HIV in Asia and the Pacific

UNAIDS report 2013
HIV in Asia and the Pacific
UNAIDS report 2013
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.

1. Reduce sexual transmission of HIV by 50% by 2015

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

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

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

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

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

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

8. 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

9. Eliminate HIV-related restrictions on entry, stay and residence

10. 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

<table>
<thead>
<tr>
<th>Year</th>
<th>Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>UN Millennium Declaration</td>
</tr>
<tr>
<td>2001</td>
<td>MDG 6a: Have halted by 2015 and begun to reverse the spread of HIV/AIDS</td>
</tr>
<tr>
<td>2006</td>
<td>2001 UN Declaration of Commitment on HIV/AIDS: Global Crisis—Global Action</td>
</tr>
<tr>
<td>2010</td>
<td>2006 UN Political Declaration on HIV/AIDS</td>
</tr>
<tr>
<td>2011</td>
<td>UN General Assembly 2011 Political Declaration on HIV and AIDS</td>
</tr>
<tr>
<td>2011</td>
<td>Resolution 66/10 of the UN Economic and Social Commission for Asia and the Pacific (ESCAP)</td>
</tr>
<tr>
<td>2011</td>
<td>Resolution 67/9 of UN ESCAP</td>
</tr>
</tbody>
</table>

Deadlines for UN Millennium Development Goals Targets and Elimination commitments of the UN 2011 Political Declaration

- 2001: MDG 6a
- 2011: UN 2011 Political Declaration

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 provide 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.
HIV in Asia and the Pacific: Time to focus

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.

- 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;

- involving affected communities and networks at all stages of the AIDS response—from planning to delivery and monitoring;

- 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.
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, 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.
The big picture

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. 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%.

An estimated 3–4 million people living in Asia inject drugs. In three countries with expanding epidemics—India, 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.

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. 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%.

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

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 2012 or Jayawijaya, Indonesia, 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 Pathein, Myanmar, were living with HIV.

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, as did 31% of transgender (waria) sex workers in Jakarta and 19% in Maharashtra. 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%–15% 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.

Research conducted in Asia and the Pacific suggests that the transgender population in the region is around 9–9.5 million, made up predominately of transgender women. 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, 23.7% in Port Moresby and 18.8% in Maharashtra, India (2010–2011 data).
More young people aged 15–24 live in Asia and the Pacific than in any other region. In 2012, an estimated 690,000 young people were living with HIV (among which 46% are female). The epidemic in this age group is driven mainly by unprotected sex and injecting drug use, as it is among adult populations.

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.

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%.

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 number 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 condom 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 inject drugs per year—half the level recommended level of 200. 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).
Data on opiate substitution therapy were reported by 13 countries; more than 297 000 people were in programmes. 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.

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.

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.

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.

Between 2011 and 2012, the number of people accessing antiretroviral treatment increased by 150 000. However, under the 2010 WHO guidelines, 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.

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%].

Source: www.aidsinfoonline.org

**Figure 5**

Number of people accessing antiretroviral treatment 2003–2012

1250 000

13% increase between 2011 and 2012

20% increase between 2010 and 2011

Source: www.aidsinfoonline.org
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.

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**Figure 6**

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Eligible adults</th>
<th>Accessing antiretroviral treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>783</td>
<td>2900</td>
</tr>
<tr>
<td>Cambodia</td>
<td>44 318</td>
<td>54 000</td>
</tr>
<tr>
<td>India</td>
<td>570 620</td>
<td>1 000 000</td>
</tr>
<tr>
<td>Indonesia</td>
<td>29 960</td>
<td>170 000</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>2212</td>
<td>4100</td>
</tr>
<tr>
<td>Malaysia</td>
<td>14 594</td>
<td>35 000</td>
</tr>
<tr>
<td>Myanmar</td>
<td>49 676</td>
<td>110 000</td>
</tr>
<tr>
<td>Nepal</td>
<td>7168</td>
<td>22 000</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>11 042</td>
<td>13 000</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2996</td>
<td>21 000</td>
</tr>
<tr>
<td>Philippines</td>
<td>3459</td>
<td>4500</td>
</tr>
<tr>
<td>Thailand</td>
<td>232 816</td>
<td>280 000</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>68 883</td>
<td>120 000</td>
</tr>
</tbody>
</table>


*Under 2010 WHO HIV treatment guidelines.
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, 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.

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.
HIV in Asia and the Pacific

The big picture

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.

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.

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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.
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, 48 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.56 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,49 as well as the Global Commission on HIV and the Law,50 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

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>MEN WHO HAVE SEX WITH MEN</th>
<th>SEX WORKERS</th>
<th>PEOPLE WHO USE DRUGS</th>
<th>PEOPLE LIVING WITH HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maldives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Generally not prohibited but exceptions apply

Sources and Acknowledgements

The information and data in this table refers to countries in Asia, the Pacific and Oceania and is not exhaustive and is not included in the UNAIDS Regional Support Team for the Asia and the Pacific. Refer to page 99 of HIV in Asia and the Pacific: Getting to Zero (UNAIDS, 2011) for the list of countries included.

The information and data have been compiled by the Global Network of People Living with HIV, the International Harm Reduction Association, the International Lesbian and Gay Association, the International Planned Parenthood Federation, the Asia Pacific Coalition on Male Sexual Health, UNAIDS, UNFPA, UNODC and UNDP. The data are compiled and updated. For countries included in the list of Table 2, relevant information received by the UNAIDS Regional Support Team for Asia and the Pacific and the AIDS Data Hub, and data not updated up to October 2013. UNAIDS takes reasonable steps to validate information generated by other institutions and organizations.
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. 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.

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). 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.

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. 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.

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.

Reports suggest transgender people in the region are frequently subject to violence and hate crimes, and experience stigma and discrimination in accessing health services. 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. 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. 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.

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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.
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).46 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.47 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%).48

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.49 Spending on programme management and administration is 18%, which is higher than the global average (12%).50

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 and rights literacy, must be introduced and scaled up.

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
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.
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. 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. 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 2020 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.

**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). 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. 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 with 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. In countries where data are available, men who have sex with men reported up to six male sexual partners in the last six months. High proportions also have regular female partners (86% in China (Chengdu and Guangzhou), 64% in Indonesia and 49% in Viet Nam), 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-based 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.

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-
Among 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 sheds 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 Kruys
Director, UNAIDS Regional Support Team for Asia and the Pacific;
Clifton Cortez
HIV Health and Development Practitioner Leader, UNAIDS Asia-Pacific Regional Centre;
Midnight Poonkasetwattana
Executive Director, Asia Pacific Coalition on Male Sexual Health

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.

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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.

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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 provided are of high quality and meet needs. Expansion of such programmes to other countries in the near future will be important step.

Figure 9

<table>
<thead>
<tr>
<th>Consistent condom use and condom use at last anal sex among men who have sex with men, 2009–2011</th>
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</thead>
<tbody>
<tr>
<td>Country</td>
</tr>
<tr>
<td>Thailand National, 2010</td>
</tr>
<tr>
<td>Bangkok Thailand, 2010</td>
</tr>
<tr>
<td>Chiang Mai Thailand, 2010</td>
</tr>
<tr>
<td>Myanmar National, 2009</td>
</tr>
<tr>
<td>Viet Nam National, 2009</td>
</tr>
<tr>
<td>Hanoi Viet Nam, 2009*</td>
</tr>
<tr>
<td>Ho Chi Minh City Viet Nam, 2009*</td>
</tr>
<tr>
<td>China National, 2011</td>
</tr>
<tr>
<td>Ulaanbaatar Mongolia, 2011</td>
</tr>
<tr>
<td>Ulaanbaatar Mongolia, 2011</td>
</tr>
<tr>
<td>Indonesia National, 2011</td>
</tr>
<tr>
<td>Jakarta Indonesia, 2011*</td>
</tr>
<tr>
<td>Bandung Indonesia, 2011*</td>
</tr>
<tr>
<td>Manipur India, 2009*</td>
</tr>
<tr>
<td>Mumbai India, 2009*</td>
</tr>
<tr>
<td>Philippines National, 2011</td>
</tr>
</tbody>
</table>

Table 3

<table>
<thead>
<tr>
<th>Rate of HIV transmission through male-to-male sex and share of total HIV prevention spending allocated to men who have sex with men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>Indonesia</td>
</tr>
<tr>
<td>Malaysia</td>
</tr>
<tr>
<td>Philippines</td>
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<tr>
<td>Sri Lanka</td>
</tr>
</tbody>
</table>

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. 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

<table>
<thead>
<tr>
<th>Regional HIV prevention spending, latest available year</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
</tr>
<tr>
<td>Total prevention spending</td>
</tr>
<tr>
<td>189m</td>
</tr>
<tr>
<td>Prevention spending on key populations</td>
</tr>
<tr>
<td>67m</td>
</tr>
<tr>
<td>Prevention spending on men who have sex with men</td>
</tr>
<tr>
<td>13m</td>
</tr>
</tbody>
</table>

![Image](image-url)
Accelerating action

I n 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 in the country to establish service delivery sites offering including HIV testing and counselling, syndromic diagnosis and treatment of sexually transmitted infections and related referral services. NMHA enrols 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%. 15

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.

“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!”
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.

**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.

**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...
Concerted efforts are required to move beyond laws, policies and practices that punish consensual programmes on the specific needs of key populations. Weak linkages between HIV programmes and other reproductive health services are reported as hampering progress. 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.

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 vulnerability to HIV. Policy-makers must take this into consideration and tailor interventions for migrants 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.

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. Combined with specific and culturally sensitive local strategies, this will improve access to HIV testing and counselling, prevention and treatment services.
- Target 1: 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.
HIV in Asia and the Pacific

Target 1

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

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 goal is, 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

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Target 1

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 who inject drugs in Asia and the Pacific.

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’. Though 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.
Stronger collaboration is needed between drug detention and rehabilitation. Additional focus is needed on the intersection on Hepatitis C and HIV prevention and treatment. There is an urgent need for greater investment 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 drug dependence treatment. Malaysia has taken the lead in making the change by transforming eight compulsory detention centres 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. 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. 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.

**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 relapse 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.
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 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 counselling, 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 new paediatric HIV infections and congenital syphilis in Asia and the Pacific, 2011–2015. 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.

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

- Prevention of unintended pregnancies in women living with HIV
- Prevention of HIV transmission from women living with HIV to their children
- Primary prevention of HIV infection in women and girls
- Primary prevention of HIV infection in women and girls

A comprehensive approach to preventing mother-to-child transmission rests on four main pillars:
**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 guidelines), 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.
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...
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 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 palpability 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 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.
**Target 4**

**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 co-infection, as well as hepatitis B and C co-infection. 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.

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**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.
**Target 4**

**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.

**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 shortcoming 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 co-infection 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 coinfected people.

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

**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

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 co-infection 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.

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.

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**Figure 11**

Scaling up HIV and TB coinfection screening, 2006–2011

Source: WHO Global Tuberculosis Report 2012
Target 5

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

Thailand’s programme on HIV/tuberculosis co-infection 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.16

6. Achievements and challenges

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
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-making. 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 2010

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

**Li Keqiang**  
President of China and former (2003-2013) Vice President of China

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

### 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.*

**Wen Jiabao**  
Premier of China (2003-2013)

### 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)
7.

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.111 There are also few examples in the region of integrated programmes that routinely report on gender-based
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. Studies show that women from key populations, such as female drug users, female sex workers and transgender women are particularly likely to experience violence. While there is strong policy commitment in the region to integration of sexual and reproductive health and HIV services, 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. Too often, HIV prevention efforts among female key affected populations are too 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. 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.

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.
Target 7

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

Mian Saqib Nisar, Justice of the Supreme Court of 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 Boby, 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.
Punitive and discriminatory legal environments continue to hinder effective HIV responses in almost every country in the region — despite evidence 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 in 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 Philippines 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 communi ties: 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.

- There are many excellent initiatives in the region and countries can and should learn from their neighbours’ experiences. Key lessons include the importance of focusing on priority issues; engaging affected communities to build public acceptance for reform; basing policy discourse on evidence and rights, not morality; recognizing the value of incremental policy change that can remove barriers and pave the way for law reform; engagement of national justice and rights institutions in the HIV response; and investing in programmes to create more enabling environments notwithstanding punitive laws.

### 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
Target 8

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.

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.”

Spotsight

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. 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 for 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 for people living with HIV. The amended Law on Prevention of HIV and AIDS removes prior HIV-related travel restrictions in the region, allowing that nationals of the region traveling overseas can still 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.

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 ensure that 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.
HIV in Asia and the Pacific

10 targets

Target 9

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

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.

Spotlight

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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 postnatal 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.

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 coinfected 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.

India reported a 57% decline among adults alone since 2000, which is a 30% reduction in total (adult and children) new infections if measured from 2001 to 2012. Technical Report India HIV Estimates. New Delhi: National Institute of Medical Statistics & National AIDS Control Organisation (Department of AIDS Control), 2012.


Ibid.


Ibid.

Ibid.


Data provided by UNAIDS Country Office India (as part of preparation for the 9th UNAIDS Regional Management Meeting in the Asia and the Pacific) based on HIV Sentinel Surveillance 2010-11. New Delhi: National AIDS Control Organisation (Department of AIDS Control), 2012.


Indonesia & Thailand GARPRs.

Ibid.


Indonesia IBHS 2011; op. cit.


Ibid.

Technical Annex to the report of the Commission on AIDS in Asia; op. cit.

Ibid.

Technical Annex to the report of the Commission on AIDS in Asia; op. cit.


In order to be comparable across the reporting years, the regional median is calculated based on data from 11 countries for female sex workers (and five countries for male sex workers) that consistently reported in all three rounds of Global AIDS Reporting in the past three years (2010–2013).


WHO, UNODC, UNAIDS Technical guide... op. cit.

Ibid.


India GARPR 2013 online reporting.

WHO 2010 Guidelines on HIV... op. cit.

Calculated median based on the data from 17 low-and middle-income countries.

UNAIDS Global report 2015; op. cit.


Ibid.


The Law on the Prevention and Control of HIV/AIDS (2000) allows a minor to consent to an HIV test on his or her own behalf. Consent to HIV testing can be obtained from the minor’s legal guardian. The law specifies that the health care provider may be under an obligation to seek the parent’s consent as the first option. The health care provider should only seek the minor’s consent as a second option, if the parent’s consent cannot be obtained.


Legal protections. UNDP; op. cit.

Implementation of the UN General Assembly 2011 Political Declaration on HIV and AIDS and of Resolution 66/10 and 67/09 of the UN Economic and Social Commission for Asia and the Pacific (UNESCAP).

http://www.unescape.org/tag/hiv/.


UNAIDS Global Report 2013; op. cit.


Sex work and violence: understanding factors for safety and protection. [A multi-country study under way by UNFPA, UNDP, the Asia Pacific Network of Sex Workers, Partners for Prevention (P4P), and UNAIDS with country-level work organizations in Indonesia, Myanmar, Nepal and Sri Lanka].


UNAIDS estimates. 2012.

Ibid.

Ibid.

Ibid.

Ibid.

The calculation is based on the latest available year between 2009-2012 in 22 low and middle-income countries that reported care and treatment spending.

Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

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Ibid.

Ibid.

Ibid.

This calculation is based on the latest available year between 2009-2012 in 22 low and middle-income countries that reported care and treatment spending.

Ibid.


For a list of countries, see page 27 of this report.


Huong T, Tuan NA, VLN et al. Integrated Biological and Behavioral Surveillance in the region (www.aidsdatahub.org) that reported on HIV testing coverage among men who have sex with men.


Calculated regional median from 15 low-and middle-income countries in the region (www.aidsinfoonline.org) that reported on HIV testing coverage among men who have sex with men.


Ibid.

Ibid.

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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

Funding
Domestic spending from public sources, 2012

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

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

HIV-related restrictions on entry, stay and residence

0.5% HIV prevalence (%)

People living with HIV
Low estimate 1600 High estimate 14 000 trend ↑
Women living with HIV
Low estimate <1000 High estimate 4600
New HIV infections ...
Pregnant women who received treatment to prevent new HIV infections among children
7
Adults 15+ eligible for ART
Low estimate <1000 High estimate 3500
Adults 15+ accessing ART
192
AIDS-related deaths
Low estimate <100 High estimate <1000 trend ↓

Condom use at last sex (%) Men who have sex with men
11
People who inject drugs
33
Female sex workers
13
Safe injection practice (%)

Prevention coverage (%)
Unit for people who inject drugs = needles/syringes distributed per person per year

0.5 0.5 0.6 15.7 0.3 0.9
National Kabul National Herat National Herat

HIV-related restrictions on entry, stay and residence

No

No Stigma Index conducted

0.5% HIV prevalence (%)
National Herat

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

No Stigma Index conducted
Bangladesh

People living with HIV
Law estimate 3100 High estimate 82000 Total ↑
Women living with HIV
Law estimate 1000 High estimate 210000 New HIV infections
Law estimate <500 High estimate 19000
Pregnant women who received treatment to prevent new HIV infections among children
16 Adults 15+ eligible for ART
Law estimate 1300 High estimate 29000 Adults 15+ accessing ART
785 AIDS-related deaths
Law estimate <200 High estimate 2300
Condom use at last sex (%)
Men who have sex with men 11 People who inject drugs 66 Female sex workers 87
Safe injection practice (%)

Prevention coverage (%)
Unit for people who inject drugs = needle/syringes distributed per person per year

HIV prevalence (%)
National 0.9 Dhaka 1.1 Casual FSW, Hili 0.3

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

20%

Bhutan

People living with HIV
Law estimate <1000 High estimate 2700
Women living with HIV
Law estimate <200 High estimate <1000 New HIV infections

Pregnant women who received treatment to prevent new HIV infections among children
9 Adults 15+ eligible for ART
Law estimate <200 High estimate <1000 Adults 15+ accessing ART
33 AIDS-related deaths
Law estimate <100 High estimate <200
Condom use at last sex (%)
Men who have sex with men 14 People who inject drugs 31 Female sex workers 42
Safe injection practice (%)

Prevention coverage (%)
Unit for people who inject drugs = needle/syringes distributed per person per year

HIV prevalence (%)
National — — —

Funding
Domestic spending from public sources

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
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
### Cambodia

- **People living with HIV**
  - Low estimate: 76,000
  - High estimate: 120,000
- **Women living with HIV**
  - Low estimate: 39,000
  - High estimate: 76,000
- **New HIV infections**
  - Low estimate: 1400
  - High estimate: 2900
- **Pregnant women who received treatment to prevent new HIV infections among children**
  - Low estimate: 1058
  - High estimate: 2116
- **Adults 15+ eligible for ART**
  - Low estimate: 54,000
  - High estimate: 95,000
- **Adults 15+ accessing ART**
  - Low estimate: 44,318
  - High estimate: 77,600

#### Stigma and discrimination

- Criminalization of people who use drugs
- Stigma and discrimination on entry, stay and residence
- HIV-related restrictions on entry, stay and residence
- Laws, policies and practice only allow some HIV services provision in closed settings

#### Funding

- Domestic spending from public sources, 2012

- **Prevention coverage (%)**
  - National: 72%
  - Siem Reap: 129%

- **Condom use at last sex (%)**
  - National: 86%
  - Siem Reap: 82%

- **Safe injection practice (%)**
  - National: 3.4%

- **HIV prevalence (%)**
  - National: 2.1%
  - Siem Reap: 4.9%

- **AIDS-related deaths**
  - Low estimate: 1900
  - High estimate: 7400

### China

- **People living with HIV**
  - Low estimate: 780,000
  - High estimate: 1,940,000
- **Women living with HIV**
  - Low estimate: 223,000
  - High estimate: 529,000
- **New HIV infections**
  - Low estimate: 48,000
  - High estimate: 54,000
- **Pregnant women who received treatment to prevent new HIV infections among children**
  - Low estimate: 3007
  - High estimate: 10,000
- **Adults 15+ eligible for ART**
  - Low estimate: 54,000
  - High estimate: 95,000
- **Adults 15+ accessing ART**
  - Low estimate: 44,318
  - High estimate: 77,600

#### Stigma and discrimination

- 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

#### Funding

- Domestic spending from public sources, 2012

- **Prevention coverage (%)**
  - National: 74.1%
  - Siem Reap: 105.8%

- **Condom use at last sex (%)**
  - National: 3.4%

- **Safe injection practice (%)**
  - National: 4.9%

- **HIV prevalence (%)**
  - National: 2.1%
  - Siem Reap: 4.9%

- **AIDS-related deaths**
  - Low estimate: 2700
  - High estimate: 2440

- **Pregnant women who received treatment to prevent new HIV infections among children**
  - Low estimate: 1900
  - High estimate: 4700

**Note:**
- 2013 China GARPR report.
- Data not reported.
### Fiji

- **People living with HIV**: 
  - Low estimate: <1000
  - High estimate: 1200

- **Women living with HIV**: 
  - Low estimate: <500
  - High estimate: 500

- **New HIV infections**:...

- **Pregnant women who received treatment to prevent new HIV infections among children**: 14

- **Adults 15+ eligible for ART**: 
  - Low estimate: <500
  - High estimate: 500

- **Adults 15+ accessing ART**: 127

- **AIDS-related deaths**: 
  - Low estimate: <100
  - High estimate: 100

<table>
<thead>
<tr>
<th>Category</th>
<th>Low Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>condom use at last sex (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>safe injection practice (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prevention coverage (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV prevalence (%)</td>
<td>National</td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td>Domestic spending from public sources, 2011</td>
<td></td>
</tr>
</tbody>
</table>

### India

- **People living with HIV**: 
  - Low estimate: 1 700 000
  - High estimate: 2 600 000

- **Women living with HIV**: 
  - Low estimate: 610 000
  - High estimate: 940 000

- **New HIV infections**: 
  - Low estimate: 82 000
  - High estimate: 217 000

- **Pregnant women who received treatment to prevent new HIV infections among children**:...

- **Adults 15+ eligible for ART**: 
  - Low estimate: 1 000 000
  - High estimate: 1 100 000

- **Adults 15+ accessing ART**: 570 620

- **AIDS-related deaths**: 
  - Low estimate: 113 000
  - High estimate: 178 000

<table>
<thead>
<tr>
<th>Category</th>
<th>Low Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>condom use at last sex (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>safe injection practice (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prevention coverage (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV prevalence (%)</td>
<td>National</td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td>Domestic spending from public sources, 2009</td>
<td></td>
</tr>
</tbody>
</table>

### Stigma and discrimination

- **Criminalization of sex work**: 21%

- **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 (2009)**: 30%

- **HIV-related restrictions on entry, stay and residence**: No

### Stigma and discrimination

- **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**

### Funding

- **Domestic spending from public sources, 2009**
- **Domestic spending from public sources, 2011**

---

*Estimates are based on 2011 national data*
### Indonesia

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

#### Funding
Domestic spending from public sources, 2010

#### 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
- Stigma Index
  - No Stigma Index conducted

### Lao People’s Democratic Republic

#### Stigma and discrimination
Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012
- Stigma and discrimination
  - Criminalization of people who use drugs (in some provinces or districts)
  - Criminalization of sex work

#### Funding
Domestic spending from public sources, 2011

#### 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
- Stigma Index
  - No

### Annex

#### Lao People’s Democratic Republic

<table>
<thead>
<tr>
<th>Category</th>
<th>People living with HIV</th>
<th>Women living with HIV</th>
<th>New HIV infections</th>
<th>Pregnant women who received treatment to prevent new HIV infections among children</th>
<th>Adults 15+ eligible for ART</th>
<th>Adults 15+ accessing ART</th>
<th>AIDS-related deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low estimate</td>
<td>12 000</td>
<td>4900</td>
<td>1 000</td>
<td>49</td>
<td>1 700</td>
<td>297 960</td>
<td>27 000</td>
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<tr>
<td>High estimate</td>
<td>13 000</td>
<td>5 600</td>
<td>1 200</td>
<td>49</td>
<td>2 400</td>
<td>2 212</td>
<td>&lt;500</td>
</tr>
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</table>

#### HIV prevalence (%)

<table>
<thead>
<tr>
<th>Location</th>
<th>HIV prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>4.4</td>
</tr>
<tr>
<td>Jakarta</td>
<td>56.4</td>
</tr>
<tr>
<td>Jayapura</td>
<td>38.4</td>
</tr>
</tbody>
</table>

#### Condom use at last sex (%)

<table>
<thead>
<tr>
<th>Group</th>
<th>Low estimate</th>
<th>High estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men who have sex with men</td>
<td>60</td>
<td>61</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>Female sex workers</td>
<td>25</td>
<td>28</td>
</tr>
</tbody>
</table>

#### Safety injection practice (%)

<table>
<thead>
<tr>
<th>Group</th>
<th>Low estimate</th>
<th>High estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men who have sex with men</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>30</td>
<td>24</td>
</tr>
<tr>
<td>Female sex workers</td>
<td>27</td>
<td>29</td>
</tr>
</tbody>
</table>

#### Prevention coverage (%)

<table>
<thead>
<tr>
<th>Unit for people who inject drugs = needles/syringes distributed per person per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
</tr>
<tr>
<td>Jakarta</td>
</tr>
<tr>
<td>Jayapura</td>
</tr>
</tbody>
</table>

#### AIDS-related deaths

<table>
<thead>
<tr>
<th>Low estimate</th>
<th>High estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 000</td>
<td>13 000</td>
</tr>
</tbody>
</table>

#### HIV-related restrictions on entry, stay and residence

- No
Malaysia

People living with HIV
- Low estimate: 60,000
- High estimate: 110,000
- Total: 82,000

Women living with HIV
- Low estimate: 8500
- High estimate: 16,000
- Total: 12,000

New HIV infections
- Low estimate: 4800
- High estimate: 11,000
- Total: 7400

Pregnant women who received treatment to prevent new HIV infections among children
- Total: 342

Adults 15+ eligible for ART
- Low estimate: 28,000
- High estimate: 45,000
- Total: 35,000

Adults 15+ accessing ART
- Total: 14,594

AIDS-related deaths
- Low estimate: 3100
- High estimate: 8000
- Total: 5200

Condom use at last sex (%) 31%
Safe injection practice (%) 27%
Prevention coverage (%) 35%
HIV prevalence (%) 10.7%

Funding
- Domestic spending from public sources, 2012
  - Total: 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 14%

Mongolia

People living with HIV ...
Women living with HIV ...
New HIV infections ...
Pregnant women who received treatment to prevent new HIV infections among children ...
Adults 15+ eligible for ART ...
Adults 15+ accessing ART 53
AIDS-related deaths ...

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

Stigma Index
- HIV-related restrictions on entry, stay and residence
  - Yes
- No

Funding
- Domestic spending from public sources, 2012
  - Total: 31%
Nepal

- People living with HIV
  - Low estimate: 49,000
  - High estimate: 65,000
  - Trend: ↓

- Women living with HIV
  - Low estimate: 14,000
  - High estimate: 19,000
  - Trend: ↓

- New HIV infections
  - Low estimate: 1,200
  - High estimate: 2,700
  - Trend: ↓

- Pregnant women who received treatment to prevent new HIV infections among children
  - Low estimate: 110
  - High estimate: 22,000
  - Trend: ↓

- Adults 15+ eligible for ART
  - Low estimate: 22,000
  - High estimate: 27,000

- Adults 15+ accessing ART
  - Low estimate: 7,168
  - High estimate: 7,168

- AIDS-related deaths
  - Low estimate: 1,200
  - High estimate: 1,400
  - Trend: ↓

Condom use at last sex (%)
- Men who have sex with men: Low estimate - High estimate
- People who inject drugs: Low estimate - High estimate
- Female sex workers: Low estimate - High estimate

Safe injection practice (%)

Prevention coverage (%)

HIV prevalence (%)
- National
  - Low estimate
  - High estimate

Funding

Domestic spending from public sources, 2011
- Low estimate
  - High estimate

Myanmar

- People living with HIV
  - Low estimate: 200,000
  - High estimate: 220,000

- Women living with HIV
  - Low estimate: 63,000
  - High estimate: 71,000

- New HIV infections
  - Low estimate: 7,100
  - High estimate: 8,900

- Pregnant women who received treatment to prevent new HIV infections among children
  - Low estimate: 28,900
  - High estimate: 110,000

- Adults 15+ eligible for ART
  - Low estimate: 95,000
  - High estimate: 110,000

- Adults 15+ accessing ART
  - Low estimate: 49,676
  - High estimate: 49,676

- AIDS-related deaths
  - Low estimate: 12,000
  - High estimate: 14,000

Condom use at last sex (%)
- Men who have sex with men: Low estimate - High estimate
- People who inject drugs: Low estimate - High estimate
- Female sex workers: Low estimate - High estimate

Safe injection practice (%)

Prevention coverage (%)

HIV prevalence (%)
- National
  - Low estimate
  - High estimate

Funding

Domestic spending from public sources, 2011
- Low estimate
  - High estimate

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

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)

- No

HIV-related restrictions on entry, stay and residence

- No

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

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)

- No

HIV-related restrictions on entry, stay and residence

- No
### Papua New Guinea

#### People living with HIV
- **Low estimate**: 25,000
- **High estimate**: 31,000

#### New HIV infections
- **Low estimate**: 10,000
- **High estimate**: 16,000

#### Pregnant women who received treatment to prevent new HIV infections among children
- **Low estimate**: <1,000
- **High estimate**: 1,200

#### Adults 15+ eligible for ART
- **Low estimate**: 13,000
- **High estimate**: 15,000

#### Adults 15+ accessing ART
- **Total**: 11,042

#### AIDS-related deaths
- **Low estimate**: <1,000
- **High estimate**: 1,600

#### HIV prevalence (%)
- National: 19.0%
- Port Moresby: 52.5%

#### Stigma and discrimination
- **Criminalization of men who have sex with men**: Yes
- **Criminalization of people who use drugs**: Yes
- **Criminalization of some drug-related activities**: Yes
- **Criminalization of sex work**: Yes
- **Customary law takes precedence over statutory law**: Yes

#### Funding
- **Domestic spending from public sources, 2010**: 27.2%
**Philippines**

- **People living with HIV**: 15,000 (Low estimate), 23,000 (High estimate)
- **Women living with HIV**: 2,200 (Low estimate), 3,200 (High estimate)
- **New HIV infections**: 1,800 (Low estimate), 4,000 (High estimate)
- **Pregnant women who received treatment to prevent new HIV infections among children**: 19
- **Adults 15+ eligible for ART**: 4,500 (Low estimate), 6,400 (High estimate)
- **Adults 15+ accessing ART**: 3,459
- **AIDS-related deaths**: <500 (Low estimate), <1,000 (High estimate)

**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)

**Funding**
- Domestic spending from public sources, 2011
  - 52%

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

**Sri Lanka**

- **People living with HIV**: 3,000 (Low estimate), 5,000 (High estimate)
- **Women living with HIV**: <1,000 (Low estimate), 1,500 (High estimate)
- **New HIV infections**: <500 (Low estimate), <1,000 (High estimate)
- **Pregnant women who received treatment to prevent new HIV infections among children**: 5
- **People eligible for ART**: 1,100 (Low estimate), 1,700 (High estimate)
- **Adults 15+ accessing ART**: 363
- **AIDS-related deaths**: <200 (Low estimate), <500 (High estimate)

**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

**Funding**
- Domestic spending from public sources, 2010
  - 30%

**HIV-related restrictions on entry, stay and residence**
- No
Thailand

**People living with HIV**
- Low estimate: 380,000
- High estimate: 450,000
- Trend: ↓

**Women living with HIV**
- Low estimate: 160,000
- High estimate: 200,000
- Trend: ↓

**New HIV infections**
- Low estimate: 7,000
- High estimate: 9,000
- Trend: ↓

**Pregnant women who received treatment to prevent new HIV infections among children**
- 4,918

**Adults 15+ people for ART**
- Low estimate: 252,000
- High estimate: 291,000
- Trend: ↓

**Adults 15+ accessing ART**
- 232,816

**AIDS-related deaths**
- Low estimate: 13,000
- High estimate: 19,000
- Trend: ↓

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

**Condom use at last sex (%)**
- Men who have sex with men: 16%
- People who inject drugs: 6%
- Female sex workers: 6%

**Safe injection practice (%)**
- 63%

**Prevention coverage (%)**
- Condom use at last sex: 43%
- Safe injection practice: 54%

**HIV prevalence (%)**
- National: 7.1%
- Bangkok: 24.3%
- National: 18.0%
- Bangkok: 18.0%
- National*: 1.7%
- Bangkok*: 6.0%

**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)

**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).

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

**Vanuatu**

**People living with HIV**

**Women living with HIV**

**New HIV infections**

**Pregnant women who received treatment to prevent new HIV infections among children**

**Adults 15+ eligible for ART**

**Adults 15+ accessing ART**

**AIDS-related deaths**

**Condom use at last sex (%)**
- Men who have sex with men: 71%
- People who inject drugs: 64%

**Safe injection practice (%)**
- 60%

**Prevention coverage (%)**
- Condom use at last sex: 69%
- Safe injection practice: 69%

**HIV prevalence (%)**
- 2%

**Funding**
- Domestic spending from public sources, 2011

**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)

**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

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

**No Stigma Index conducted**
Viet Nam

People living with HIV

<table>
<thead>
<tr>
<th>Level</th>
<th>Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low estimate</td>
<td>260,000</td>
<td></td>
</tr>
<tr>
<td>High estimate</td>
<td>490,000</td>
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</tr>
</tbody>
</table>

Women living with HIV

<table>
<thead>
<tr>
<th>Level</th>
<th>Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low estimate</td>
<td>71,000</td>
<td></td>
</tr>
<tr>
<td>High estimate</td>
<td>140,000</td>
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</table>

New HIV infections

<table>
<thead>
<tr>
<th>Level</th>
<th>Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low estimate</td>
<td>13,000</td>
<td></td>
</tr>
<tr>
<td>High estimate</td>
<td>230,000</td>
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</table>

Pregnant women who received treatment to prevent new HIV infections among children

<table>
<thead>
<tr>
<th>Level</th>
<th>Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low estimate</td>
<td>1294</td>
<td></td>
</tr>
<tr>
<td>High estimate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adults 15+ eligible for ART

<table>
<thead>
<tr>
<th>Level</th>
<th>Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low estimate</td>
<td>120,000</td>
<td></td>
</tr>
<tr>
<td>High estimate</td>
<td>220,000</td>
<td></td>
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</tbody>
</table>

Adults 15+ accessing ART

<table>
<thead>
<tr>
<th>Level</th>
<th>Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low estimate</td>
<td>68,883</td>
<td></td>
</tr>
<tr>
<td>High estimate</td>
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</table>

AIDS-related deaths

<table>
<thead>
<tr>
<th>Level</th>
<th>Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low estimate</td>
<td>12,500</td>
<td></td>
</tr>
<tr>
<td>High estimate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 registers of Ashar Alo Society, Confidential Approach to AIDS Prevention and Multikahsi 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


India


Lao People’s Democratic Republic


Mongolia

Adults 15+ receiving ART: 2012 Health Statistics, Ministry of Health, Mongolia.

Papua New Guinea


Thailand

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


HIV spending: www.aidsinfoonline.org


Additional sources and information

Table 4

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>8</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>48</td>
</tr>
<tr>
<td>Bhutan</td>
<td>5</td>
</tr>
<tr>
<td>Cambodia</td>
<td>4595</td>
</tr>
<tr>
<td>Fiji</td>
<td>7</td>
</tr>
<tr>
<td>India</td>
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</tr>
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<td>Indonesia</td>
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</tr>
<tr>
<td>Lao PDR</td>
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<td>Malaysia</td>
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<td>Myanmar</td>
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<td>Nepal</td>
<td>699</td>
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<td>Pakistan</td>
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<tr>
<td>Papua New Guinea</td>
<td>722</td>
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<tr>
<td>Philippines</td>
<td>33</td>
</tr>
<tr>
<td>Sri Lanka</td>
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<tr>
<td>Thailand</td>
<td>6274</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>3828</td>
</tr>
</tbody>
</table>

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