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Review of national progress in meeting the commitments contained in General Assembly resolution 65/277 on the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, and ESCAP resolutions 66/10 and 67/9

Overview of progress in achieving universal access to HIV prevention, treatment, care and support in Asia and the Pacific

Note by the secretariat**

Summary

This report has been produced in response to the request made by the Commission through its resolution 67/9, which called upon the Executive Secretary to coordinate with other relevant United Nations agencies to produce an overview of the progress made in achieving universal access to HIV prevention, treatment, care and support in Asia and the Pacific.

The report takes stock of the progress made by, among others, ESCAP members and associate members towards: reducing the transmission of HIV, in particular among key populations; promoting access to affordable medicines, diagnostics and vaccines; reviewing legal and policy barriers; enhancing financial sustainability, effectiveness, and national ownership and capacity; ensuring gender equality in the AIDS response; and addressing the key priorities and policies identified by countries in the region for the era beyond 2015.

Delegations may wish to share views and experiences on the key challenges and priorities in delivering an effective AIDS response in the era beyond 2015.

* E/ESCAP/HIV/IGM.2/L.1.

** This document has been submitted late due to the need to incorporate the latest data from responses of several member States to the intergovernmental survey as well as from other sources.

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I. Introduction

1. In its resolution 67/9, the Commission called upon the Executive Secretary to coordinate with other relevant United Nations agencies to produce an overview of the progress made in achieving universal access to HIV prevention, treatment, care and support in Asia and the Pacific. In pursuance of that mandate, the objectives of the present overview report are: (a) to appraise progress in implementing the commitments in the 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, and Commission resolutions 66/10 and 67/9; and (b) to provide a forward-looking perspective through the inclusion of recommendations for future action based on best practices in the region and the priorities identified by ESCAP member States.

2. This overview report draws on information gathered from Governments and other existing sources, including the results of the Joint United Nations Programme on HIV/AIDS (UNAIDS) 2013 mid-term review of progress in achieving the commitments contained in the 2011 Political Declaration on HIV and AIDS and annual Global AIDS Response Progress Reporting (GARPR), in addition to an intergovernmental survey carried out in mid-2014 among ESCAP members and associate members on progress in achieving universal access to HIV prevention, treatment, care and support in Asia and the Pacific.

3. In Asia and the Pacific, 21 countries conducted mid-term reviews in 2013 of national progress in relation to the 10 targets of the 2011 Political Declaration on HIV and AIDS. In addition, 29 countries submitted reports within the framework of GARPR in 2014. Some 23 members and associate members responded to the intergovernmental survey on achieving progress in universal access to HIV prevention, treatment, care and support administered by the ESCAP secretariat in 2014. An analysis of the information provided by ESCAP members and associate members is presented below.

II. Overview of trends

4. The AIDS response in Asia and the Pacific has witnessed some of the world's greatest successes. Nevertheless, the course of the HIV epidemic in the ESCAP region shows that current efforts need to be refocused to ensure that all countries are able to meet the commitments made at regional and global levels.

5. Notable trends include the following:

(a) There has been a significant reduction in new HIV infections since 2001 (though the number of new infections has remained largely unchanged since 2008), an increase in access to treatment and a decrease in AIDS-related deaths;

(b) Low levels of prevalence at national level often mask high absolute numbers of new infections and people living with HIV (PLHIV). There have been concentrated epidemics in major cities and among key populations;

(c) There are several countries where new HIV infections are on the rise, in part due to growing epidemics concentrated in some geographical areas and within key populations at higher risk of HIV exposure, notably men who have sex with men (MSM), sex workers and people who inject drugs (PWID). In five Central Asian countries (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan), more than half of newly diagnosed HIV infections occur among PWID;[1]

(d) Clients of sex workers are the largest population at risk of HIV infection in Asia and the Pacific;

(e) Coverage of effective antiretroviral regimens for prevention of new HIV infections among children remains low in the region, especially in South Asia. Early infant diagnosis of HIV varies widely across the region.

III. Reduce transmission of HIV, in particular among key populations

6. While the overall number of new HIV infections in the Asia-Pacific region has gone down since 2001, in the past five years the number of new infections has remained largely unchanged and emerging epidemics are becoming evident among key populations and in specific geographical locations, such as major cities.

7. According to the Commission on AIDS in Asia and the Pacific, modelling indicates that about 60 per cent of key populations need to adopt safer behaviours if HIV epidemics among them are to be reversed, and HIV prevention coverage has to reach about 80 per cent of key populations for that

[1] Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization, *HIV/AIDS in Europe and Central Asia: Progress Report 2011* (Geneva, UNAIDS, 2012), p. 25.

level of behaviour change to occur.[2] That estimate is reflected in the commitment made by ESCAP member States in Commission resolution 67/9 to develop national strategic plans and establish strategic and operational partnerships at the national and community levels between representatives of public health, law enforcement and civil society and key populations to scale up high-impact HIV prevention, treatment, care and support to achieve 80 per cent coverage for key populations with a view to achieving the universal access target.

A. Process indicators

1. Existence of multisectoral national strategic plan on HIV and AIDS (survey responses)

8. Of the 23[3] members and associate members in the Asia-Pacific region that responded to the intergovernmental survey on progress in achieving universal access to HIV prevention, treatment, care and support in Asia and the Pacific, 19 reported having in place a multisectoral national strategic plan on HIV and AIDS, as called for in Commission resolution 67/9.

2. Specific targeting of key populations in national strategies (survey responses)

9. According to the survey, 18 of the 19 existing national strategic plans on HIV contained strategies to address legal and policy barriers to universal access to HIV prevention, treatment, care and support, in particular for PLHIV and key populations at higher risk of HIV. Of these 18 strategies, 15 have been costed and budgeted to enhance financial sustainability and national ownership, and to improve the programmatic effectiveness of AIDS response, in line with Commission resolution 67/9. In addition to outlining specific strategies to address legal and policy barriers for key populations, 17 member States reported having a national strategy to address all forms of gender-based violence.

B. Outcome indicators

1. Percentage of MSM and sex workers reached by HIV prevention programmes (know where to get an HIV test and received condoms in the past year)

10. MSM and sex workers are driving the epidemic in the region in terms of the number and the pace of new HIV infections. In 2008, the Commission on AIDS in Asia and the Pacific predicted that if MSM did not become a greater focus of HIV prevention efforts, this population would bear nearly half of the total new infections among key populations. In 2013, UNAIDS reported that overall trends indicated that the Commission's prediction is becoming a reality. Despite evidence indicating an alarming HIV prevalence rate among this key population, essential HIV prevention efforts remain inadequate and far from the 80 per cent target in nearly every ESCAP member State.

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[2] Commission on AIDS in Asia and the Pacific, *Redefining AIDS in Asia: Crafting an Effective Response* (New Delhi, Oxford University Press, 2008).

[3] As of 24 October 2014, survey responses had been received from the following ESCAP members and associate members: Afghanistan; Armenia; Australia; Azerbaijan; Bangladesh; Bhutan; Brunei Darussalam; Cambodia; Fiji; France; Georgia; Iran (Islamic Republic of); Japan; Malaysia; Maldives; Mongolia; New Zealand; Pakistan; Russian Federation; Tajikistan; Thailand; Timor-Leste; and Hong Kong, China.

Table 1
Percentage of MSM and sex workers reached by HIV prevention programmes (know where to get an HIV test and received condoms in the past year) in selected countries in the ESCAP region

Country	Target group	Year	*Total*	*Age*		*Sex*		
				25+	<25	Female	Male	Transgender populations
East and North-East Asia								
China	MSM	2012	76.9	77.6	75.7	-	-	-
	Sex workers	2012	82.7	84.8	79.6	82.7	-	-
Mongolia	MSM	2012	63.5	63.6	63.4	-	-	-
	Sex workers	2012	63.8	65.4	59.4	63.8	-	-
Republic of Korea	MSM	2011	44.2	48.15	34.06	-	-	-
South-East Asia								
Indonesia	MSM	2011	23.4	25.2	20.5	-	-	-
	Sex workers	2011	18.5	78.7	14.2	19.9	11.85	-
Malaysia	MSM	2012	45.7	47.4	42.5	-	-	-
	Sex workers	2012	45.7	49.0	33.3	45.7	-	-
Philippines	MSM	2013	22.6	30.1	18.2	-	-	-
	Sex workers	2013	48.0	56.0	41.8	-	53.8	32.3
Singapore	Sex workers	2007	100.0	..	..	100.0	-	-
Thailand	MSM	2012	52.6	61.1	48.7	-	-	-
	Sex workers	2012	73.8	..	..	53.9	73.8	..
South and South-West Asia								
Afghanistan	Sex workers	2011	6.3	31.0	5.2	6.3	-	-
Bangladesh	MSM	2013	24.4	21.2	28.7	-	-	-
	Sex workers	2013	25.5	33.8	18.8	7.5	62.2	70.7
India	MSM	2013	68.1	..	..	-	-	-
	Sex workers	2013	84.6	..	..	84.6	-	-
Nepal	MSM	2013	64.0	73.3	54.5	-	-	-
	Sex workers	2011	..	..	..	60.0	-	-
		2013	..	..	..	-	79.3	-
Pakistan	Sex workers	2013	13.8	14.7	12.5	10.8	9.7	19.8
North and Central Asia								
Armenia	MSM	2012	52.0	57.9	49.0	-	-	-
	Sex workers	2012	49.2	49.0	48.9	49.2	-	-
Georgia	MSM	2012	48.6	57.8	33.7	-	-	-
	Sex workers	2012	65.0	68.2	32.0	65.0	-	-
Kyrgyzstan	MSM	2013	78.9	77.6	82.1	-	-	-
	Sex workers	2013	64.9	65.7	63.4	64.9	-	-
Russian Federation	MSM	2007	17.0	16.0	19.0	-	-	-
	Sex workers	2009	22.0	28.0	21.0	22.0	-	-
Pacific								
Fiji	Sex workers	2012	68.0	70.1	39.8	62.2	77.7	-
Papua New Guinea	MSM	2011	66.6	79.6	80.3	-	-	-
	Sex workers	2011	36.4	84.8	38.8	37.2	34.2	-

Sources: Database of Global AIDS Response Progress Reporting, prepared by the Data Team at the HIV and AIDS Data Hub for Asia and the Pacific (www.aidsdatahub.org) and UNAIDS, AIDSinfo Online Database (www.aidsinfoonline.org).

Note: A hyphen (-) indicates that the item is not applicable and two dots (..) indicate that data are not available.

11. The 2014 GARPR report data (see table 1 above) show large disparities in prevention coverage of MSM and sex workers in the region, ranging from 6.3 per cent of sex workers in Afghanistan to 84.6 per cent in India, and reaching every female sex worker (100 per cent) in Singapore. Overall, the percentage of sex workers reached by HIV prevention efforts tends to be higher than the percentage of MSM.

12. Data on HIV prevention disaggregated by sex are very limited, as most surveys cover only men or only women, with few exceptions. A survey of sex workers in Indonesia and Papua New Guinea indicates that more female sex workers were reached by HIV prevention efforts. In Bangladesh and Fiji, on the other hand, more male sex workers knew where to get an HIV test and receive condoms.

13. Almost no data is available on transgender populations reached by prevention programmes in the region, with the exception of the data on transgender sex workers in the Philippines (32.3 per cent) and Bangladesh (70.7 per cent).

2. Percentage of MSM, PWID and sex workers who received an HIV test in the past 12 months and know their results

14. Access to testing and counselling, together with knowing one's HIV status, are essential components of HIV prevention. The level of coverage required to affect HIV transmission and access available services is hampered by stigma and discrimination, legal and policy barriers as well as law enforcement practices.

15. Wide disparities exist in terms of the access of MSM, PWID and sex workers to HIV services, including testing and counselling. For example, in South-East Asia the percentage of MSM who had an HIV test in the previous 12 months ranges from 9.3 per cent in the Philippines to 79 per cent in Malaysia; the percentage of PWID ranges from 6.3 per cent in the Philippines to 78 per cent in Malaysia. Overall, South and South-West Asia and North and Central Asia subregions had low coverage of PWID with the notable exceptions of India and Kazakhstan respectively. In some countries, only three or four per cent of PWID were tested for HIV in the previous 12 months and knew their HIV status.

3. Percentage of MSM, PWID and sex workers reporting the use of a condom

16. Access to and use of condoms is one component of harm reduction strategies. The latest available data on the key populations in the region — MSM, PWID and sex workers — indicate significant disparities in terms of reported condom use among them. Reported condom use among MSM ranges from 1.3 per cent to over 90 per cent, although the majority of countries have achieved rates over 50 per cent. Among PWID, reported condom use ranges from 7.7 per cent to 77.6 per cent, while among sex workers the corresponding range is from 7.6 per cent to 95.8 per cent.

17. Very little of the available data is disaggregated by sex and almost no data are available on the transgender populations in the region. Where sex-disaggregated data are available, more females who inject drugs than males report the use of a condom, apart from Kazakhstan, Kyrgyzstan, the Philippines, the Russian Federation and Thailand.

4. Number of needles distributed per person

18. The number of needles distributed per person is an indicator of access to prevention services among the PWID population. Needle and syringe programmes are part of the comprehensive prevention package for PWID. Lack of access to clean needles and syringes leads to sharing of equipment. In particular, in North and Central Asia, a region where the number of new infections is rising, national HIV epidemics are typically driven by the use of contaminated injecting equipment and by onward transmission to the sexual partners of PWIDs. In order for needle exchanges to prevent HIV transmission and to make an impact on the HIV epidemic, an annual distribution rate of 200 needles/syringes per PWID is needed.

19. In Asia and the Pacific, the number of needles distributed per PWID ranges from 9 to 326. Several countries in the region, including Australia, Cambodia, Kazakhstan, Kyrgyzstan, Lao People's Democratic Republic and New Zealand distributed more than 200 needles per PWID. However, on average, the level of coverage indicates inadequate access to prevention services in the region.

5. Percentage of PWID who reported using sterile injecting equipment the last time they injected

20. There is a clear correlation between access to safe injecting equipment and HIV prevalence rates among PWID in Asia and the Pacific. The latest data, where available, indicate that in most of the region at least 30 per cent of PWID used sterile injecting equipment the last time they injected. More than 90 per cent of PWID used sterile injecting equipment in the Islamic Republic of Iran, Kyrgyzstan, Malaysia, Nepal, Viet Nam and Tajikistan.

6. Percentage of young people aged between 15 and 24 who correctly identified ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission

21. Awareness of ways of preventing the sexual transmission of HIV among young people aged between 15 and 24 is key to prevention efforts and the ability of young men and women to protect themselves from HIV.

22. Based on the latest available data (see table 2), there are wide disparities in HIV awareness between young men and young women, at national, subregional and regional levels. Overall, young men in the Asia-Pacific region tend to have higher awareness levels compared with young women, although more young women than men can identify the correct ways of preventing sexual transmission in Armenia, Cambodia, Indonesia, Kyrgyzstan, Mongolia, Myanmar, the Russian Federation, Singapore and Turkey. In eight member States, less than 10 per cent of women could correctly identify ways of preventing sexual transmission while rejecting major misconceptions about HIV.

23. Across the region, where data are available, the awareness level for both sexes is less than 55 per cent.

Table 2
Percentage of young women and men aged between 15 and 24 in selected countries in the Asia-Pacific region who correctly identified ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission

Country	Year	*Both sexes*	*Females*	*Males*
East and North-East Asia				
China	2013	54.9	52.9	57.2
Democratic People's Republic of Korea	2011		7.9	
Mongolia	2011	30.85	31.62	29.29
Republic of Korea	2011	14.71	6.67	21.05
South-East Asia				
Cambodia	2013		44.4	43.7
Indonesia	2011	14.3	15.12	13.66
Lao People's Democratic Republic	2012	25.1	24	27.6
Malaysia	2012	27	26.5	27.5
Myanmar	2011	47.51	47.56	47.47
Philippines	2013		11.8	17.6
Singapore	2007	17	20	15
Thailand	2009	37	30	44
Timor-Leste	2013		12.2	19.7
Vietnam	2013		42.3	50.3
South and South-West Asia				
Bangladesh	2011	17.7	13.4	22.5
Bhutan	2012		21	
India	2013		19.9	36.1
Iran (Islamic Republic of)	2011	18.27	16.21	20.63
Maldives	2009		35	
Nepal	2013		25.8	33.9
Sri Lanka	2011		17.3	
Turkey	2007	37	39	35
North and Central Asia				
Armenia	2013		22.6	15.1
Azerbaijan	2013		4.8	5.3
Georgia	2011	10.22	9.25	11.23
Kazakhstan	2011	31.91	30.16	34.34
Kyrgyzstan	2011	2.98	3.37	2.48
Russian Federation	2009	37	39	35
Tajikistan	2012	17.1	10.8	22.9
Turkmenistan	2000		3	
Uzbekistan	2009	13	11	14
Pacific				
Kiribati	2011		44	48.6
Marshall Islands	2011	6.09	3.76	8.42
Micronesia (Federated States of)	2011	26.2	20	32.6
Palau	2011	26.8	26.8	
Papua New Guinea	2011	22.6	20.51	23.79
Samoa	2011	8.8	3	5.8
Solomon Islands	2011	32.12	26.85	37.86
Tuvalu	2009	48	39	61
Vanuatu	2011	24	20	29

Source: Database of Global AIDS Response Progress Reporting, prepared by the Data Team at the HIV and AIDS Data Hub for Asia and the Pacific (www.aidsdatahub.org).

7. Coverage of effective antiretroviral regimens for prevention of mother-to-child transmission of HIV

24. The coverage of pregnant women who receive antiretroviral treatment (ART) for preventing mother-to-child-transmission (PMTCT) tends to be higher than the percentage of infants born to HIV positive mothers who are tested within two months of birth. The former ranges from 2 per cent in Afghanistan to more than 95 per cent in Thailand and Kyrgyzstan. According to the available data, in seven countries the coverage of pregnant women who received ART had reached more than 70 per cent.

25. New infections among children in Asia and the Pacific are declining. Low regional coverage of pregnant women by effective antiretroviral medications hampers the prevention of new HIV infections among children.

26. Some countries in the region have achieved relatively high coverage levels for the percentage of infants born to women living with HIV who received a virological test for HIV within two months of birth. In 2013, more than 95 per cent of infants in Viet Nam and 79 per cent of infants in Papua New Guinea were tested for HIV within two months of birth. However, for most of the region the coverage level remains extremely low: of the 19 countries that provided data on this indicator, 9 reported that less than 10 per cent of infants born to HIV positive mothers had been tested within two months of their birth.

IV. Promote access to affordable medicines, diagnostics and vaccines

27. Access to treatment is an essential part of the right to the highest attainable standard of health,[4] as recognized in numerous national constitutions and international human rights treaties. The 2011 Political Declaration on HIV and AIDS called for member States to remove obstacles that limit the capacity of low- and middle-income countries to provide affordable and effective HIV treatment, diagnostics, medicines and commodities, and to reduce costs associated with lifelong chronic care, including by amending national laws and regulations. In the regional context, Commission resolution 67/9 highlighted "processes that encourage stakeholder consultation in promoting access to affordable medicines, diagnostics and vaccines, bearing in mind the relevant provisions in General Assembly resolution 60/262", such as increased flexibility of national intellectual property laws to more closely follow the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS Agreement) and to allow for wider, more cost-efficient distribution of generic medicines.

28. In Asia and the Pacific, the number of people accessing life-saving HIV medicines has more than tripled since 2007, primarily as a result of the drastic price reductions achieved due to the competition from generic medicine manufacturers.[5] Between 2009 and 2012, the number of people accessing ART in China, India, Myanmar and Viet Nam more than doubled in each country. However, under the 2013 guidelines of the World Health Organization (WHO) on the use of antiretroviral drugs for treating and preventing HIV infection, the region's coverage rate of eligible people lags

[4] See article 12 of the International Covenant on Economic, Social and Cultural Rights (General Assembly resolution 2200 A (XXI), annex).

[5] Joint United Nations Programme on HIV/AIDS (UNAIDS), *HIV in Asia and the Pacific, UNAIDS Report 2013* (Bangkok, 2013).

behind the global coverage rate. AIDS-related deaths have not decreased at the same rate as in other regions, and the benefits of prevention provided by ART are not being maximized. An effective national AIDS response requires a significant expansion of HIV testing and counselling to improve access to prevention and care.

29. Facility-based HIV testing and counselling, while essential, is unlikely to reach key populations at higher risk of HIV exposure due to incomplete knowledge about sexuality and sexual health, and high levels of stigma and discrimination on the part of health care institutions and personnel.[6] Community-based testing and counselling, however, achieve high rates of service uptake, reach people with high CD4 counts and link people to care.[7] In line with the 2013 WHO guidelines, community-based testing and counselling for key populations are recommended in all HIV-epidemic settings, in addition to provider-initiated testing and counselling. In ESCAP resolution 67/9, the Commission called on members and associate members to consider processes that encourage stakeholder consultation in promoting access to affordable medicines, diagnostics and vaccines.[8]

30. Recent increases in intellectual property protection and enforcement measures in free trade and investment agreements often go beyond what is required by the TRIPS Agreement, which is administered by the World Trade Organization (WTO). That development threatens to pose a serious impediment to efforts by countries in the region to achieve effective, sustainable and affordable universal health coverage.

31. However, the TRIPS Agreement has a number of flexibilities, which allow implementation of measures for better access to essential medicines, including specific arrangements for least developed countries. At the same time, flexibilities have still not been fully exploited by most countries in the region to sustain affordable medicines. According to the 2012 joint report of UNAIDS and the United Nations Development Programme (UNDP),[9] in order to retain the benefits of TRIPS flexibilities, countries should, at a minimum, avoid entering into free trade agreements that contain obligations that could affect the affordability or availability of essential medicines.

A. Process indicators

Number of countries that have conducted reviews or multi-stakeholder consultations on intellectual property law

32. Countries in Asia and the Pacific have made progress towards ensuring that legal frameworks enable the full utilization of TRIPS flexibilities to increase access to affordable treatment, and in utilizing those flexibilities. Cambodia, China, Indonesia, Myanmar and Papua New Guinea have conducted specific national assessments of intellectual property rights,

[6] United Nations Development Programme (UNDP) and the World Health Organization, *The Time Has Come: Enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific* (Bangkok, UNDP, 2013).

[7] Amithab B. Suthar and others, "Towards universal voluntary HIV testing and counselling: a systematic review and meta-analysis of community-based approaches", *PLOS Medicine*, vol. 10, No. 8 (August 2013).

[8] Para. 1(c).

[9] Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Development Programme, *The Potential Impact of Free Trade Agreements on Public Health* (Geneva, UNAIDS, 2012).

TRIPS and access to medicines. Evidence from India, Indonesia, Malaysia and Thailand suggests that the use of TRIPS flexibilities has helped to significantly lower the cost of medicines, including ART. Member States that have managed to successfully utilize TRIPS flexibilities could provide guidance and policy advice to other countries.[10]

B. Outcome indicators

1. Percentage of people receiving ART among all PLHIV

Table 3
Percentage of people receiving ART among all PLHIV

Country	Total	Those aged 15 or more	Under 15s
	estimate	estimate	estimate
East and North-East Asia			
Mongolia	14	15	
South-East Asia			
Cambodia	67	67	78
Lao People's Democratic Republic	45	46	35
Malaysia	20	20	68
Myanmar	35	35	43
Thailand	57	56	62
Viet Nam	33	32	85
South and South-West Asia			
Afghanistan	5	5	7
Bangladesh	11	11	21
Bhutan	20	21	
India	36	36	30
Iran (Islamic Republic of)	6	6	8
Maldives	19	19	
Nepal	23	22	34
Pakistan	6	7	4
Sri Lanka	18	18	
North and Central Asia			
Armenia	16	15	
Azerbaijan	14	13	21
Georgia	33	33	74
Kyrgyzstan	13	10	95
Tajikistan	10	9	26
Uzbekistan	24	16	95
Pacific			
Fiji	32	31	
Papua New Guinea	46	50	20

Source: Database of Global AIDS Response Progress Reporting, prepared by the Data Team at the HIV and AIDS Data Hub for Asia and the Pacific (www.aidsdatahub.org).

[10] Mohammed El Said and Amy Kapczynski, "Access to medicines: The role of intellectual property law and policy", working paper prepared for the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law, 7-9 July 2011. Available from http://hivlawcommission.org/index.php/report-working-papers?task=document.viewdoc&id=86.

33. According to estimates from 2013 (see table 3 above), the percentage of people receiving ART among all PLHIV varies significantly across the region and within subregions. The total percentage, including those of all ages, ranges from 5 per cent in Afghanistan and 6 per cent in Iran and Pakistan to 67 per cent in Cambodia. The range is between 5 per cent and 67 per cent for those aged 15 or more and between 4 per cent and 95 per cent for those aged under 15.

34. Little data is available on treatment coverage in East and North-East Asia and the Pacific. Five countries in South-East Asia have coverage of over 30 per cent for those aged 15 or more, while in North and Central Asia, as well as in South and South-West Asia, only one country in each subregion provides coverage of more than 30 per cent. In general, the percentage of those under 15 receiving ART is higher than that of those aged 15 or more, but data for the former are missing in several member States.

2. Percentage of PLHIV known to be on treatment 12 months after initiation of ART

Table 4
Percentage of PLHIV known to be on treatment 12 months after initiation of ART, 2013

Country	Value
Cambodia	85
Malaysia	95
Myanmar	84
Thailand	83
Uzbekistan	92
Viet Nam	85

Source: Database of Global AIDS Response Progress Reporting, prepared by the Data Team at the HIV and AIDS Data Hub for Asia and the Pacific (www.aidsdatahub.org).

35. Data on the above indicator is mainly available for South-East Asia and ranges from 95 per cent coverage in Malaysia to 83 per cent coverage in Thailand, with most member States in the subregion covering more than 80 per cent of PLHIV. In Uzbekistan, 92 per cent of PLHIV were still on treatment 12 months after initiation of ART.

C. Key challenges

36. The affordability of antiretroviral drugs is a constant challenge for the region and calls for systematic incorporation of TRIPS flexibilities into national intellectual property laws and also for the wider utilization of such drugs.

37. Another key challenge in ensuring access to affordable medicines, diagnostics and vaccines in the region is how to reach people most at risk. Key populations continue to experience barriers to access to testing and treatment, often as a result of fear of discrimination from mainstream health providers. Scaling-up efforts to address social and structural barriers to service uptake, including stigma, discrimination, gender inequality and punitive legal environments, is critical for expanding treatment coverage.

Increased emphasis on community-based HIV testing and counselling, with linkages to treatment services and scaled-up access to treatment, is also needed.

V. Review legal and policy barriers

38. The elimination of stigma, discrimination and injustice against people affected by HIV remains one of the most important and challenging milestones to end AIDS in the region. All countries in the Asia-Pacific have laws, policies and practices that drive stigma and discrimination. Creating an enabling legal environment is key to eliminating the stigma, discrimination and violence that hamper access to HIV services.

39. Commission resolution 66/10 called on member States to ground universal access in human rights and to address legal barriers to AIDS responses. Commission resolution 67/9 called for a review of national laws, policies and practices to enable the full achievement of universal access targets with a view to eliminating all forms of discrimination against people at risk of infection or living with HIV, in particular key affected populations, a commitment similarly echoed in the Political Declaration on HIV and AIDS.[11] Furthermore, the ESCAP road map to 2015 suggested that countries should consider reviewing the findings and recommendations of the Global Commission on HIV and the Law, engage with key stakeholders including civil society and key populations, and address gender-related concerns when conducting their reviews.

A. Process indicators

1. Notable changes in the legal environment since 2012

40. There has been significant progress in removing legal and policy barriers to universal access to HIV services in the Asia-Pacific region since endorsement of the ESCAP road map.

41. India is moving towards enactment of its first comprehensive national HIV law. The HIV/AIDS (Prevention and Control) Bill 2014 was introduced to the upper house of the Indian Parliament in February 2014. Under the proposed law, PLHIV will be protected against discrimination in employment, health care, education, travel and insurance, both in the public and private sectors. They will also have a right to antiretroviral therapies and legal protection from breaches of confidentiality relating to HIV status.

42. Indonesia took action in 2013 to provide PLHIV with legal protection against discrimination in the provision of health care. Ministerial Regulation No. 21/2013 on the HIV and AIDS Response prohibits discrimination in the provision of health care and requires health programmes to actively engage key populations while adhering to the principles of respect for human dignity, justice and gender equality. The Regulation provides that care and treatment costs for PLHIV who are poor are to be borne by the State, and health services are prohibited from refusing them treatment or care.[12]

43. Mongolia updated its Law on the Prevention of HIV and AIDS in December 2012. Mongolia's national AIDS law was first introduced in 1994, and a revised Law on the Prevention of HIV and AIDS came into effect in

[11] Para. 78.

[12] Indonesia, Ministerial Regulation No. 21/2013 on the HIV and AIDS Response, art. 46 (2013).

January 2013, creating provisions for enforcing zero tolerance of HIV-related stigma and discrimination. It removed all HIV-related restrictions on entry, stay and residence and other discriminatory provisions for PLHIV. Foreigners applying for visas to Mongolia are no longer required to disclose or provide documentation on their HIV status. The Law also removed employment restrictions that prevented PLHIV from undertaking certain jobs, including in the food industry.

44. In Pakistan, progress was made in 2013 through the introduction of legal protection at the provincial level, with the enactment of an HIV/AIDS law in Sindh Province. The process by which the law was introduced was influenced by consultations carried out as part of the national legal review process in 2013.

45. The Philippines is also in the process of updating its national HIV law, which was first introduced in 1998. The Revised Philippine HIV and AIDS Policy and Program Act of 2013 (House Bill 1593) was introduced into the Congress in 2013 and approved by the House of Representatives in 2014; it is currently under consideration in the Senate. When enacted, the act will strengthen protection against discrimination and non-consensual testing, provide increased confidentiality protection and support harm reduction interventions to address HIV prevention among PWID. Extensive consultations with civil society and government agencies were conducted as part of the Bill's development in 2011-2012.

46. Timor-Leste enacted a new labour law in 2012; it offers protection to all citizens, including PLHIV, under a broad prohibition of discrimination on the grounds of health or disability in employment or when applying for employment.[13] It also prohibits compulsory workplace HIV testing.[14]

47. The Government of Fiji has provided regional leadership by introducing one of the few national constitutions in the world to give specific recognition to sexual orientation and gender identity issues. Fiji's new national constitution, introduced in 2013, provides that a person must not be unfairly discriminated against because of their health status, sexual orientation, gender identity or gender expression.[15]

48. Viet Nam's National Assembly passed the Law on the Handling of Administrative Sanctions in 2012, which required authorities to release sex workers detained in rehabilitation centres by July 2013. Sex workers may still be fined for administrative violations, but are no longer ordered to undergo detention or compulsory rehabilitation.

49. Since 2012, laws have been introduced in Cambodia and Sindh Province, Pakistan, that provide a legal framework for harm reduction programmes for PWID. Policy frameworks in Malaysia and Viet Nam are also now more supportive of harm reduction programmes than in the past.

50. The Committee on the Rights of the Child issued a General Comment in 2013[16] recommending that Governments consider empowering children under 18 with the legal capacity to consent to certain medical treatments and

[13] Timor-Leste, Labor Law, art. 6(2) (2012).

[14] Ibid., art. 72.

[15] Fiji, Constitution of the Republic of Fiji, art. 26 (2013).

[16] See General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24) (CRC/C/GC/15).

interventions, such as HIV testing and sexual and reproductive health services, without the permission of a parent, caregiver or guardian. The Philippines has provided leadership on this issue by drafting new legal provisions addressing children's and young people's rights in medical decision-making, which appear in the above-mentioned Program Act of 2013.

2. Number of countries and territories that have conducted at least one national review and/or multisectoral consultation on legal and policy barriers

51. An analysis of the information provided by ESCAP members and associate members, along with other United Nations data, suggests at least 27 have conducted reviews and/or consultations on legal and policy barriers in accessing HIV services since the 2012 endorsement of the ESCAP road map. At the national level, Afghanistan, Azerbaijan, Bangladesh, Bhutan, Cambodia, China, Indonesia, the Islamic Republic of Iran, Japan, Malaysia, Mongolia, Myanmar, Pakistan, the Philippines, the Russian Federation, Sri Lanka, Tajikistan, Thailand, Viet Nam and Hong Kong, China, conducted at least one review and/or multisectoral consultation. In addition, at the subregional level, a review and consultation for seven Pacific island countries (Fiji, Kiribati, Papua New Guinea, Samoa, Solomon Islands, Tuvalu and Vanuatu) was conducted in 2013.

52. Before the 2012 Intergovernmental Meeting, a regional multisectoral consultation for South and South-West Asian countries, namely Bangladesh, Bhutan, India, Maldives, Pakistan and Sri Lanka, was organized in November 2011.[17] Similarly, Armenia held several desk reviews and meetings with key stakeholders related to travel restrictions (2007-2008), recommendations from the Universal Periodic Review of the Human Rights Council (2011) and the development of the National AIDS Programme 2013-2016 (in 2012).

VI. Enhance financial sustainability, effectiveness, and national ownership and capacity

53. The financing of the AIDS response in the region has increased significantly over the past decade, with estimated regional HIV spending rising from US$ 700 million in 2005 to US$ 2.2 billion in 2012, which represents a threefold increase[18] in seven years. Governments in the region have acted decisively to implement the concept of shared responsibility by increasing domestic spending as a proportion of total HIV expenditure, which has increased from US$ 400 million in 2005 to US$ 1.3 billion in 2012, representing 59 per cent of total AIDS spending compared with the global average of 53 per cent.[19] However, the demand for resources in the region still outstrips the supply. It is estimated by UNAIDS that in order to achieve the 10 targets of 2011 Political Declaration on HIV and AIDS in Asia and the Pacific by 2015, the region has to mobilize US$ 5.4 billion. Taking into account the current level of funding of US$ 2.2 billion, the estimated shortfall is US$ 3.2 billion.

[17] International Development Law Organization, *South Asia Roundtable Dialogue: "Legal and Policy Barriers to the HIV Response", Kathmandu, Nepal 8-10 November 2011* (Rome, 2011).

[18] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013* (Geneva, 2013).

[19] Synthesis of country data conducted by the Data Team at HIV and AIDS Data Hub for Asia and the Pacific (www.aidsdatahub.org).

A. Process indicators

Costing of national strategic plans

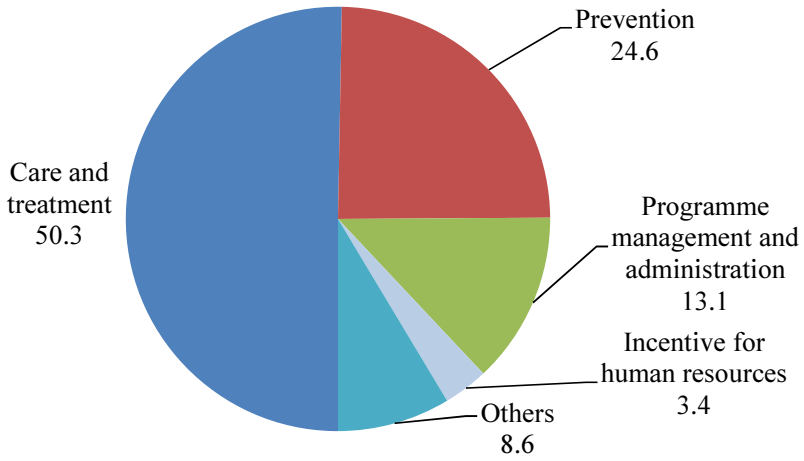
54. Of the 23 respondents to the intergovernmental survey, 19 reported that they had a national strategic plan on HIV and AIDS. Of those 19 countries, 15 stated that their strategies to address legal and policy barriers to access HIV prevention, treatment, care and support for PLHIV and key populations were fully costed and budgeted.

55. In addition, a number of countries are conducting HIV investment cases and sustainability plans. HIV investment cases and sustainability plans provide tools for countries: to deliver strategic, rights-based, sustainable AIDS responses and the options for innovative funding and service delivery; to identify specific steps to be taken to ensure access for key populations; and to use the available evidence to make smart investments and to eliminate inefficiencies in HIV programmes. Myanmar, Nepal, Thailand and Viet Nam have developed strategic investment cases and plans, while others, including Bangladesh and Cambodia, are in the process of doing so. By optimizing fund allocations, it is envisaged that considerable amounts could be saved for reinvestment.

B. Outcome indicators

AIDS spending by categories

Figure
Distribution of AIDS expenditure by category in Asia and the Pacific, according to the latest data available (in percentages)



Source: Database of Global AIDS Response Progress Reporting prepared by the Data Team at the HIV and AIDS Data Hub for Asia and the Pacific (www.aidsdatahub.org).

56. Overall, based on 2013 GARPR data covering 34 countries in the region (see figure above), countries spend on average 50.3 per cent of total AIDS expenditure on care and treatment, 24.6 per cent on prevention, 13.1 per cent on programme management and administration, 3.4 per cent on incentives for human resources, and 8.6 per cent on other areas, which

includes 1.7 per cent for an enabling environment. Some 21 per cent of the expenditure on prevention is used to target key populations.

57. The following key trends can be noted with regard to financing of the AIDS response:

(a) There is a trend towards increased funding for HIV and AIDS in most countries in the region;

(b) The share of domestic funding has also shown a significant increase, indicating the willingness of countries to "share responsibility" for financing the AIDS response;

(c) In general, the Asia-Pacific region is failing to focus spending on HIV prevention among key populations. Additionally, many countries have higher than average programme administration costs. These challenges compromise the effectiveness of HIV spending;

(d) Some countries' spending allocations do not reflect the actual nature of national epidemics.

58. The document entitled "Review of the financing of national HIV and AIDS responses in the Asia-Pacific region"[20] may be consulted for more details on this subject.

VII. Ensure gender equality in the AIDS response

59. Discrimination on the grounds of gender, including gender-based violence and gender inequality, hinder AIDS responses. One of the goals of the Political Declaration on HIV and AIDS calls for eliminating both gender inequalities and gender-based violence, and for increasing the capacity of women and girls to protect themselves from HIV.

60. Mounting evidence suggests that gender-based violence makes women, girls, MSM and transgender people more vulnerable to sexually transmitted infections, including HIV. Studies also show that women from key populations, such as female drug users, female sex workers and transgender women, are particularly likely to experience violence.

61. It is critical to understand the epidemic from the gender perspective and to ensure that routinely collected data are disaggregated by sex and age, to include women, men and transgender people into decision-making processes and to promote gender-responsive budgeting.

A. Process indicators

Gender-responsiveness of multisectoral strategic plans

62. Commission resolution 67/9 called upon member States to continue developing their national strategies to address all forms of gender-based violence, including sexual violence, particularly against women and girls.

63. Of the 23 countries and territories in the Asia-Pacific region that responded to the intergovernmental survey, 17 reported having a national strategy to address all forms of gender-based violence, as called for in Commission resolution 67/9.

[20] E/ESCAP/HIV/IGM.2/3.

B. Outcome indicators

Proportion of ever-married or partnered women aged between 15 and 49 who have experienced physical or sexual violence from a male intimate partner in the previous 12 months

64. In Asia and the Pacific, women living with HIV and women from key populations, including transgender women, are more likely to report a history of intimate partner violence than women from the general population. Research suggests that physical violence combined with sexual violence from partners is associated with an increase in HIV prevalence. Furthermore, transgender people in the region were frequently found to be subject to violence and hate crimes, and to experience stigma and discrimination in accessing health services.

65. Based on the 2014 GARPR data, prevalence of recent intimate partner violence, measured as a percentage of ever-married or partnered women aged between 15 and 49 who experienced physical or sexual violence from a male intimate partner in the past 12 months, varies greatly across the region, ranging from 1.87 per cent in Georgia to 68 per cent in Kiribati.

66. Where data are available, more than half of women reported experiencing physical or sexual violence in Kiribati, the Solomon Islands and Vanuatu. In North and Central Asia, between 1.87 per cent and 17.1 per cent of ever-married or partnered women reported experiencing violence. It is important to note that violence against women, and especially intimate partner violence, remains significantly underreported.

VIII. The way forward: priorities and policies for the region

67. In the intergovernmental survey on the implementation of the commitments made in the Political Declaration on HIV and AIDS, and Commission resolutions 66/10 and 67/9, member States were asked to list the key achievements, challenges and priorities for future action.

A. Achievements

1. Reducing sexual transmission of HIV and preventing transmission among PWID

68. Out of the 23 respondents that responded to the intergovernmental survey, 16 highlighted their success in reducing sexual transmission of HIV and preventing transmission among PWID as key achievements. The strategies outlined included improved and scaled-up HIV testing, improved targeting of key populations and harm reduction programmes for PWID.

2. Development of national strategic plans, policies, guidelines and laws

69. Ten respondents highlighted the development of national strategic plans, policies, guidelines and laws as being one of the key achievements leading to more effective governance and management of the AIDS response. They also highlighted examples of stronger government support to PLHIV, key populations and civil society organizations.

3. Scaling up life-saving ART

70. Fifteen respondents to the survey referred to their efforts in scaling up life-saving ART as a key achievement. Those efforts included strengthening

policies for distribution of free or affordable antiretroviral drugs to the eligible population, taking steps to increase the coverage of ART and adjusting treatment guidelines to bring more PLHIV into the treatment cascade at an earlier stage.

4. Implementing PMTCT programmes

71. Three countries highlighted their success in implementing PMTCT programmes as a step towards eliminating new HIV infections in children, while other countries emphasized their achievements in integrating HIV services within universal health care schemes and chronic disease care programmes.

72. It is clear that the region has made significant progress in implementing an effective AIDS response through increasing domestic funding; putting in place national strategic plans, policies and laws to reduce HIV transmission; and taking steps to ensure access of all PLHIV to ART. However, much still needs to be done as is evident from the challenges that were highlighted in the survey responses.

B. Challenges

73. Some of the key challenges identified by ESCAP member States to mounting a stronger response to HIV included limited international and domestic funding, lack of support for an enabling environment for key populations to access services, weak governance and stewardship of HIV programmes and poor targeting of funding and resources for achieving optimum results.

1. Insufficient funding

74. Of the 23 respondents, 15 highlighted insufficient funding as being a major challenge to realizing universal access to comprehensive HIV prevention, treatment, care and support. Out of these, eight referred to the need for increased domestic funding, whereas five highlighted the shrinking pool of international funding as a key challenge. Seven countries emphasized that lack of institutional capacity and human resources were critical challenges. The high prices of antiretroviral drugs and increasing number of PLHIV were cited as key factors challenging the sustainability of AIDS responses.

2. Lack of an enabling environment for PLHIV and key populations

75. Thirteen respondents referred to a lack of an enabling environment for PLHIV and key populations to access HIV services, including discriminatory and stigmatizing customs and social practices, as being a key challenge. Some countries referred to a lack of involvement of relevant civil society partners as a challenge.

3. Weak governance of HIV programmes

76. Nine respondents highlighted weak governance of HIV programmes as a critical challenge, including lack of political will and coordination among stakeholders, poor data management, and gaps between laws and policies and their implementation. Five respondents referred to poor targeting of financial and human resources as a key challenge that needed to be addressed.

77. Even in areas where progress has been made, a number of challenges have been noted, highlighting the need to step up efforts.

C. Future priorities

1. Improvement of HIV services including treatment and care

78. Sixteen respondents cited improvement of HIV services, including treatment and care, as a top priority. The following key priorities were identified under this topic:

(a) Fourteen countries highlighted the need to scale up HIV testing, care and treatment services, including adopting an evidence-based approach towards key populations;

(b) Four countries prioritized community-based HIV treatment;

(c) Two countries recommended a "treatment as prevention" approach;

(d) Three countries highlighted scaling up of ART coverage as a key priority.

2. Integration of HIV services

79. Strengthened integration of HIV services within primary health care and the general health delivery system, including universal coverage systems, was cited as a key priority by five countries.

3. Improvement of HIV governance

80. Thirteen countries identified improvement of governance of the AIDS response as a critical priority. This included the following:

(a) Actions to sustain and increase domestic funding for HIV (five countries);

(b) Well-coordinated multisectoral coordination (four countries);

(c) Greater targeting of key populations (three countries);

(d) Stronger monitoring and evaluation (three countries);

(e) Decentralization.

4. Reducing stigma and discrimination, and increasing access to justice for key populations and PLHIV

81. Reducing stigma and discrimination against key populations and PLHIV was cited as a key priority by five countries, with actions to be taken to sensitize lawmakers, law enforcement officials, political and religious leaders and medical care providers.

D. Conclusions and recommendations

82. Despite the significant progress made by the Asia-Pacific region in reducing new infections and increasing domestic funding for the AIDS response, the epidemic requires much stronger action if the targets agreed to in the Political Declaration on HIV and AIDS are to be met.

83. Most importantly, despite some progress, all countries in the region have to address more effectively legal and policy barriers to HIV services for key populations and PLHIV.

84. The proportion of PLHIV who access treatment varies from 5 per cent in Afghanistan to 67 per cent in Cambodia; in many subregions it is around 30 per cent. This is partly due to the fact that not enough PLHIV, especially from key populations, know their HIV status, which is hampering access to treatment.

85. There are growing localized epidemics in certain geographical areas, especially major cities, and among key populations in many countries. There is growing evidence that greater success would be achieved by involving affected communities and networks at all stages of the disease response.

86. Domestic funding for the AIDS response has considerably increased but the epidemic outpaces it, and domestic financing remains inadequate in a situation where international funding is also shrinking.

87. Reaching the targets agreed to in the Political Declaration on HIV and AIDS in 2011 — and moving towards the vision of Asia and the Pacific with zero new HIV infections, zero discrimination and zero AIDS deaths — requires the following urgent actions to be taken by countries in the region:

(a) Strengthening political leadership and commitment, as well as fully involving PLHIV and key populations at all stages of the AIDS response;

(b) Enhancing HIV prevention efforts, with a particular focus on key populations and geographical priority areas within countries;

(c) Expanding and sustaining HIV testing and counselling and access to ART, including community-based HIV testing with the goal of bringing all PLHIV under treatment;

(d) Ensuring affordable access to medicines, diagnostics and prevention commodities for the region and beyond;

(e) Advancing human rights and gender equality through the removal of laws, policies and practices that fuel stigma and discrimination, violate rights and hinder access of key populations and PLHIV to HIV services;

(f) Increasing and sustaining domestic resources for financing of the AIDS response and ensuring that funding is directed to where it will have the greatest impact.