction Association, the International Lesbian and Gay Association, the International Planned Parenthood

Federation, the Asia Pacific Coalition on Male Sexual Health, UNDP, UNFPA, UNODC, and UNAIDS. The data are maintained and updated as necessary based on additional information received by the UNAIDS Regional Support Team for Asia and the Pacific and the AIDS Data Hub, and were last updated on 15 October 2013.

UNAIDS takes reasonable steps to validate information generated by other institutions and organizations.

Timor-Leste have been actively engaged in capacity building and activities on HIV and sexual orientation and gender identity in order to strengthen the legal response to HIV and promote an enabling legal environment. In countries such as Cambodia, India and Thailand, the police are engaged in programmes to strengthen their role in protecting communities vulnerable to human rights violations and HIV.

Gender inequality and violence fuel vulnerability

Discrimination on the grounds of gender, including gender-based violence and gender inequalities, hinder AIDS responses.

There is growing evidence to suggest that gender-based violence (including the threat or fear of violence) makes women, girls, men who have sex with men and transgender people more vulnerable to sexually transmitted infections, including HIV.^{54,55,56} This may be due to a variety of factors, ranging from physical trauma that increases the risk of HIV infection to being less capable of negotiating safe sex.

In Asia and the Pacific, women living with HIV are more likely to report a history of intimate partner violence than women from the general population. Studies show that women from key populations, such as female drug users, female sex workers and transgender women are particularly likely to experience violence.^{57,58}

A study of 28 139 married women in India showed that physical violence combined with sexual violence from husbands was associated with a nearly four-fold increase in HIV prevalence. The study concluded that prevention of intimate partner violence may contribute to other efforts to reduce the spread of HIV.⁵⁹

Reports suggest transgender people in the region are frequently subject to violence and hate crimes, and experience stigma and discrimination in accessing health services.⁶⁰ A study in Bangladesh and Papua New Guinea demonstrated the multiple forms of gender-based violence faced by men who have sex with men, male sex workers and transgender communities, as perpetrated by family members, sexual partners, transactional sex clients and community members.^{61,62} Two key perpetrators of such violence were found to be police officers and health workers. This poses a serious challenge to access to HIV services. Legal safeguards for men who have sex with men, and transgender people are often further limited due to the criminalization of male-to-male sex.

Sustainable financing for the AIDS response

AIDS response financing reached record levels in Asia and the Pacific in 2012, thanks to increased contributions from both domestic sources and international partners. Estimated HIV spending in the region in 2012 totalled US\$ 2.2 billion, an increase of 5% over the 2011 level and a threefold increase compared to 2005.⁶³ Funding for the AIDS response in the region now accounts for approximately 12% of the global total, while the region accounts for some 14% of the global HIV epidemic burden.

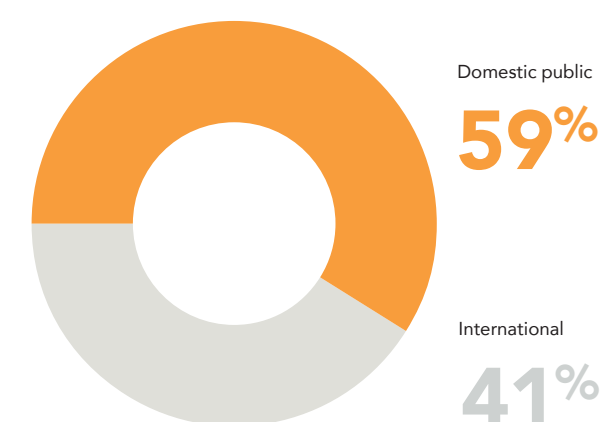
Resource needs are still greater than resources available. To achieve the 10 targets in low- and middle-income countries in Asia and the Pacific, UNAIDS estimates that approximately US\$ 5.4 billion must be mobilized. With current funding levels, this is approximately US\$ 3.2 billion short of the 2015 funding target.⁶⁴

Domestic public spending on the AIDS response has been rising steadily. Domestic public spending in Asia and the Pacific was approximately US\$ 1.3 billion in 2012 (59% of total regional AIDS spending).⁶⁵ This is above the global average of 53% (Figure 8). In three of the 10 countries with the highest HIV burden in the region, Malaysia funds 97% of its AIDS response, China funds 88% and Thailand 85%. India has committed to finance more than 80% of its national response from 2014 domestically.

As the region's economic growth continues, reducing eligibility for a shrinking pool of donor funding, the only way to sustain the AIDS response is to increase domestic financing, develop innovative financing mechanisms and increase spending efficiency.

Figure 8

HIV spending in Asia and Pacific, 2012



Source: UNAIDS estimates 2012

However, many countries in the region rely heavily on international assistance. Ninety-two percent of international funding comes from just six sources: two multilateral donors (the Global Fund and the World Bank) and four bilateral donors (Australia, Germany, the United Kingdom and the United States).⁶⁶ Many donors have already either withdrawn or are significantly reducing their investments in Asia and the Pacific.

Greater spending efficiencies required

Spending needs to be more efficient and more investments need to align with the demographic characteristics of the HIV epidemic. Care and treatment services accounted for 48% total regional AIDS spending for low-and middle-income countries.⁶⁷ However, a sizeable share (24%) was spent on prevention programmes in Asia and the Pacific, higher than the global low- and middle-income country average (19%).⁶⁸

Countries that prioritized funding for focused HIV prevention among key populations have the highest impact and return on investments. But in Asia and the Pacific, an estimated 8% of the overall AIDS spending is for HIV prevention among key populations at higher risk.⁶⁹ Spending on programme management and administration is 18%, which is higher than the global average (12%).⁷⁰ The region has limited reliable data on the extent of investment in critical enablers. This includes programmes implemented by (or in partnership with) affected communities, monitoring the response, holding governments to account and addressing legal and social barriers to access HIV services.

Identify and eliminate overlap

By identifying areas of overlap and integrating services so more people can access the services they need, the AIDS response becomes more effective and sustainable. Many countries in the region have made significant strides in integration of HIV and tuberculosis services. Progress is slower in integrating HIV services within sexual and reproductive health settings—a critical challenge for countries with concentrated epidemics. Further integration of health and community systems is essential in Asia and the Pacific to ensure scale-up, particularly of HIV testing and counselling, as well as treatment services for increased coverage and impact.

Regional experience shows that across all key populations at higher risk, projects initiated, managed and implemented by communities involved have the most credibility, trust and success. Consequently, to improve access, reach the 10 targets and enable sustainability, HIV services need to be decentralized, empowering communities to take a greater role in service delivery.

Asia and the Pacific is at a pivotal juncture

Across the region, there are impressive examples of successful approaches in prevention, treatment, care and support and multiple regional and national political commitments— many of them visionary, ambitious and showing results.

Countries in the region have the knowledge, expertise, technology and capacity needed to meet the 10 targets and elimination commitments, towards the ultimate vision of ‘Getting to Zero’.

However, to sustain gains and put commitments into concrete and lasting action, the region needs to embrace innovation and effective investment strategies that will move the AIDS response to the next level. Long-term progress will therefore depend on ensuring that HIV continues to feature prominently within the region’s future health and development agenda and goals.

The power of data

Information is vital for Asia and the Pacific to turn the epidemic around. Clear guidelines are needed on appropriate epidemic analysis tools and programme monitoring indicators to increase strategic data collection and analyses to assess progress. This can better inform focused and appropriately designed HIV programmes at the subnational and sub-population levels.

Dedicated national data analysis units can support policy-makers to make more informed decisions on strategic investments in the AIDS response. Systems for collecting sex- and age-disaggregated specific data that provide intelligence on where the epidemic is occurring (population, geography), legal and social barriers to access and uptake, as well as monitoring on where investments and strategies are working, will be crucial. The next generation of monitoring and evaluation and accountability systems needs to make use of advances in information technology that provide policy-makers and programme implementers with real-time information.

Focus, focus, focus

Renewed focus—both in terms of programmes and investment—from all countries on geographical areas of highest burden and key populations at higher risk will drive progress. A particular focus on addressing HIV among men who have sex with men is an urgent priority for the region.

Programmes must be rights-based if key populations are to access them in a timely manner. They must be responsive to the needs and experiences of key populations and be provided in safe and non-judgmental settings. Focusing efforts in these ways saves time and resources, enabling countries to increase scale and impact more quickly.

More proactive, simplified HIV testing and counselling strategies

Only when people know their HIV status can they access treatment, care, and prevention services. HIV testing should be done with rapid testing methodology with same day results delivery. Testing can be normalized within health care settings and community-based HIV testing and counselling, as well as treatment and rights literacy, must be introduced and scaled up.

Affected communities are well-placed to create demand for and promote HIV testing and counselling—communities are trusted and understand how to deliver services that are

ethical, convenient, acceptable and effective. Ministries of Health need to partner with community organizations that already provide communities with HIV prevention, treatment, care and support.

Maximizing the benefits of antiretroviral treatment

Initiating antiretroviral therapy earlier is vital for successful treatment. The median CD4 count when antiretroviral treatment is initiated is rising, but it is too low at CD4 counts below 100 cells/mm³. Treatment improves quality of life and can significantly reduce the risk of onward HIV transmission.

Antiretroviral treatment regimens must be simplified as a matter of urgency. Reducing the number of regimens will also help simplify procurement and supply systems, ultimately leading to greater efficiencies. Ensuring affordable treatment is critical and TRIPS flexibilities need to be more widely utilized.

Mobilize to reduce stigma, discrimination and punitive laws

Countries that have not progressed in strengthening human rights and gender equality report less progress in other targets. Investment in programmes to create enabling environments for accessing HIV services is absolutely crucial to scale up HIV prevention and treatment effectively and sustainably. The region has experience in rights-based law reform and programmes to reduce stigma and discrimination, as well as increase access to justice; this experience is a rich resource that countries should draw upon.

Communities at the centre

Often the best examples of effective HIV testing, prevention, treatment and care programmes are led and implemented by communities. The meaningful involvement of key populations in the design, implementation, monitoring, evaluation and delivery of HIV services is the key to success. Capacity needs to be built among communities to enable them to be more centrally involved in and leading community-based services, and facilitating access to non-discriminatory health services.

Smart investments, maximum return

The next generation of HIV investments in Asia and the Pacific must focus on increased domestic financing, national ownership of the response and smarter investments in strategies that will maximize returns. A number of actions can be initiated, ranging from better integration to greater efficiencies through improved investment focus.

Further innovation on financing the response is needed in the short to medium term to sustain gains. New models for mobilizing public and private sector resources and increasing the Global Fund's role (as well as that of regional funding entities) to invest on key populations in the region are critical.

Special in-depth feature

HIV among men who have sex with men in Asia and the Pacific: a matter of urgency

The HIV epidemic across this vast geography of Asia and the Pacific has a unique characteristic: it is predominantly among men. An estimated 64% of people living with HIV are men.⁷¹ Clients of sex workers, men who inject drugs and others are counted within these figures. But region-wide — as across the globe — it is among men who have sex with men that new infections are consistently growing, and growing fast.

The total regional population of men who have sex with men is estimated to be between 10.5 and 27 million people — a sizeable population.⁷² Five years ago, the Commission on AIDS in Asia predicted that if men who have sex with men did not become a greater focus of HIV prevention efforts, this population would bear nearly half of all new infections by 2020⁷³ and represent the largest share of new infections among key populations at higher risk. Five years later, overall trends of new HIV infection hint that the Commission's prediction is becoming a reality.

#HIVyoursay

In September 2013, UNAIDS Asia and the Pacific social media channels ran a campaign to encourage people from around the region have their say on the issue of HIV among gay men and other men who have sex with men, and the specific focus needed for this key population. These are the most outstanding tweets and Facebook posts:



Jeff Klein

@AkoSiGeisha 16 Sep



@UNAIDS_AP: In the Philippines #Gay & #MSM needs proper education, strong support group and empowerment. #HIVyoursay

Men who have sex with men and HIV: In figures

National HIV prevalence is estimated to be more than 5% for men who have sex with men in at least six countries (China, Indonesia, Malaysia, Myanmar, Thailand and Viet Nam), and continues to rise in several cities and regions within these countries and also in India, Mongolia and the Philippines.

Prevalence is particularly high — 15% to nearly 25% — in large urban areas including Bangkok, Hanoi and Jakarta, among others (Figure 8).⁷⁴ In the Philippines, the number of reported HIV cases jumped from one per day in 2007 to thirteen by August 2013, with men who have sex with men accounting for ten of those thirteen cases.⁷⁵ Many men who have sex with men are becoming infected at a young age, based on comparing the HIV prevalence of men who have sex who are aged less than and older than 25 surveyed at the same locations.

Male sex workers are more likely to be infected than their female counterparts in the same cities, with an HIV prevalence as high as 18%. Among men who have sex with men in high prevalence countries, 6–20% buy sex from male sex workers.⁷⁶ In countries where data are available, men who have sex with men reported up to six male sexual partners in the last six months.^{77,78} High proportions also have regular female partners (86% in China (Chengdu and Guangzhou), 64% in Indonesia and 49% in Viet Nam),⁷⁹ and buy sex from women (6% in Mumbai and 14% in Hanoi) — all of which influences onward HIV transmission.

Limited response to rising HIV trends

Major urban centres in several countries are recording dramatically higher HIV prevalence rates among men who have sex with men than the average national estimates for this key population at higher risk. Despite some examples of alarming HIV prevalence levels, programmatic coverage for this key population remains inadequate across the region. Essential HIV prevention services (such as peer outreach, distribution of condoms and lubricants, HIV testing and counselling, antiretroviral treatment and linkages to other services) are far from the 80% coverage target in nearly every country: the median coverage (i.e. those who knew where to get a HIV test and received condoms in the previous year) among 12 reporting countries is around 60%.

About two-thirds of the men surveyed reported using a condom at last anal sex; however, fewer than half used condoms consistently in the cities with rising HIV prevalence (Figure 9). WHO recommends using water- and silicone-based lubricants for condoms to function correctly during anal sex, but the lack of access to lubricants in many countries and lack of data collection on lubricant use is a challenge to consistent and correct condom use among men who have sex with men.⁸⁰

A number of countries have developed HIV strategies that specifically include comprehensive package of services for men who have sex with men, but programme coverage and quality are too limited. Many other countries are yet to implement such packages. Even in countries and cities with strong leadership on the issue, there are challenges to men who have sex with men having access to HIV prevention, testing and treatment services — and these programmes and services are insufficient and underfunded.

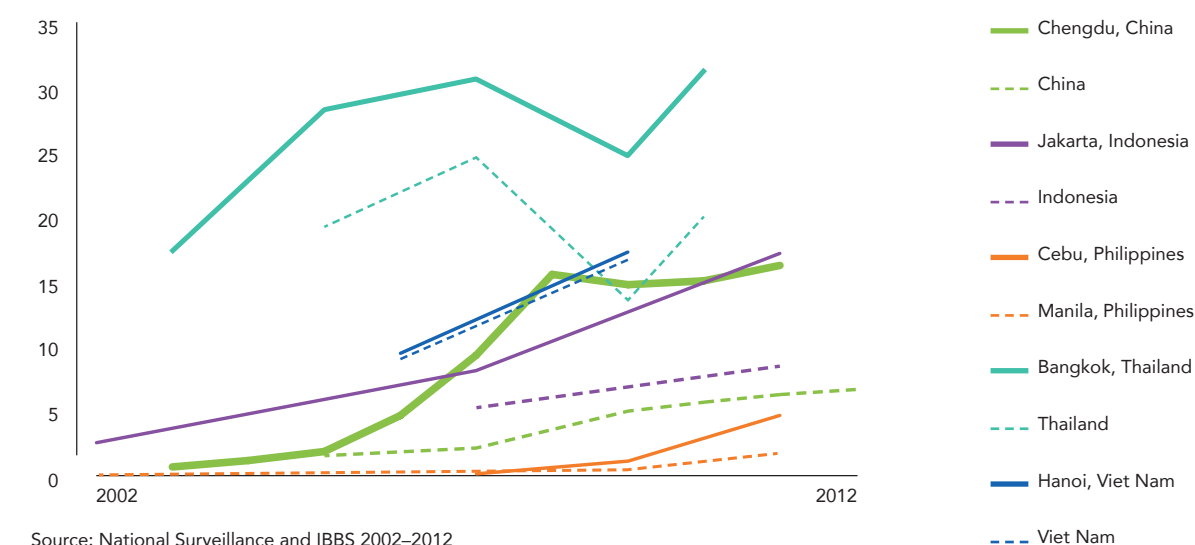
Social prejudice, punitive legislation and discriminatory practices contribute to lessen the priority and action accorded to the HIV response among men who have sex with men. Many countries in the region do not know the magnitude of the problem; size estimates of the number of men who have sex with men are only available from 18 countries and are a strategic information gap in the remaining countries.

Know your status: the need for an uptake in HIV testing and counselling

As the affordability and accessibility of condoms and lubricants improves across much of the region, uptake of critical services such as HIV testing and counselling is lagging behind. In Asia and the Pacific, over two-

Figure 8

HIV prevalence trends among men who have sex with men 2002–2012



thirds (a median of 34%)⁸¹ of men who have sex with men surveyed do not know their HIV status — in the Philippines, that figure was 5%.⁸²

Young men who have sex with men are less likely to take an HIV test than men aged 25 and older,⁸³ pointing to the need for particular efforts to reach these young populations at higher risk with prevention programmes. Fewer men who have sex with men getting tested means fewer men starting antiretroviral treatment when they need to, which also reduces the preventative benefits that are made possible through treatment.⁸⁴

HIV testing and counselling, with a follow-up referral for treatment and prevention, is one of the most important and high-impact strategies that can be employed to address HIV — especially in cities. Encouraging more men who have sex with men to get tested, and get tested earlier, demands community involvement at all stages of the interventions. Examples of pioneering new HIV testing, counselling and prevention approaches are showing promise: in China, a project in Shenzhen and Nanning involving local non-governmental organizations, peer support groups, local health authorities and UN agencies in a coordinated and user-friendly way showed that voluntary testing can be scaled up significantly.⁸⁵

With the 2013 WHO guidelines recommending new criteria for early initiation of treatment among key populations at highest risk,⁸⁶ building understanding on the benefits of regularly screening for HIV and other sexually transmitted infections — and early HIV treatment — is necessary to create more demand for services by men who have sex with men.

Punitive obstacles

Many men who have sex with men avoid health and HIV services and/or seeking help for fear of legal and social repercussions, discrimination and even violence. Criminalizing men who have sex with men is an obvious barrier to providing HIV prevention and treatment and does not facilitate health-seeking behaviours.

Some 18 out of 38 countries in Asia and the Pacific criminalize same-sex sexual activities,⁸⁷ with penalties including imprisonment, corporal punishment and even death.⁸⁸ In a number of countries in the region, laws

prohibiting sex between consenting males are infrequently enforced; however, according to communities of men who have sex with men, the threat of enforcement can lead to harassment, rape and extortion by police. In some countries, members of the community of men who have sex with men report policing use condom and lubricant possession as evidence of male prostitution — therefore warranting arrest.⁸⁹

There are some examples of legislation moving in the right direction. In Fiji, for example, sex between men was decriminalized in 2010; in India, 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. But policy changes and legal reforms need to take place in virtually all countries in the region.



Brondongmanis.com
@brondongmaniss 15 Sep



In Indonesia, Young [#Gay](#) & [#MSM](#) avoid [#HIV](#) testing they face a double burdens stigma based on sexual orientation and age [#HIVyoursay](#)

Many men who have sex with men report that high levels of stigma and discrimination among health personnel also dissuade them to access health services. A new WHO/UNDP training package to address this issue are being disseminated and integrated in health training curricula throughout the region.⁹⁰ It is hoped that as increasing numbers of health workers become more knowledgeable and understanding about HIV and men who have sex with men, more men will feel comfortable accessing HIV services.

Reaching and involving communities

Involving communities of men who have sex with men in the design, delivery and monitoring of HIV services needs to increase in scale and quality. Across the region, surveillance data show that men who have sex with men are not well informed enough about their risk to HIV infection (28–71% have comprehensive knowledge about HIV).⁹¹ Even when knowledge is there, self-perception of risk is low. Evidence suggests men who have sex with men are not practising safer sex

Viewpoint

Defining moment: Action now for Asia and the Pacific—and the world

Across the globe, in most countries and most contexts a common trend is occurring—rising rates of HIV among men who have sex with men.

In Asia and the Pacific, the figures tell the same story: new HIV infections among men who have sex with men are increasing in a majority of countries, with little sign of rates abating.

This is a defining moment for our region’s response to men who have sex with men and HIV. We have the tools, evidence, experience and know-how to rapidly mobilize to action, across all sectors, and turn the epidemic among men who have sex with men around.

Our call is simple: We must focus, invest, empower, mobilize.

We urgently need innovative, appropriately designed programmes that can be rapidly scaled up and supported by a range of investments by governments, donor agencies, the private sector, and communities of men who have sex with men. Responding to the evidence, city-based responses ensuring links between HIV testing, counselling, prevention and treatment, need to be prioritized.

Deep-rooted stigma and discrimination remain central to the HIV challenge, often compounded by oppressive laws that target men who have sex with men and further fuel the epidemic. All stakeholders must consistently tackle these issues to ensure equality and justice for all.

Everyone has their role to play and we need to mobilize, together, for maximum effect. The Asia Pacific Coalition on Male Sexual Health (APCOM) plays a pivotal role in ensuring that communities of men who have sex with men across the region are generating demand for services and are involved in processes that can positively affect their and their peers’ lives. UN agencies in the region are increasingly promoting programmes to bring community networks together to work in coordinated ways on grassroots mobilization, programme planning, information-gathering and sharing, and evaluation. Donors and funding agencies have also supported community-led HIV responses. For example, there is increasing Global Fund support in line with its Community System Strengthening Framework. This needs to move to the next level.

Genuine partnerships between governments and civil society must be established, recognizing the urgency to help mobilize and empower communities of men who have sex with men to be treated with dignity and respect. Governments should meet with communities and organizations of men who have sex with men and ensure they are accorded a central role at all stages in the HIV response. Community-Government dialogues, facilitated by the UN and other partners, can generate greater discussion and joint decision-making capacity.

Meaningful involvement of men who have sex with men in the initiation, development and delivery of HIV programmes and services, as well as in advocating for safe sex and increased HIV testing and counselling, is critical and proven to have a significant impact. Community leaders can provide critical information and evidence on HIV testing and the benefits of knowing one’s status for early treatment, mobilizing the larger community as a whole.

Asia and the Pacific can—and must—lead by example. There is a growing list of good practices in this region that should be emulated and expanded further. There is also a growing body of research into related health issues that shed new light on risk factors and social determinants of health for men who have sex with men. And there is growing recognition that men who have sex with men can and should play a key role in helping to reverse the growing epidemic trends.

Our collective capacity at the regional, national and community levels is the key to our success. Our success could, in turn, inspire other regions to take similar action. Seizing the opportunity to act now will positively impact millions of lives and strengthen the long-term health and well-being of communities, countries and our region as a whole.

Steve Kraus
Director, UNAIDS Regional Support Team
for Asia and the Pacific;

Clifton Cortez
HIV, Health and Development Practice
Leader, UNDP Asia-Pacific Regional Centre;

Midnight Poonkasetwattana
Executive Director, Asia Pacific Coalition
on Male Sexual Health

consistently, do not get tested for HIV often enough (see below) and report feeling outcast and uninvolved in the AIDS response.

There are important examples in the region of initiatives led by (and ensuring the greater involvement of) men who have sex with men in all aspects of programme development, implementation and delivery that have resulted in significant impact and results, with higher uptake of services reported (see examples of such initiatives on page 40–41). These examples and others demonstrate the central role communities can play in generating demand for effective HIV services for men who have sex with men while ensuring that services provided are of high quality and meet needs.

With the prolific expansion of the Internet, social media and new media devices and services (such as smart phones), particularly among the younger generation, men who have sex with men have new ways and means to interact, date and network. Much more focus needs to be given to the utilization of these new media to enhance the reach, impact and efficiency of the HIV response among men who have sex with men.

In Thailand, a number of projects currently implemented by the Thai Red Cross Research Centre, the Rainbow Sky Association and Population Services International use these means of outreach to deliver information about health and human rights and services, especially for the community of young men who have sex with men. This method is proving very effective, as it is individualized and discreet. Expansion of such programmes to other countries in the near future will be important step.



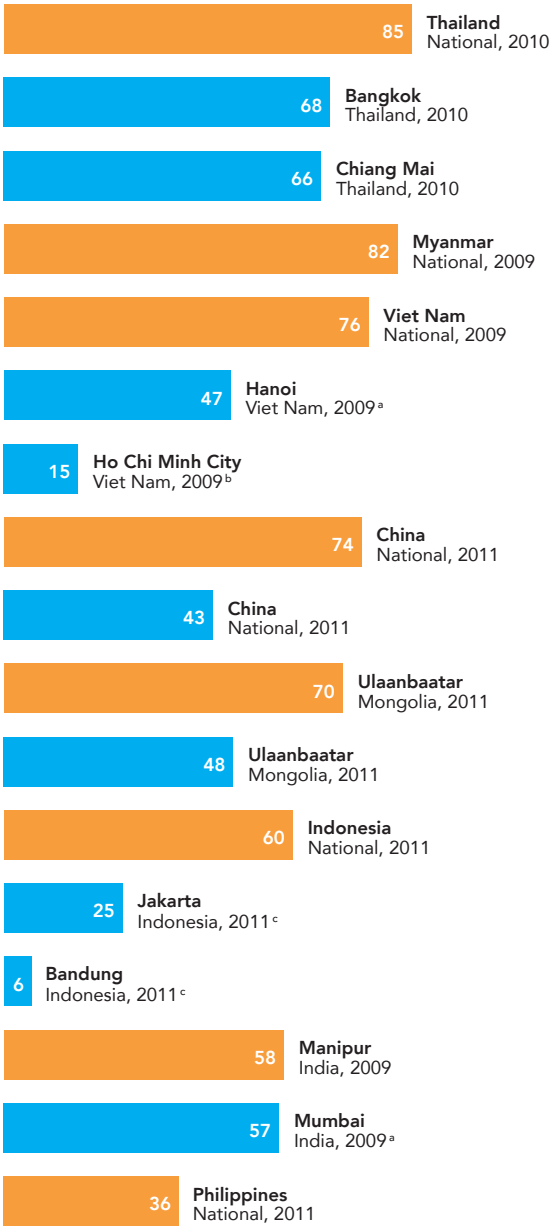
Bharat Shrestha

In Nepal Gay and MSM need community engagement program to provide safe spaces to meet other MSM, safe spaces to receive health care services, access to comprehensive health care as well as family support program and stable financial resources, sustainable work opportunity and education.



Figure 9

Consistent condom use and condom use at last anal sex among men who have sex with men, 2009–2011



- Consistent condom use
- Condom use at last anal sex
 - ^a With clients
 - ^b With male sex workers
 - ^c With commercial partners

Source: National Behavioural Surveillance surveys and IBBS 2009–2011

Table 3

Rate of HIV transmission through male-to-male sex and share of total HIV prevention spending allocated to men who have sex with men

	MSM among reported cases	Spending on MSM out of total prevention spending
Indonesia	7%	1%
Malaysia	19%	0.2%
Philippines	80%	9%
Sri Lanka	15%	6%

Source: Ministries of Health HIV Statistics and AIDS registries

Invest for success

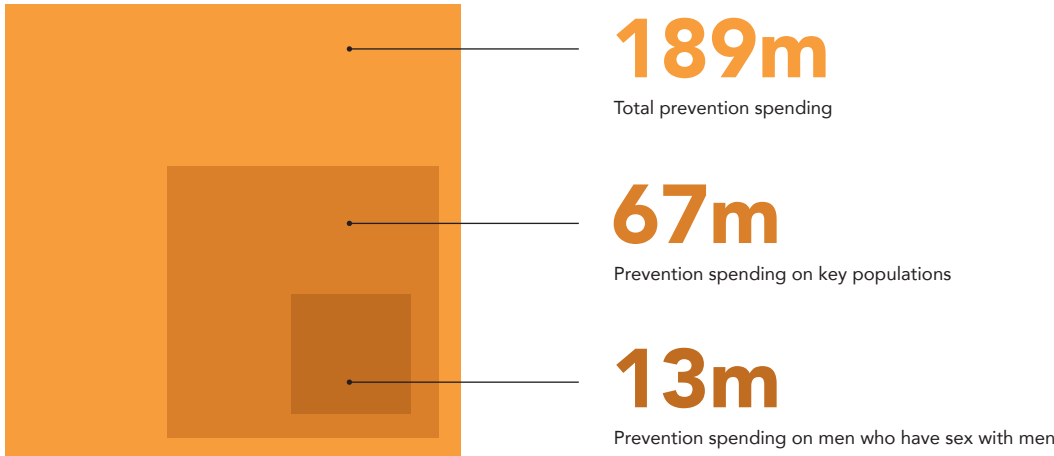
Financing for programmes and services for men who have sex with men must increase dramatically. Although countries in Asia and the Pacific have ramped up overall HIV spending over the last few years, very little is spent on programmes and services for men who have sex with men — even in countries recording high percentages of HIV transmission through unprotected sex between males.

For instance, Sri Lanka spent 6% of its total HIV prevention budget on men who have sex with men in 2010, although HIV transmission through unprotected sex between men accounts for 15% of cumulative reported HIV infections.⁹² In 2011, the Philippines spent 9% of its prevention budget on men who have sex with men, but they represent 80% of newly reported HIV cases (Table 3).⁹³

As countries move into the middle-income category, international donors are withdrawing funds in certain countries — but corresponding increases in domestic spending on men who have sex with men are not yet forthcoming. Such shifts can lead to coverage gaps and weaken community participation.⁹⁴ Only with smart investment focused in the areas where most impact can be achieved will the region start seeing current epidemic trends among men who have sex with men reverse.

Figure 10

Regional HIV prevention spending, latest available year



Source: www.aidsinfoonline.org

Accelerating action

In recent years, a number of innovative HIV initiatives for men who have sex with men designed and implemented by a range of players, including non-governmental and community-based organizations, have been initiated in Asia and the Pacific. Such programmes are showing impact and results that provide vital lessons and guidance for the future scaling up of programmes and services for men who have sex with men. Among others, the following examples show how communities are increasingly taking the lead.

Breaking new ground in Pakistan

The Naz Male Health Alliance (NMHA), Pakistan's first (and so far only) community-based organization of men who have sex with men, has, despite a particularly challenging environment, developed robust organizational systems and procedures. The Alliance brings together men who have sex with men and transgender/hijra populations from six different locations and works with the communities to establish service delivery sites offering including HIV testing and counselling, syndromic diagnosis and treatment of sexually transmitted infections and related referral services. NMHA enrolls counsellors, lab technicians and sexually transmitted infection services providers, and uses rapid HIV test kits. The number of people tested and provided with status results has surpassed initial project targets by approximately 10%.⁹⁵

NMHA is working to demonstrate that for this initial success to be sustained, the Government needs to scale up HIV-related services focused on key populations, as well as address the social, cultural, legal and political challenges that men who have sex with men and transgender/hijra populations currently face.

"We've accomplished more than we expected in supporting our communities and charting out a systematic, focused process rather than the ad hoc approach that previously existed," said Qasim Iqbal, Executive Director, NMHA.

"Even though we've chosen to work discreetly, almost in an 'invisible' way, we ultimately will need the Government to partner with us to help strengthen the gains we've made and carry the programme forward in the long term." The Punjab AIDS Strategy 2012–2016 acknowledged the impact and value of community empowerment and prevention, care and support services provided by NMHA. It has envisaged scaling up its programmes and services, including for adolescent men who have sex with men.

Using a human rights lens to focus on men who have sex with men HIV issues and the law

Recognizing the need to address punitive laws, the International Development Law Organization and the UNDP Asia-Pacific Regional Centre brought stakeholders together for a capacity assessment exercise. They examined the capacity of national human rights institutions to address human rights in relation to sexual orientation, gender identity and HIV in select countries across south-east Asia and south Asia.

"While the project gave us a comprehensive picture of the work done so far, from successes to the gaps that remain, what the effort ultimately accomplished was a commitment on the part of all involved to strengthen genuine partnership between government and civil society to create an enabling environment that best serves men who have sex with men, transgender persons and other key populations to freely access social, legal and health services," noted Edmund Settle, Policy Advisor, HIV, Rights, Law and Sexual Diversity, UNDP Asia Pacific Regional Centre.

We can't effectively tackle HIV among men who have sex with men and transgender populations in a vacuum. Realistic processes grounded in a human rights context are increasingly being conceptualized and established as a result of this introspection and dialogue," he added.

Accelerating action

Pacific hope through evidence

By addressing social, legal and health issues affecting men who have sex with men, and transgender people, the country is addressing its HIV epidemic. The country's President, who has openly expressed his support for gay and transgender rights, has officially welcomed a significant report, *Secret Lives, Other Voices*,⁹⁶ the first research study in 13 years on men who have sex with men and transgender people in Fiji, led by the AIDS Task Force of Fiji, a community organization, with support from international partners and donors including the AIDS Council of New South Wales and the United Nations Development Fund. Although not necessarily representative of all men who have sex with men and transgender individuals in the country, the data gathered have helped better identify risk behaviours and other factors contributing to the epidemic, as well as develop recommendations for future HIV prevention and health promotion initiatives.

"Given the sheer diversity and complexity of our communities, we now have a far better idea of how to prioritize and customize our approaches for specific sub-groups," explained Niraj Singh, Project Manager, AIDS Task Force of Fiji.

"We've also learned valuable lessons on how to better involve our communities in crafting HIV interventions to ensure a genuinely egalitarian and grassroots response rather than an elitist and authoritarian one."

AIDS Care China initiative shows impressive service uptake

Responding to the growing epidemic among men who have sex with men in China, the Bill & Melinda Gates foundation China programme gave support to the AIDS Care China community-based initiative promoting community HIV testing and counselling and linkage to treatment and care in 15 major

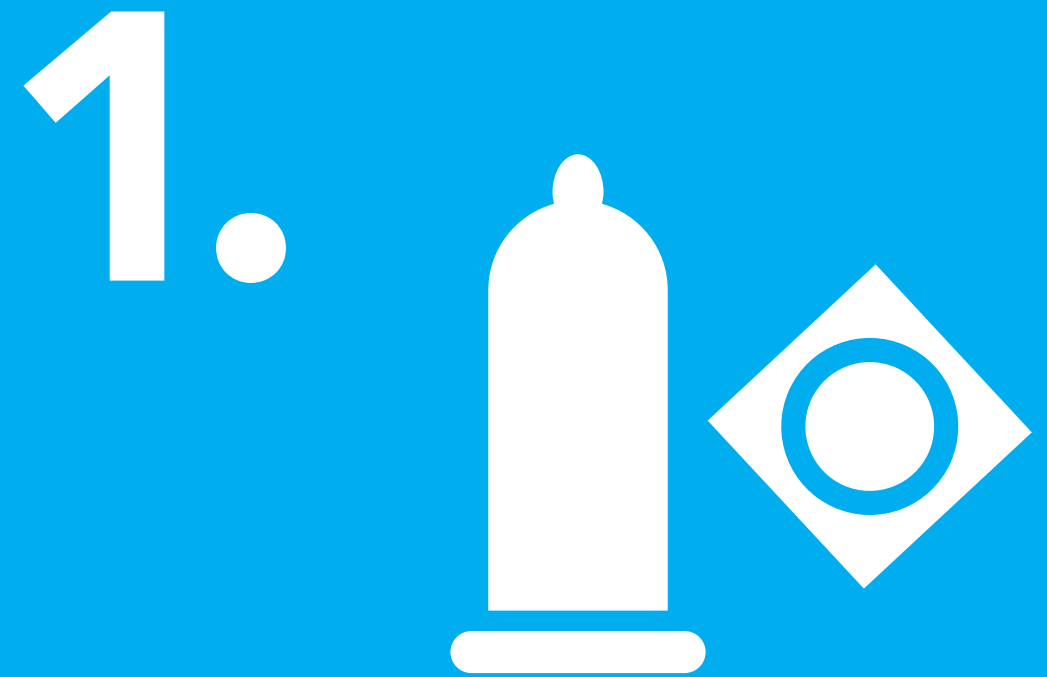
cities in China. The overall objectives of the programme are: scaling up coverage of HIV testing among men who have sex with men, and increasing awareness on HIV prevention within the community; and identifying people living with HIV as early as possible and referring to treatment and care services. The programme has had impressive results. For example, in one of the organizations using this model, the number of people coming for HIV testing and counselling increased nine-fold in as many months. Read more about results of this community-led programme in a Viewpoint by AIDS Care China Director, Thomas Cai, on page 62.

Youth Voices Count!

Young men who have sex with men in Asia and the Pacific need particular attention when it comes to HIV programming and community empowerment. In 2010, with support from Hivos and various agencies, Youth Voices Count (YVC) was created as a regional network to address HIV-related health issues of young men who have sex with men, and transgender people, through mobilization, advocacy and capacity building. With its secretariat in Bangkok, Thailand and with representation from various countries and subregions, YVC holds high-level consultations in which participants share insightful, personal stories and case studies on how to deal with self-stigma; how to advocate better access to psychosocial support as well as HIV prevention, treatment and care; and how to establish and strengthen community-based organizations.

"We're working to move our peers from a sense of powerlessness to a foundation of strength," said YVC coordinator Tung Bui. "Through our networks we're demonstrating that no one needs to stand alone. You've got an entire community to support you. If we're to achieve an 'AIDS-free generation', we've got to start with young people now!"

10 targets



50% reduction of sexual transmission by 2015

Sexual transmission is fuelling the fastest growing epidemics in Asia and the Pacific, particularly among men who have sex with men. New HIV infections in the region have fallen 26% since 2001, but annual new infections numbers have remained largely unchanged for the last five years.

To reach the target of 50% fewer HIV infections through sexual transmission, it is crucial to focus efforts on key populations and their sexual partners, and to take a far more geographically-focused approach.

As countries in Asia and the Pacific strive to reach the ten targets agreed to in the United Nations General Assembly 2011 Political Declaration on HIV and AIDS, they reviewed their progress so far in 2013. Twenty-one countries in the region conducted mid-term reviews of national progress. This section synthesizes, target by target, country reported achievements and challenges, as well as onward actions to be taken towards meeting the targets. The findings of the countries' mid-term reviews are complemented by personal viewpoints from key figures in the region's HIV response and highlights of good practice.

Achievements and challenges

Thanks to focused interventions, HIV prevalence among female sex workers declined in the early epidemics of Cambodia, India, Myanmar and Thailand, and has been kept low in some countries such as China, Nepal and the Philippines.

Mobilization and engagement with key populations at higher risk has been credited with having boosted reach of programmes and services and having contributed to falling infections rates.

A number of countries in the region have shown that scale-up and 80% coverage in prevention services are possible. Scale, focus and caliber of programmes vary

across countries. Programmes for men who have sex with men and transgender people are too few.

In the mid-term review of progress against this target, around half of responding countries said that despite actions taken to reduce sexual transmission of HIV, they were not on track to reach the 2015 target.

Despite overall progress on sex work interventions, certain locations continue to show high levels of HIV infection among sex workers, even in countries where national trends are declining. The changing nature of sex work, away from formal venues to mobile phone-based contact between sex worker

Target 1

and client, requires ongoing adjustment and evolution of traditional brothel-based programmes to promote condom use. Countries emphasized the need for greater efforts to expand outreach to and engage with the community of men who have sex with men.

It was also noted that more had to be done to address the HIV vulnerability of migrant workers including those in mining, construction, transport services, fisheries and agriculture. While mobility and migration are not themselves risk factors for HIV intrinsically, a number of conditions surrounding the mobility process can lead to engagement in risk behaviours (such as unprotected sex, drug use, etc.) that increase vulnerability to HIV. Policy-makers must take this into consideration and tailor interventions for migrants and mobile populations who face increased risk of HIV infection. At the same time, efforts must be made to reduce barriers faced by migrants and their communities to access health services.⁹⁷

Programmes do not sufficiently reach out to young key populations, who often experience challenges accessing health services due to their age. This includes laws requiring parental consent to obtain HIV testing and counselling for young people under 18 in some countries in the region.

Almost all countries continue to cite social, cultural and legal barriers as critical challenges to enhanced scale-up. Marginalization means it is often difficult to obtain data on key populations, which hinders programming. Weak linkages between HIV programmes and other reproductive health services are reported as hampering progress.

How Asia and the Pacific can reach target 1

- Scaled-up, quality HIV prevention programmes have shown significant results in the region. Countries need to further scale up and sustain programmes for key populations, including promotion of consistent condom use. Intense geographical focus on high-prevalence areas in the region and within countries is required.
- Concerted efforts are required to move beyond the business-as-usual approach to reducing sexual transmission of HIV. This will mean providing of

a range of service choices — condoms, HIV testing and counselling, sexual health services, strategic use of antiretroviral treatment as prevention, greater efforts to reach out to key populations and enhanced community engagement.

- Programmes on the specific needs of key populations at higher risk, with concomitant levels of funding, will be most effective at reducing sexual transmission. Scale and coverage must be improved across programmes, but the focus on quality is crucial.
- HIV testing and counselling is the gateway for people to reach prevention, treatment and care services. Increasing the uptake of HIV testing and counselling and early access to antiretroviral treatment are therefore essential to HIV prevention efforts.
- Community-led interventions show compelling results in contacting hard-to-reach key populations and facilitating access to services. There is a growing regional momentum and action towards strengthening community institutions for sustained impact, including in the area of community-based HIV testing and counselling for key populations integrating sexual and reproductive health and HIV services, and preventing and addressing violence. This needs to continue to be intensified.
- Laws, policies and practices that punish consensual sex between males and/or restrict sex workers’ ability to protect themselves and their clients from HIV need to be addressed, revised and removed.
- Within key populations, enhanced sub-population analysis is needed, for example focusing on different types of sex workers or men who have sex with men, women who inject drugs and transgender people (separately from men who have sex with men). Combined with specific and culturally sensitive local strategies, this will improve access to HIV testing and counselling, prevention and treatment services.

Spotlight

Seven actions that changed the course of India’s HIV epidemic

Numbers of new HIV infections among adults in India have declined by 57% since 2000 thanks to the combination of seven actions. India serves as a prime example of how coordinated efforts in the AIDS response can produce results greater than the sum of their parts.

- 1 **Leadership**—The detection of India’s first HIV in 1987 led to the establishment of a national strategy working group. Since the early 1990s, India’s political leaders have provided consistent support for large-scale prevention programmes for key populations.
- 2 **Information**—From 15 surveillance sites in 1990, the country today now has over 1400 sites nationwide covering pregnant women, sex workers, men who have sex with men, transgender people and truck drivers and providing reliable epidemic information. Research into sexual networks and practices, mapping of key populations and a computerized management information system also elucidate the dynamics of the epidemic and support investment for maximum impact.
- 3 **Focus**—Based on available data on specific regional drivers of epidemic, India focused HIV prevention efforts among people who inject drugs in the north-east, and sex workers and their clients and men who have sex with men in the south. Key districts with higher prevalence received the most investment, a highly cost-effective approach.
- 4 **Thinking big**—India started by aiming to reach the 80% coverage level essential to reversing the epidemic among key populations. Programmes were refined as they matured, rather than waiting for perfect interventions to be piloted and then scaled up.
- 5 **Doing the right things**—India’s experience reaffirms the importance of placing communities at the centre. India engaged communities in the design and delivery of appropriate services, ensuring ownership and sustainability.
- 6 **Managed network**—India’s multisectoral response within a managed network to provides effective services for key populations. This entailed brokering networks and building collaborative relations between the health system, communities, private providers, academic institutions, researchers, police and the judiciary.
- 7 **Strong systems**—Policy and donor coordination are centrally managed, while programme implementation is decentralized through state and district AIDS control societies. These quasi-autonomous agencies provide flexibility and speedy decision-making. The state-level societies are headed by a senior civil servant, which ensures the engagement of Government bodies. A strong management system for monitoring the work of the public sector and civil society provides quality assurance. Similarly, strong central management through a National AIDS Control Organisation (Department of AIDS Control) provides better management of external partners so that investments are directed to where they are needed.

Viewpoint

Thinking global, acting local:
the AIDS response in ASEAN cities

Datuk Zainal bin Abu, Mayor of Melaka Historic City Council, Melaka, Malaysia

In Asia, as in many parts of the world, we are increasingly seeing the highest levels of HIV prevalence and the greatest concentration of new infections occurring in urban areas among key populations at highest risk.

To maximize the efficiency of our response to this health crisis, ASEAN is promoting a city-based initiative: ASEAN Cities Getting to Zero.

Melaka has already made impressive progress against HIV. The city fully funds all its AIDS activities, and we have seen declines in new HIV infections since the introduction of a comprehensive package of prevention, treatment, care and support services.

In September 2013, Melaka launched its Getting to Zero HIV initiative. Our aim is to focus efforts where they are most needed and strengthen the implementation of HIV programmes through cooperation between government and non-government agencies. The ultimate goals are, by 2015, reducing the number of new infections by 50%, to help more people access treatment and to create a more enabling environment by reducing stigma and discrimination. As well as benefiting our citizens, our hope is that Melaka’s initiative will inspire other city-based HIV responses across ASEAN.

The ASEAN Cities Getting to Zero project is a truly revolutionary programme, representing a cross-border, multisectoral and interagency partnership. Within its framework, each country, each city and each community can improvise and adapt to local priorities and contribute towards a regional and global revolution in getting to Zero HIV.

Spotlight

Empowered innovation:
community-led sex work and HIV responses

In Yangon, a young woman relaxes at a drop-in centre set up by the Targeted Outreach Programme (TOP) Myanmar, which has made remarkable progress in scaling up integrated sexual and reproductive health and HIV services for sex workers. Since it was launched in 2004, TOP Myanmar has established 19 drop-in centres across the country, reaching an estimated 50 000 sex workers annually. Of its 270 non-clinical staff, 90% are sex workers and/or men who have sex with men. “If I feel frustrated, I come to this centre and rest or talk to friends or sing songs or watch movies. We can raise issues with our peers and get information on how to resolve problems,” the young woman says.

In India, the Veshya Anyay Mukti Parishad (or VAMP Plus), facilitates access to HIV testing, counselling and treatment services through raising awareness, education and outreach. It has also created a community care and safety net that helps sex workers living with HIV to advocate, seek and receive treatment, care and support while addressing problems related to health and well-being, including nutrition and shelter.

In Bangladesh, Durjoy Nari Sangha is empowering its 3500 registered female sex workers to demand their rights to equality, dignity, health, safety and freedom from violence. Durjoy’s anti-violence initiatives have led to a reduction in violence against sex workers and a greater understanding among sex workers about their rights. And in China, Dark Blue’s efforts show the impact that providing rapid HIV testing in community settings can have, resulting in doubling HIV testing and counselling among male and transgender sex workers from 2000 to 4000.

One of the key populations hardest hit by HIV in Asia and the Pacific, sex workers across the region are mobilizing to participate in and run HIV prevention campaigns, undertaken advocacy strategies and engaged in peer-to-peer initiatives to respond to the epidemic. TOP Myanmar, VAMP Plus, Durjoy and many others across the region illustrate how innovative community-led efforts have empowered sex workers to assert their human rights, take control over their work environments and improve their health and social conditions.

Examples taken from The HIV and sex work collection—innovative responses in Asia and the Pacific, a collection of case studies jointly produced by the United Nations Population Fund (UNFPA), UNAIDS and the Asia-Pacific Network of Sex Workers (APNSW).

Viewpoint

Want to reach young people?
Talk about sex, drugs and rock’n’roll!

Thaw Zin Aye, Coordinator of YouthLEAD—the Asia Pacific network for young people from key populations at highest risk of HIV

We’re young, we’re free and we’re everywhere—there are more young people aged 15–24 in Asia and the Pacific than anywhere else in the world.

Evidence shows that for a variety of social, cultural and economic reasons, many young people engage in risky behavior. Young sex workers, people who use drugs, men who have sex with men, transgender people and migrants therefore must be a central to all strategies to respond to HIV.

This means not just talking about us. It means talking with us. To do this, one thing is abundantly clear: we need to tear down some of the traditional cultural and social barriers around sex, sexuality and drug use. Asia Pacific needs to talk about sex, drugs and rock’n’roll!

So let’s talk about sex. Young people are having sex—and selling sex. Young people are exploring their sexualities and gender identities. And young people are becoming infected with HIV. Face it: we’re doing it, but we need to know how to do it safely and where we can get the support and services we need.

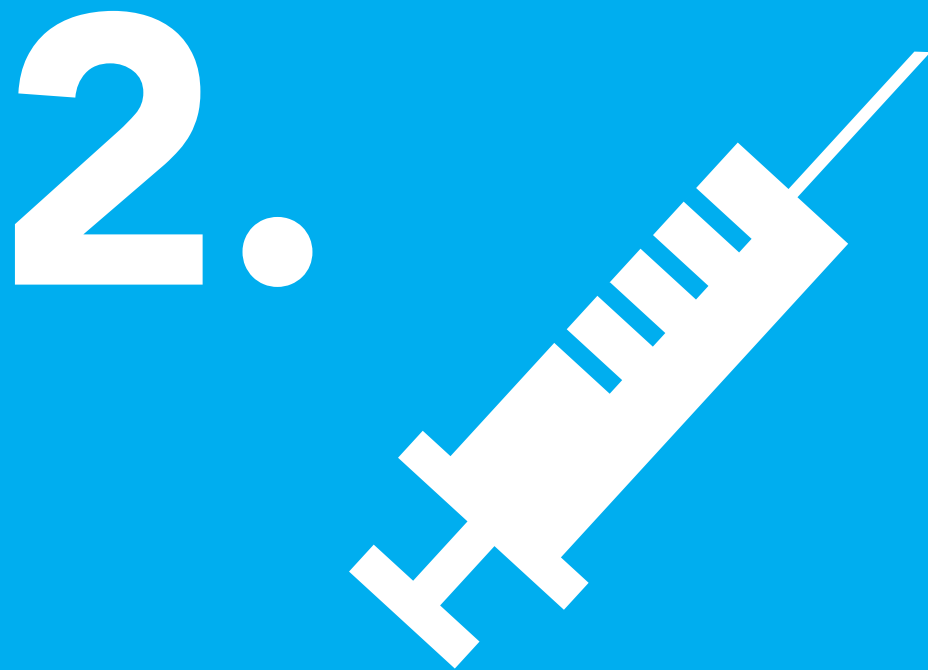
In too many countries, many young people are not even aware about HIV risks, often because sexuality education isn’t made available at an early enough age. In some countries, we are not able to get HIV tests or access health services because of legal obstacles and the need for parental consent. We need comprehensive sexuality education—including on HIV prevention and sexual and reproductive health issues—to be integrated into education systems and we need access to services.

So what about drugs? Evidence shows many people who inject drugs started to do so before they reached their mid-twenties. Young people who use drugs are often afraid to approach harm reduction services for fear of recrimination and harsh implementation of punitive drug use laws and policies. Greater attention to enabling young people who use drugs to access services is vital.

The rock’n’roll? We’ll bring it! Young key populations have to take ownership of the HIV response. In doing so, we can lead the world in ‘getting to zero’. Through leadership initiatives, the mobilization of young key populations in the region is building momentum. But a much louder, bigger movement is needed to reinvigorate HIV activism. We have to stand up and be counted.

So let’s raise our voices. Let’s talk about sex and drugs and all the difficult things in between. And most of all, let’s ROCK this!

The Youth LEAD initiative was launched in 2011 and has grown into a network, building capacity and leadership skills of young key populations. Part of YouthLEAD’s programme is the NewGen Asia initiative, which involves leadership training for young people living with HIV, sex workers, people who inject drugs, men who have sex with men and transgender people.



Reduce transmission of HIV among
people who inject drugs by 50% by 2015

Many countries in Asia and the Pacific are expanding access to HIV prevention, treatment and care for people who inject drugs and HIV prevalence is declining in a few countries. However, there are wide variations in HIV prevalence: in some locations, over 50% of people who inject drugs are living with HIV and, in some countries, the epidemic is expanding due to continued HIV transmission in this population.

Urgent action is needed to scale up access to HIV services for people who inject drugs and their sexual partners to coverage levels required for countries in the region to reach target 2.

Achievements and challenges

Over the last decade, harm reduction has gained wider acceptance in the region: Bangladesh, China, India, Indonesia, Malaysia, Myanmar, Pakistan and Viet Nam all report expansion of services. Still, access to harm reduction services does not meet demand. The level of coverage required to affect HIV transmission and access available services is hampered by the stigma, discrimination, legal barriers and law enforcement practices that people who inject drugs regularly face.

There is a clear correlation between access to safe injecting equipment and HIV prevalence among people

who inject drugs in Asia and the Pacific. Nepal and Pakistan stand in sharp contrast to illustrate this: with rates of consistent use of clean needles and syringes rising from 54% in 2002 to 97% in 2011, Kathmandu saw a drop in HIV prevalence among people who inject drugs from 68% to 6.3% over the same period. Conversely, prevalence in Lahore, Pakistan, rose from 3.8% in 2005 to over 31% in 2011, while consistent use of sterile injecting equipment rates fell from 45% to 28%.

Coverage of HIV prevention services has been increasing, but the pace of scale-up in most countries

Target 2

currently remains too slow to have a significant impact on preventing new HIV infections.

Drug detention and rehabilitation centres — closed settings where people who use (or are suspected of using) drugs are confined — are widespread in east and south-east Asia. In 2011, almost 240 000 people were being held in over 1000 such centres in six countries, according to a survey conducted by the United Nations Office on Drugs and Crime (UNODC).⁹⁸ While the number of compulsory centres increased during 2005–2011, there are now signs of increasing political commitment in the region to move away from this approach and expand access to voluntary and rights-based drug dependence treatment.

In March 2012, 12 UN agencies issued a joint statement on compulsory drug detention and rehabilitation centres, calling for their closure and replacement with voluntary, evidence-informed and rights-based health and social services in the community.⁹⁹ Malaysia has taken the lead in making the change by transforming eight compulsory detention centres for drug users into ‘Cure and Care’ centres. This has been widely praised as a best practice model for the region.

How Asia and the Pacific can reach target 2

- There is an urgent need for greater investment to expand access to the comprehensive package of prevention, care and treatment services for people who inject drugs, including safe injection programmes and opioid substitution therapy, and antiretroviral treatment, with intensified geographical prioritization at country level to reach larger numbers of this key population.
- Stronger collaboration is needed between drug control and law enforcement officials and the health sector, as well as the removal of legal and policy barriers that either prevent governmental and non-governmental agencies from expanding HIV services or that prevent people who inject drugs from seeking services.
- Compulsory drug detention and rehabilitation centres 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, pre-trial facilities and other closed settings.

- Additional focus is needed on the intersection between injecting drug use and high-risk sexual behaviour, where sex work is undertaken to buy drugs use and in the context of drug use among people who sell sex, men who have sex with men, and transgender people. HIV prevention, treatment and care services for women, adolescents and children who inject drugs and intimate partners of men who inject drugs, and partners and clients of women, men and transgender people who inject drugs and sell sex need to be more adequately addressed.
- Hepatitis C and HIV prevention and treatment services for people who inject drugs need to be offered jointly and scaled up.

HIV/hepatitis C coinfection is neglected

Hepatitis C and HIV coinfection is particularly prevalent among people who inject drugs. The few available data suggest that 60-90% of people who use drugs and live with HIV in Asia and the Pacific also have hepatitis C.¹⁰⁰ Because people living with HIV are living longer thanks to antiretroviral therapy, they are increasingly facing the effects of other chronic diseases, such as hepatitis C.¹⁰¹ The lack of international guidelines for the clinical management of HIV/hepatitis C coinfection, and the high cost of antiviral drugs for hepatitis C strongly limit access to hepatitis C treatment for people with HIV.¹⁰²

Spotlight

Alternative action to compulsory detention: Malaysia’s innovative ‘Cure and Care’ clinics

When a progress report suggested that Malaysia was lagging behind on Millennium Development Goal 6—to halt and reverse the spread of HIV, the Government took decisive action. In November 2005, after reviewing its policy of using compulsory detention as the main response to injecting drug use, the cabinet introduced harm reduction and voluntary treatment.

Compulsory detention of people who use drugs is associated with high rates of relapse¹⁰³ and in 2010 the Malaysian Government began to gradually introduce a number of voluntary and community-based treatment services. Although some compulsory drug detention centres still exist in Malaysia, the National Anti-Drug Agency has already transformed eight such facilities into ‘Cure and Care’ clinics.

These voluntary outpatient treatment facilities provide a range of services based on an individual clinical assessment, including provision of food, a place to rest and bathing facilities, medical check-ups, methadone maintenance therapy, counselling, support for re-integration and access to HIV services.

Malaysia’s transformation of compulsory centres into voluntary services is now being showcased in the region, with high-level delegations from Cambodia, Myanmar, Thailand and Viet Nam visiting the clinics to see for themselves how moving from a punitive approach to one of health-based, client-centered treatment is possible and effective.

3.



Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

Recent rates of decline in new infections among children appear to be slowing. Between 2010 and 2012, an 8% reduction occurred in new infections among children. Low regional coverage of antiretroviral medications to prevent new HIV infections among children, suboptimal access to antenatal care and stigma associated with the virus mean that many babies are born with HIV.

Greater commitment of resources and the integration of HIV services into routine maternal, newborn and child health services are needed for the region to reach this target.

Achievements and challenges

All countries in the region have prioritized programmes to stop new HIV infections among children and have included them in their national strategic plans. Many countries have successfully integrated such services into standard antenatal care, while others have set up separate clinics for antenatal HIV prevention services.

Some countries are reaching relatively high coverage levels for services to prevent new HIV infections among children — notably Cambodia, Malaysia,

Myanmar and Thailand, where coverage rates are above 50%. Yet, the regional coverage rate (19%) is below the 62% global average.

In 2012, 14 523 pregnant women living with HIV received antiretroviral treatment in low- and middle-income countries in the region (excluding India).

HIV testing and counselling coverage among pregnant women has expanded substantially. China and Fiji are exceptional in offering HIV testing

A comprehensive approach to preventing mother-to-child transmission rests on four main pillars:



and counselling as part of a package of antenatal screening that includes syphilis and hepatitis B. This has contributed to cost-savings, the normalization of HIV testing and counseling, and a strengthened, integrated maternal, newborn and child health approach. Focused services to reach and screen women at high risk of HIV infection have been piloted in districts of Pakistan, though such programmes are not regionally widespread.

Most countries reported that within routine antenatal care, there are many challenges to promoting programmes to stop new HIV infections among children. Maternal, newborn and child health programmes are typically overstretched, HIV testing and counselling is not routinely offered, men are not engaged and there is limited access to couples HIV testing and counselling. Equally, there is a lack of focus on key populations at higher risk and other vulnerable groups. Existing efforts to offer services to prevent new HIV infections among children to women from key populations have also remained insufficient, inadequate and donor-driven.

Some countries also report poor or absent integration of programmes to stop new HIV infections among children within antenatal care services, a lack of sustainable funding for programmes, limited infrastructure and human resource capacity, weak monitoring and high rates of loss to follow-up.

Dependence on donor funds, as well as high levels of stigma and discrimination towards women living with HIV (which hamper access to services and HIV testing and counselling uptake) are other challenges for the region in achieving this target.

The combined goal of eliminating new HIV infections and congenital syphilis among children is gaining momentum in Asia and the Pacific. Eight countries (Cambodia, China, Fiji, Indonesia, Malaysia, Sri Lanka, Papua New Guinea and Thailand) have committed to the dual goal of eliminating HIV and congenital syphilis among children based on the Framework for the elimination of new paediatric HIV infections and congenital syphilis in Asia and the Pacific, 2011–2015.¹⁰⁴

Target 3

How Asia and the Pacific can reach target 3

- Improving services for mothers, children and families living with HIV should build on the strong foundation for reducing maternal and child mortality in the region. HIV services aimed at mothers and their children must be integrated into programmes for maternal, child and reproductive health and sexually transmitted infections. This requires strengthening existing integration efforts at all levels, from policy to management and service delivery.
- Greater efforts are needed to reduce the number of women acquiring HIV infection, and all women living with HIV eligible for antiretroviral therapy must have access to it.
- Efforts must be made in terms of focused training and capacity building for health workers, further integration and decentralization of services, as well as the implementation of task shifting and other measures to address human resource challenges.
- Countries need to work towards the elimination of new HIV infections among children by: scaling up partner HIV testing, immediate antiretroviral treatment initiation (as per the 2013 WHO guidelines¹⁰⁵), high retention in care and treatment, and improving early infant diagnosis. More efforts must be made to reach pregnant women living with HIV from key populations at high risk, as well as female partners of men who inject drugs, and ensure they have access to non-discriminatory maternal child health care, including services to eliminate new HIV infections among children.
- Technical, programmatic and financial support is needed to increase access to early infant diagnosis, adopt paediatric treatment guidelines, expand treatment programmes, relieve bottlenecks in children's treatment access (such as late turnaround of HIV test results and loss to follow up) and to strengthen drug procurement.
- Community involvement can have an effective impact in eliminating new HIV infections among children. Greater civil society involvement can generate demand for HIV testing and counselling among pregnant women from key populations at higher risk and establish effective linkages to services preventing new HIV infections among children.

Spotlight

Thailand: Towards the elimination of new HIV infections among children—and beyond

In 2012, out of an estimated 4900 infants born to women living with HIV, an estimated 135 babies were born with HIV, putting Thailand well on the way to reach the goal of eliminating new infections among children and keeping mothers alive.

The transmission rate among infants exposed to HIV who were tested with the standard polymerase chain reaction test was just 2.1% in 2012. Transmission rates have been decreasing every year, dropping steadily from 118 new confirmed HIV cases in 2008 to 81 in 2011.

In public health care facilities, Thailand offers almost complete coverage of services to prevent new infections among children: 100% of women in antenatal care are tested for HIV, 94% of pregnant women living with HIV receive antiretroviral drugs and 99% of HIV-exposed infants receive antiretroviral prophylaxis. Thailand has also steadily improved its coverage of early infant HIV diagnosis. In 2012, 77% of infants born to women with HIV in Thailand received an HIV test within two months of being born.

Since it started in 2000, Thailand's national prevention programme on new HIV infections among children has hinged on the breadth of service availability. The comprehensive service package includes free HIV screening (using an opt-out approach), prophylaxis, treatment, care and support for pregnant women with HIV and their partners and children.

In reaching the 'last mile' towards eliminating new HIV infections among children, Thailand has progressively made systemic evidence-informed improvements in service delivery. This is demonstrated by routinely adding important new services (such as CD4 and virological testing) to the standard package of care, or the adoption of new antiretroviral regimens when the evidence proves their increased effectiveness in preventing or treating HIV.

Given that ratios of HIV infection acquired via sexual transmission in Thailand are increasing (32% of new infections occur in serodiscordant relationships), the Ministry of Public Health has prioritized the expansion of voluntary HIV screening of the partners of women accessing antenatal care at public health facilities. In addition, an active case management programme for pregnant women living with HIV and their children will be launched to reach the goal of elimination of new HIV infections among children and promote early antiretroviral therapy in infants living with HIV.

Simultaneously, discussions are under way to expand the use of treatment as prevention, including full adoption of Option B+ where all pregnant women diagnosed with HIV are offered lifelong treatment, while at the same time ensuring that the autonomy and rights of women are upheld.

Viewpoint

Positive and pregnant? How dare you!

Signed by WAPN+ (Women's arm of the Asia Pacific Network of People Living with HIV)

Pregnant women living with HIV face stigma, discrimination and sometimes violence, compromising their health and endangering their lives and their children's. People look at us and say: "You're positive and pregnant? How dare you!" Such discrimination leads to poor quality care, refusal of antenatal care and delivery services, and increased coercion to be sterilized.

Against this backdrop, WAPN+ conducted a study¹⁰⁶ on access to reproductive and maternal health care and services among women living with HIV in Bangladesh, Cambodia, India, Indonesia, Nepal and Viet Nam. The objective was to assess the experience of women living with HIV aged 16 and above and pregnant in the past 18 months when accessing reproductive and maternal health services. Using quantitative and qualitative methods, we surveyed 757 women, interviewed 17 interviews and conducted 10 focus group discussions.

Our findings are significant, sometimes shocking, particularly regarding the issue of sterilization and medical termination. The evidence suggests this is a major issue facing pregnant women living with HIV in many countries in our region.

We found that 30% of the women surveyed had been encouraged by their health care provider to undergo sterilization and almost 40% of these were not provided with any other option. In all, 22% of pregnancies were medically terminated, of which nearly two thirds occurred specifically because of the mother's HIV status. One woman from India was so happy when she found out she could deliver a baby despite living with HIV and had informed herself about the medications to take during and after pregnancy—the community care centre would provide educational support. But her husband and mother-in-law did not believe that the baby could be born HIV-free and said that if she did not abort the pregnancy, they would abandon her. This is the story of countless other women across the region.

Based on this study's findings, WAPN+ has made a submission, 'Allegations of human rights violations affecting the status of women' to the Commission on the Status of Women for Cambodia, India, Nepal and Viet Nam. Preparations are under way with key regional partners to see how we can build on the study to ensure action on the issues raised through its findings.

We will continue to strive to ensure pregnant women living with HIV are treated with the same respect as all pregnant women.

For more on the WAPN+ report: Positive and Pregnant? How dare you! see www.apnplus.org



Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

Treatment is a cornerstone of the AIDS response and fulfills double duty by keeping people living with HIV alive and healthy, while also preventing new HIV infections. Early knowledge of one's HIV status and early treatment initiation are fundamental to maximizing prevention benefits and reducing HIV incidence.

More people than ever have access to antiretroviral treatment for HIV in Asia and the Pacific. However, until treatment access is fully brought to scale, avoidable deaths will continue to occur. To promote universal access to treatment, more active approaches to HIV testing and counselling are crucial to promote access to treatment. These include supporting communities to create demand for and promote HIV testing and counselling, introducing and/or scaling up community-based HIV testing and counselling (including treatment and rights literacy) and linking HIV testing and counselling to prevention, care and treatment services.

Achievements and challenges

With 1.25 million people in Asia and the Pacific accessing antiretroviral treatment in 2012, a number of countries have made great strides in scaling up treatment access. China, India, Myanmar and Viet Nam more than doubled the number of their people accessing antiretroviral treatment in 2009–2012. Numbers in Thailand tripled between 2004 and 2007.

In China, strong Government political and funding commitments, coupled with efforts to expand HIV

testing and counselling, have led in recent years to a rapid increase in the number of people accessing antiretroviral treatment. Between 2010–2011, the number of people on treatment increased by almost 50% — from 86 000 to over 126 000. In 2011–2012, the number of people accessing treatment increased to over 150 000.

Viet Nam is rapidly scaling up, with new patients accounting for 23% of the 72 711 individuals accessing antiretroviral treatment in 2012. Viet Nam

Target 4

has expanded antiretroviral therapy in closed settings (such as drug detention and rehabilitation centers and prisons) and achieved a retention rate exceeding 80%. It has implemented projects in two districts for early antiretroviral treatment initiation.

However, in their mid-term review of progress towards the 10 targets, 18 out of the region's 21 countries cited challenges to reaching treatment access targets.

Earlier diagnosis and treatment are critical for success. The impact of late diagnosis due to lack of access to HIV testing and counselling is severe: one in four people who start on antiretroviral therapy in low-income countries globally have CD4 counts under 100, putting people at high risk of HIV-related illness and death.¹⁰⁷

The challenge remains how to reach people most at risk. In most countries, the proportion of key populations at higher risk who know their HIV status is especially low. Helping people find out about their HIV status earlier requires scaling up of both facility- and community-based HIV testing and counselling across the region, as well as recognition of the role of communities in creating demand for it.

High rates of loss to follow-up, usually between HIV testing and counselling and initiation of treatment, remain a serious problem in many countries. Inadequate facilities to test the CD4 counts and viral load of people currently on treatment are also reported as hampering progress in a number of countries.

In the quest to optimize HIV treatment, the HIV treatment cascade has emerged as an important tool that illustrates key transitions in the HIV service continuum. Treatment cascade is a model used to identify issues and opportunities related to improving the delivery of services to people living with HIV across the entire continuum of care — from diagnosis of HIV infection to initiation of antiretroviral treatment, to retention, and eventual viral suppression. Recent cascade analyses in China and Viet Nam confirm that many individuals are lost at various stages of the HIV treatment continuum, reducing the proportion of people living with HIV who achieve viral load suppression and other treatment benefits.¹⁰⁸

In terms of treatment adherence specifically, the region appears to be showing high levels of retention, with 87% median adherence in 2012.¹⁰⁹ More widespread implementation of the 2013 WHO guidelines,¹¹⁰ which recommend that eligible patients receive a simplified daily single-pill regimen where possible, should help to maintain high levels of adherence.

Inadequate supplies of second- and third-line drugs hamper the maximization of the treatment benefit at individual and population levels. Cultural and religious beliefs and attitudes are also cited by many countries as a barrier to treatment access.

Key populations continue to experience unique barriers to access HIV testing, counselling and treatment services, often as the result of fears that they will experience discrimination or legal recriminations if they seek services from mainstream health providers. There are no reliable estimates of HIV treatment coverage for men who have sex with men, people who inject drugs, sex workers and transgender people, but previous reports¹¹¹ indicate that these populations face substantial barriers to accessing essential health services. There has been a lack of clear commitment to scaling up HIV testing, counselling and treatment coverage for key populations.

A concerted effort is needed to improve access to antiretroviral treatment for children, which has substantially lagged behind that of adults. Implementation bottlenecks in early infant diagnosis, which remains low in most countries in the region, along with long turnaround time for HIV test results, low levels and/or delayed antiretroviral treatment initiation and the high rate of loss to follow ups are issues that require urgent attention. Despite advances in HIV treatment for children, there remain challenges in dispensing the recommended regimen to infants and children under three due to requirements for cold-chain storage and palatability issues regarding boosted lopinavir (it tastes bitter) that could affect adherence.

How Asia and the Pacific can reach target 4

- Human and financial resources must be increased and better harnessed to achieve universal access

to treatment by 2015. Bringing services closer to people living with HIV through decentralization will improve treatment uptake.

- To generate robust demand for HIV treatment, countries should align national programmes with the 2013 WHO guidelines,¹¹² re-conceptualize HIV testing and counselling, as well as adopt multiple, proactive strategies to encourage knowledge of HIV status, remove deterrents to treatment access and emphasize the prevention, as well as therapeutic, benefits of HIV treatment.
- Cascade analyses can help national planners and programme implementers in devising focused interventions to improve programme outcomes. These exercises also provide useful guidance for planning and implementing studies to identify risk factors for non-retention and evaluate intervention to reduce patient loss during the HIV treatment process.
- Faced with limited human resources for health, countries should restructure (decentralize) service delivery, including through community involvement. Task sharing in clinical settings can be considered, with nurses administering antiretroviral treatment, as well as intensifying efforts to train and deploy new physicians, nurses and community health workers. Civil society can play a vital role in many aspects of treatment access and HIV testing and counselling, including creating demand, service delivery, treatment and rights education, as well as the development of monitoring systems for antiretroviral drug stocks.
- In line with the 2013 WHO guidelines,¹¹³ community-based HIV testing and counselling for key populations, with linkages to prevention, care and treatment services is recommended in all HIV epidemic settings, in addition to provider-initiated HIV testing and counselling.
- There must be more emphasis on treatment literacy to increase communities' understanding of HIV treatment, health rights and to help improve adherence. Similarly, there is a need to have clear treatment cascade information and develop and

implement systems to track and reduce loss to follow-up.

- Antiretroviral treatment regimens must be simplified as a matter of urgency. The use of less toxic and more convenient regimens as fixed-dose combinations is recommended for first-line antiretroviral treatment. Reducing the number of regimens will also contribute to simplification of drug procurement and supply chain management.
- The affordability of antiretroviral drugs is a prevailing challenge for the region. TRIPS flexibilities need to be systematically incorporated into national intellectual property laws and more widely utilized. Closer collaboration is needed between the trade and health sectors so that trade agreements will not hinder access to affordable medicines.
- A concerted effort is needed to improve early infant diagnosis and optimize treatment for children.

Spotlight

Towards Zero HIV in Indonesia

Indonesia is taking bold action to rapidly and strategically expand HIV testing, counselling and treatment services. In March 2013, Ms Nafsiah Mboi, the Minister of Health of Indonesia, released an official call to expand access to HIV treatment across the country.

A ministerial circular addressed to district health authorities and hospital directors in 33 provinces provided specific recommendations to better focus HIV testing, counselling and treatment services in order to reach people most at risk of infection. These included routine screening and treatment for sexually transmitted infections, and promoting consistent condom use.

Early initiation of antiretroviral treatment, regardless of CD4 count, can now be offered to people living with HIV (including pregnant women and serodiscordant couples), all members of key populations living with HIV and people living with HIV and tuberculosis coinfection, as well as hepatitis B and C coinfection. Local health authorities are also requested by the Ministry of Health to absorb the cost of HIV testing, CD4 and viral load testing. The programme is currently being rolled out in 10 districts across the country and will be expanded to 74 districts by the end of 2014.

Indonesia has taken a key regional leadership role in the Asian AIDS response. As chair of the 2011 ASEAN summit, Indonesia championed the adoption of the ASEAN Declaration of Commitment in Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-related deaths. Indonesia also plans to become one of several countries in the region to offer universal health care by 2014, with HIV treatment included in the health coverage.

Ms Mboi, who took up a two-year term as Chair of the Board of the Global Fund in 2013, met with UNAIDS Executive Director Michel Sidibé in October 2012 during his visit to Indonesia and pledged to scale up HIV testing, counselling and treatment programmes.

“Expanding HIV treatment is part of the Indonesian Government’s effort towards achieving the Millennium Development Goals and in getting to zero on AIDS. We need to act boldly and to leverage on the science which is telling us that treatment can also serve as prevention,” she said. “It is critical that we mobilize HIV testing and encourage early initiation of treatment. By so doing we reduce AIDS related deaths, prevent vertical transmission, delay progression of HIV infection to AIDS, improve the quality of life of people living with HIV, reduce HIV transmission and stop the HIV epidemic,” Ms Mboi added.

Given Indonesia’s vast geography, a central challenge now will be ensuring that the Ministry of Health recommendations are implemented at the local level. Tono Permana, national coordinator of a national network for men who have sex with men and transgender people, applauded the introduction of early treatment policy for key populations at higher risk in Indonesia. However, he urged investment to encourage provision of community-friendly services, strengthen the management of the drug supply-chain to reduce stock-outs and promote treatment literacy and demand creation for HIV testing, counselling and treatment.

Viewpoint

Access to affordable medicines saves millions of lives

Anand Grover, UN Special Rapporteur on Human Rights and Shiba Phurailatpam, regional coordinator Asia Pacific Network of People Living with HIV

It is 12 years since the WTO introduced flexibilities to the TRIPS agreement. Since then, countries in Asia and the Pacific have come a long way in using these flexibilities to adapt intellectual property law and policy to protect public health.

There is evidence from India, Indonesia, Malaysia and Thailand that the use of TRIPS flexibilities has helped to substantially lower the cost of medicines, including antiretroviral drugs, across the region, including antiretroviral treatment.

Currently, Indian manufacturers account for more than 80% of generic antiretroviral medicines—supplying the majority of developing countries with affordable medicines. But TRIPS flexibilities have yet to be fully exploited by most countries to sustain affordable medicines.

Countries are facing mounting challenges to produce or procure affordable HIV drugs. International funding for the AIDS response is being cut back. At the same time, increasingly restrictive intellectual property measures are emerging in free-trade agreements.

WTO’s recent decision to extend the TRIPS transition period until 2021 for least developed countries is an important opportunity for low-income countries in this region to maximize their ability to fulfill basic health and access goals. These countries are encouraged to make full use of this policy space and ensure that any patent regimes implemented do not apply to medicines until after the expiration of the transition period.

In 2012, UNAIDS and the United Nations Development Programme jointly published an issues brief on the potential public health impact of free trade agreements. The brief stated that to retain the benefits of TRIPS flexibilities, countries should at a minimum avoid entering into free trade agreements that contain obligations that can affect pharmaceutical price or availability. The brief further recommends that where such commitments may have already been agreed, efforts should be made to mitigate the negative impact on access to treatment by using what public health-related flexibilities are still available.

A number of countries in our region are currently initiating, negotiating and ratifying new bilateral and/or multilateral trade agreements. We are mobilizing around these issues to press for pro-development provisions that would enable, not impede, affordable access to treatment in low- and middle-income countries.

The health of the people must not be traded away by countries in return for economic gains. By taking bold steps to ensure that intellectual property and free trade agreements do not impede access to treatment, countries of Asia and the Pacific can help make sure that medicines remain affordable. In doing so, millions of lives can be saved.

Viewpoint

Impact like no other: Community-led treatment and HIV testing and counselling

Thomas Cai, Director of AIDS Care China

At AIDS Care China, community ownership and involvement are the keys to success. Founded by a group of people living with HIV in 2001, we now work in five provinces reaching over 30 000 people annually, approximately a quarter of all people living with HIV who are on treatment in China. Our Red Ribbon centres provide treatment education and support to people living with HIV taking antiretroviral medicines. Focusing on people who use drugs, prisoners and men who have sex with men, we also run three clinics to provide high quality, affordable health care for people living with HIV, including provision of community-based HIV testing and counselling.

Community-based services like ours are absolutely critical to reaching HIV targets and goals. Community workers know the concerns and culture of the people they are working with, enabling them to address issues efficiently and represent people’s rights. This creates an ownership shift towards the person living with HIV. It means people on treatment fully understand the importance of adherence, can monitor their own health better and can better negotiate their regimens, medicines and plans with their doctors. No other effort could be so effective.

In 10 years, we have successfully helped people adhere to HIV treatment and retain very high viral suppression rates, even among marginalized populations. For example, we have seen 91% viral suppression among people who use drugs. Loss to follow-up has decreased dramatically and quality of life of the people we are working with has much improved.

Since 2010, we have also supported community-led voluntary HIV testing and counselling using a model based on respect for people’s rights, confidentiality and making people feel comfortable to come to test. The success of the model is clear. In one of the organizations using this model, the number of people coming for HIV testing and counselling increased nine times in as many months. Loss to follow-up on testing is now less than 10%, compared to 30-40% before, and community-led HIV testing and counselling is lowering costs, from US\$ 450 to identify one positive case to US\$ 200 per case through our programme.

One of our most important strategies for success has been building good relationships with health care providers and hospital officials as they recognize the invaluable role our staff play in improving treatment understanding and adherence. Doctors have their areas of expertise and so do community members and people living with HIV. It is not a competition — rather, we complement each other’s work.

We need to ensure that this complementarity continues and grows, and that more community-led services are introduced and given the trust, space, autonomy and resources needed to be successful. Together we can have a spectacular impact.

Viewpoint

Bringing treatment closer to home in Viet Nam

Dr Bui Duc Duong, Deputy Director General, Viet Nam Administration for HIV/AIDS Control

Up until a year ago, Ms Lo Thi Hoa had to ride her bicycle for four hours every time she picked up her husband’s antiretroviral medicines. But in August 2012, the Treatment 2.0 initiative, currently implemented in two provinces, with plans to scale up to five more, brought HIV testing and treatment to her commune in the mountainous north-western province of Dien Bien.

Ms Hoa took an HIV test at her commune health station and tested positive. One month later, she started treatment at the district hospital. After three months of problem-free care, she was referred back to her commune for monthly prescription re-fills and health check-ups.

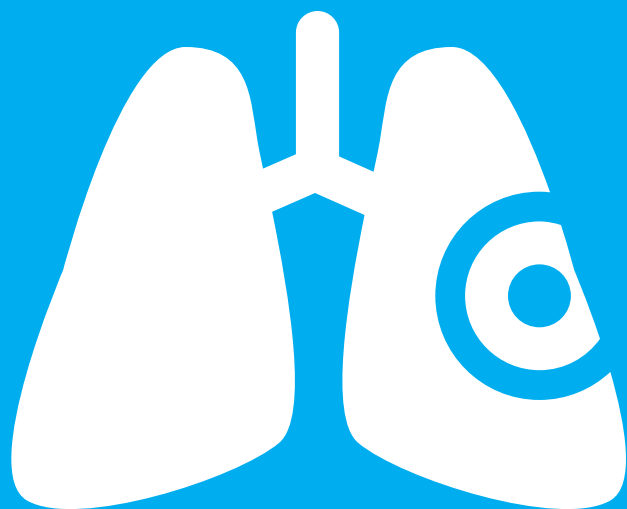
“Antiretroviral drugs for both my husband and I are now only few minutes away from home,” Ms Hoa said. “I no longer have to spend the whole morning cycling to and from the district hospital.”

HIV services in Viet Nam are usually provided at district, provincial or national health facilities. The current HIV and CD4 testing procedures require several follow-up visits and long waits for test results and treatment initiation. Many people are lost to follow-up along the way.

The Ministry of Health recognized this as a barrier to treatment scale-up. The country’s Treatment 2.0 initiative (currently implemented in two provinces, with plans to scale up to five more) has been mobilizing village health workers, people living with HIV and people who inject drugs to reach out to people at higher risk of HIV and encourage them to take a rapid screening test right in their commune.

Ms Hoa successfully persuaded her neighbour, a young widow whose drug-injecting husband died a few years ago, to take a HIV test. She also tested positive. Mobilizing people like Ms Hoa to improve uptake of HIV services is a critical part of the Treatment 2.0 initiative and the wider national response to HIV.

5.



Reduce tuberculosis deaths in people living with HIV by 50% in 2015

Reducing tuberculosis among people living with HIV is a priority for many countries in the region.

Critical steps for countries are: intensified case-finding, isoniazid preventive therapy for tuberculosis prevention among people living with HIV and initiating antiretroviral treatment in all tuberculosis patients living with HIV, irrespective of their CD4 count.

Achievements and challenges

Prompt diagnosis is essential for effective HIV and tuberculosis treatment and the number of people in the region living with HIV who are screened for tuberculosis is increasing each year.

Stronger linkages between HIV and tuberculosis programmes are critical to improve screening and there have been impressive gains in ensuring people living with both diseases are treated. India and Nepal, for example, are both taking steps towards greater integration of the two services, thereby improving case-finding and uptake of treatment.

However, HIV testing and counselling is not a routine component of tuberculosis care. Unless this short-

coming is addressed, further progress in reaching HIV-positive tuberculosis cases with essential HIV treatment cannot accelerate.

Almost all countries report a lack of robust routine monitoring systems despite having tuberculosis and HIV committees. Collaboration between HIV and tuberculosis programmes has so far been limited, even if they are both within health ministries.

Despite progress in identifying HIV and tuberculosis coinfection and in reducing tuberculosis-related deaths, antiretroviral treatment coverage for people in the region living with both HIV and tuberculosis remains inadequate — six out of seven high HIV/

tuberculosis burden countries in the region achieve less than 50% antiretroviral coverage among coinfecting people.

Most countries report challenges, including the emergence of multidrug- and extremely drug-resistant tuberculosis. There is also a lack of information, including on people living with latent tuberculosis who are also living with HIV.

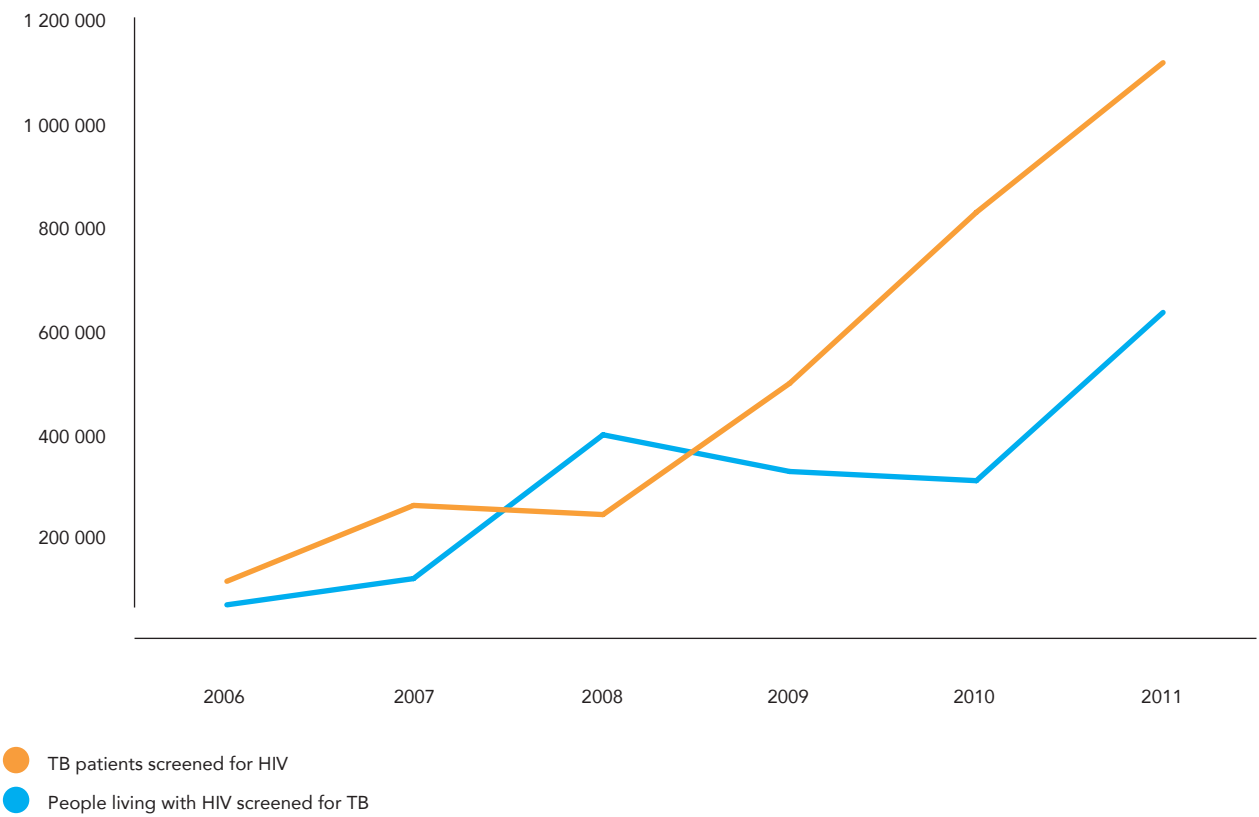
Full and rapid implementation of the 2013 WHO guidelines¹¹⁵ and earlier guidance on collaborative HIV/tuberculosis activities is essential. The WHO-recommended package of collaborative HIV/tuberculosis activities to reduce the burden of coinfection comprises routine HIV testing and counselling for tuberculosis patients; co-trimoxazole preventive therapy and early initiation of antiretroviral treatment for co-infected patients; screening for tuberculosis among people living with HIV and provision of isoniazid preventive therapy to eligible patients.

How Asia and the Pacific can reach target 5

Improving access to early HIV diagnosis and antiretroviral treatment for people who test positive is essential to reducing tuberculosis deaths among people living with HIV. Of all available tools, antiretroviral treatment is the single most powerful for HIV-associated tuberculosis, reducing the risk of death by 54–95%.¹¹⁴

Innovative strategies are urgently needed to improve the reach, timeliness and effectiveness of tuberculosis screening and treatment programmes for people living with HIV. Countries should adopt innovative HIV testing and counselling and delivery strategies, and communities need to be engaged as partners in the effort to reduce tuberculosis deaths among people living with HIV.

Figure 11
Scaling up HIV and TB coinfection screening, 2006–2011



Source: WHO Global Tuberculosis Report 2012

Spotlight

Thailand’s TB/HIV programme shows how the 10 targets can be reached

Thailand’s programme on HIV/tuberculosis coinfection has already reached, and in some aspects surpassed, reduced mortality and universal coverage targets.

In 2004, Thailand initiated a very strong provider-initiated HIV testing and counselling programme for tuberculosis patients, which has now reached near universal coverage. At the same time, the coverage of antiretroviral treatment in Thailand is high—around 70%. Thanks to the comprehensive programme, the target of halving HIV/tuberculosis mortality since 2004 was reached in 2007—well before the 2015 target deadline.

Documented HIV test results, falling prevalence of HIV among tuberculosis patients and increases in antiretroviral treatment coverage for tuberculosis patients living with HIV suggest that the HIV strategies implemented are succeeding and that provision of care for those with HIV-associated tuberculosis is improving each year.

Immediate antiretroviral treatment (regardless of CD4 count) among new tuberculosis patients living with HIV has proven to be the single most important predictor of survival of a tuberculosis episode. Improvements in antiretroviral treatment coverage contributed to the decline of AIDS/tuberculosis mortality, which dropped from 20.4 per 100 000 in 2001 to 3.34 per 100 000 in 2012, an 84% decline in mortality over 11 years.¹¹⁶



Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22–24 billion in low- and middle-income countries

Domestic funding for the AIDS response has been growing significantly across the region, but many countries continue to be reliant on international funding. Gaps left by the withdrawal of development assistance may not be met by domestic increases.

If Asia and the Pacific is to reach the level of resources called for in this target by 2015, countries need to increase their domestic investment on HIV, strengthen country ownership of the AIDS response and take a long-term sustainable view of what ongoing investment in the AIDS response will entail. At the same time, emerging trends in the HIV epidemic indicate that programme priorities and corresponding funding allocation must be better targeted to maximize impact and efficiency to reduce new HIV infections and save more lives.

Achievements and challenges

Countries are increasingly aware of the need to face the funding issue head-on. In the mid-term review of the 10 targets, countries emphasized the need for strategic investment thinking. They also recognized that long-term investment plans for the AIDS response must be anchored to national strategic plans, as well as broader health and social protection plans and financing schemes.

Three of the 10 countries with the highest HIV burden in the region (China, Malaysia and Thailand) are now largely self-sufficient in funding their HIV

programmes. In their mid-term review of progress, 12 countries (Cambodia, India, Kiribati, Lao People’s Democratic Republic, Mongolia, Myanmar, Pakistan, Papua New Guinea, the Philippines, Sri Lanka, Thailand and Viet Nam) reported having increased the domestic budgetary allocation for HIV programmes, as well as prioritizing national resources towards high-impact locations and key populations for maximum benefit.

India has reported plans to significantly increase Government contribution to the 4th National AIDS Control

Target 6

Programme (NACP IV) to an estimated 80% of the total US\$ 3.1 billion. This compares to the Government’s 25% contribution for the NACP III. Emphasis will be on ensuring effective and efficient resource allocation, with scale-up of interventions among specific population groups and, in particular, in geographical locations that have higher HIV prevalence and incidence.

The Global Fund’s new funding model, which is designed to enable strategic investment for maximum impact, aims to ensure greater alignment with country-level priorities and focuses on countries with the highest disease burden and lowest ability to finance their own responses. Through the new funding model, Myanmar’s response to HIV, tuberculosis and malaria received a boost with the announcement of over US\$ 315 million to support efforts on the three diseases over the next four years through. For the country’s HIV response, over US\$ 160 million will be made available until 2016. The new HIV grants will build on significant progress already made in the country, allowing for the strategic expansion of services to more geographical areas to reach more people in need of support.

Despite significant examples of progress and sustainability development in the region, in the mid-term review of progress, only 10 countries reported expectations of reaching the target levels of required funding. The majority of countries reported that prevailing negative attitudes towards HIV and sexual minorities mean that HIV is not high on the national funding agenda.

The withdrawal of international funding without adequate transition time or ‘bridging plan’ is starting to cause difficulties for some countries.

Some countries reported having insufficient evidence to inform country decisions and have recommended yearly national AIDS spending assessments, establishing a mechanism to keep track of AIDS resource flow, and carrying out studies on cost effectiveness/benefit. Timely flow of funding to points of implementation, as well as the capacity of countries to use existing resources, need to be examined more closely.

External financing has been able to influence the overall governance of AIDS response in countries, fostering strong participation of civil society organizations and key affected communities in programme decision-mak-

ing. As those funding sources diminish, key community player involvement could be weakened.

How Asia and the Pacific can reach target 6

- Countries in the region need to gradually move from international to domestic sources to finance an effective response to HIV, but this requires a phased approach. Without this, current gains in the AIDS response may be lost. Donor exit from programme funding must be carefully planned and managed over a realistic timeframe so countries can prepare a transition plan and bridge the gap.
- Not only must the level of funding increase, but the direction of funding also needs to change for maximum impact. A strategic shift is needed, towards a concerted investment in key populations. Communities of people at higher risk need to be accorded a central role in the response. Systems are needed to monitor whether and where funds are reaching populations at higher risk. Further investment in strengthening health and community systems is necessary to sustain the response over the long term.
- International development partners, including the Global Fund, need to continue to work closely with countries and explore alternative ways of approaching AIDS financing, particularly in building funding models that take into priority consideration key populations and geographical areas of high HIV prevalence and incidence within countries.
- Innovative funding mechanisms, such as levies on financial transactions, airline travel, alcohol and tobacco are promising ways to boost resources for domestic funding. At the same time, increased return on investment will be possible through better integration, moving from stand-alone HIV programmes into broader health systems strategies.
- Several countries, including Indonesia, Myanmar, Nepal, the Philippines, Thailand and Viet Nam, have started to develop AIDS investment plans that have clear investment objectives, strategic targets, priorities and funding needs to end AIDS by 2030 and/or to meet the 2015 targets. On-going development and implementation of such investment plans is critical for an enhanced country ownership and long-term financing of the AIDS response.

Spotlight

Increasing domestic financing for HIV in China: Leadership in action

August 2013

“The Chinese government attaches great importance to fighting AIDS, and has been making increasing efforts to achieve the AIDS-related Millennium Development Goals.”

Liu Yandong

Vice Premier of China

December 2011

“China is willing to play its part... I have asked the Minister of Finance to close the gap left by the Global Fund. We will rely on our own efforts.”

Wen Jiabao

Premier of China (2003-2013)

November 2012

“Civil societies play an indispensable role in the national battle against HIV, particularly in better reaching out to vulnerable groups, and the government should support them in funding, registration, and boosting their capacity.”

Li Keqiang

Premier of China and former (2008-2013) First Vice Premier of China

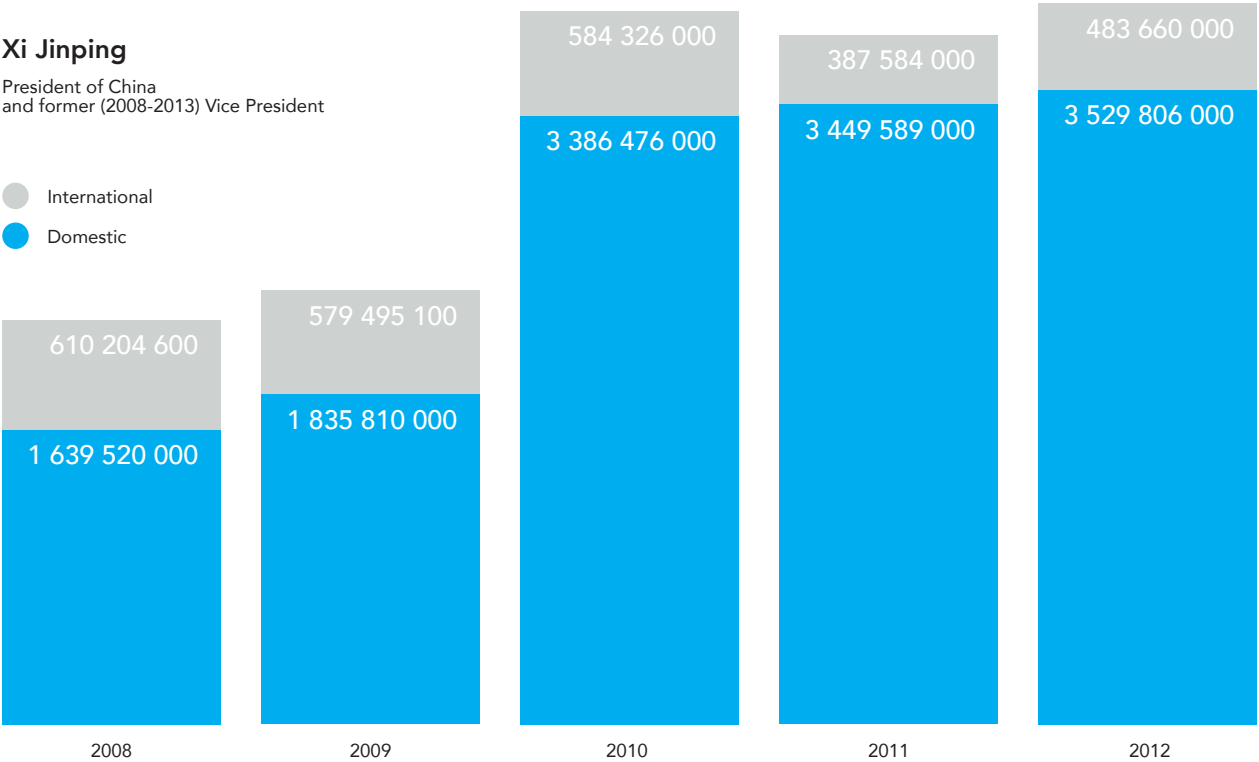
August 2010

“The Chinese Government attaches great importance to the prevention of HIV, which has become the country's leading infectious disease killer. With increased funding for anti-AIDS programmes, China has implemented prevention, treatment and care policies to secure the rights and interests of people living with HIV.”

Xi Jinping

President of China and former (2008-2013) Vice President

- International
- Domestic



Viewpoint

Ownership and focus:
Taking AIDS financing to the next level

JVR Prasada Rao, United Nations Secretary General’s Special Envoy on AIDS in Asia and the Pacific

Funding for the AIDS response has gone from millions to billions: US\$ 90 million in the late 1990s to US\$ 18.9 billion in 2012. This financial transformation represents an unprecedented victory, helping to save millions of lives.

However, global funding on AIDS falls short of estimated global needs. And as more and more people gain access to life-saving treatment, the need for sustainability of funding has never been more critical.

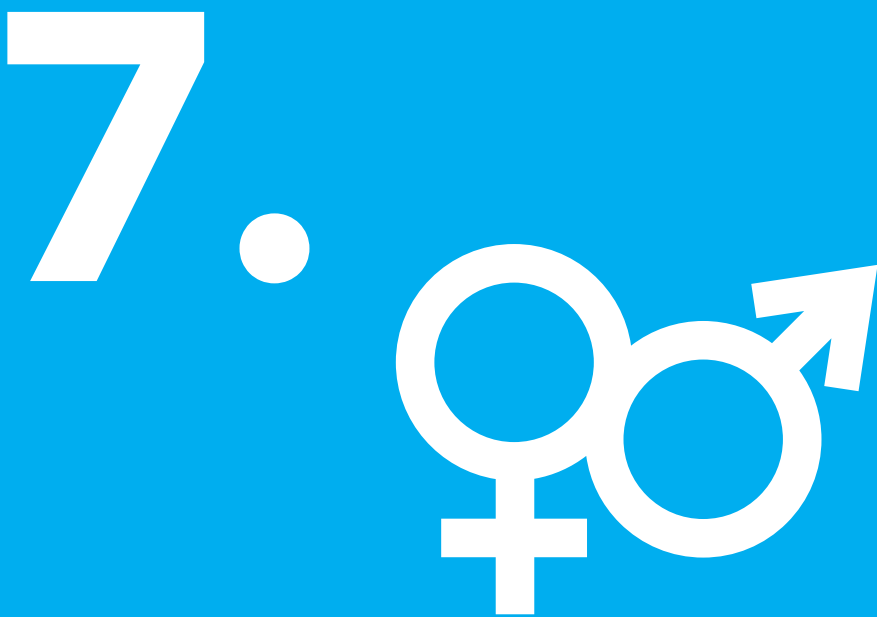
In the face of difficult economic times, where donor countries are continually lowering their development aid allocations, our biggest hope for sustainability is to push for the next victory moment: the AIDS response fully financed by domestic funds. A number of countries in the region are leading the way. What is needed is for all countries to gradually, if not fully, fund their AIDS response domestically and start investing for its long-term sustainability. Countries need to rally behind the principle of global solidarity and shared responsibility, and why not towards a goal of fully-funded domestic responses by 2020?

At the same time, we must do more to ensure that the money we already have is being put to work in the most effective way to drive down the epidemic. Despite overwhelming evidence that spending on HIV prevention focused on populations at higher risk will drastically reduce new infections, all too often in this region we see large amounts of AIDS funding directed to ‘soft’ programmes that are not focused in the areas where they can have the most impact.

There are trailblazing examples of impressive programmes in China, India, Myanmar, Thailand and many other countries in which clearly targeted spending on prevention among high-risk populations substantially reduced new infections. But elsewhere, continuing the business-as-usual approach of low-level AIDS spending on key populations will not lead us to the breakthroughs needed to trigger significant decreases in HIV infection rates.

With so much experience, knowledge and evidence on our side, we must face the facts and direct AIDS spending where it really needs to go. Taking AIDS financing to the next level will spur the global response, towards our ultimate aim: zero new HIV infections; zero discrimination; zero AIDS-related deaths.

UN Secretary General’s Special Envoy Prasada Rao is also the Chair of the High Level Panel on the AIDS funding landscape in Asia and the Pacific, a new initiative to help countries and development partners to decide on future funding priorities and develop long-term, sustainable investment plans.



Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

For the AIDS response to be effective, it is imperative to tackle gender inequalities, gender-based abuse and violence as well as harmful gender norms and practices that promote unsafe sex and reduce access to HIV and sexual and reproductive health services for women, men and transgender people. HIV services should be tailored to be needs-sensitive and to respect and protect sexual and reproductive health and rights, particularly of people living with HIV and key populations at higher risk.

To increase the capacity of women and girls to protect themselves from HIV, women and girls in all their diversity—and especially those at higher risk—must have equitable access to services. This includes promoting empowerment and addressing underlying economic, social and legal factors, such as lack of access to education, employment, resources and decision-making power, that impede women and girls’ ability to protect themselves from HIV.

Achievements and challenges

In the mid-term reviews of the 10 targets, most countries reported signs of progress, citing efforts to address gender inequalities through the development of national laws, strategies, programmes, mechanisms and assessments related to gender, gender-based violence, health and human rights.

However, many countries also reported challenges in coordination, implementation and a monitoring

strategy to lead to tangible and measurable progress towards achieving this target.

Few countries have HIV policies or programmes that prioritize gender equality and address the full range of vulnerabilities faced by women, men and transgender people through gender-sensitive programmes.¹¹⁷ There are also few examples in the region of integrated programmes that routinely report on gender-based

Target 7

violence and effectively address the link between HIV and gender-based violence.

In mid-term reviews, countries highlighted challenges posed to HIV responses by gender-based violence. Growing evidence suggests that gender-based violence (including the threat or fear of violence) makes women, girls, men who have sex with men and transgender people more vulnerable to sexually transmitted infections, including HIV and less likely to be able to negotiate safer sex.^{118, 119, 120} Studies show that women from key populations, such as female drug users, female sex workers and transgender women are particularly likely to experience violence.^{121, 122}

While there is strong policy commitment in the region to integration of sexual and reproductive health and HIV services,¹²³ there is limited experience in how to tailor service integration so that services are accessible to women living with and those at higher risk of HIV.¹²⁴ Too often, HIV prevention efforts among female key affected populations are often narrowly focused on access to HIV prevention commodities and diagnosis and treatment of sexually transmitted infections — missing a critical opportunity to address reproductive health needs.

The 2011 ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths pledges to eliminate gender inequalities and gender-based abuse and violence, and to empower women and young people to protect themselves from HIV.¹²⁵ The South Asian Association for Regional Cooperation (SAARC) will address the needs and rights of key affected women and girls in its new HIV strategy, to be published in 2014.

In Asia and the Pacific, the Unzip the Lips platform brings together individuals and organizations working for the rights and meaningful participation of key affected women and girls. Its aim is support and collective advocacy to ensure that the voices of key affected women and girls are included in national and regional AIDS responses.¹²⁶

Since its launch, the Unzip platform has made a series of public calls to action directed at policy-making bodies and/or individuals and at high-level events.

Spotlight

Who are key affected women and girls?

The following definition was prepared by the Asia-Pacific Interagency Task Team on Women, Girls, Gender Equality and HIV and Unzip the Lips platform and agreed through extensive consultations. Subsequently it has been adopted by the Association of Southeast Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation (SAARC) and included in a number of official documents.

Key affected women and girls in Asia and the Pacific include (depending on the circumstance and country):

- women and girls living with HIV
- female sex workers
- women and girls who use drugs
- transgender women and girls
- mobile and migrant women
- female prisoners
- women with disabilities
- women in serodiscordant relationships
- female intimate partners of men who engage in behaviours that put them at a higher risk of HIV infection
- women and girls in HIV-affected households.

These calls to action aim to increase the level of attention on key affected women and girls, ensure that resources are directed strategically for maximum impact and create a coordinated movement.

How Asia and the Pacific can reach target 7

- It is critical to understand the epidemic, context and response from a gender perspective and to ensure that routinely collected data, wherever possible, is disaggregated by sex and age and identifies key populations that are particularly vulnerable to HIV due to gender inequalities. Using gender-specific monitoring and evaluation indicators will assist in measuring progress of such a gender-transformative HIV response.
- Women and girls, men who have sex with men and transgender people living with HIV must be included in policy- and decision-making processes that address HIV prevention, care and support so that responses encompass their gender-specific needs. The response must include capacity development, supporting networks and fostering leadership skills.
- Gender-responsive budgeting for the AIDS response can promote adequate budget allocations for policy and programmes that transform underlying harmful gender norms and prevent gender-based violence.
- Fundamental societal changes, such as eliminating gender inequality and gender-based violence and transforming harmful gender norms, require a comprehensive approach, take time. The changes must involve men, women and transgender people, with a particular emphasis on key populations. The evidence base must continue to be strengthened to successfully respond to the gender dimensions of the HIV epidemic in the region.

Spotlight

New regional agenda incorporates important elements on sexual orientation and gender identity

A landmark declaration adopted by the 53 Member States at the Sixth Asian and Pacific Population Conference in September 2013 firmly integrates HIV into all aspects of population and development, and reinforces the crucial need to uphold human rights, address gender inequalities—including respecting sexual orientation and gender identity—and to better serve the needs of young people.

The Asian and Pacific Declaration on Population and Development underlines Member States’ responsibility to protect the human rights of all citizens, including the right to universal and equitable access to sexual and reproductive health services—a crucial part of the AIDS response.

The declaration places strong emphasis on promoting gender equality including bringing an end to gender-based violence as well as early and forced marriage, all known risk factors for the spread of HIV. The declaration also highlights the needs of young people for comprehensive sexuality education and access to contraception, both of which can help to tackle the growing epidemic of HIV among the region’s youth.

The adoption of the declaration sends a clear message that Asia and the Pacific can continue its global leadership role in protecting the rights of its citizens, promoting sustainable development and ensuring an effective response to the region’s HIV epidemic.

Viewpoint

Third gender rulings pave the way to end discrimination towards transgender people

Nasir Aslam Zahid, Chief Justice of the Sindh High Court, Pakistan

It is the duty of the courts to ensure that the rights of key populations are upheld and enforced. When these rights are denied, we know it can lead to people fearing stigma, discrimination and sometimes violence. People may feel less able to access key health services, including those related to HIV. The law can therefore be a critical tool for ending HIV discrimination and other human rights violations.

In Pakistan, we have seen important developments with regards to the recognition and protection of the rights of transgender people. These developments pave the way to ensuring a safer environment for transgender people to access HIV services, if needed, and to reduce discrimination against them.

In a series of rulings in 2009-2011, the Supreme Court of Pakistan held that transgender people, being equal citizens of Pakistan, should have equal rights and access to Government benefits under the protections guaranteed by Article 4 (rights of individuals to be dealt with in accordance with the law) and Article 9 (security of person) of the Constitution of Pakistan.

Before these landmark rulings, transgender individuals could only apply for national identity cards if they identified themselves as male. In the decisions, the Supreme Court also directed the National Database and Registration Authority to add a third gender column to national identity cards for transgender people, giving them the right to register to vote.

The Supreme Court also warned the police not to engage in any highhandedness when dealing with transgender persons and required that a mechanism be established to protect transgender people from police harassment. The Court ordered the federal and provincial governments to ensure protection of transgender persons' inheritance and voting rights and to provide them with education and employment opportunities. Toward this end, it directed authorities to register transgender people in electoral rolls and to establish a mechanism to assist them with inheritance rights.

We are seeing positive reactions to these rulings and also a positive impact among the transgender community in Pakistan. The president of the Pakistan Shemale Foundation, Almas Bobby, has said that the Supreme Court of Pakistan has given transgender people their rights, that transgender people are now also contesting elections and that thousands of transgender people will vote for them. She argues that transgender people will receive better treatment in society if they manage to reach assemblies.

This is encouraging indeed. When individuals and communities have the courage and means to claim their rights through the courts, the judiciary can uphold those rights and order the government to effect the policy changes necessary to ensure that members of marginalized and vulnerable groups enjoy the same constitutional rights and protections as others.

I hope that this significant contribution to jurisprudence on the rights of transgender people in Pakistan will be a lead for other countries to follow.



Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

Continuing high levels of stigma and discrimination are major obstacles to effective investments in the AIDS response. Governments in Asia and the Pacific acknowledge that HIV-related stigma and punitive legal environments are holding back progress. Those countries that have taken bold action on stigma and discrimination report better results in achieving the 10 targets.

Countries in Asia and the Pacific are more aware than ever about the specific barriers within their local contexts. Now it is time to focus on eliminating punitive laws, enforcing protective laws, empowering communities to know and claim their rights, and institutionalizing programmes to reduce stigma and discrimination in key sites and institutions—namely healthcare and law enforcement settings.

Achievements and challenges

Progress has been made towards this target through coordinated policy advocacy and focused programmatic efforts. These now need to be taken to scale and implemented for the benefit of not only people living with HIV but also for key populations at higher risk. Law reform takes time, but there are examples

of progress towards creating enabling legal and social environments in the region. Countries that have taken bold action are seeing the positive impact on HIV programmes.

Target 8

Punitive and discriminatory legal environments continue to hinder effective HIV responses in almost every country in the region — despite evidence as to the public health and human rights issues raised by such environments. Reforms to remove punitive laws or strengthen protective laws have been achieved through coordinated, inclusive and evidence-informed dialogue in countries as diverse as Fiji, Mongolia, Pakistan, the Philippines and Viet Nam. Structural change to legal systems that can hinder access to HIV services is also being driven by communities. For example, successful legal challenges have been made to laws in India to decriminalize sex between men and to cancel illegitimate drug patents; and legal challenges in the Hong Kong Special Administrative Region of China, Nepal and Pakistan have resulted in recognition and protection of the rights of transgender people. Courts in this region, particularly south Asian countries, are increasingly showing that they can play a key role in protecting people from HIV-related stigma and discrimination. Additional investment in dissemination and implementation of protective laws and court rulings is required for these structural changes to have the intended impact on the lives of individuals.

Although analysis and understanding of the legal environments in the region have increased, countries face significant legal barriers to effective HIV responses. Implementation of recommendations developed through legal reviews and in national, multisectoral consultations on legal and policy barriers will be crucial between now and 2015.

In their mid-term reviews, most countries in the region acknowledged the need for improved implementation of existing protective laws. To this end, Cambodia, India, Nepal and Thailand have invested in engaging the police as protective agents of vulnerable groups. Efforts to sensitize the judiciary and national human rights institutions through regional and country-level initiatives are starting to bear fruit in terms of increased attention to and protection of human rights of people living with HIV and key populations at higher risk.

Whilst legal services and legal literacy programmes for people living with HIV and key populations have been implemented in many countries, these are not at the scale necessary to close the significant gap between law and practice. Non-existent or weak systems for monitoring and documenting HIV-related stigma and discrimination are also hampering strategic responses in this area.

Among the examples of progress from the engagement of national human rights institutions in the HIV response, the Philippine Commission on Human Rights included HIV as one of its new strategic focus areas and is developing its HIV policy to institutionalize its commitments. Human rights barriers to access to health and HIV services for men who have sex with men and transgender people were analyzed in the 2013 annual report of the National Human Rights Commission of Mongolia. National human rights institutions are critical actors in holding governments to account on human rights obligations and should be an influential partner in national efforts to achieve this target.

In the mid-term reviews, more than a third of countries in the region identified the need to implement or further expand programmes to reduce stigma related to HIV and key populations in health care settings. Progress in this area has been slow notwithstanding the importance of the interface between health workers and key populations in the response. Initiatives such as those in China, Malaysia and India to train health workers on HIV, stigma and patients’ rights and establish internal and external complaints mechanisms and referral to legal services need to be implemented at scale and integrated in a sustainable way across the health sector in all countries. . Tools and systems for routine monitoring of HIV-related stigma in health care settings, (such as those currently being developed in Thailand) inform national responses and are needed in countries across the region.

Programmes addressing HIV-related stigma and discrimination in the workplace, schools and faith-based organizations were also reported as contributing to progress towards this target in several countries, though such programmes are rarely implemented at a large enough scale.

How Asia and the Pacific can reach target 8

- Empowered communities are healthy communities: strengthening access to justice programmes is an investment not only towards the elimination of HIV-related stigma and discrimination, but also in rule of law and social justice. At the same time, strategies that support community mobilization, monitoring of stigma and discrimination, and rights-based activism as a core element of the HIV response will be critical to future progress.
- Routine tools for measuring stigma and discrimination that hinder access to HIV services by people living with HIV and key populations (such as the People Living with HIV Stigma Index) need to be implemented to inform the national response and monitor progress. The UNAIDS Human Rights Costing Tool (implemented in Indonesia in 2013) can also help countries to properly plan and budget for relevant programming, and to better understand spending, efficiencies, resource needs and gaps.
- Efforts to address HIV-related stigma and discrimination should focus on health care and law enforcement. This should include training for health care workers to combat discrimination and enable them to deliver rights-based and gender-sensitive health care to key populations, and sensitization and engagement of law enforcement agents on HIV and human rights.
- Fair access to employment for people living with HIV is also critical for both prevention and treatment adherence and steps must be taken to ensure elimination of all forms of HIV-related discrimination in the workplace.
- Strategies that institutionalize financial and other support for community engagement, rights literacy and rights-based activism as a core element of the HIV response will be critical to future progress towards this target, through their impact on both self-stigma and discriminatory social and legal environments.

Spotlight

Key programmes to reduce stigma and discrimination and increase access to justice

- 1 Stigma and discrimination reduction
- 2 HIV-related legal services
- 3 Monitoring and reforming laws, regulations and policies relating to HIV
- 4 Legal literacy (“know your rights”)
- 5 Sensitization of policy-makers and law enforcement agents
- 6 Training for health care providers on human rights and medical ethics related to HIV
- 7 Reducing discrimination against women in the context of HIV

Viewpoint

Start with the law to eliminate stigma and discrimination

Ratu Epeli Nailatikau, President of Fiji

Punitive laws fuel stigma and discrimination, undermining our efforts to bring an end to AIDS. Punitive legal environments impede the implementation of programmes targeting people living with HIV and key populations at higher risk, including men who have sex with men, transgender people, sex workers, people who use drugs, young people, prisoners and women and girls. At the same time, differences in culture, lifestyle and behaviour contribute to building barriers that people think will protect them, leading to the denial of the existence of behaviours outside their own personal or cultural norms. This is why legal reform is crucial to the AIDS response.

Pacific island nations have a history of leadership in the AIDS response, and Fiji has risen to the challenge of removing legal barriers to effective HIV programmes and tackling stigma and discrimination through legal reform. In Fiji, we saw that the constant threat of arrest, conviction and incarceration faced by men who have sex with men increased their vulnerability to HIV and made them hard to reach. 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.

In early 2011, the Government of Fiji enacted the Fiji HIV/AIDS Decree. This was internationally compliant in addressing the human rights violations that acted as barriers to the HIV response. The decree removed HIV-related restrictions on entry, stay and residence, adding Fiji to a growing list of countries that are aligning national HIV legislation with international public health standards. The decree also removed HIV-specific criminal offences for HIV transmission or exposure.

Soon the benefits of these legal changes began to show, with improved access to services for those populations most at risk of HIV. Our work in Fiji is not done, but the decree was a significant starting point in harnessing the protective power of laws to tackle stigma and discrimination head-on and to bring our island nation closer to the goal of an end to AIDS.

Spotlight

China’s Guangdong province lifts HIV restrictions on teacher recruitment

In early 2013, a bold HIV-related policy decision took place in Guangdong, China’s most populous province and home to an estimated 50 000-80 000 people living with HIV. In the wake of concerted advocacy efforts—including by UNAIDS, the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the International Labour Organization (ILO)—the province announced the abolition of restrictions preventing people living with HIV from working as teachers.

In early 2013, when the Guangdong education authorities were revising policy, UNAIDS, UNESCO and ILO jointly advocated that teaching restrictions for people living with HIV be removed. Subsequently, the authorities responded in a letter that stated “after having fully considered feedback from all sectors of society ... we are minded to delete Article 1” (the Article that excluded those living with HIV and other sexually transmitted infections). The provisions pertaining to HIV and other sexually transmitted infections were removed from the final draft of the regulations, and the policy changes came into force in September 2013.

Meng Lin, the Coordinator of the China Alliance of People Living with HIV, underlined the significance of the developments in the Guangdong education recruitment policy. “When people know that a positive diagnosis may result in them being unable to find employment, or losing their job, they often prefer to just avoid getting tested for HIV. The move by the Guangdong Department of Education sends out the message that people living with HIV have the right to equal employment opportunities, and makes us hopeful for the future.”

Quotable

“We have made exceptional progress on AIDS. Commitment and bold actions have saved many lives. But we can and must do more. Because of stigma, many people do not come to receive life-saving treatment or prevention services. This is costing lives.

Too many people are facing isolation, loneliness, hopelessness.

You and I, we can make a difference –by reaching out and letting people lead a life with dignity irrespective of their HIV status or sexual orientation. Compassion is what binds us together as human beings, regardless of race, religion, national borders.

We need an Asia-Pacific community of compassion to end discrimination.”

Excerpt from Aung San Suu Kyi’s welcome message for the 11th International Congress on AIDS in Asia and the Pacific, 2013



Eliminate HIV-related restrictions on entry, stay and residence

Four countries in the region, namely China, Fiji, Mongolia and the Republic of Korea have removed restrictions on entry, stay and residence for people living with HIV in recent years, but these restrictions still exist in 11 countries.¹²⁷ Citizens of several countries in the region with large populations of migrant workers are also severely affected by such limitations imposed in destination countries.

Restrictions on entry, stay and residence for people living with HIV can harm public health by creating false perception that Government policy keeps HIV outside. These restrictions may limit the uptake of HIV testing and counselling, as well as hinder adherence to treatment, thereby undermining progress on other targets. They also restrict people’s basic freedom of movement, and should be eliminated.

Achievements and challenges

Countries in the region are realizing that restrictions on entry, stay and residence of people living with HIV are ineffective and counter-productive in protecting public health. They are also associated with practices such as mandatory HIV testing and high levels of stigma and discrimination that violate the human rights and dignity of migrants and people living with HIV.

Mongolia’s new HIV law, which took effect on 15 January 2013, eliminated HIV-related restrictions on entry, stay and residence and other punitive laws, including criminalization of non-disclosure. Ensuring that such law reforms are reflected in immigration policies, forms and practices is an important next step for Mongolia and other countries that have eliminated such restrictions.

Countries that have already eliminated HIV-related restrictions on entry, stay and residence acknowledge that laws and policies applying to migrants from and within the region remain a significant challenge to effective AIDS responses. Many of the region’s citizens face discrimination as a result of restrictions on entry, stay and residence when travelling overseas as migrant workers.

Mandatory HIV testing without consent, compulsory disclosure to prospective employers and HIV-related stigma all violate migrants’ human and labour rights. Often, these practices take place before the prospective migrant has departed and are therefore within the control of governments that have committed to eliminating HIV-related travel restrictions and HIV-related discrimination in the context of employment.

How Asia and the Pacific can reach target 9

Reaching target 9 in the remaining 11 countries — Australia, Brunei Darussalam, Democratic People’s Republic of Korea, Malaysia, Marshall Islands, New Zealand, Papua New Guinea, Samoa, Singapore, Solomon Islands, Tonga — will require a greater rate of progress and will entail raising awareness among policy-makers and key decision-makers in ministries of health, interior, justice, labour and migration. Regional and national coalitions of Government officials and civil society, including people living with HIV, can play an important role in building momentum for the elimination of travel restrictions in the region.

- To protect the rights of migrant workers living with HIV, collaborative efforts by migrant sending countries (largely in south and south-east Asia) towards the elimination of travel restrictions in destination countries are critical. This requires effective advocacy targeting migrant-receiving countries within the region as well as concerted action between the Asia and the Pacific and the Middle-East and North Africa regions, the latter absorbing the bulk of the former’s migrants.
- Regional mechanisms (such as ASEAN and SAARC) can be effective and influential in advocating the rights of their citizens going abroad as migrant workers. The Pacific Islands Forum should also actively address the elimination of HIV-related travel restrictions in seven of its member countries.
- At home, countries must educate all workers about their rights, and take responsibility to ensure that policies and practices applied to prospective migrants do not contravene national laws prohibiting mandatory HIV testing, HIV testing without informed consent, disclosure of HIV status and HIV discrimination in the context of employment.
- The Global Commission on HIV and the Law recommends that countries offer the same standard of protection to migrants, visitors and residents who are not citizens as they do to their own citizens. It also recommends countries repeal travel and other restrictions that prohibit people living with HIV from entering a country and regulations that mandate HIV tests for foreigners within a country. In addition, countries are urged to take steps, as Thailand is doing, to ensure equal access to HIV services for non-citizens within their jurisdiction.

Spotlight

Mongolia eliminates HIV-related restrictions on entry, stay and residence

On 15 January 2013, sweeping legal reforms came into effect in Mongolia that included the removal of a range of discriminatory provisions against people living with HIV and putting in place improved legal protections against HIV-related discrimination.

The amended Law on Prevention of HIV and AIDS removes prior HIV-related travel restrictions on entry, stay and residence, meaning that foreigners applying for residency visas are no longer required to disclose their HIV status or face deportation if they are found to be HIV positive. Employment restrictions that previously prevented HIV positive people from undertaking certain jobs, including in the food industry, were also removed.

The law also mandates the establishment of a multisectoral body, comprising Government, civil society and private-sector representatives, to oversee the country’s HIV and AIDS efforts and implement the necessary reforms to reflect the new laws.

These changes to the law are consistent with Mongolia’s commitment to eliminate HIV-related restrictions on entry, stay and residence, and to make solid progress towards the elimination of HIV-related stigma and discrimination. By taking bold steps to eliminate discriminatory, restrictive or punitive measures against people living with HIV, the Mongolian Government has demonstrated its strong commitment to protecting the fundamental rights of individuals and minorities affected by the epidemic, and to controlling the spread of HIV.

Spotlight

Thailand's new initiative to protect migrant workers' health

Thailand has taken leading steps towards realizing international human rights protections for migrant workers and to ensure that all people in Thailand can access basic health care.

In a bid to ensure migrant workers can gain equal access to health services, the Government has extended the national health insurance policy to include all migrant workers and their families, regardless of their documentation status.

In the past, health insurance failed to reach migrant workers who were working in Thailand without registration documents, who will now be eligible under the new initiative.

This forward-moving policy meets the high standards set in the Constitution of Thailand and the National Health System Charter that affirms health as a fundamental human right and guarantees that health protections apply to everyone living in Thailand.

The policy is expected to benefit an estimated three million migrant workers and their families—mostly from neighbouring Cambodia, Lao People's Democratic Republic and Myanmar—who form a significant and valuable part of Thailand's workforce and communities.

All migrants will now be able to register for health service access and buy health insurance at an annual cost for adults of 2200 Thai baht and 365 baht for children up to seven years old. The insurance provides for comprehensive health care, including HIV treatment and maternity care. While there remain challenges for migrants who cannot afford the annual health insurance fees, for many families and communities the new programme will provide vital access to health services.

Four working groups will be set up to oversee and examine the implementation of the new policy to ensure that migrants, employers and health services can realize better health outcomes.

The initiative was launched in September 2013 at a joint meeting hosted by Prime Minister Yingluck Shinawatra, bringing together key ministries and government agencies, United Nations agencies, international organizations and civil society.

10.



Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

Reducing parallel systems is essential to increase the equity and effectiveness of HIV programmes and health outcomes. In Asia and the Pacific, countries are scaling up efforts to increase effectiveness through greater integration.

To reach target 10, countries in the region need to develop and implement a roadmap for integrating the AIDS response over the long term, based on the specific characteristics of their own AIDS epidemic. Strengthening both health and community systems to deliver is critical to progress in this area.

Achievements and challenges

Many countries in the region have made significant strides in integrating HIV and tuberculosis services. Progress is slower in integrating HIV services within sexual and reproductive health settings—a critical challenge for countries with concentrated epidemics. There has similarly been limited progress in integration for prevention of new HIV infections among children with maternal and child health care in settings where such focus is essential.

Where there has been integration of health and community systems at the level of specific projects, there have been clear benefits, including increased uptake of HIV testing and counselling, as well as improved adherence to treatment. However, resource constraints and disagreement on approaches have meant initiatives have largely been small-scale. Approaches need to be tailored to country contexts. As such, countries have yet to achieve broad national

Target 10

adoption and scale-up necessary for integration to have a significant impact.

When reviewing their progress towards the 10 targets, most countries included reaching target 10 in their national strategic plans. However, many countries reported a lack of clarity about integration and how to monitor it. There are varying interpretations of service integration, including integration of Government-driven and donor-driven programmes, or integrating HIV services into the broader health system. The inherent need for an effective AIDS response to be multisectoral is not well understood.

There are multiple country-level coordination mechanisms for the AIDS response, including national AIDS committees, Country Coordinating Mechanisms for Global Fund grants and other donor-led mechanisms. Separate planning, funding, management and delivery systems create challenges in developing and implementing a harmonized response.

In some countries, multiple coordination streams have hampered the effective integration of HIV programmes within the health sector and other sectors. In India and Thailand, social protection initiatives that are integrated with the AIDS response have shown significant benefits in risk reduction and improved health-seeking behaviour, including adherence to HIV treatment.

How Asia and the Pacific can reach target 10

- In the early years of the HIV epidemic, national AIDS committees were vital for AIDS programmes to be effective. There is now an opportunity for Asia and the Pacific to create a revised model of national AIDS governance architecture. On-going efforts should focus on coordination between sectors, ensuring engagement, financing and monitoring of services provided for key populations.
- The HIV response should be integrated into broader health financing with specific resources set aside for delivery and strengthening of community systems. Strengthening of community

systems will enable greater reach to people who may not come into contact with traditional systems and services. This process will likely be helped by the Global Fund's new funding model, which creates incentives for integrated programme planning and management.

- Integration of sexual and reproductive health and HIV services must be improved to ensure women living with HIV and female key populations at higher risk can access the range of service they need: a full range of contraceptive methods; HIV testing and counselling, prevention, treatment and care services; antenatal, delivery and post natal care including programmes to stop new HIV infections among children; and services and support to respond to gender-based violence including emergency contraception and post-exposure prophylaxis.
- As social protection is established across the region, steps should be taken to ensure full access to services of employment and skills training, education and nutritional support and income subsidies for people living with HIV in need. Where possible, partnerships between Government service providers and civil society organizations servicing key populations should be established to ensure accessibility.
- In many countries, governance structures, such as the National AIDS Committee and Country Coordinating Mechanism, should be strengthened and adapted to support integration and should be streamlined or merged where relevant. This is particularly important for smaller countries and those with a low-level epidemic.
- To increase service uptake at the point of care, there is a need for greater engagement and development of communities in the delivery of services — particularly for HIV testing, counselling and treatment. These essential services need to be linked within the health system so that people who are tested are then able to seek whatever HIV prevention or treatment services they need.

Spotlight

Cambodia 3.0 gives a boost to continuum of care

In an effort to tackle the slow progress of coverage for preventing new HIV infections among children, Cambodia's National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Disease Control and the National Maternal and Child Health Centre introduced a collaborative strategy in 2008 — the Linked Response. The strategy was piloted in five districts, where it achieved 80% HIV testing coverage among pregnant women within the first year. This was thanks to good linkages between the antenatal care and HIV testing and counselling services, and from there to antiretroviral treatment delivery sites. Community-based organizations played a pivotal role, collaborating with health service providers to facilitate referral of the patients. The Linked Response approach was so successful that it was rolled out nationally in 2009.

Since then, a similar strategy — the Continuum of Care — has been used for the management of HIV and tuberculosis coinfection. Cambodia's HIV and tuberculosis services began collaborating more closely, from planning to mutual referral and monitoring results. Since its launch in mid-2010, it has reached more than 80% of coinfecting patients with tuberculosis screening, HIV testing and counselling and antiretroviral treatment for notified TB patients.

In 2013, building on these encouraging results and in response to the commitments set in the United Nations General Assembly 2011 Political Declaration on HIV and AIDS, the Government launched Cambodia 3.0, a plan to eliminate new HIV infections and AIDS-related deaths by 2020. The plan consists of three complementary 'boosted' strategies: the boosted Linked Response), the boosted Continuum of Care and the boosted Continuum of Prevention to Care and Treatment.

Key components of the strategies include enabling more people to find about their HIV status through earlier HIV testing and counselling (including for partners), and better management to reduce loss to follow-up. Cambodia 3.0 is expected to yield benefits beyond HIV as the measures and tools being put in place will further improve the linkages between services, strengthening each of them in the process. The impact of Cambodia 3.0 will be assessed in 1–2 years.

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127 Eleven countries reported to impose some form of restriction on entry, stay and residence based on HIV status: Australia, Brunei Darussalam, Democratic People's Republic of Korea, Malaysia, Marshall Islands, New Zealand, Papua New Guinea, Samoa, Singapore, Solomon Islands, Tonga.

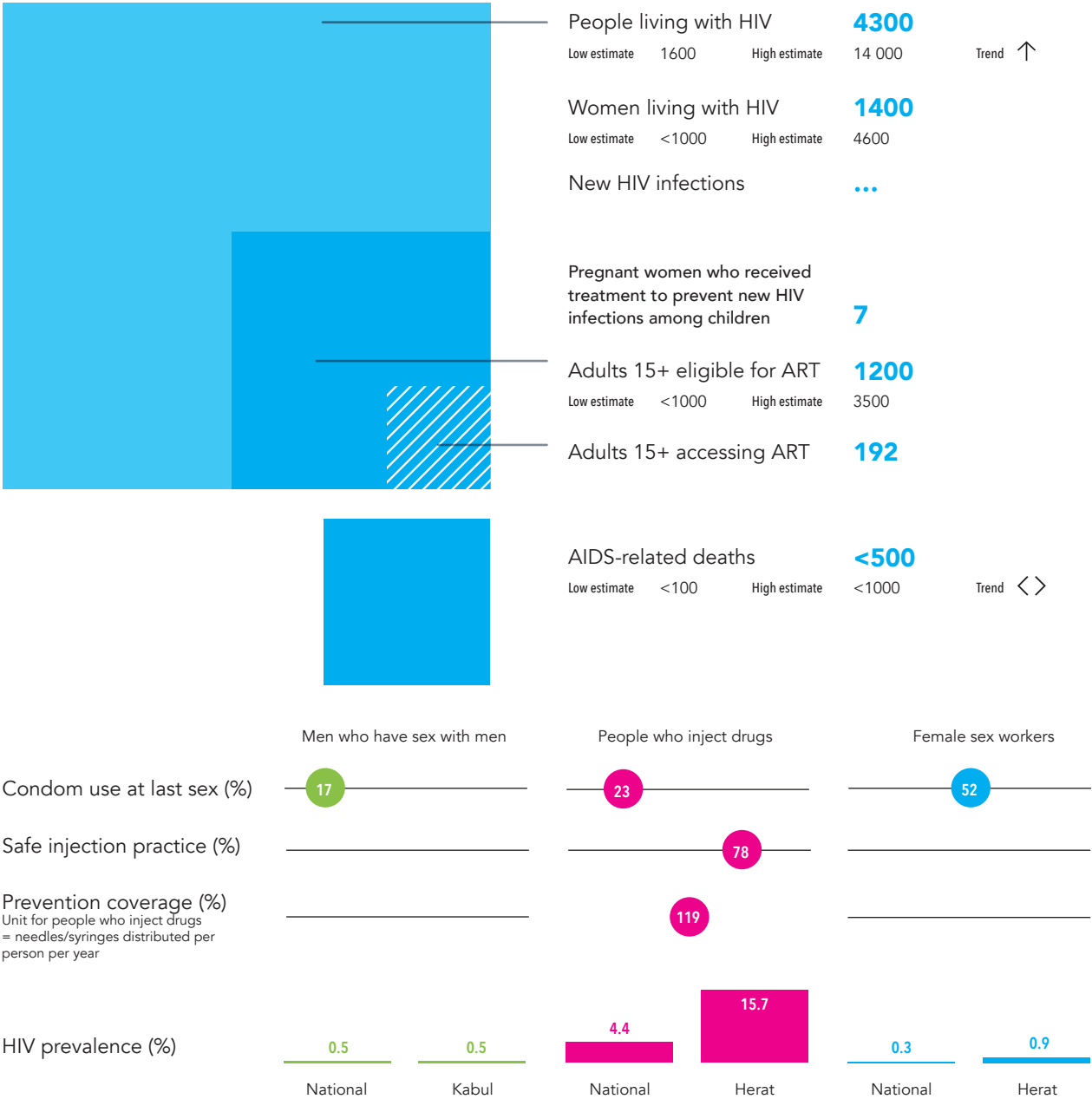
Annex

This Annex provides country-by-country data sheets on the HIV epidemic, the response and stigma and discrimination issues, based on the sources described in the first page of this report. All data on HIV-related restrictions on entry, stay and residence is UNAIDS 2013 data. The 20 countries featured in this annex are those that completed the 2013 mid-term reviews of UN 2011 Political Declaration targets and elimination commitments and those where data is available.

Differences between numerical information within the pages that follow and the Global report: UNAIDS report on the global AIDS epidemic 2013 are the result of more recent estimates that countries recommended to be reflected, as instructed through national review. Relevant citations and sources can be found at the end of the country-by-country annex (pXX).

- ↑ Increasing
- ↔ No change
- ↓ Decreasing
- ... No data available or no data published
- ART Antiretroviral therapy

Afghanistan



Funding

Domestic spending from public sources, 2012



0.5%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men and transgender people
- Criminalization of people who use drugs
- Criminalization of sex work

HIV-related restrictions on entry, stay and residence

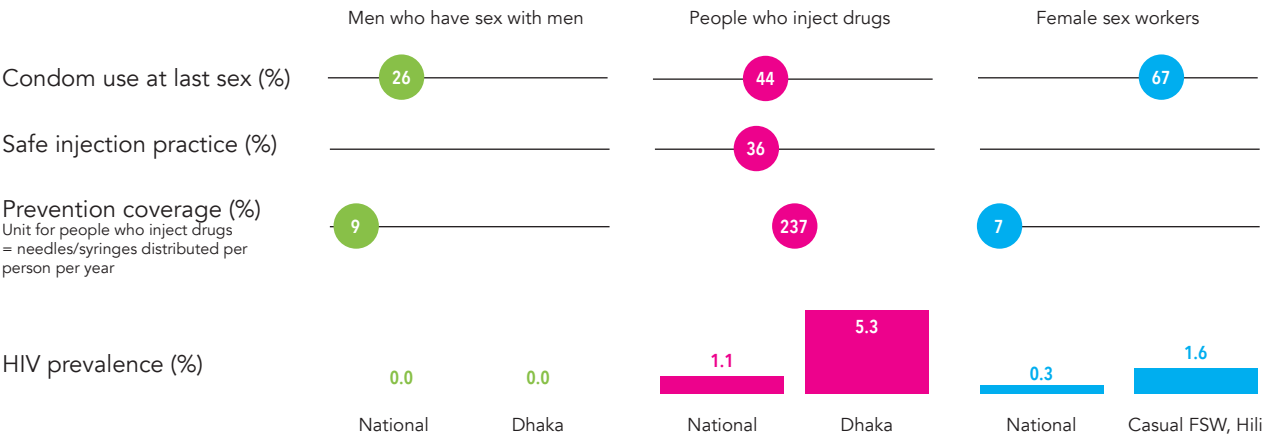
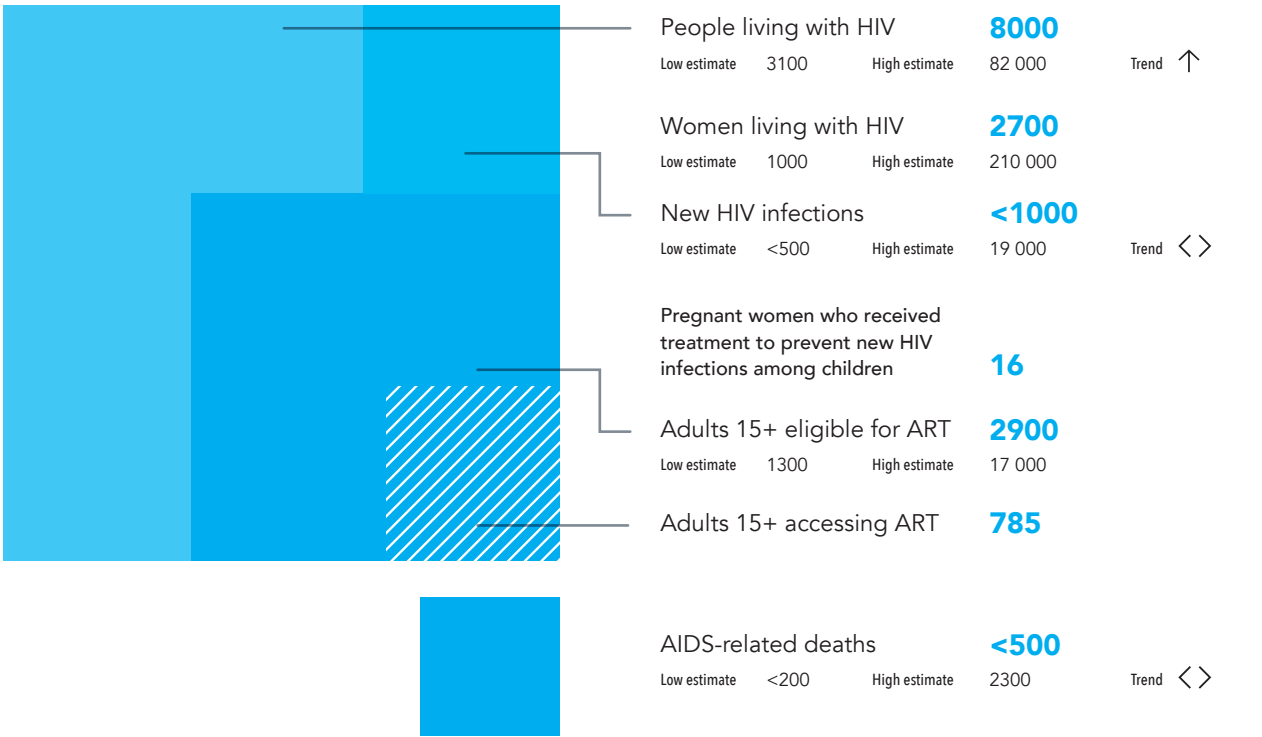
- No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

No Stigma Index conducted

Bangladesh



Funding

Domestic spending from public sources, 2012



8%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men and transgender
- Criminalization of people who use drugs
- Criminalization of sex work
- Public order offences, against sex workers
- Laws and policies preventing some HIV service provision in closed settings

HIV-related restrictions on entry, stay and residence

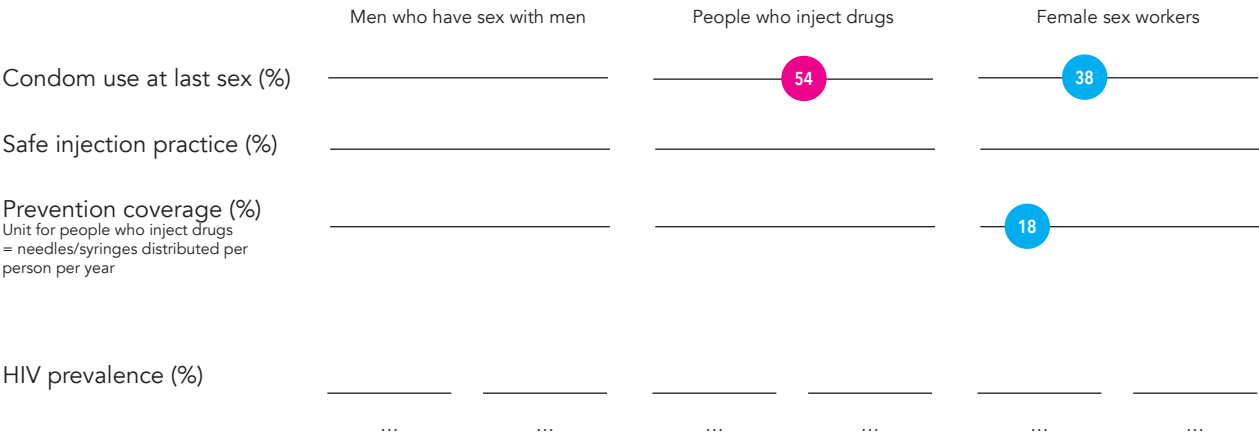
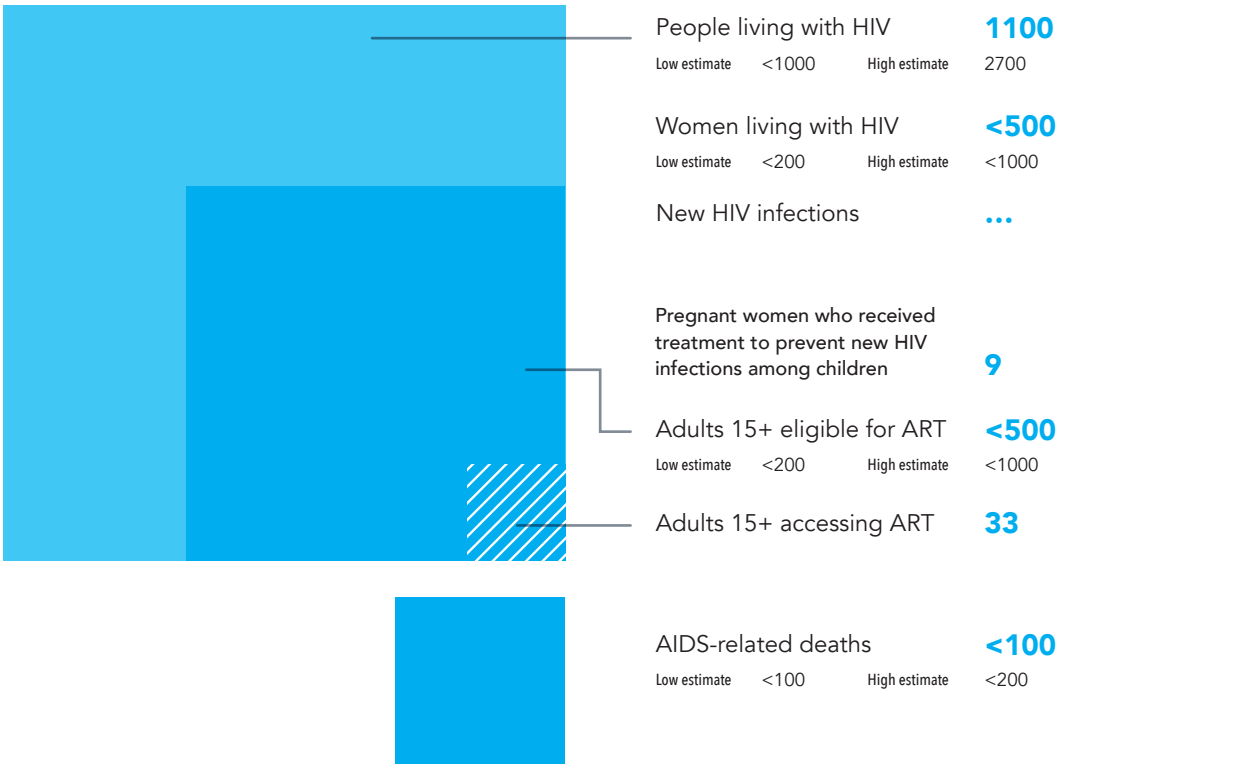
- No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2008)

20%

Bhutan



Funding

Domestic spending from public sources

- No

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

No legal barriers to access reported

HIV-related restrictions on entry, stay and residence

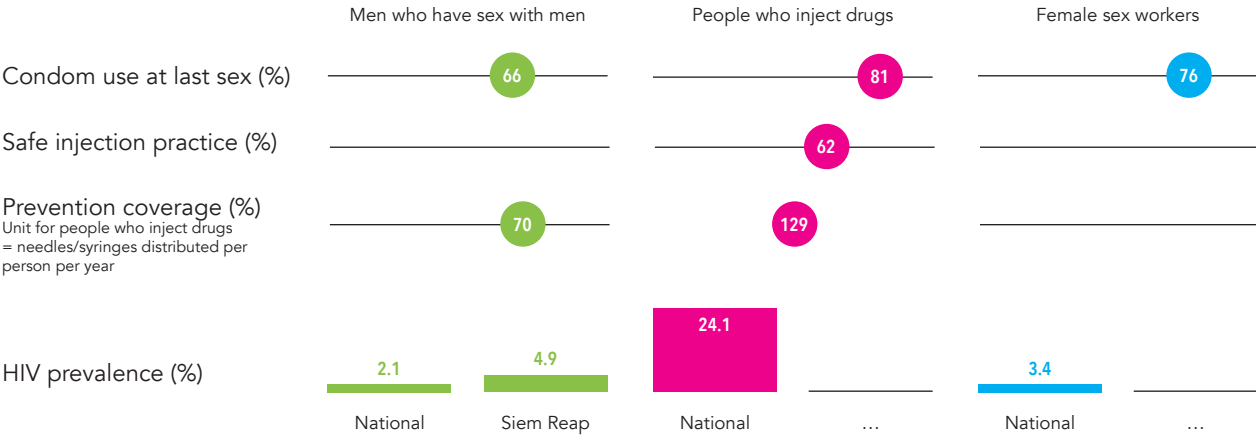
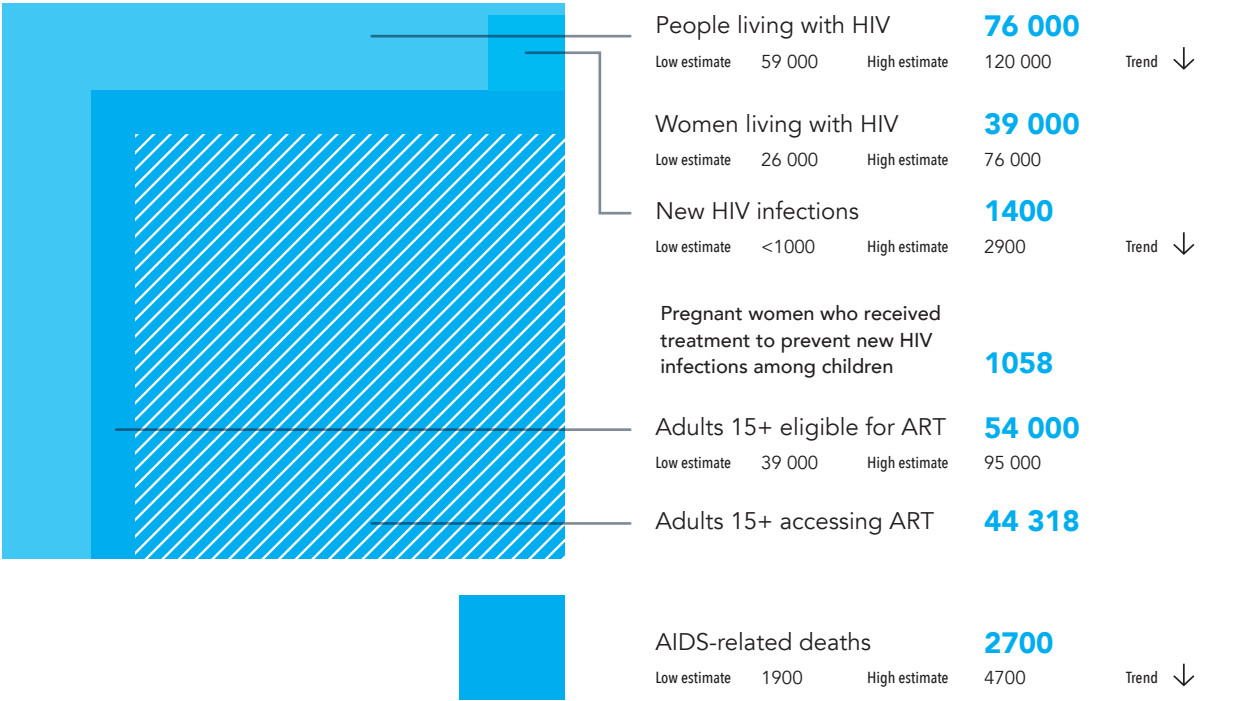
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Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

No Stigma Index conducted

Cambodia



Funding

Domestic spending from public sources, 2012



11%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of people who use drugs
- Criminalization of soliciting allows for arbitrary detention of and other abuses towards sex workers
- Policies allowing compulsory detention of people who use drugs and sex workers
- Laws, policies and practice only allow some HIV services provision in closed settings

HIV-related restrictions on entry, stay and residence

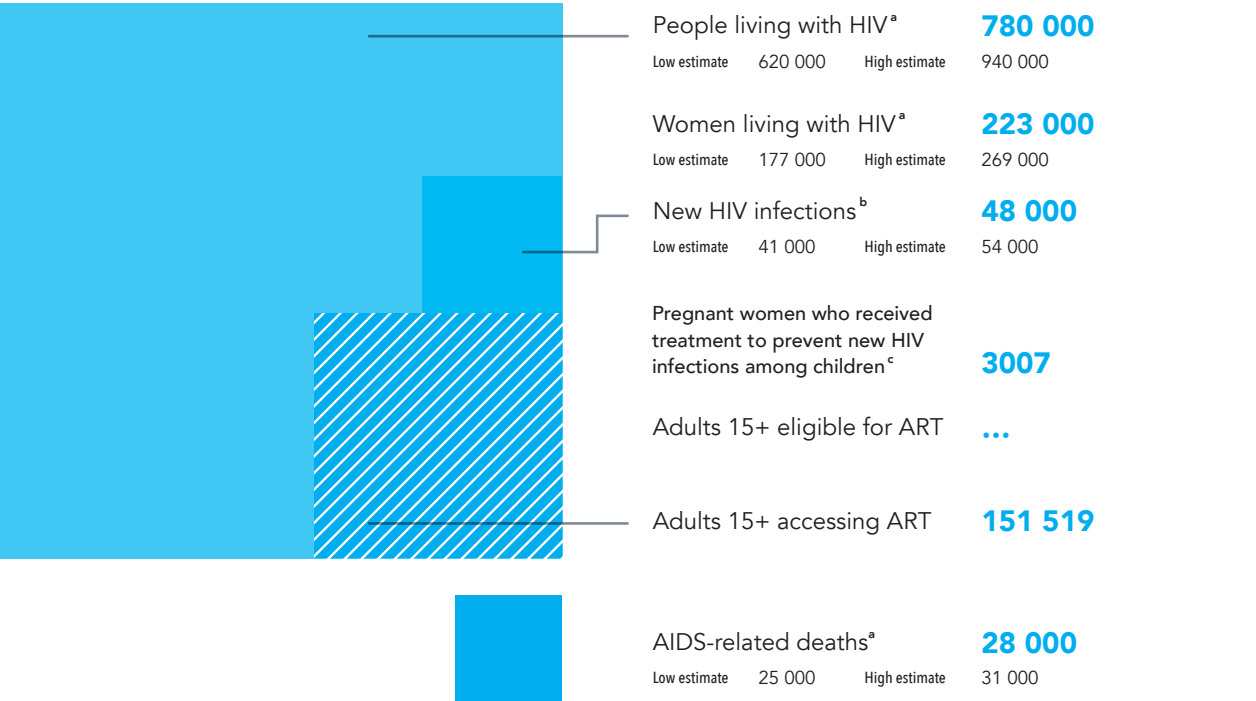
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Stigma Index

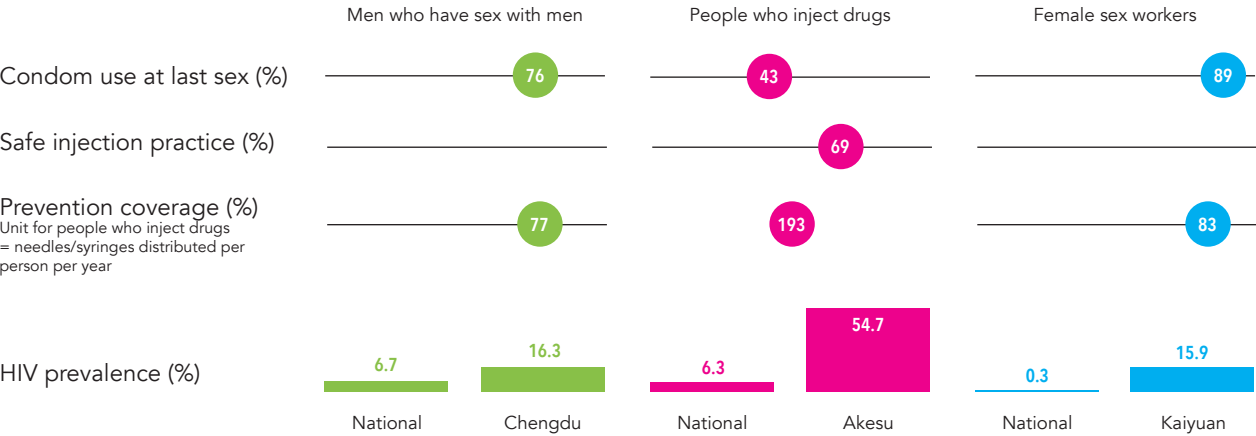
Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2010)

24%

China



^a 2011 estimates for the HIV/AIDS epidemic in China. ^b National Center for AIDS / STD Prevention and Control (NCAIDS), China. 2011 China HIV Estimates Report (unpublished). ^c 2013 China GARPR report.



Funding

Domestic spending from public sources, 2012



88%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of people who use drugs
- Criminalization of sex work
- Compulsory detention of sex workers for re-education / punishment / productive labour
- Laws that discriminate against migrants

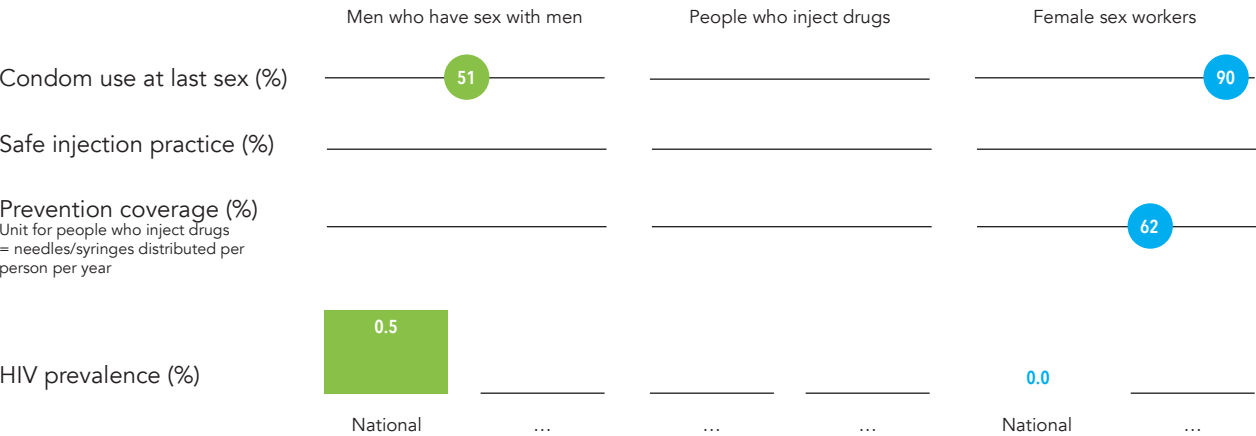
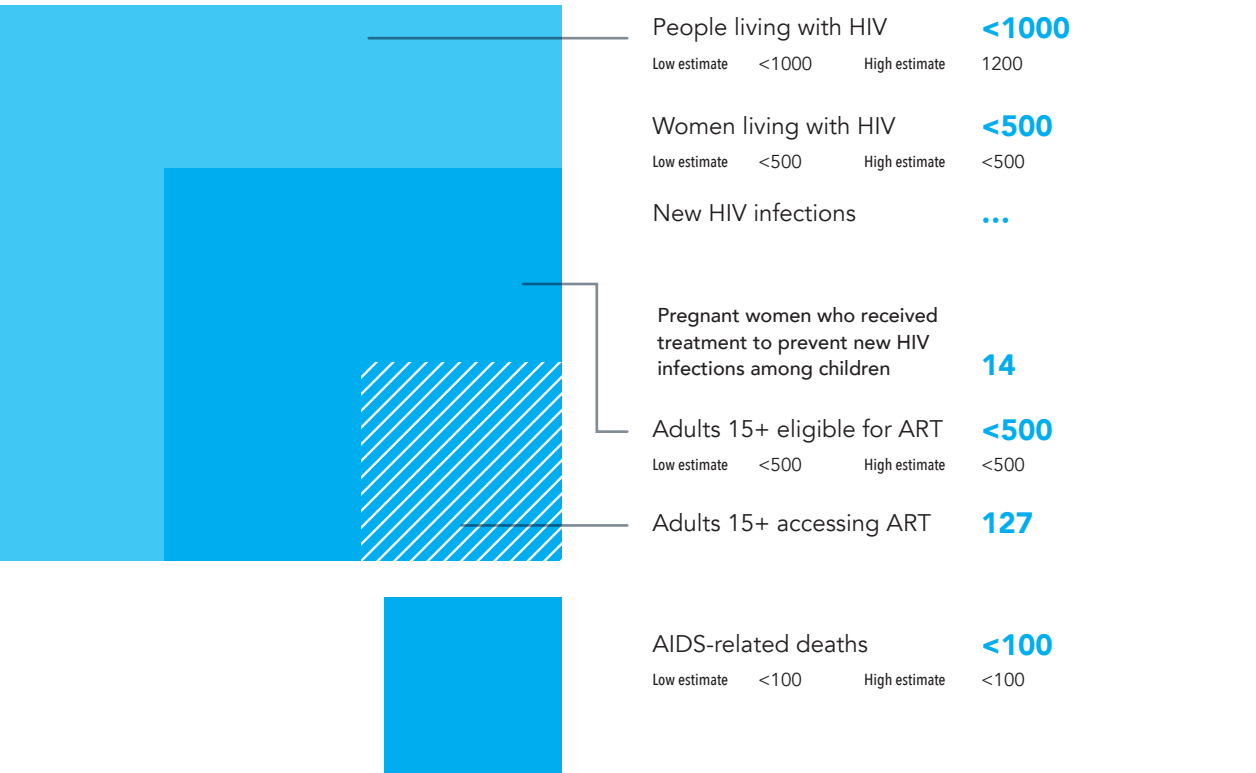
HIV-related restrictions on entry, stay and residence

- No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

Data not reported



Funding

Domestic spending from public sources, 2011



21%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of sex work

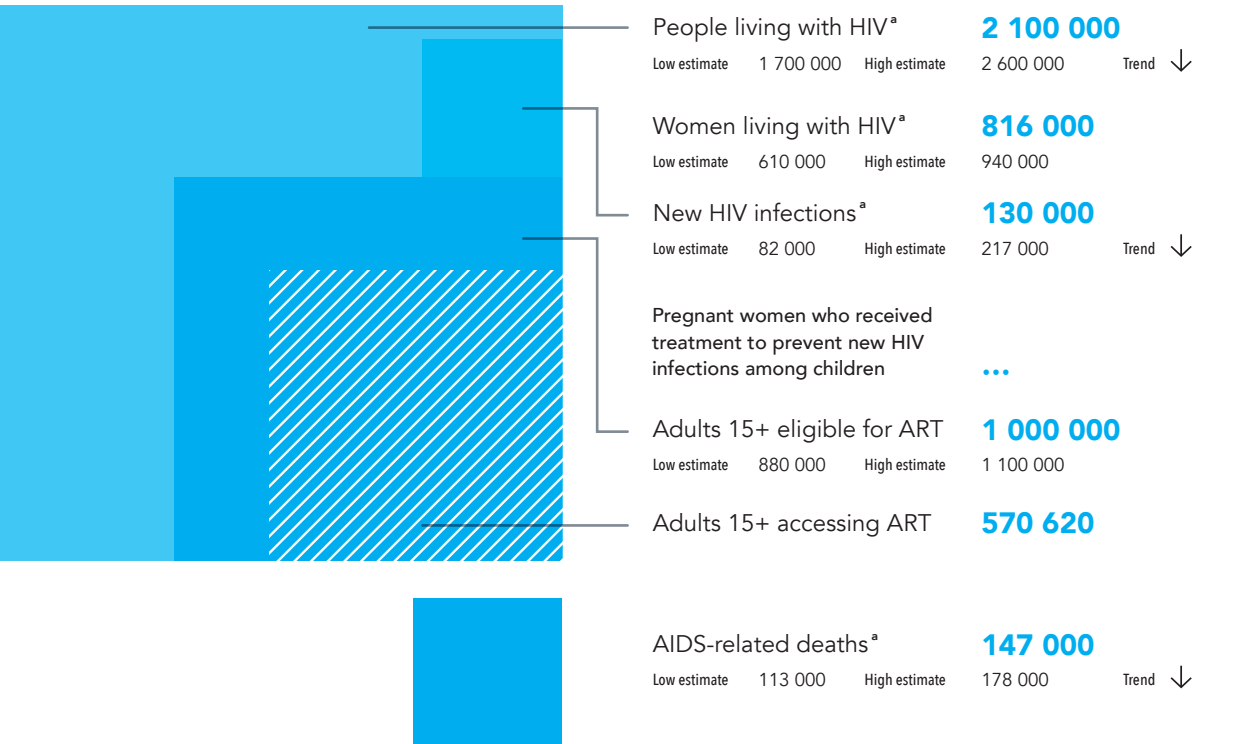
HIV-related restrictions on entry, stay and residence

- No

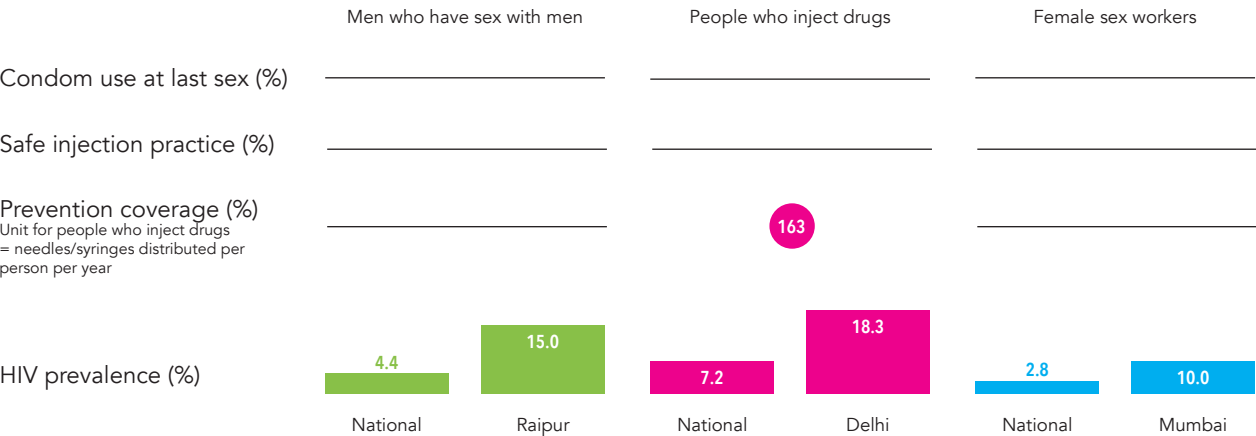
Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2009)

30%



^aEstimates are based on 2011 national data



Funding

Domestic spending from public sources, 2009



16%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of people who use drugs
- Anti-trafficking law (enforcement against sex workers, including compulsory detention of sex workers for rescue/rehabilitation)
- Public order offences against sex workers, men who have sex with men and transgender

HIV-related restrictions on entry, stay and residence

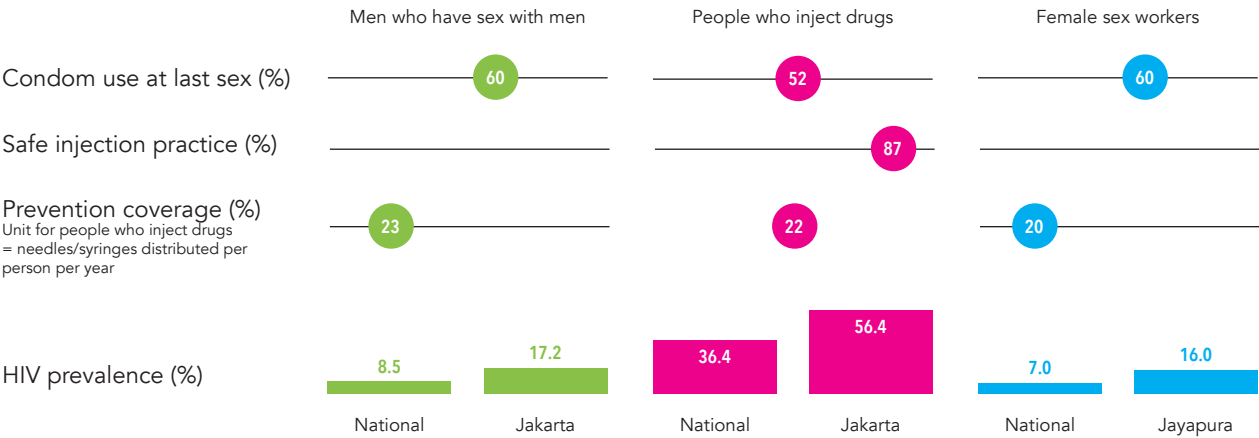
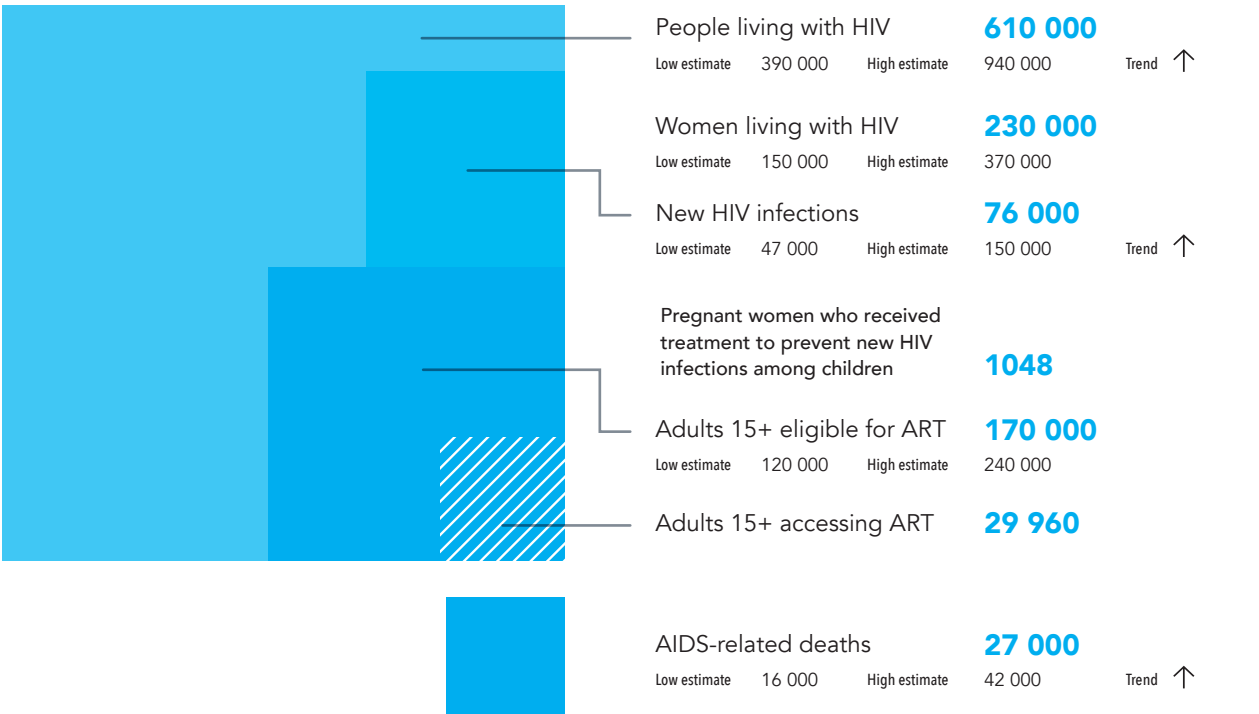
- No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

No data (pilot only)

Indonesia



Funding

Domestic spending from public sources, 2010



40%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of sex work (in some provinces or districts)
- Criminalization of men who have sex with men (in some provinces or districts)
- Criminalization of people who use drugs (in some provinces or districts)
- Compulsory drug treatment
- Laws concerning migrant workers
- Overly broad pornography laws hindering HIV information and programming

HIV-related restrictions on entry, stay and residence

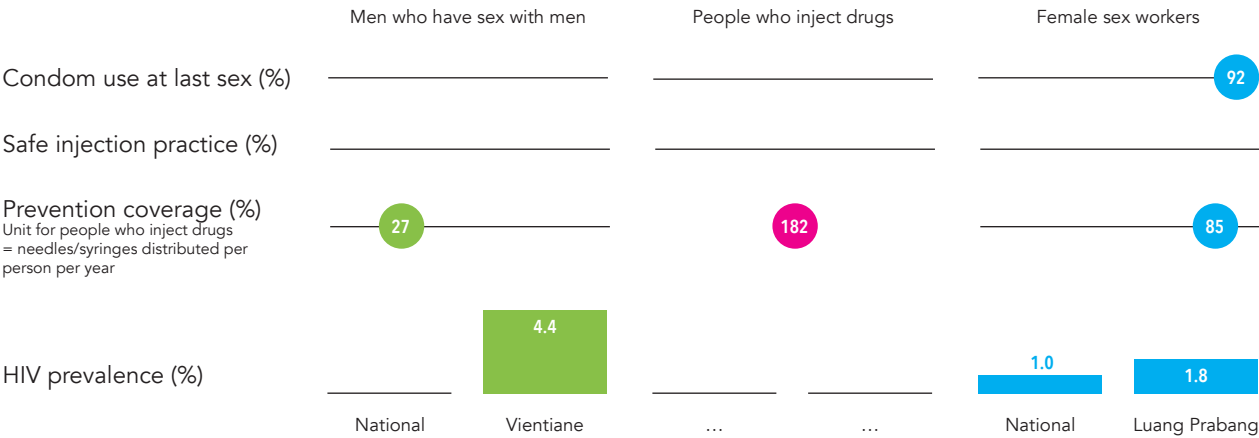
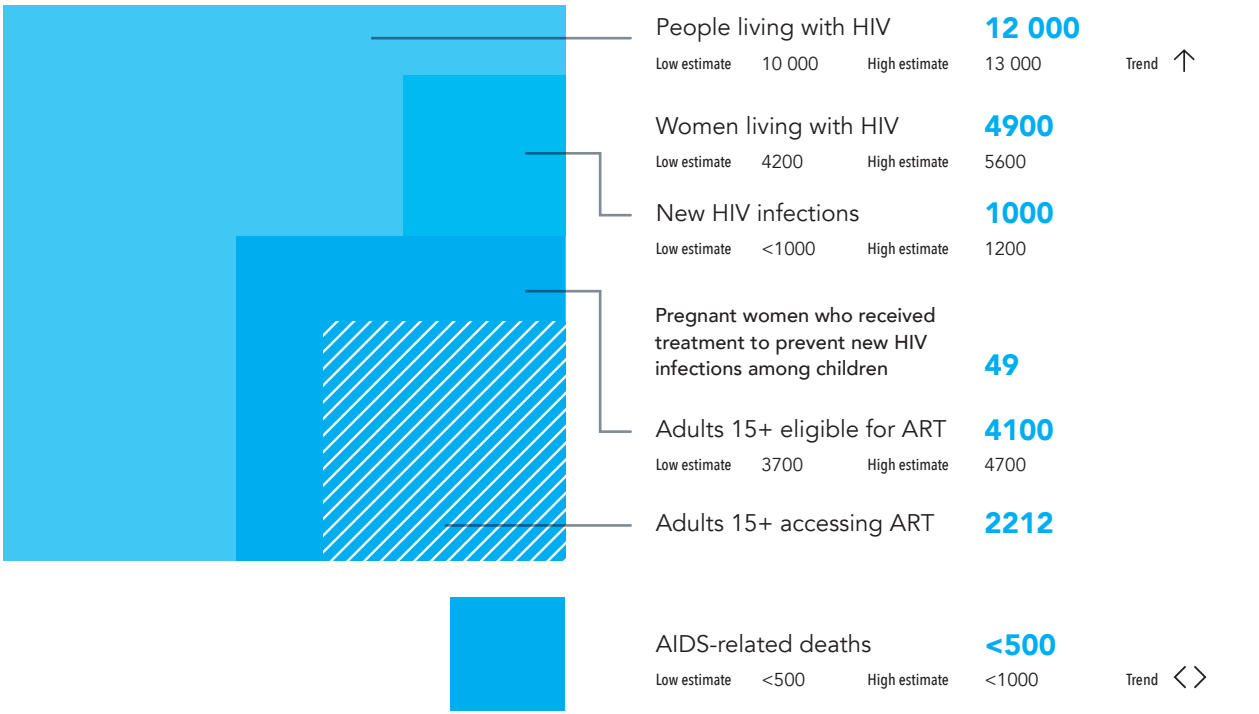
● No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

No Stigma Index conducted

Lao People's Democratic Republic



Funding

Domestic spending from public sources, 2011



7%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of people who use drugs
- Criminalization of sex work

HIV-related restrictions on entry, stay and residence

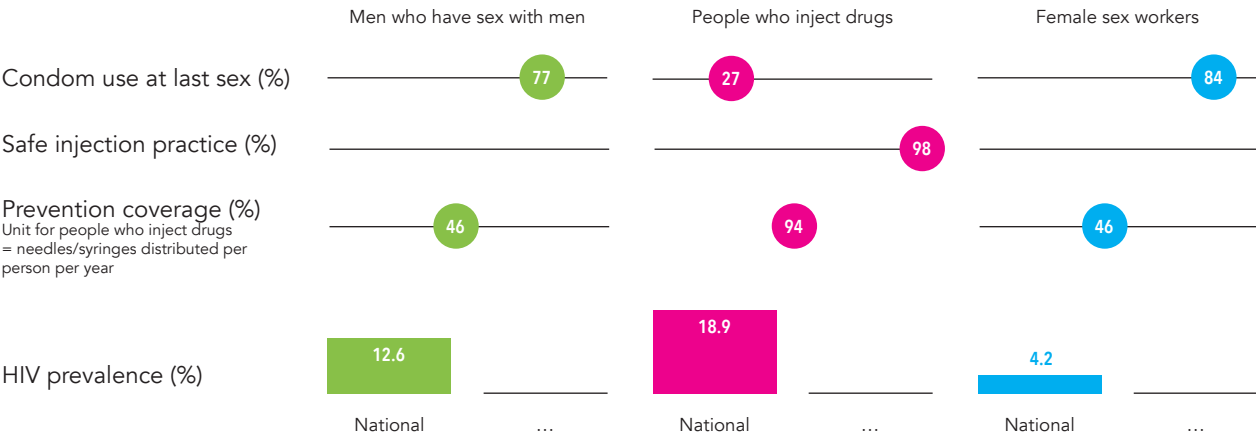
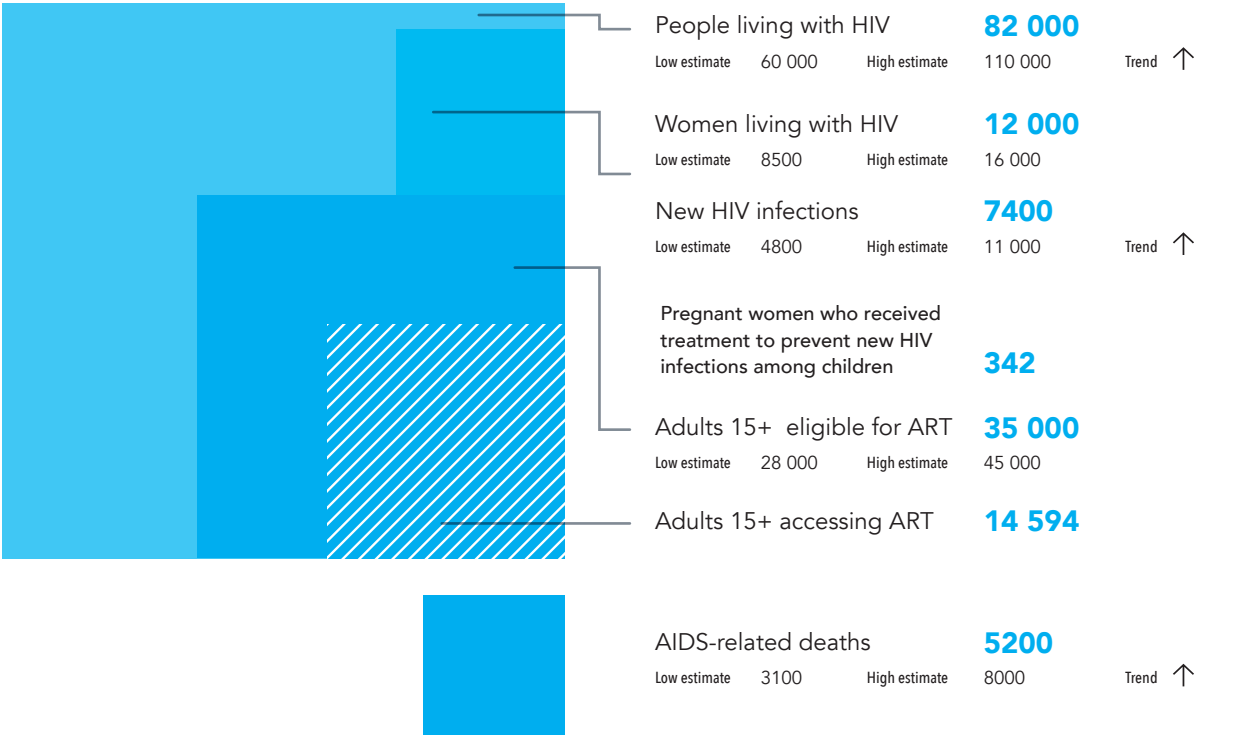
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Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2012)

36%

Malaysia



Funding

Domestic spending from public sources, 2012



97%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men
- Criminalization of people who use drugs
- Overly broad pornography laws hindering HIV information and programming
- Laws relating to migrant workers (mandatory testing)
- Criminalization of transgender (cross-dressing)

HIV-related restrictions on entry, stay and residence

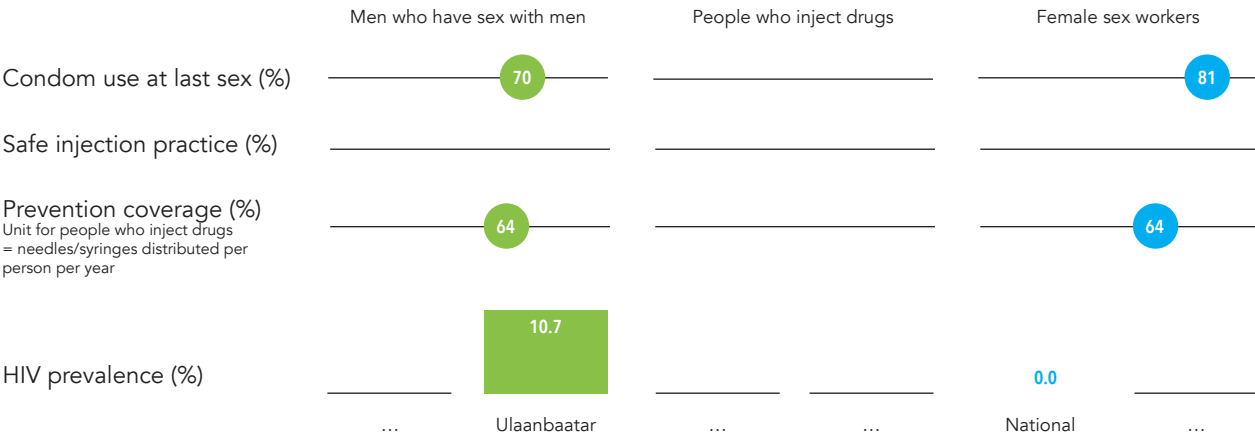
- Yes

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2010–2011)

14%

Mongolia



Funding

Domestic spending from public sources, 2011



31%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of sex work (also penalized under administrative laws)
- Penalties for drug use

HIV-related restrictions on entry, stay and residence

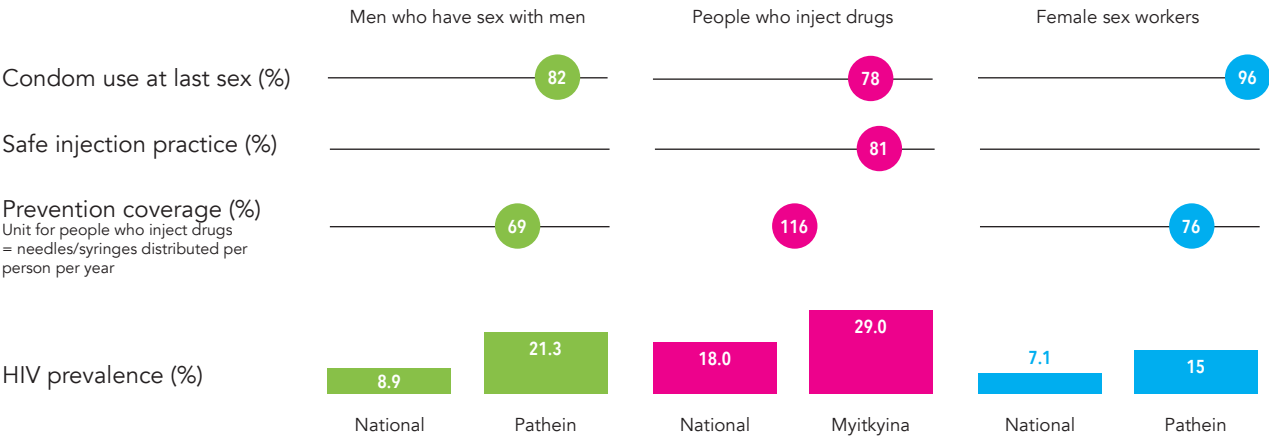
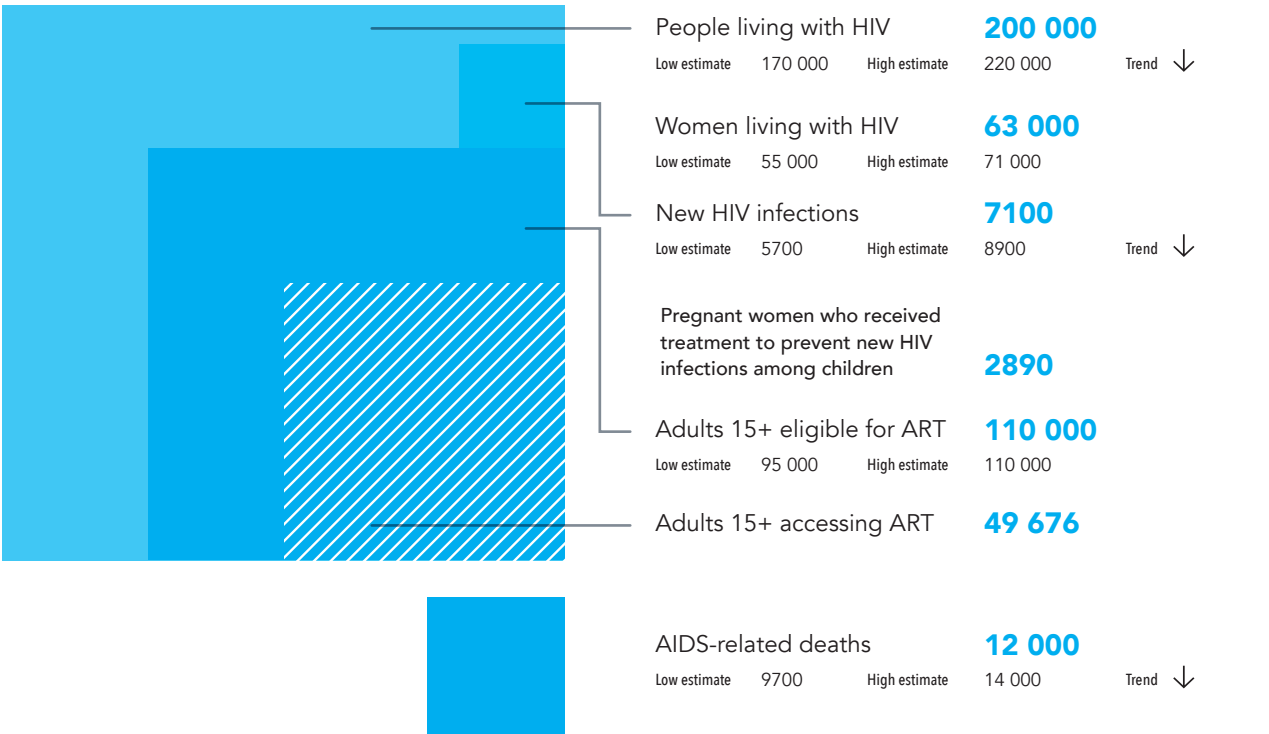
- No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

No Stigma Index conducted

Myanmar



Funding

Domestic spending from public sources, 2011



9%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men
- Criminalization of people who use drugs
- Criminalization of sex work

HIV-related restrictions on entry, stay and residence

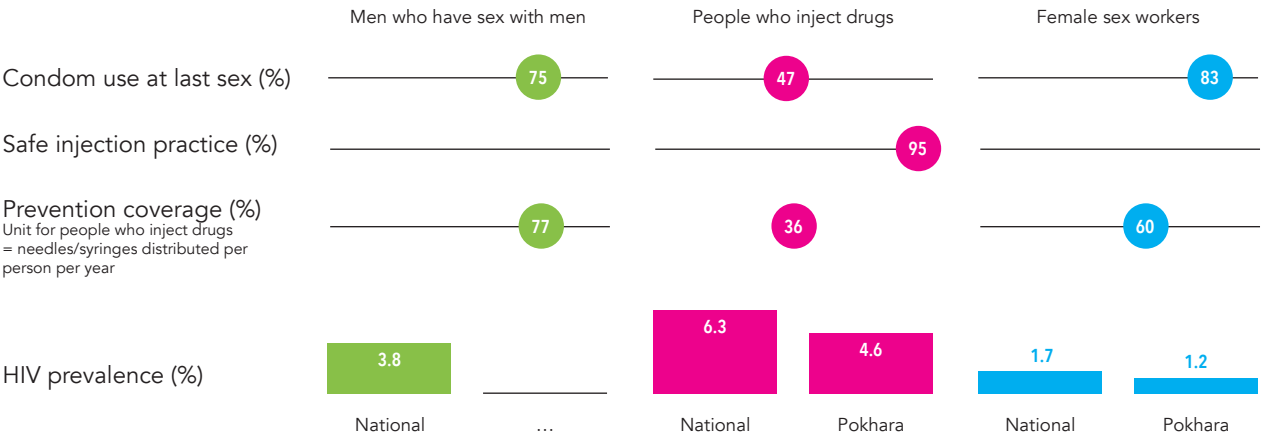
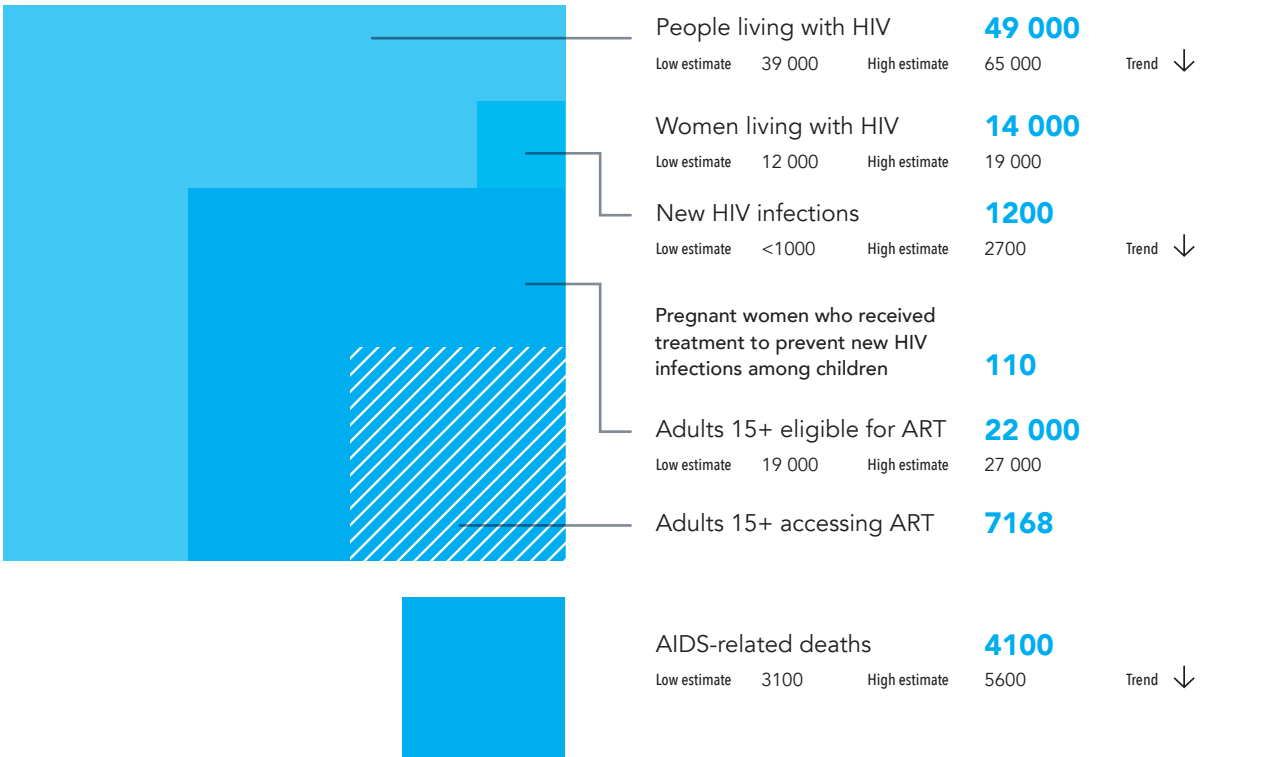
- No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2009)

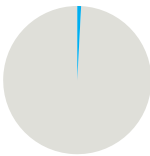
7%

Nepal



Funding

Domestic spending from public sources, 2009



1%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of people who use drugs
- Public order offences, against sex workers (including transgender sex workers)
- Laws and policies preventing some HIV service provision in closed settings

HIV-related restrictions on entry, stay and residence

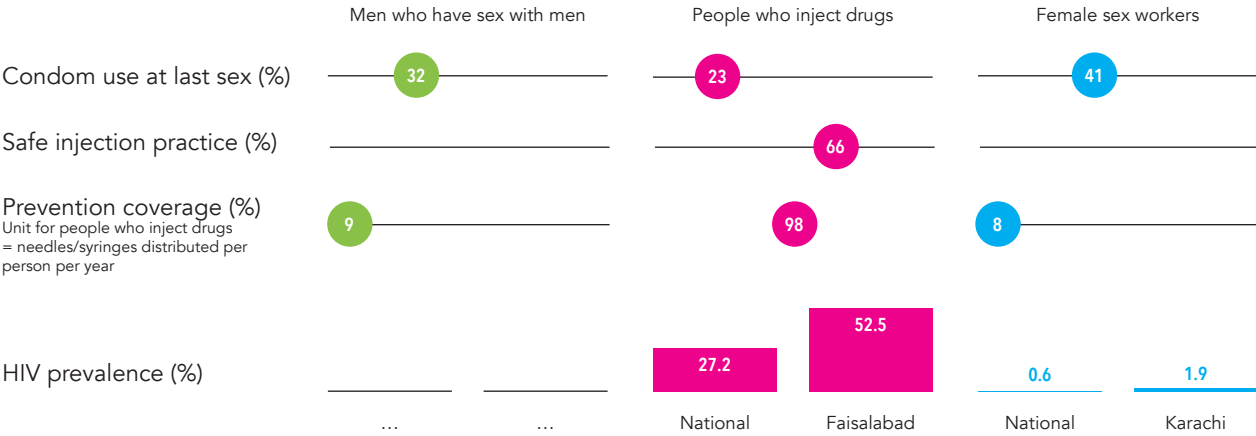
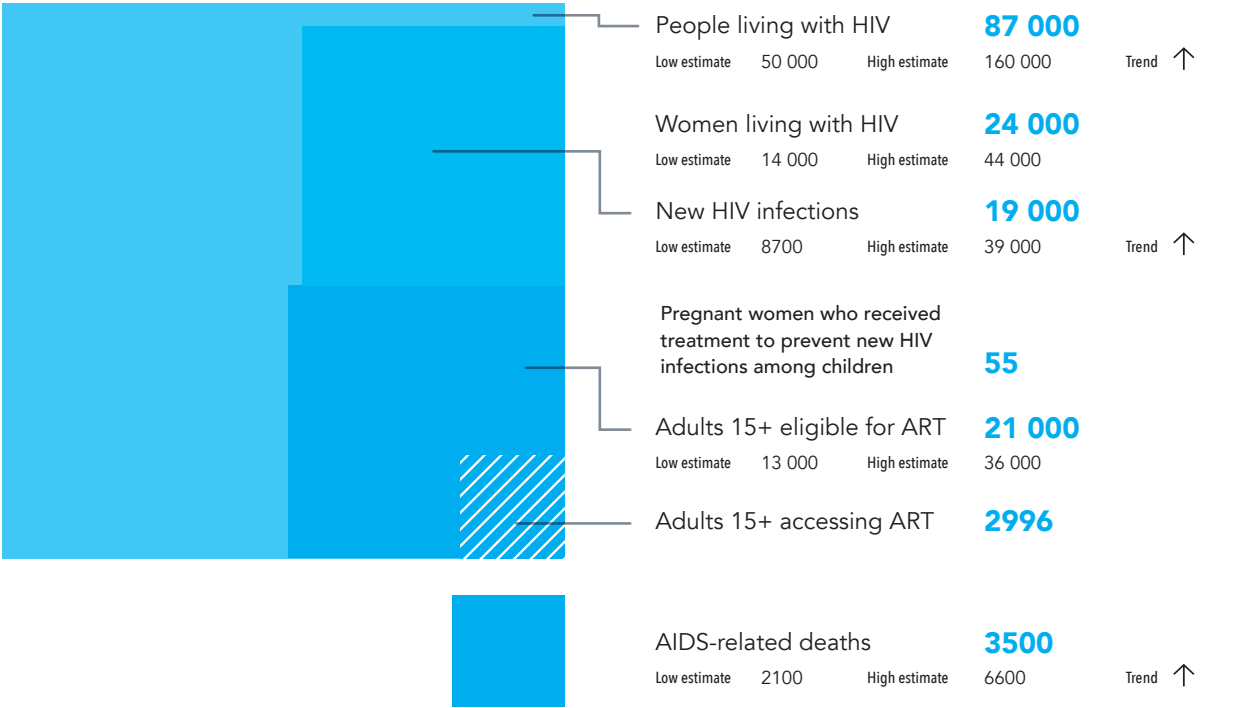
- No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2011)

11%

Pakistan



Funding

Domestic spending from public sources, 2010



37%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men
- Criminalization of some drug-related activities
- Criminalization of sex work

HIV-related restrictions on entry, stay and residence

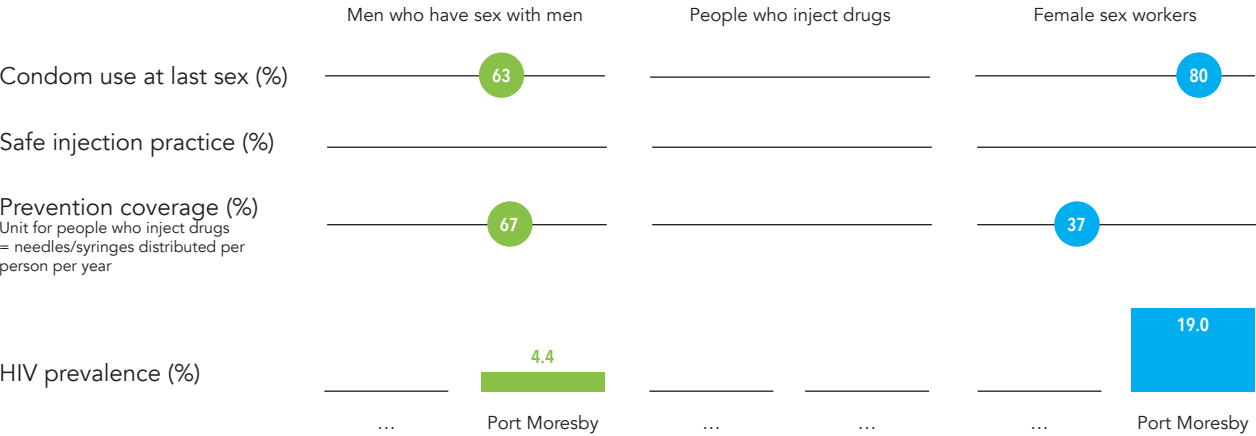
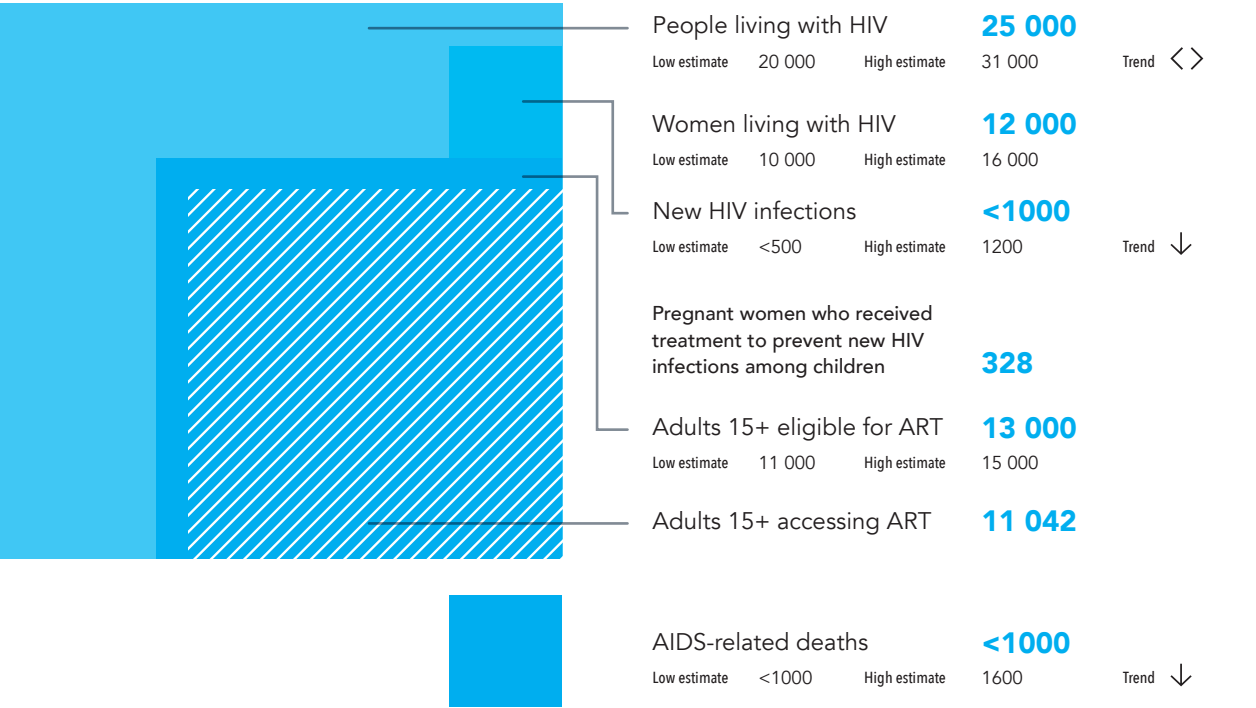
- No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2009–2010)

20%

Papua New Guinea



Funding

Domestic spending from public sources, 2010



24%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men
- Criminalization of people who use drugs
- Criminalization of sex work
- Customary law takes precedence over statutory law

HIV-related restrictions on entry, stay and residence

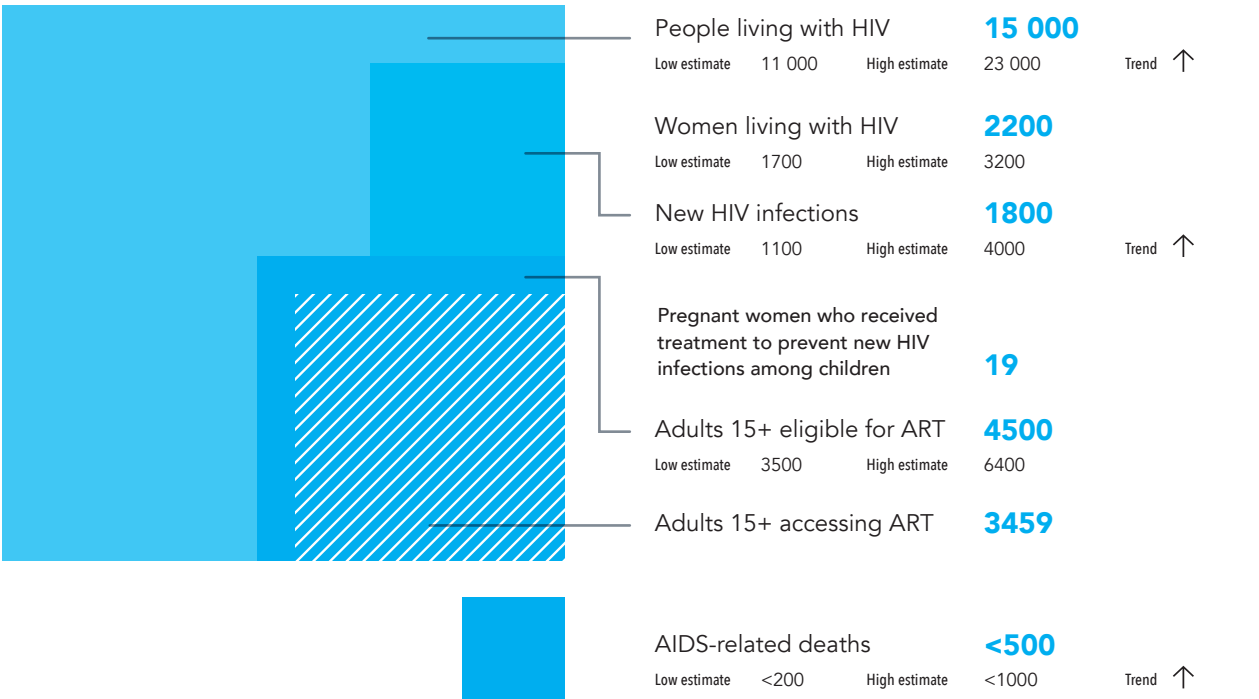
- Yes

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2012). Data is from 2 highlands provinces only.

41%

Philippines



Funding

Domestic spending from public sources, 2011



52%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Punitive laws relating to drugs (possession of drug paraphernalia)
- Criminalization of sex work
- Age of consent for HIV testing (18 years)

HIV-related restrictions on entry, stay and residence

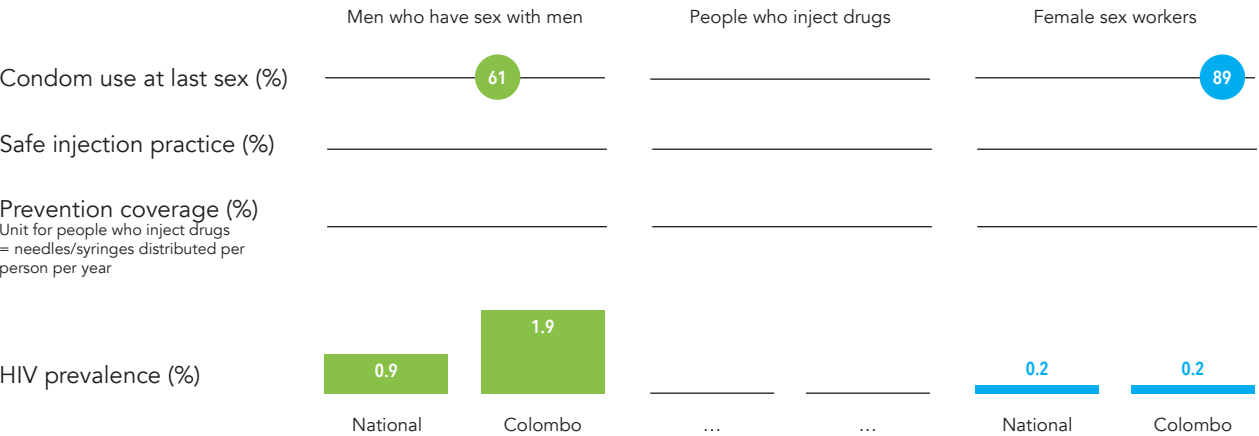
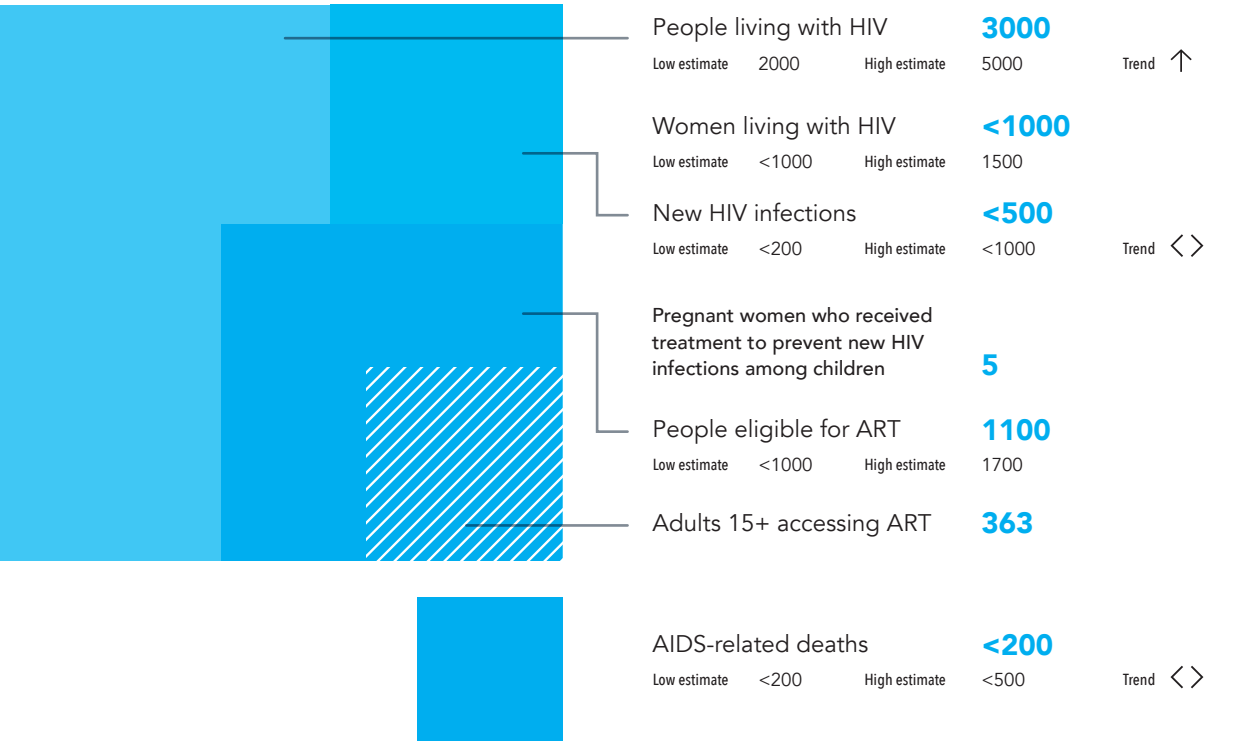
● No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2009).

32%

Sri Lanka



Funding

Domestic spending from public sources, 2010



53%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men
- Punitive laws relating to drug use (compulsory treatment)
- Criminalization of sex work
- Public order offences, against sex workers
- Laws and policies preventing some HIV service provision in closed settings

HIV-related restrictions on entry, stay and residence

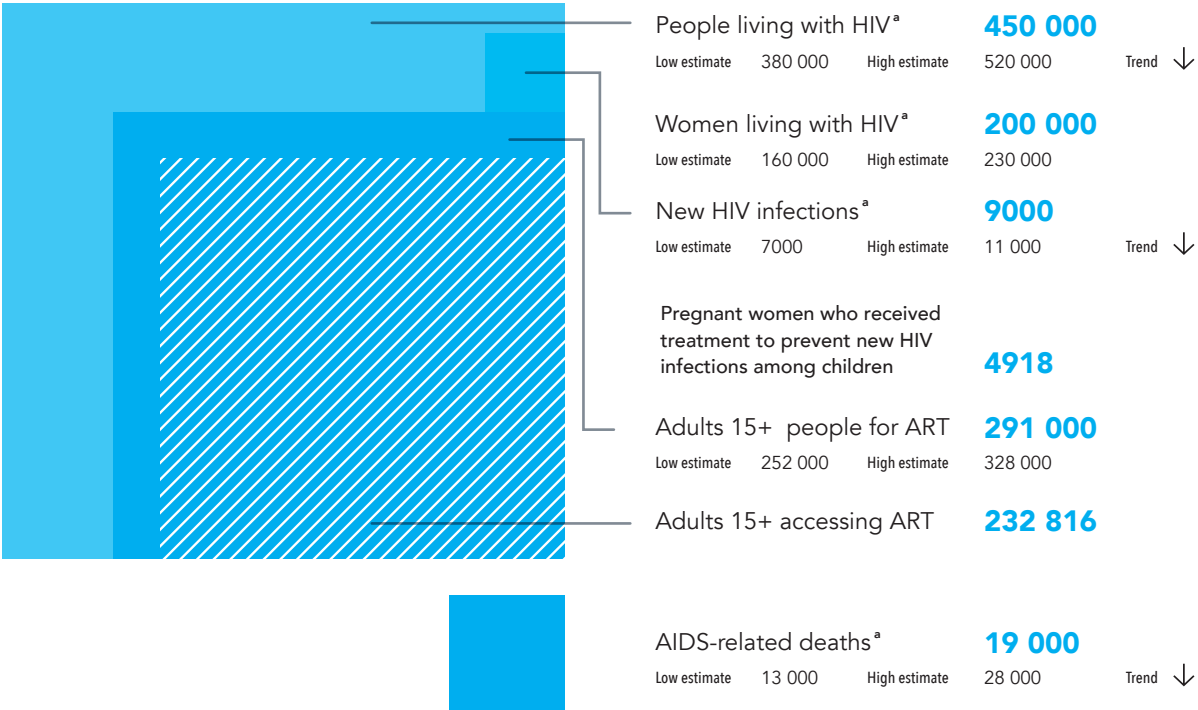
● No

Stigma Index

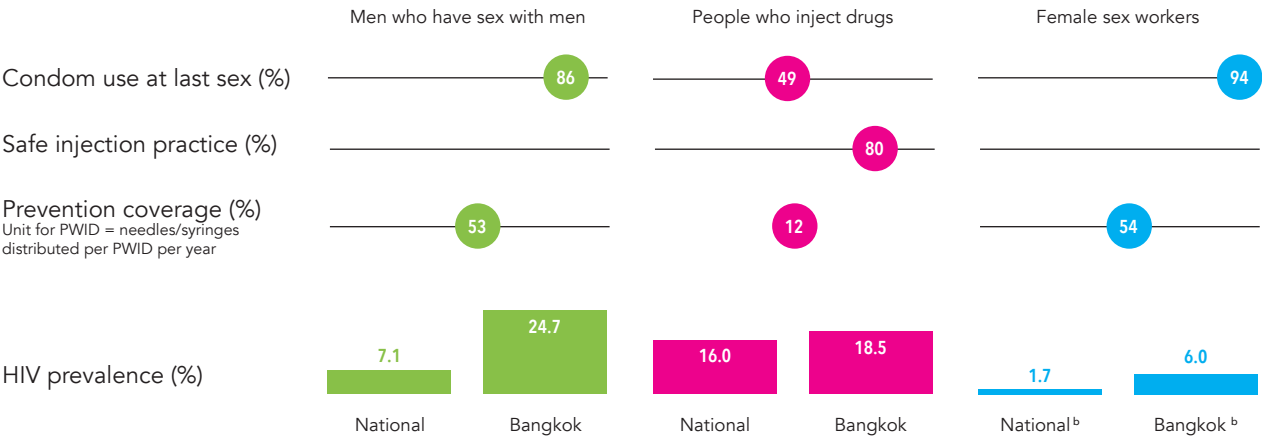
Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2009–2010).

30%

Thailand

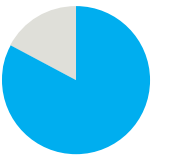


^a HIV infection estimates: Thailand Bureau of Epidemiology, Bureau of AIDS, National AIDS Management Center.



^b Indirect sex workers.

Funding
Domestic spending from public sources, 2010



85%

Stigma and discrimination
Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

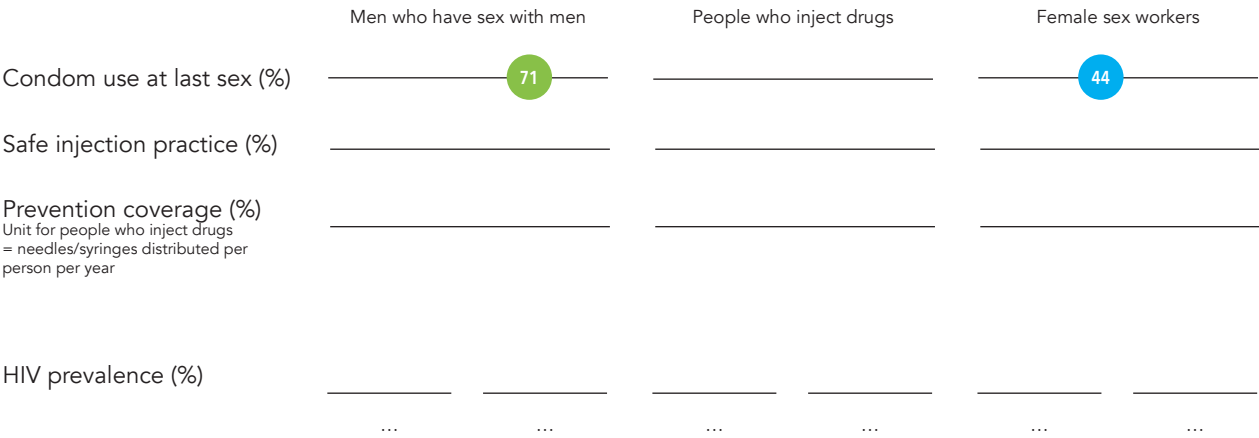
- Criminalization of people who use drugs
- Criminalization of sex work
- Age of consent for HIV testing (18 years)

HIV-related restrictions on entry, stay and residence
● No

Stigma Index
Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2009).

27%

Vanuatu



Funding
Domestic spending from public sources, 2011



2%

Stigma and discrimination
Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

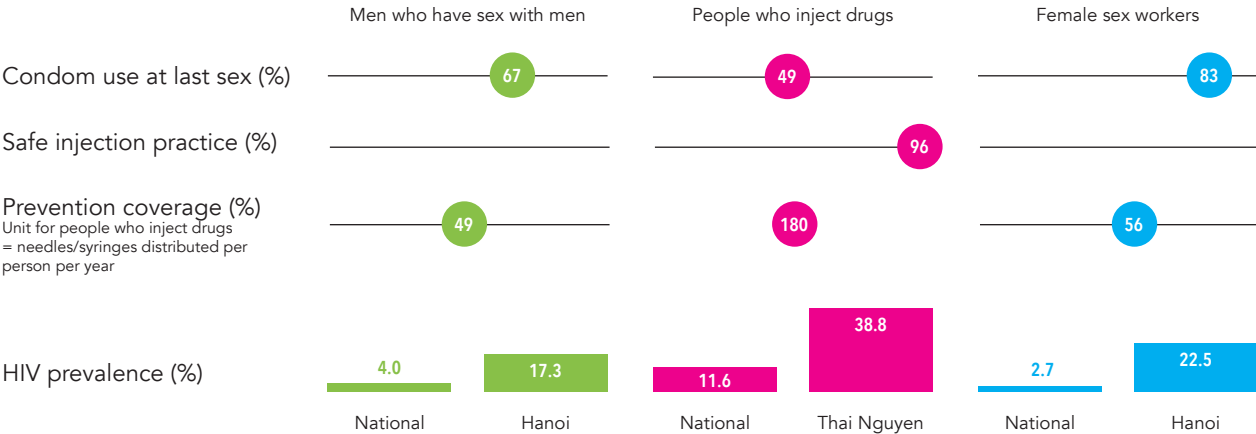
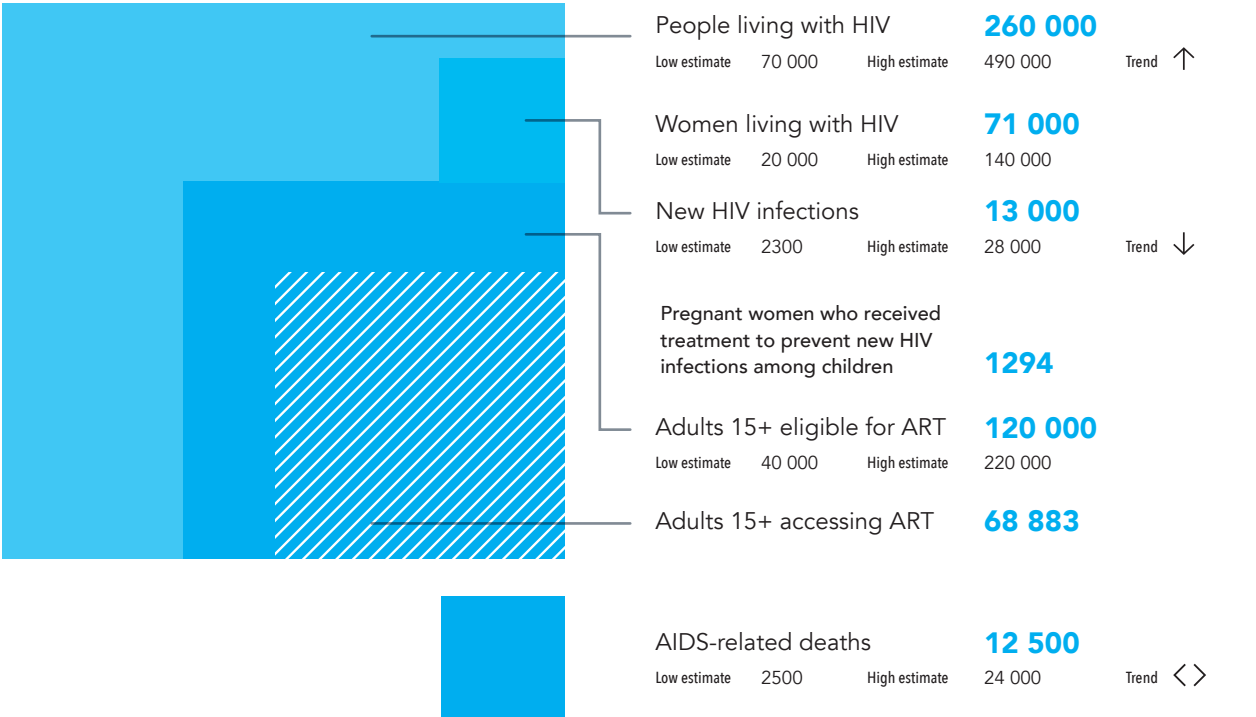
- Laws, regulations or policies present obstacles to effective HIV services for people living with HIV, men who have sex with men, people who inject drugs, orphans and vulnerable children, prisoners, sex workers, women and girls, young women/young men (specific type/nature of laws not detailed)

HIV-related restrictions on entry, stay and residence
● No

Stigma Index
Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

No Stigma Index conducted

Viet Nam



Funding

Domestic spending from public sources, 2010



17%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of sex work
- Compulsory detention of people who use drugs
- Laws and policies preventing some HIV service provision in closed settings
- Laws that discriminate against migrants
- Laws requiring disclosure of HIV status in certain contexts

HIV-related restrictions on entry, stay and residence

- No

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status (2011).

5%

Additional sources and information

For numerical information contained in country-by-county annex, where necessary, as instructed through national review.

Afghanistan Adults 15+ receiving ART: Data from Treatment Centers as of October 2013 based on National AIDS Control Programme Afghanistan. (2013).	Bangladesh Adults 15+ receiving ART: 2012 Program records and registrars of Ashar Alo Society, Confidential Approach to AIDS Prevention and Muktakash Bangladesh
Cambodia HIV prevention coverage, people who inject drugs: Cambodia Universal Access Report 2013 HIV spending: Estimate based on incomplete NASA IV data, April 2013 (final data to be released by end 2013)	China HIV infection estimates: National Center for AIDS/STD Prevention and Control (NCAIDS), China. 2011 China HIV Estimates Report (unpublished) HIV prevalence, men who have sex with men (sub-national): Lan, W., Lu, W., L. Norris, J., Dong-min, L., Wei, G., Zheng-wei, D., & Ning, W. (2012). HIV Prevalence and Influencing Factors Analysis of Sentinel Surveillance among Men who have Sex with Men in China, 2003–2011. Chinese Medical Journal, 125(11), 1857–1861.
India HIV infection estimates: National Institute of Medical Statistics, & National AIDS Control Organisation (2012). Technical Report India: HIV Estimate, 2012.	Lao People's Democratic Republic HIV infection estimates: Centre for HIV/AIDS/STI (CHAS) and UNAIDS Lao PDR. (2013). HIV Estimates and Projection. HIV prevention coverage: Centre for HIV/AIDS/STI (CHAS) and Ministry of Health Lao PDR. (2012). Annual Programme Report 2012.
Mongolia Adults 15+ receiving ART: 2012 Health Statistics, Ministry of Health, Mongolia.	Papua New Guinea HIV prevalence, men who have sex with men (sub-national): Papua New Guinea Country UNGASS Report 2010. HIV prevalence, female sex workers (sub-national): A. M. Kelly, A., Kupul, M., Nicola Man, W. Y., et al. (2011). Askim Na Save (Ask and Understand): People Who Sell and Exchange Sex in Port Moresby. Key Quantitative Findings. Sydney: Papua New Guinea Institute of Medical Research and the University of New South Wales.

Thailand

HIV infection estimates: Thailand Bureau of Epidemiology, Bureau of AIDS, National AIDS Management Center

HIV prevalence: Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health, Thailand (2013). Surveillance of HIV infection in Thailand, Round 30, 2012 (in Thai), retrieved from www.boe.moph.go.th/ on 7 July 2013.

HIV spending: www.aidsinfoonline.org

ART coverage: National AIDS Committee Thailand. (2013). 2011 United Nations General Assembly Political Declaration on HIV/ AIDS Closing the Gap: A Mid-Term Review at Country Level.

MSM Sub-national HIV prevalence: National AIDS Prevention and Alleviation Committee Thailand. (2010). UNGASS Country Progress Report: Thailand.

Additional sources and information

Table 4

Reported numbers of children aged 0–14 receiving antiretroviral treatment, 2012

Afghanistan	8
Bangladesh	48
Bhutan	5
Cambodia	4595
Fiji	7
India	34 367
Indonesia	1695
Lao PDR	163
Malaysia	490
Myanmar	4033
Nepal	699
Pakistan	139
Papua New Guinea	722
Philippines	33
Sri Lanka	24
Thailand	6274
Viet Nam	3828

Source: Global report: UNAIDS report on the global AIDS epidemic 2013



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unaids.org