



Economic and Social Council

Distr.: General
24 August 2011

Original: English

Economic and Social Commission for Asia and the Pacific

Asia-Pacific High-level Intergovernmental Meeting on the Assessment of Progress
against Commitments in the Political Declaration on HIV/AIDS
and the Millennium Development Goals

Bangkok, 1-3 November 2011

Item 5 of the provisional agenda

**Consideration of measures to promote multisectoral
cooperation and build national capacity in addressing
policy and legal barriers to universal access to HIV
prevention, treatment, care and support**

Overview of good practices in promoting multisectoral cooperation and enhancing national capacity in addressing policy and legal barriers to universal access to HIV prevention, treatment, care and support in the Asia-Pacific region

Note by the secretariat

Summary

The present document will review existing measures that promote cooperation among key sectors, including justice, law and order, drug control, health and social welfare. With three decades of experience in addressing HIV and AIDS, the region is home to a number of good practices in addressing policy and legal barriers that impede effective HIV responses. Additionally, areas identified by the Asia-Pacific Regional Dialogue of the Global Commission on HIV and the Law, which was jointly organized by the United Nations Development Programme, the Joint United Nations Programme on HIV/AIDS, ESCAP and the Secretariat of the Global Commission (Bangkok, February 2011), have been considered in the present document.

A notable outcome of the Dialogue was the need for interventions to address the root causes of vulnerability and risk of key affected populations (for example, sex workers, people who inject drugs, men who have sex with men and transgender persons), particularly stigma and discrimination, as doing so significantly increases universal access to prevention, treatment, care and support. Policies and practices that eliminate or mitigate such negative factors and reinforce the necessary individual behavioural change are therefore highlighted within the document.

The present document provides examples of effective programmes in the region which have explicitly addressed the linkage between HIV and stigma/discrimination. Such programmes have been based upon meaningful partnerships among all key stakeholders, including people living with HIV and key affected populations. The Meeting may wish to review those regional experiences which demonstrate that environments can be made more enabling by working through a multisectoral approach and involving key affected populations in the planning, design and implementation of such programmes.

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I. Introduction

1. Despite some clear progress in the past decade (see E/ESCAP/HIV/IGM.1/1), governments in the region have struggled to sustainably reverse and control the HIV epidemic. In 2008, the Commission on AIDS in Asia outlined elements of a dramatic new response to HIV in the region. One critical recommendation was that countries should target their prevention efforts strategically to focus on reaching 80 per cent of the key affected populations, namely sex workers, people who use drugs, transgender persons and men who have sex with men.¹ The Commission's recommendation was based on an acknowledgement of the reality of the shape of the epidemic in Asia. As acknowledged by governments in the region, these key affected populations face a continuing high prevalence of HIV.² Globally, young people aged 15-24 represent 45 per cent of all new HIV infections, and in Asia, over 95 per cent of these new infections occur among young people in key affected populations.³ The Commission concluded its report with a number of predictions that emphasized the dire consequences and the escalation of HIV in the region if prevention interventions were not intensified.

2. Since the publication of the Commission's recommendations, all available data continues to indicate that HIV prevalence among key affected populations remains significantly higher than in the general adult

¹ Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response* (2008), p. 132.

² See ESCAP resolution 66/10.

³ Joint United Nations Programme on HIV/AIDS (UNAIDS), *2008 Report on the Global AIDS Epidemic*, Geneva, Switzerland: UNAIDS, 2008. p. 13.

population. However, most countries in the region continue to spend the bulk of their prevention efforts on low-risk populations.⁴ Recent UNGASS data for Asia and the Pacific indicates that, though there have been some notable increases in coverage, approximately one third of MSM and female sex workers (FSW) are covered by prevention efforts, and with regard to people who use drugs, this figure drops below 17 per cent.⁵

3. One reason for the persistence of HIV in the region is the significant gap in access to services by key affected populations. Recent studies show that, in many countries of the region, less than 20 per cent of MSM and transgender people access HIV prevention services.⁶ A primary reason for the low rates of access to needed services is the lack of an enabling environment.

4. According to the Commission, 90 per cent of countries in the region still have laws that act as barriers to the HIV response. In Asia and the Pacific, 16 countries impose travel bans on people living with HIV, 20 countries imprison individuals engaging in same-sex relations and 29 countries criminalize sex work.⁷ Several countries detain people who use drugs in compulsory centres and retain the death penalty for drug offences. In addition to resulting in de facto discrimination against key affected populations, such an environment drives the epidemic underground, stymieing a government's efforts to halt and reverse the HIV epidemic in its country. Given the complexity of the dynamics within policy frameworks as well as the dynamics within key affected populations, which are often overlapping, the purpose of the present document is to identify measures that are designed to address stigma, discrimination, social exclusion and gender-based violence as related to HIV.

II. Countering stigma and discrimination involves a multisectoral response

5. In the region, the ability of governments to develop an effective response has often been hampered by a legal and policy environment that remains unwelcoming to efforts that target key affected populations effectively. In the past decade, governments have found it challenging to design and implement programmes for people engaged in behaviour that is often viewed as illegal or unacceptable not only by the general population but also by their judicial and legislative systems.

6. The ongoing stigmatization of key affected populations leads to a variety of negative consequences. In particular, such stigma undermines an individual's self-esteem, which often leads to greater risk-taking behaviours. In the context of HIV, this translates into low levels of condom usage and a

⁴ Report of the Secretary-General, "Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths" (A/65/797), para. 16.

⁵ UNAIDS, UNICEF, WHO, ADB, HIV and AIDS Data Hub for Asia-Pacific, available from www.aidsdatahub.org (accessed 23 August 2011).

⁶ John Godwin, *Legal Environments, Human Rights and HIV Responses among Men Who Have Sex with Men and Transgender People in Asia and the Pacific: An Agenda for Action* (United Nations Development Programme, 2010), p. 3.

⁷ UNAIDS, *Regional Consultation Outcome Report, Universal Access in Asia and the Pacific* (2011).

reduced propensity to seek testing and treatment. Access to treatment may also be compromised when health service providers refuse to provide treatment due to personal prejudice or fear of possible arrest/harassment from law enforcement officials.

A. Reducing HIV among sex workers and their clients requires peer-led interventions

7. By some estimates, the number of men who have unprotected commercial sex is the single most important determinant of the potential size of the HIV epidemic in the region. On a regular basis, an estimated 10 million women sell and at least 75 million men — between 0.5 and 15 per cent of adult males — purchase sex in the region.⁸ Clients of female sex workers (FSW) make up the largest HIV-affected population group in Asia.

8. The ongoing demand for commercial sex may explain why the HIV prevalence among sex workers approaches 20 per cent in some countries.⁹ In some countries in the region, more than 90 per cent of women acquired HIV from their husbands or male partners.¹⁰ The most effective way to prevent HIV infections in low-risk women, therefore, is to prevent their partners from becoming infected. Ensuring that men who visit sex workers have consistent levels of condom use is therefore an important component in any national response.

9. Given the strong link between a country's HIV prevalence rate and commercial sex, the low level of HIV prevention coverage for sex workers in the region — estimated to reach only one third of all sex workers in Asia — poses a significant threat that countries have acknowledged must be addressed.

10. Initial efforts to reduce the explosive rise of HIV among female sex workers focused almost exclusively on mandatory condom use ("100% condom use programmes") by sex workers and their clients. While these programmes had a significant and rapid impact, a number of critiques have subsequently arisen regarding the sustainability of such an approach. Data have shown that interventions which are primarily led by government workers or brothel owners, often working in concert, result in only temporary increases in condom usage among female sex workers and, in some cases, actually lead to increases in HIV prevalence among sex workers.¹¹ In some countries, such programmes have shown insufficient increases in consistent condom use among clients or non-client partners in the long term, and there has been little sustained impact on voluntary testing rates among sex workers. Most significantly, sex worker groups in some countries that have implemented 100 per cent condom use programmes

⁸ Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response* (2008), p. 2.

⁹ UNAIDS, WHO, UNICEF, ADB, *Asia-Pacific Regional Review of HIV* (2010), p. 26.

¹⁰ Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response* (2008), p. 203.

¹¹ Center for Advocacy on Stigma and Marginalisation (CASAM), *Rights-based Sex Worker Empowerment Guidelines: An Alternative HIV/AIDS Intervention Approach to the 100% Condom Use Programme* (2008).

have reported increased violence against sex workers by both clients and partners.¹²

11. At the same time, peer-led programmes have had striking and sustained success. Of particular note is the work of Durbar Mahila Samanwaya Committee, a collective organization of 65,000 sex workers in Sonagachi, in Kolkata, India. From 1999 to 2007, largely due to their innovative programming, condom use among sex workers increased from 2 per cent to 85 per cent.¹³ The Sonagachi project runs health clinics for over 20,000 workers as well as HIV support groups, a drama troupe that engages in public outreach and a savings and banking cooperative. Importantly, their success at increasing condom usage has been replicated at 49 sites in West Bengal.¹⁴

12. Peer-directed interventions have proven effective in the long term due to their focus on improving the self-awareness and confidence of sex workers in negotiating consistent condom usage with their clients and non-client sexual partners. Additionally, their strong group cohesion allows for collective mobilization against stigma and discrimination and has also been used to counter threats of physical violence and assault.¹⁵

13. Importantly, such peer-led interventions operate in concert with government institutions, particularly with local government, public health practitioners and police officials. In these situations, the development of strategic alliances has led to strong community ownership, reduced stigma in health-care settings and the creation of an enabling environment.¹⁶ These programmes have also included reaching out to the private sector and mobilizing the clients of sex workers, who often are overlooked in prevention interventions.¹⁷

B. Meaningful multisectoral responses can decrease HIV among people who use drugs

14. As with sex workers, high HIV prevalence rates have been reported among people who inject drugs in the region. In the countries most affected by HIV in the region, HIV infection can be traced to injecting drug use in 30 per cent to 90 per cent of cases.¹⁸ Over one in three people who inject

¹² E. Jamts, "Response to 100% condom use program implementation among female sex workers in Mongolia". Paper presented at the XVII International AIDS Conference. Mexico City, Mexico. August 2008.

¹³ Ray, P. "Demystifying the Discourse: The Sonagachi Experience". Paper presented at the XVII International AIDS Conference. Mexico City, Mexico. August 2008.

¹⁴ Toorjo Ghose, Dallas Swendeman, Sheba George, and Debasish Chowdhury, "Mobilizing collective identity to reduce HIV risk among sex workers in Sonagachi, India: The boundaries, consciousness, negotiation framework". *Social Science & Medicine*. 2008 July; 67(2): 311–320. Available at <http://www.sciencedirect.com/science/article/pii/S0277953608001895> (accessed 19 August 2011).

¹⁵ Ibid.

¹⁶ UNAIDS, *Reducing Harm, Rebuilding Lives: HIV/AIDS and High Risk Populations, Law Enforcement Agencies as Agents of Change*, 2010.

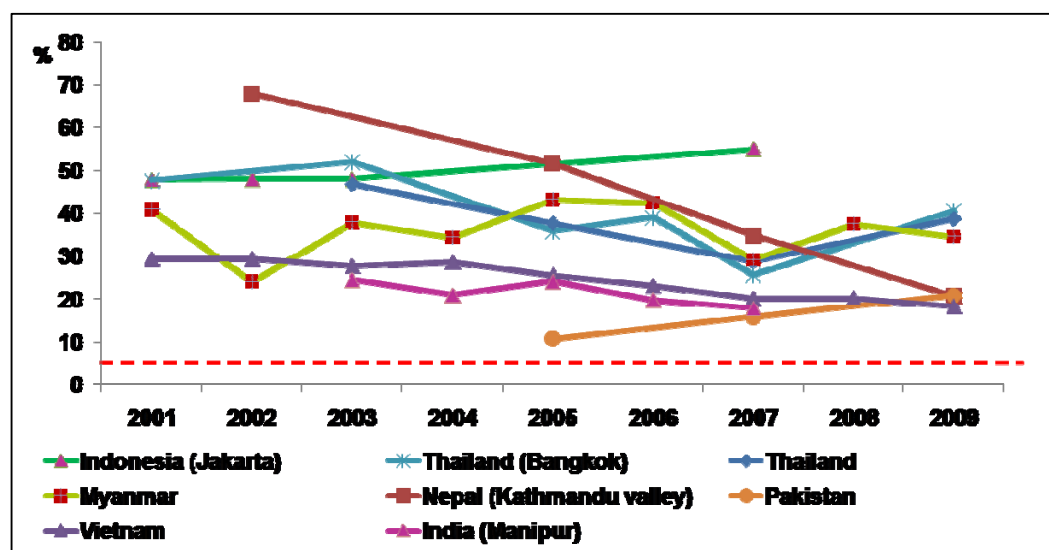
¹⁷ Commission on AIDS in Asia, *Redefining AIDS in Asia: Crafting an Effective Response* (2008), p. 202.

¹⁸ UNAIDS, WHO, UNICEF, ADB, *Asia-Pacific Regional Review of HIV* (2010).

drugs surveyed in Indonesia, Myanmar and Thailand are HIV+ (> 30 per cent prevalence) and about one in five in Nepal, Pakistan and Viet Nam.¹⁹

Figure

HIV prevalence among people who inject drugs (selected areas in the region)



Source: Joint United Nations Programme on HIV/AIDS, Regional Support Team for Asia and the Pacific, "Our journey towards universal access since 2006: A regional overview", presented at the Asia-Pacific Regional Consultation on Universal Access to Prevention, Treatment, Care and Support, Bangkok, 30 March 2011.

15. As the figure demonstrates, HIV among people who inject drugs has declined in some areas of the region. In Nepal, for example, HIV prevalence among people who inject drugs declined from 68 per cent (2003) to 21 per cent (2009).²⁰ However, it is equally clear that some epidemics in the region have persisted at the same rates for decades. In Bangkok, for example, the HIV infection rate among people who inject drugs has remained above 30 per cent for more than two decades.²¹

16. An additional concern is the high rate of HIV among persons in closed settings, such as detention centres and prisons. Currently, there are approximately 350,000 people who use drugs located in approximately 1,000 compulsory centres for drug users (CCDUs) in East and South East Asia.²² Existing data indicate that, overall, such centres are largely ineffective in reducing drug dependence.²³ Many countries have reported

¹⁹ Ibid.

²⁰ Sharma et al., *HIV epidemics among people who inject drugs* (AIDS 2009) accessed at http://www.searo.who.int/LinkFiles/HIV-AIDS_PWID_in_SEA.pdf on 23 August 2011), which notes that the decline in Nepal, India and Bangladesh is largely attributed to effective needle-syringe programmes.

²¹ WHO, *HIV/AIDS in Asia and the Pacific Region 2003* (WHO, 2004).

²² WHO, UNAIDS, UNODC, The Global Fund to Fight AIDS, Tuberculosis and Malaria and Asian Network of People who Use Drugs. *A strategy to halt and reverse the HIV epidemic among people who inject drugs in Asia and the Pacific 2010-2015*. 2010.

²³ Martin, Gayle, Stephens, David, Burrows, David and others. "Does compulsory rehabilitation in closed settings work in Vietnam?" Paper presented at the Informal Consultation on Compulsory Centres for Drug Users. Bangkok, Thailand. September 2010.

relapse rates following release from a CCDU ranging from 60 per cent to 100 per cent.²⁴ Fear of arrest and admission to CCDUs has also been noted as a reason why people who inject drugs do not access services, further hampering uptake of HIV prevention and drug dependence treatment services at the community level.

17. In the past decade, involuntary treatment as a response to drug dependence, particularly in the context of HIV arising from injecting drug use has been widely discredited in the international public health community.²⁵ The World Health Organization (WHO) Expert Committee on Drug Dependence, for example, views drug dependence as a multifactorial health disorder that often follows the course of a relapsing and remitting chronic disease.²⁶ To facilitate greater adoption of harm reduction, it has been recognized that wider adoption of a public health perspective of drug use viewing dependence as a chronic relapsing health disorder is needed.

18. Modelling suggests that, without harm reduction activities, HIV transmission among people who inject drugs can rise to 40 per cent or more within two years after introduction of the virus.²⁷ In recognition of the high HIV prevalence among people who inject drugs, WHO, the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommended a package of HIV prevention, treatment and care interventions, including opiate substitution and other drug dependence treatment.²⁸ Of the 11 countries in the region with drug-related HIV epidemics, however, none offers the full recommended harm reduction package.²⁹

19. By November 2010, the majority of countries and territories in East and South-East Asia, including Cambodia, China, Indonesia, Malaysia, Myanmar, Thailand and Viet Nam as well as Hong Kong, China, had operational opioid substitution therapy (OST) programmes in place.³⁰ In July 2010, Bangladesh launched its first ever pilot OST centre in Dhaka to enhance the health and social status of people who inject drugs. To date,

²⁴ World Health Organization: Western Pacific Region. *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles*. 2009.

²⁵ Mesquita, Fabio, Jacka, David, Dominique Ricard, Graham Shaw and others, *Accelerating harm reduction interventions to confront the HIV epidemic in the Western Pacific and Asia: the role of WHO (WPRO)*. (Harm Reduction Journal, 2008). Available at <http://www.harmreductionjournal.com/content/5/1/26> (accessed on 23 August 2011).

²⁶ UNODC and WHO, "Principles of Drug Dependence Treatment". Discussion Paper. United Nations Office on Drugs and Crime. Vienna. 2008.

²⁷ Sharma et al. p. 2.

²⁸ WHO, UNODC, UNAIDS. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. (World Health Organisation 2009).

²⁹ Burnet Institute, *Harm reduction in Asia: Progress towards universal access to harm reduction services among people who inject drugs*. (United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific, 2009). p. 10.

³⁰ Catherine Cook, ed., *The Global State of Harm Reduction 2010: Key issues for broadening the Response*. IHRA. 2010. Available at: http://www.ihra.net/files/2010/06/29/GlobalState2010_Web.pdf (accessed on 23 August 2011).

their experiences have shown that OST is effective in reducing criminal activity, opiate use, and episodes of injecting as well as increasing employment prospects and lowering the risk of HIV transmission.³¹ Harm reduction programmes have successfully expanded in response to the need to provide HIV prevention, treatment, care and support service in closed settings, such as prisons, most notably in the Islamic Republic of Iran.³² Though there has been an expansion of needle exchange programmes, the region's overall rate of access (14 per cent) is very low when compared to the global average of 40 per cent.³³

20. Since the start of the epidemic in Malaysia, injecting drug use has been the primary transmission route for HIV infections. In 2005, Malaysia began a significant scale-up of its harm reduction programming.³⁴ From a pilot phase of 17 methadone maintenance treatment (MMT) sites in nine states, the programme has expanded to 240 sites for MMT and 357 needle exchange sites. From 2002 to 2009, new HIV infections have fallen from approximately 7,000 to 3,000.³⁵

21. Additionally, as part of an emerging approach that favours harm reduction over punitive measures, Malaysia has moved from involuntary treatment to voluntary "cure and care" centres into its national policy. This evolution from involuntary to voluntary treatment required a concerted, multisectoral effort in order to balance public security concerns with a public health model which addresses drug use and dependence.

22. Beginning in 2010, the 1Malaysia Cure and Care Clinics replaced the Narcotics Addiction Rehabilitation Centres (PUSPEN). These voluntary centres provide a "range of treatment alternatives to meet the needs of the people who use drugs" and integrate HIV prevention, care, treatment and support services.³⁶ Unlike PUSPEN, admission to the clinic is voluntary. By 2011, six such clinics had been established with 1,897 people having used the service.³⁷

³¹ Pang L, Hao Y, Mi G, Wang C, and others. *Effectiveness of first eight methadone maintenance treatment clinics in China*. AIDS 2007, 21:S103-108 Available at <http://www.ncbi.nlm.nih.gov/pubmed/18172377> (accessed 23 August 2011); see also Ministry of Health of the People's Republic of China. *Progress Report on Monitoring of the United Nations General Assembly Special Session on HIV and AIDS*. 2010.

³² Islamic Republic of Iran, National AIDS Committee Secretariat, Ministry of Health, *Progress Report on Monitoring of the United Nations General Assembly Special Session on HIV and AIDS*, February 2010.

³³ UNAIDS, Regional Consultation Outcome Report, Universal Access in Asia and the Pacific (2011).

³⁴ Malaysia, Ministry of Health, *Good Practices in Asia: Scale-up of Harm Reduction in Malaysia*, 2011.

³⁵ Ibid.

³⁶ Ibid.

³⁷ Ibid.

C. Effective outreach for men who have sex with men: know your status³⁸

23. While there is significant variability, HIV prevalence among MSM in the region is rising (see E/ESCAP/HIV/IGM.1/1). In several countries in East Asia, male-to-male sex has become the dominant mode of transmission among newly diagnosed infections.³⁹ Modelling projections presented by the Commission on AIDS in Asia in 2008 indicated that, unless prevention measures were strengthened and expanded, an increasing proportion of new HIV infections in the region would be among MSM, representing up to 50 per cent of new infections by 2020.

24. Further, studies have shown that, in some countries, although the level of basic knowledge about HIV/AIDS was high among MSM, a high proportion of MSM perceive their risk of contracting HIV as low. While limited data is available, one study noted that less than 20 per cent of MSM know their status.⁴⁰

25. Voluntary HIV testing is part of a national response for prevention and treatment. Testing offers an important opportunity for risk assessment and prevention counselling and for those who test positive, an opportunity to access antiretroviral therapy, which lowers their viral load and subsequent infectivity. The WHO Priority Health Sector Interventions Report recommends synergistic relationships between community organizations, which should deliver services (such as peer support and counselling) preferably inside public clinics and hospitals, which would provide related biomedical services.

26. There are effective programmes to encourage uptake of HIV services among MSM through a broad range of activities. In Thailand, “testing hot spots”, small-scale clinics that operate on the “borders” of the public health system and highly mobile clinics in other countries, have been successful in generating demand among MSM for testing and counselling. Outreach has taken the form of film festivals, media workshops, social media and mobile phone messaging as well as vocational and life skills programmes.⁴¹

III. Enabling environments must stretch beyond medical needs

27. Ensuring that discrimination does not exist in health-care settings is a prerequisite for any government committed to providing universal access to prevention, treatment, care and support. Similarly, people living with

³⁸ The term “men who have sex with men” encompasses homosexual, bisexual and transgender men, and heterosexual men who occasionally engage in male-to-male sexual contact.

³⁹ Mumtaz G, Hilmi N, McFarland W, Kaplan RL, Akala FA, et al. 2011 *Are HIV Epidemics among Men Who Have Sex with Men Emerging in the Middle East and North Africa?: A Systematic Review and Data Synthesis*. PLoS Med 8(8): e1000444. doi:10.1371/journal.pmed.1000444.

⁴⁰ United States Agency for International Development, *HIV/AIDS profile: Asia*, Available at http://www.usaid.gov/our_work/global_health/aids/Countries/asia/hiv_summary_asia.pdf (accessed 19 August 2011).

⁴¹ United Nations Development Programme. *Towards Universal Access: Examples of Municipal HIV Programming for Men who have Sex with Men and Transgender People in Six Asian Countries*. 2011.

HIV (PLHIV) need equal access to all other government programmes and services, such as employment services, education and protective legislative frameworks.

28. Many constitutions in the region guarantee their citizens basic civic rights, such as equal access to services, privacy and freedom from discrimination. Due to stigma and the potentially illegal nature of their work or behaviour, key affected populations often find themselves unable to access government services on an equal basis with other citizens. Ensuring that PLHIV have the necessary ability to travel, work, and become educated should be included in any national response.

A. Basic recognition as a citizen can combat stigma

29. Legal protection of transgender people is particularly important due to their vulnerability to HIV. As recently decided by the Supreme Courts of Pakistan⁴² and Nepal,⁴³ recognition of a third gender is an important way to broaden the view of transgendered persons as equal citizens. The ability to vote, be appropriately identified in legal documents, and inherit are basic rights for any citizen. Being afforded basic protections and simply being counted, as in Nepal's recent census, is an important acknowledgement as well. Such low-cost interventions are effective in eroding stigma on a society-wide basis, which increases the likelihood of PLHIV accessing services related to HIV prevention, treatment, care and support.

B. Key affected populations need equal access to labour protection

30. Like other parts of the informal economy, sex work does not always take place in a formalized setting but rather fluctuates depending upon economic conditions. For some, sex work is an occasional form of employment to earn extra income rather than a long-term occupation.

31. The Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health to the Human Rights Council at its fourteenth session underlines how access to treatment is lowered due to stigmatization of the profession, the creation of unhealthy working conditions and the opening of opportunities for violence.⁴⁴

32. Without standard labour protections, sex work is often conducted in unsafe working environments. In such situations, sex workers cannot gain access to benefits or legitimate legal redress for workplace grievances. Occupational health and safety regulations that routinely protect employees in other industries would not protect them. Due to the hidden nature of the work, business owners may take greater risks regarding the personal safety of their workers. Sex workers may be pressured by management to avoid taking precautions against HIV and sexually transmitted infections as

⁴² Supreme Court of Pakistan, *Dr. Muhammed Aslam Khaki and Almas Shah v. SSP Rawalpindhi and others*, 2009.

⁴³ Supreme Court of Nepal, *Sunil Babu Pant and others v. Nepal Government and others* 2 NJA L.J. 261-285. 2008.

⁴⁴ See A/HRC/14/20, para. 19.

condoms may be used by police as evidence of an actionable offence or harassment and intimidation.⁴⁵

33. Such unsafe working conditions co-exist in an environment with a high potential for violence. Arbitrary detention, sexual assault and other basic violations to a person's physical integrity have been experienced by 50 to 90 per cent of sex workers in the region.⁴⁶ In some countries in the region, sex workers routinely experience detention at re-education centres. Such detentions, which occur without access to legal counsel or right to appeal, may last from three months to two years⁴⁷ and will primarily involve education sessions on morality and labour and may include forced examinations for sexually transmitted infections.

C. Reducing stigma through law and policy reform

34. Criminal laws prohibiting behaviours that key affected populations engage in lead to stigma and discrimination, which hamper efforts to engage in prevention, treatment, care and support.⁴⁸ Recently, a number of countries in the region, notably India,⁴⁹ Fiji,⁵⁰ and Australia,⁵¹ have amended legislation to create a more enabling environment. Decriminalizing same sex behaviour, prohibiting discrimination and recognizing same sex relationships are important ways to challenge the stigma and discrimination experienced by key affected populations in the community, including in health settings.

IV. Conclusion

35. In the three decades since HIV emerged in the Asia-Pacific region, it has become clear that key affected populations need services targeted to their needs, in languages they understand, delivered by trusted messengers. Due to the complex interplay of stigma and HIV, peer-led interventions have proven effective in addressing issues (such as low self-esteem) that act as barriers in ensuring that key affected populations can access HIV prevention, treatment, care and support services.

⁴⁵ Megan Kendall, *Law, Policy & HIV in Asia and the Pacific, Implications for men who have sex with men, female sex workers and injecting drug users* (HIV and AIDS Data Hub in Asia-Pacific, 2010), p. 18.

⁴⁶ WHO, *Violence Against Women and HIV/AIDS: Critical Intersections, Violence Against Sex Workers and HIV Prevention*, 2005. Available at <http://www.who.int/gender/documents/sexworkers.pdf> (accessed on 23 August 2011).

⁴⁷ Kendall, p. 6.

⁴⁸ UNDP, *Laws and Practices Relating to Criminalization of People Living with HIV and Populations Vulnerable to HIV* (2011) accessed at http://asia-pacific.undp.org/practices/hivaids/documents/aprd/IssuesBrief_Criminalization.pdf on 23 August 2011.

⁴⁹ *Naz Foundation v. Govt. of NCT of Delhi* 160 Delhi Law Times 277 (2009).

⁵⁰ Fiji, *Fiji National Crimes Decree*, 2010.

⁵¹ Recognition of same sex relationships and removal of discrimination against same sex couples through the *Same-Sex Relationships (Equal Treatment in Commonwealth Laws – General Law Reform) Act 2008*.

36. Experience in the region has shown that effective responses to HIV focus on improvement in the overall well-being and sense of worth of key affected populations rather than satisfying formulaic criteria. Forming strategic and deliberate partnerships between public security, drug control, social welfare and the public health sectors has been critical for the successful implementation of these programmes. Coordination and cross-dialogue are critical to ensure that HIV and AIDS programmes do not operate in isolation from other efforts (such as programmes to eliminate gender-based violence). In the light of their effectiveness in reaching key affected populations, engagement, support and strengthening of community groups should constitute a priority in any national response.

37. While this effort may initially require significant multisectoral cooperation, this approach ultimately saves time, money and lives in the long term. Countries in Asia and the Pacific have a depth of experience in developing programmes for harm reduction and meaningful engagement with key affected populations, particularly regarding the efficacy of peer-led programmes, which can be drawn upon through regional cooperation and knowledge sharing. Continued inadequate coverage of key affected populations not only poses a challenge to reaching universal access, but if unchecked, also carries with it a danger of resurgent epidemics.

38. In moving forward, the Meeting may wish to note ESCAP resolution 67/9, in which Governments agreed upon, inter alia, “initiating, as appropriate, in line with national priorities, 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.” The Meeting may thus wish to consider the means of ensuring implementation of these national reviews, including the need for multisectoral participation.

39. The United Nations system in Asia and the Pacific stands ready to support member States in this process through promotion of exchanges of information, research, evidence and experiences among countries in the Asia-Pacific region. Further, the Meeting may wish to consider undertaking periodic and inclusive intergovernmental reviews at the regional level of national efforts and progress made in line with the commitment made by member States attending the 2011 General Assembly High-level Meeting on AIDS.
