United Nations E/ESCAP/HIV/IGM.1/1

Economic and Social Council

Distr.: General
25 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 4 of the provisional agenda
Review of regional implementation of the Political Declaration on HIV/AIDS and the Millennium Development Goals and efforts to ensure universal access, including regional follow-up to the outcome of the 2011 General Assembly High-level Meeting on AIDS

Overview of regional implementation of the Political Declaration on HIV/AIDS and the Millennium Development Goals and efforts to ensure universal access in Asia and the Pacific, including regional follow-up to the outcome of the 2011 General Assembly High-level Meeting on AIDS

Note by the secretariat

Summary

Much progress has been made in addressing the HIV epidemic in the Asia-Pacific region since the adoption of the Millennium Development Goals in 2000, the Declaration of Commitment on HIV/AIDS in 2001 and the Political Declaration on HIV in 2006. However, given the persistent challenges facing HIV responses in the region, some of the goals and targets set out in Millennium Development Goal 6 as well as the 2001 and 2006 United Nations Declarations on HIV and AIDS remain unmet.

In recognizing that the gains made in controlling the HIV epidemic are uneven and fragile, States Members of the United Nations adopted the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS in June 2011. The Declaration expressed the commitment of those Member States, including those in the Asia-Pacific region, to revitalize and intensify the comprehensive global and regional HIV and AIDS response through decisive, inclusive and accountable leadership, with a view to achieving Goal 6, in particular, to halt and begin to reverse by 2015 the spread of HIV.

In the Asia-Pacific region, the call for renewed commitment had been earlier supported by, among others, two ESCAP resolutions: (a) resolution 66/10, Regional call for action to achieve universal access to HIV prevention, treatment, care and support in Asia and the Pacific and (b) resolution 67/9, Asia-Pacific regional review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS.

Effective implementation of the 2011 Political Declaration and the two ESCAP resolutions will require strong political leadership as well as considerable multisectoral support across the broad range of relevant key stakeholders. To help Governments chart the way forward in implementing these commitments, the present document provides an overview of the progress made, including some major challenges that the region faces in responding to HIV. On the basis of this review and the key commitments highlighted in the 2011 Political Declaration and the above-mentioned ESCAP resolutions, the Meeting may wish to consider prioritizing certain areas for further action, some of which could be considered under items 5 and 6 of the provisional agenda.

Contents

I. Introduction

1. Much progress has been made in the Asia-Pacific region in managing the HIV epidemic since the adoption of the Millennium Development Goals in 2000, the Declaration of Commitment on HIV/AIDS (resolution S-26/2) in 2001 and the Political Declaration on HIV/AIDS (resolution 60/262) in 2006. Particularly, there have been few generalized HIV epidemics in the Asian and Pacific region, unlike in some regions of the world, with signs of stabilization or decline of the epidemic in some population groups.[1]

2. Therefore, to a good degree, at the regional aggregate level, a target set out in Millennium Development Goal 6, namely, "beginning to halt and reverse the spread of HIV and AIDS" (Target 6A) is in the process of being met. However, Target 6B, which is to achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it, has largely not been reached in the region despite efforts to scale up prevention and treatment in the last decade. Likewise, there has been mixed success in meeting the various goals set out in the 2001 and 2006 United Nations Declarations on HIV and AIDS.

3. By the end of 2010, the goals and targets agreed by States Members of the United Nations in 2001 and 2006 to guide and monitor the AIDS response expired. Having recognized the gaps and challenges in meeting these objectives, the States Members of the United Nations, including those in the Asia-Pacific region, adopted the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (resolution 65/277) in June 2011. That Declaration provides Member States with a critical opportunity to assess progress and chart the way forward.

4. The present document aims to review the progress of the HIV response in the Asia-Pacific region, with a view to identifying the opportunities for further action afforded by the 2011 Political Declaration. In doing so, it also draws on the expressed commitments undertaken by ESCAP member States to address the HIV epidemic, including those reflected in resolutions 66/10, Regional call for action to achieve universal access to HIV prevention, treatment, care and support in Asia and the Pacific (19 May 2010) and 67/9, Asia-Pacific regional review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS (25 May 2011).

II. Progress in achieving universal access in the Asian and Pacific region

A. Broad regional trends show signs of improvement

5. At the end of 2009, of the estimated 33.3 million people living with HIV (PLHIV) globally, 14.7 per cent or some 4.9 million people were in the Asia-Pacific region (Figure 1).[2] In recent years, most national HIV epidemics in Asia have stabilized, as indicated by the declining rate of growth of adults and children living with HIV and AIDS-related deaths. Positive developments include a 20 per cent reduction in the number of people newly infected with HIV over eight years, from 450,000 in 2001 to 360,000 in 2009. An estimated 300,000 people died from AIDS-related causes in 2009 or

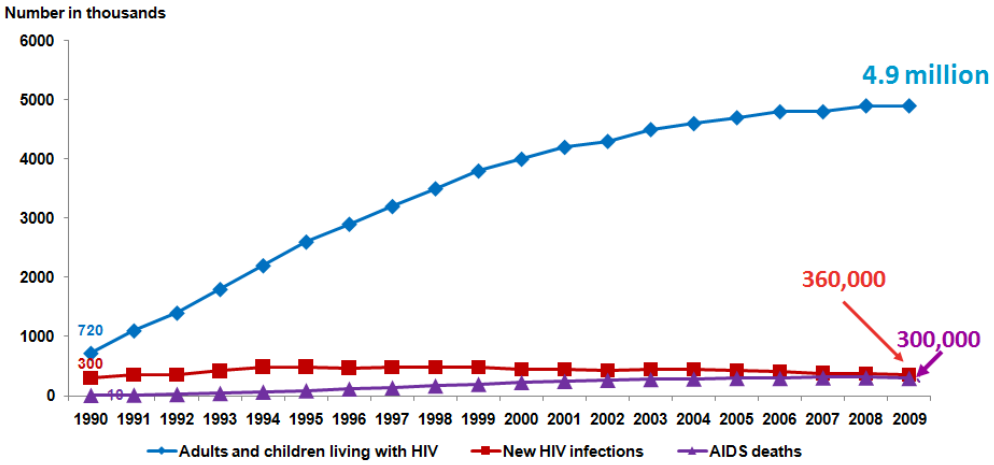
[1] A generalized epidemic is defined as one with a 1 per cent or more prevalence rate in the adult population.

[2] All data in the present document are based on UNAIDS regional classification. For the list of countries, see www.unaids.org/en/regionscountries/countries.

16.7 per cent of the global aggregate.[3] Table 1 shows some key statistics on the HIV epidemic in the region.

6. The HIV incidence of children below 15 years of age has also declined in recent years. An estimated 22,000 children from this age group were infected with HIV in 2009, a 15 per cent decrease from the 1999 estimate of 26,000. This has been in part due to some progress with regard to the provision of services that prevented parent-to-child transmission of HIV, which in turn, contributed to a drop in new HIV infections among children. AIDS-related deaths among children declined from 18,000 in 2004 to 15,000 in 2009.[4] It may be useful to note that, without intervention, the risk of parent-to-child transmission ranges from 20 per cent to 45 per cent globally.[5]

Figure 1
Estimated number of adults and children living with HIV, new infections, and AIDS-related deaths in the Asia-Pacific region (1990-2009)



Source: UNAIDS, RST Asia-Pacific, based on data compiled for the *UNAIDS Report on the Global AIDS Epidemic, 2010.*

7. The proportion of infected women has stabilized at about 35 per cent in recent years, with an estimated 1.7 million women living with HIV in 2009 (Figure 2). This figure was substantially below the global average of 52 per cent.[6]

[3] UNAIDS, *Global Report 2010.*

[4] Ibid.

[5] World Health Organization, PMTCT Strategic Vision 2010–2015: Preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals (2010). The same report said that, globally, of an estimated 430,000 children who were newly infected with HIV in 2008, over 90 per cent of them had been infected through mother-to-child transmission (MTCT).

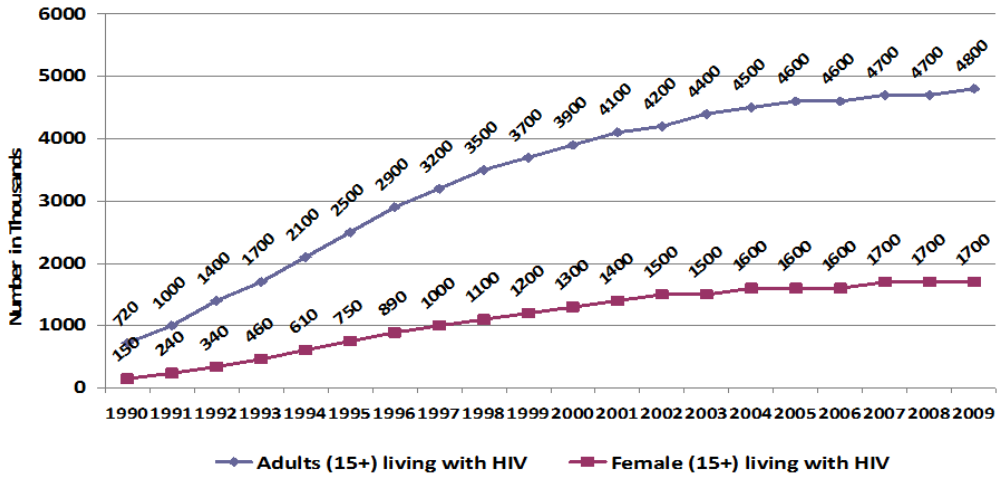
[6] UNAIDS, Regional Consultation Outcome Report, Universal Access in Asia and the Pacific (2011).

Table 1
Key statistics on the HIV epidemic for selected areas (2009)

	Adults and children living with HIV	Adults and children newly infected with HIV	Adult and child deaths due to AIDS	Adult HIV prevalence (for 15 - 49 years) (%)
South and South-East Asia	4 100 000	270 000	260 000	0.3
East Asia	770 000	82 000	36 000	0.1
Oceania	57 000	4 500	1 400	0.3
Eastern Europe and Central Asia	1 400 000	130 000	76 000	0.8
Global	33 300 000	2 600 000	1 800 000	0.8

Source: UNAIDS, Global Report 2010.

Figure 2
Estimated number of women and adults (15+) living with HIV in the Asia-Pacific region (1990-2009)



Source: UNAIDS, RST Asia-Pacific, based on data compiled for the *UNAIDS Report on the Global AIDS Epidemic, 2010.*

B. Geographical variations and epidemic concentration challenges HIV response

8. These broad figures though encouraging, mask some distinct trends that should be accounted for in HIV response programmes, especially in terms of deciding on the allocation of resources.

9. For example, seven countries have an estimated 100,000 or more PLHIV, collectively accounting for over 90 per cent of all estimated infected persons in the Asia-Pacific region. These include, in rank order, India, China, Thailand, Indonesia, Viet Nam, Myanmar and Malaysia. With 2.4 million PLHIV, India accounts for almost half of the aggregate number of PLHIV in the region.[7]

[7] Ibid.

10. Also, despite the relative large population of PLHIV in India and Thailand, the incidence of new HIV infections in these countries fell by more than 25 per cent between 2001 and 2009. In contrast, the incidence of new HIV infections in low prevalence countries, such as Bangladesh and the Philippines, has increased by more than 25 per cent in the same period.[8]

11. There are also variations within countries. In China, for example, six of the country's 31 provinces account for 61.8 per cent of the estimated total number of PLHIV.[9] In Indonesia's Papua Province, HIV prevalence is 15 times higher than the national average.[10]

12. More importantly, as highlighted by the Report of the Commission on AIDS in Asia, epidemics in Asia are largely driven by unsafe injecting drug use, sex work and sex between men.[11] A particular concern is that the HIV epidemic among men who have sex with men (MSM) has been on the increase in key cities in the region. High HIV prevalence among MSM, ranging from 13 to 32 per cent, has been reported in several geographical zones within China, India, Myanmar, Singapore, Thailand and Viet Nam.[12]

13. Similarly, HIV prevalence among people who inject drugs has also remained high in several countries, with an estimated one in six people who inject drugs in Asia being infected with HIV. More than one in three people who inject drugs in Indonesia, Myanmar and Thailand are HIV-positive, one in four in Cambodia and one in five in Nepal, Pakistan and Viet Nam.[13]

14. In the case of female sex workers, while there has been progress in HIV prevention, the rate of new HIV infections continues to increase in certain areas and settings. Male clients of sex workers—an estimated 75 million men across Asia and the Pacific—are key determinants in both the spread and magnitude of HIV epidemics in the region since they are the largest single group that transmits HIV to their regular intimate partners.[14]

15. Young people below the age of 25 constitute a distinct percentage of the region's key affected populations. It has been reported that among female sex workers, those younger than 25 years are at least as likely as their older counterparts to be HIV-positive in Indonesia, Papua New Guinea and Pakistan. HIV prevalence is 42 per cent among young people who inject drugs in Indonesia, 28 per cent among their peers in Myanmar, 23 per cent in Pakistan and 8 per cent in China.[15]

16. In the Pacific, Papua New Guinea has the largest epidemic, with an HIV prevalence of 0.9 per cent (34,000 PLHIV) though recent analysis indicated that the HIV epidemic has begun to level off.[16] A key mode of transmission of HIV in Papua New Guinea has been unprotected heterosexual intercourse. Unprotected sex between men is the dominant mode of

[8] UNAIDS, *Global Report 2010.*

[9] Information provided by the UNAIDS Country Office in Beijing.

[10] UNAIDS, *Global Report 2010.*

[11] Commission on AIDS in Asia, *Redefining AIDS in Asia-Crafting An Effective Response*, Oxford University Press (2008).

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

[13] UNAIDS, *HIV in Asia and the Pacific: Getting to Zero* (2011).

[14] Ibid.

[15] Ibid.

[16] UNAIDS, *Global Report 2010.*

transmission in the epidemics of Australia, New Zealand and Pacific countries.[17]

17. Within the Asia-Pacific region, a population group that is an emerging source of concern is returning migrants who are HIV-positive. Creating mechanisms to reduce the vulnerabilities of this large population is important in any national response. The region currently hosts about 25 per cent of the world's estimated 214 million international migrants, receiving 42 per cent of the world's remittances.[18] Among those migrating between and within countries, an increasing proportion is made up of female workers, with many of them finding themselves in conditions that increase their risk of contracting HIV. A key reason for this situation has been the lack of access to HIV-related information and health services by migrants.

18. In Eastern Europe and Central Asia, the number of PLHIV has almost tripled since 2000 and reached an estimated total of 1.4 million in 2009 compared with 760,000 in 2001.[19] A rapid rise in HIV infections among people who inject drugs at the turn of the century caused the epidemic in this region to surge. Of this group of countries, there are two in which the HIV prevalence is 1 per cent or higher, the Russian Federation and Ukraine, which together account for almost 90 per cent of newly reported HIV diagnoses.[20] The HIV epidemic in the Russian Federation has continued to grow, but at a slower pace now than in the late 1990s. The HIV epidemics in Eastern Europe and Central Asia are concentrated mainly among people who inject drugs, sex workers, their sexual partners and, to a much lesser extent, MSM. An estimated one quarter of the 3.7 million people (most of whom are men) who inject drugs in these countries are living with HIV. There were an estimated 76,000 AIDS-related deaths in 2009 compared with 18,000 in 2001, a four-fold increase during that period.[21]

19. These figures highlight the fact that, for HIV responses to be effective, intervention strategies must be based on appropriate prioritization of key affected populations and a thorough understanding of their respective behaviours. There has been a strong recognition of this need in recent years, most notably through the work of the Commission on AIDS in Asia (2008) and the Commission on AIDS in the Pacific (2009), and, as highlighted by the Governments themselves, in ESCAP resolutions 66/10 and 67/9.

III. Gaps and challenges confronting the Asia-Pacific region in achieving universal access

A. Inadequate prevention coverage could reverse gains

20. There are indications that prevention coverage has been inadequate for key affected populations in the region. In particular, regional median coverage for key affected populations (based on UNGASS indicator

[17] Ibid.

[18] International Organization for Migration and others, *Report of the Asia-Pacific Regional Preparatory Meeting for the Global Forum on Migration and Development 2010.*

[19] UNAIDS, *Global Report 2010.*

[20] Ukraine is not an ESCAP member State.

[21] UNAIDS, *Global Report 2010.*

number 9) has been substantially below the published global median for low and middle-income countries (Table 2).[22]

Table 2
Comparison of global and regional prevention coverage for key affected populations (2009)
(Percentage)

	Global median	Regional median
People who inject drugs	32	17
Men having sex with men	57	49
Female sex workers	58	40

Source: UNAIDS, *HIV in Asia and the Pacific: Getting to Zero* (2011).

21. Adequate prevention-related coverage of key affected populations is critical to addressing the HIV epidemic in the region. For example, in the case of the MSM population, modelling projections showed that, without significant investment in and scaling up of MSM programmes, including those for prevention, this population would comprise approximately 50 per cent of new infections in Asia by 2020.[23]

22. In the case of people who inject drugs, though harm reduction programmes have expanded across the region, the epidemics have persisted in many settings. A reason for the lack of progress has been the very low rates of access to needle exchange services. In Asia, the rate was in the range of 14 per cent in 2010. The coverage of opioid substitution therapy (OST) services, at only 5 per cent, was even lower. [24]

23. Indeed, a good understanding of these microtrends and populations would require highly specific data generated through adequate surveillance systems. This means that evidence-informed and focused programming would require, among other things, the availability of reliable and timely disaggregated data (by age, sex and mode of transmission) on the incidence and prevalence of HIV. Obtaining such information would necessitate both research as well as the capacity to reach these populations. With regard to the former, continuous improvement would be needed in measuring tools, data management systems and monitoring and evaluation capacities at the national and regional levels. In the latter case, the capacity to reach key affected populations would be greatly facilitated by environments that respect their rights (so as not to drive them "underground"), including their ability to access health-care services.

24. It follows that the strengthening of the evidence base requires greater community engagement. Such engagement is equally important in policy and programme formulation and not just in programme implementation. Hence, focused HIV programme responses should also include efforts to support these groups to participate more effectively at the advocacy and policy levels and in programme development.

25. The declining epidemics in Cambodia, Thailand and India illustrate the potent combination of the high level of coverage of priority services with intensive engagement of all key affected populations. Other factors

[22] UNAIDS, *HIV in Asia and the Pacific: Getting to Zero* (2011).

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

[24] UNAIDS, *HIV in Asia and the Pacific: Getting to Zero* (2011).

contributing to the success in these settings have been the appropriate use of media and the programmatic focus on clients of sex workers, a group often overlooked in prevention programmes. Similar examples of effective partnerships involving community groups and public security can be found in the delivery of harm reduction services to people who use drugs in some geographical areas in the region.[25]

26. These positive experiences should be shared with other countries in the region. Particularly, it could be useful for countries to learn about successful programmes for key interventions, such as the promotion of condom usage among sex workers, scaling-up of harm reduction programmes for people who use drugs and peer-to-peer education. Peer-based programmes have proven to be effective in prevention, counselling and support.

B. The treatment gap must be narrowed

27. In certain populations in the Asia-Pacific region, there has been improved coverage with regard to the provision of antiretroviral therapy (ART). For instance, paediatric ART coverage in the region has been estimated at 44 per cent, higher than the global average of 28 per cent. This has been largely due to the high ART coverage of over 80 per cent in Cambodia, Malaysia and Thailand. Also, in keeping with global patterns, coverage in Asia has been higher for women than for men (28 per cent compared to 22 per cent among countries reporting data disaggregated by sex).[26]

28. The broad (aggregate) trends, however, have not been as positive. In 2009, ART coverage in low and middle-income countries in the region was 31 per cent, which is lower than the global average of 36 per cent and well below the target of 80 per cent coverage required for universal access (Table 3).[27] Six countries in the region, namely China, Indonesia, India, Myanmar, Thailand and Viet Nam, account for over 90 per cent of the treatment requirement in the region.[28]

29. The new guidelines on treatment issued by WHO in 2010 pose an even greater challenge to the provision of treatment. The new guidelines recommended for ART to be initiated with CD4 counts at or below 350 cells/mm^3—a threshold higher than the previous one of 200 cells/mm^3—which would necessitate earlier commencement of treatment. With the new threshold, the number of PLHIV eligible for ART has increased by approximately 50 per cent, leading to a consequent fall in the recalculated coverage of ART.

30. ART coverage in the case of prevention of parent-to-child transmission (PPTCT) was 32 per cent in 2009, which represents a significant gap vis-à-vis the global average of 53 per cent (Figure 3). Thailand (with over 90 per cent coverage) and Malaysia (over 80 per cent) are on track to reach the goal of eliminating new HIV infections among children. The largest unmet need is in India. Several countries in the region are still using single

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

[26] Ibid.

[27] UNAIDS, *Global Report 2010.*

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

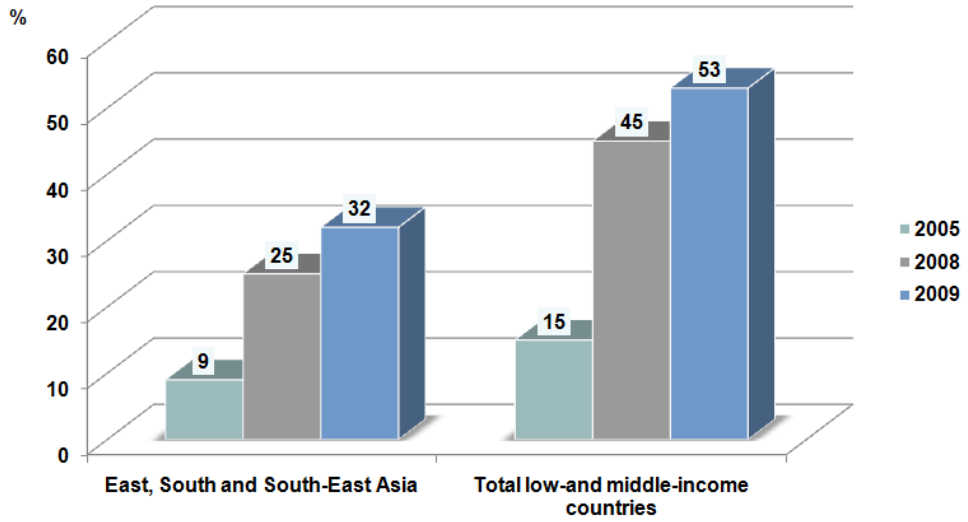
dose nevirapine, though some countries are phasing it out and aligning with the newly revised WHO guidelines at the beginning of 2012.[29]

Table 3
Antiretroviral therapy coverage in selected regions relative to the world (2009)

	People receiving ART	People needing ART	ART coverage (Percentage)
East, South and South-East Asia	739 000	2 400 000	31
Europe and Central Asia	114 000	610 000	19
Global	5 250 000	14 600 000	36

Source: WHO/UNAIDS/UNICEF, *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector: Progress Report* (2010).

Figure 3
PPTCT coverage in East, South and South-East Asia compared to all low-and middle-income countries (2005, 2008 and 2009)



Source: UNAIDS, *Regional Stocktaking Report, Universal Access in Asia and the Pacific* (2011).

31. It is therefore clear that, unless concerted efforts are made to enhance ART coverage, the regional gap between the demand and supply of ART could widen even further in future. Cambodia is the only Asian country that has reached the universal access target for ART under the 2010 WHO treatment guidelines.[30] The Lao People's Democratic Republic, Papua New Guinea and Thailand are the only other Asia-Pacific countries to have reached coverage levels of over 50 per cent under these new guidelines.[31]

32. While providing the opportunity for the scaling up of ART and PPTCT services, implementing the WHO 2010 guidelines would require greater capacity for financing, human resources, procurement of treatment products and service delivery at cost-efficient levels. Such a challenge could be greater in the light of the emerging support for the "treatment as prevention" approach which has been shown to reduce the likelihood of

[29] UNAIDS, *HIV in Asia and the Pacific: Getting to Zero* (2011).

[30] Ibid.

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

transmission if people are put on treatment earlier. Particularly, new research indicates that if an HIV-positive person adheres to an effective ART regimen early, the risk of transmitting the virus to an uninfected sexual partner can be reduced by 96 per cent.[32]

33. With the increased need for ART, it is necessary to make available good quality and affordable medicines, including generic drugs. Hence, it is important to ensure legitimate international trade in such medicines. In this regard, it may be useful to note that, for developing and least developed countries, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) incorporates certain "flexibilities" that aim to permit the use of TRIPS-compatible norms in a manner that would enable these countries to pursue their own public policies, such as those related to access to pharmaceutical products.[33]

34. Similar to prevention coverage discussed earlier, enhanced treatment coverage would necessitate more equitable access to services for key affected populations, better data and research as well as greater community engagement. More significantly, sound ART and prevention programmes should be supported by the overall strengthening of social protection systems, including that for health. For instance, incorporated in Thailand's Universal Health Care System is its increasingly comprehensive response to the HIV epidemic, including the provision of ART. According to the UNGASS Progress Report prepared by Thailand (for the reporting period January 2008-December 2009), attempts to increase early access to treatment services have led to better coverage of treatment and care. A total of 200,000 PLHIV have been receiving ART (equivalent to 75 per cent of treatment coverage) by 2009.

C. Reducing "invisibility" increases services uptake

35. In Asia and the Pacific, there are efforts being made to address legal barriers and discriminatory policies and practices which impinge on people living with, and affected by HIV. Examples include the lifting of travel restrictions in China, the replacement of mandatory detention with voluntary drug dependence treatment for people who use drugs in Malaysia and the review of outdated legislative frameworks in Papua New Guinea. [34]

36. Despite such progress, some laws, policies and practices have continued to challenge the regional HIV response. As many as 90 per cent of countries in the Asia-Pacific region have laws which are viewed as hampering effective HIV prevention, care, treatment and support.[35] In fact, there are indications that, compared to the rest of the world, there is a higher percentage of countries in the Asia-Pacific region that have laws and policies that would present obstacles to universal access, especially for key affected populations (Figure 4)

37. In particular, 20 countries criminalize sexual relations between same sex partners, more than 29 countries criminalize some aspects of sex work and 16 countries impose travel restrictions on PLHIV.[36] Many countries still

[32] Michel Sidibé, *A game-changing moment,* 28th Meeting of the Programme Coordinating Board, Geneva, June 2011.

[33] www.wipo.int/ip-development/en/legislative_assistance/advice_trips.html.

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

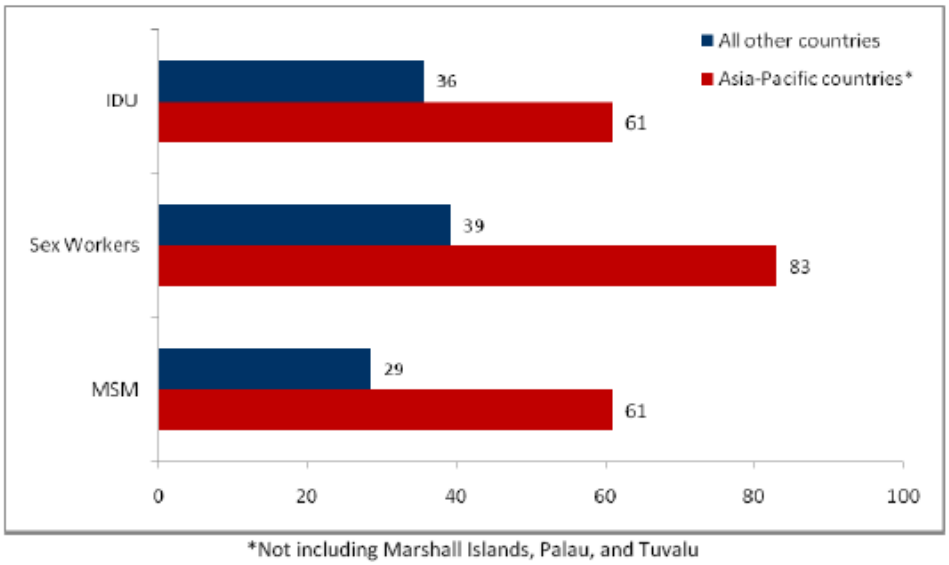
[35] UNAIDS, *Global Report 2010.*

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

detain drug users in compulsory centres, without OST services, and 11 countries retain the death penalty for drug offences.[37] The region's policy stance that focuses on public security may reflect the dominant influence of the global "war on drugs" law enforcement paradigm, as opposed to the public health aspect of drug use.[38]

Figure 4

Percentage of Asia-Pacific countries with laws and policies that hinder HIV response for selected key affected populations



Source: Evidence to Action, Law, Policy and HIV in Asia and the Pacific (2010).

38. It has been proven that key affected populations in legal and social environments that are unsupportive of their rights (including the right to health) are driven "underground", which increases the risk of their engaging in high-risk behaviours. This aspect not only undermines the health prospects of these populations and their partners but also risks derailing the progress made in managing the HIV epidemic. Furthermore, the invisibility of these populations can retard efforts to capture sound data, which, as discussed earlier, is critical for focused programming approaches.

39. The persistence of these challenges can be attributed to several key factors.[39] For instance, the public health and public security sectors appear to use differing approaches. The criminalization of the possession of injecting equipment is an example of such a variance in approach. Specifically, the provision of sterile needles constitutes "abetment" or "facilitation" of illicit consumption, which is prohibited in various countries.[40] Such laws can lead to increased use of non-sterile injecting equipment, thus heightening the risk of spreading HIV. Furthermore, there have been reports that, though relevant laws may not always be enforced by police, these laws have reportedly been used as justification in cases involving harassment and abuse of key affected populations.[41]

[37] Ibid.

[38] Ibid.

[39] Ibid.

[40] WHO and others, *A strategy to halt and reverse the HIV epidemic among people who inject drugs in Asia and the Pacific 2010-2015* (2010).

[41] John Godwin, *Legal environments, human rights and HIV responses among men who have sex with men: An agenda for action* (commissioned by UNDP and Asia Pacific Coalition on Male Sexual Health (APCOM), 2010).

40. Stigma and discrimination prevailing in work, schools and health-care settings also act as barriers to HIV prevention, treatment, care and support. In fact, the Regional Stigma Index study found that 24 per cent of respondents had lost their jobs as a result of discrimination based on their status. About 13 per cent indicated that stigma and discrimination contributed to diminished access to health care, and 19 per cent reported rights violations. Of the 27 per cent cases in which legal redress was sought, only 8 per cent were successful.[42]

41. What is clear is that the removal or reduction of discriminatory legal barriers, policies and practices would require the strengthening of the capacity of both State and civil society institutions. These efforts should include the full collaboration of all key stakeholders: public health and security sectors, legal aid, social protection services, and community-based rights monitoring mechanisms for, among others, PLHIV, key affected populations, women and girls.

D. HIV response sustainability requires greater national ownership and sound financial platforms

42. Current patterns of financing the HIV response in the region are unsustainable. First and foremost, there appears to be a significant gap between the demand for and supply of funds. The cost of a targeted regional response to reverse and control the epidemic and achieve universal targets for treatment, care and support has been estimated at $3.3 billion per year.[43] This amount is three times greater than the annual regional expenditure on HIV, which in 2009 was reported to be $1.1 billion. Without efforts to bring in additional funds, this gap is expected to widen, especially since international donors have not increased funding in recent times. The recent global financial crisis and tepid economic conditions may have contributed to this phenomenon.[44]

43. This substantial funding gap poses an even weightier concern given the possibility of current global economic uncertainties persisting for some time, and the high degree of reliance in the region on international funds. All low-income countries and many lower middle-income countries are highly dependent on international financing sources. Global funding is deemed to represent more than 50 per cent of total AIDS spending in three quarters of (19 out of 25) reporting countries. In Asia, it is estimated that the public sector finances about 53 per cent of reported expenditure. It is likely that this percentage could provide a skewed perspective of the share of public financing in the region. Two countries only, China and Thailand, already account for $500 million in public funds, a disproportionately large component of the approximately $1 billion spent in the region on HIV response annually.[45]

44. The efficient use of funds, including the appropriate allocation of resources, is as important a factor in determining the sustainability of HIV response programmes. Current allocations would appear to be inadequate. There are indications that, among countries with relatively detailed reporting,

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

[43] Ibid.

[44] Ibid.

[45] Ibid.

only about 18 per cent of expenditure has been allocated to high-impact, low-cost prevention.[46]

45. The above factors point to the fact that countries must be more self-reliant. There should be greater national ownership of the respective HIV responses of Asia-Pacific countries. It is hence essential that Governments commit a higher level of national resources for HIV programmes, undertake greater efforts to source external funds from diversified sources (including via innovative partnerships), and enhance domestic capabilities in financial governance and programme management.

E. Addressing gender norms reduces HIV vulnerability

46. As the previous section has shown, the proportion of women who are PLHIV in the region is not insignificant. For women, a major source of transmission of HIV is unprotected sex with their male partners, especially male clients of sex workers. There are indications that women have less knowledge about how HIV is transmitted and ways to prevent infection. Gender norms that reinforce traditional roles may diminish the capacity of PLHIV, including women, to access prevention, treatment and support services.[47] Gender inequality may also be reflected in violence and place women and girls at increased risk of contracting HIV.[48] Hence, reversing the spread of HIV must address the role that gender relations play in sexual and reproductive life, and how it affects HIV prevention, treatment, care and support.

IV. Opportunities to enhance national and regional actions to achieve universal access in the Asia-Pacific region

47. The 2011 Political Declaration on HIV and AIDS saw the 193 States Members of the United Nations committing to redouble efforts to achieve universal access for HIV prevention, treatment, care and support by 2015 with a view to fulfilling Millennium Development Goal 6, namely, to halt and begin to reverse by that year the spread of HIV (para. 51). Many commitments espoused in the previous Declarations on HIV and AIDS were reiterated at the high-level meeting of the General Assembly on the comprehensive review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS, held in June 2011. Many strategic elements in the recently launched UNAIDS Vision: "zero new infections, zero discrimination and zero AIDS-related deaths" are also consistent with the commitments underlined in the 2011 Political Declaration.

48. Within the Asia-Pacific region, this clarion call for renewed commitment has been supported, among others, by the two ESCAP resolutions preceding the 2011 Political Declaration, namely resolution 66/10, Regional call for action to achieve universal access to HIV prevention, treatment, care and support in Asia and the Pacific, and resolution 67/9, Asia-Pacific regional review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS.

[46] Presentation by UNAIDS RST AP, "Sustainable funding to reach the three zeros", ICAAP 2011.

[47] UNAIDS, *HIV in Asia and the Pacific: Getting to Zero* (2011).

[48] Lewis, I., Maruia, B. Mills, D. and Walker, S. (2008). Final Report on Links Between Violence Against Women and the Transmission of HIV in 4 Provinces of PNG. University of Canberra (Australia) and National HIV Support Program (Papua New Guinea).

The latter was adopted just prior to the 2011 high-level meeting on AIDS and incorporated the preceding regional deliberations arising from among others, the Asia-Pacific Regional Consultation on Universal Access to HIV Prevention, Treatment, Care and Support", which was co-organized by UNAIDS and ESCAP and held in March 2011.

49. ESCAP member States should leverage the commitments provided by these global and regional initiatives to urgently address the current gaps in the region's response to HIV.

A. Undertaking focused prevention measures

50. The 2011 Political Declaration, as with the 2006 Declaration, asserted that the prevention of the HIV epidemic should be the cornerstone of national, regional and international responses to the HIV epidemic (para. 58).

51. Specifically, the 2011 Political Declaration highlighted the need to "redouble HIV prevention efforts by taking all measures to implement comprehensive, evidence-based prevention approaches..." (para. 59). Unlike previous Declarations, the 2011 Political Declaration drew attention to the need to focus on the key affected populations by stating that "many national HIV prevention strategies inadequately focus on populations that, epidemiological evidence shows are at higher risk, specifically men who have sex with men, people who inject drugs and sex workers…" and noted "that each country should define the specific populations that are key to its epidemic and response based on the epidemiological and national context" (para. 29). The 2011 Political Declaration is the first global Declaration adopted by the General Assembly that has explicitly identified these populations as being vulnerable to the HIV epidemic.

52. More critically, the 2011 Declaration committed to time-bound and specific programmatic objectives for key affected populations. It stated that, by 2015, there should be:

(a) A 50 per cent reduction in sexual transmission of HIV (para. 62);

(b) A 50 per cent reduction in HIV transmission among people who inject drugs (para. 63);

(c) Elimination of mother-to-child transmission and a substantial reduction in AIDS-related maternal deaths (para. 64).

53. In committing to redouble HIV prevention efforts, the 2011 Declaration also highlighted the need to take all measures to implement comprehensive, evidence-based prevention approaches, taking into account local circumstances, ethics and cultural values, including conducting public awareness campaigns, harnessing the energy of young people, reducing risk-taking behaviour, expanding and promoting voluntary and confidential HIV testing, expanding harm reduction programmes and facilitating access to sexual and reproductive health-care services (para. 59).

54. It also called for financial resources for prevention to be targeted to evidence-based prevention measures that reflect the specific nature of each country's epidemic by focusing on geographic locations, social networks and populations vulnerable to HIV infection, according to the extent to which they account for new infections in each setting. It indicated that particular attention should be given to women and girls, young people, orphans and vulnerable children, migrants and people affected by humanitarian emergencies, prisoners, indigenous people and people with disabilities (para. 60).

55. In recognizing that the HIV response must follow evidence, the 2011 Political Declaration asserted that evidence-based responses "must be informed by incidence and prevalence disaggregated data, including by age, sex, and mode of transmission,…" and recommended that systems of data collection about these populations must be strengthened (paras. 46 and 61).

56. Likewise, prior to the high-level meeting of the General Assembly on AIDS in June 2011, ESCAP resolutions 66/10 and 67/9 had identified the challenges facing key populations at higher risk, such as people who inject drugs, sex workers, MSM and transgender populations. For the latter, where data is available, there are indications that transgender populations have higher prevalence rates than MSM.[49]

B. Enhancing access to treatment, care and support

57. The 2011 Political Declaration acknowledged the global gap in treatment coverage and called for the "target of working towards having 15 million PLHIV on antiretroviral treatment by 2015" (para. 66). In acknowledging this challenge, both the 2011 and 2006 Declarations acknowledged that international trade agreements, especially for goods (including products associated with treatment and prevention) and related to intellectual property rights, can hinder access to affordable treatment and that flexibilities under the TRIPS Agreement should be geared to promoting access to the trade of medicines. However, the 2011 Political Declaration went further by committing to "remove before 2015, where feasible, obstacles which limit the capacity of low- and middle-income countries to provide affordable and effective HIV prevention and treatment products, diagnostics, medicines…" (para. 71). It also suggested achieving this objective by:

(a) Promoting generic competition in order to help reduce costs associated with life-long chronic care and encouraging all States to apply measures and procedures for enforcing intellectual property rights in such a manner as to avoid creating barriers to the legitimate trade in medicines, and to provide for safeguards against the abuse of such measures and procedures (para. 71(b));

(b) Encouraging the voluntary use, where appropriate, of new mechanisms, such as partnerships, tiered pricing, open-source sharing of patents and patent pools benefitting all developing countries. (para. 71(c)).

58. In this regard, ESCAP resolution 67/9 complements the above initiatives by calling for the consideration of processes that encourage stakeholder consultation in promoting access to affordable medicines, diagnostics and vaccines in the region.

C. Strengthening the enabling legal and social environments

59. The 2011 Political Declaration recognized that effective HIV response programmes must address the need "to intensify national efforts to create enabling legal, social and policy frameworks in each national context…" (para. 77).

60. Some guidance was provided by the 2011 Declaration on how to enhance national efforts: review adverse laws and policies (para. 78), consider identifying and reviewing, in order to eliminate any remaining HIV-related restrictions on entry, stay and residence (para. 79), commit to national

[49] UNAIDS, *Regional Stocktaking Report, Universal Access in Asia and the Pacific* (2011).

HIV and AIDS strategies that promote and protect rights as well as eliminate stigma and discrimination and, where relevant, establish appropriate social protection systems for people living with and affected by HIV and AIDS, including women and girls, children, young people, migrant and mobile populations and workers and their families (paras. 80-85).

61. Equally important, the 2011 Political Declaration called for collaboration among key stakeholders to work towards reducing stigma and discrimination, including "sensitizing police and judges, training health-care workers in non-discrimination, confidentiality and informed consent, supporting national human rights learning campaigns, legal literacy, and legal services, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support" (para. 80).

62. In Asia and the Pacific, ESCAP resolutions 66/10 and 67/9 have identified the need to address stigma and discrimination and legal and policy barriers to universal access, as well as promote multisectoral efforts between health and other sectors, including justice, law and order and drug control. Resolution 67/9, as with the 2011 Political Declaration, has similarly indicated that, consistent with national priorities, a review of national laws, policies and practices should be initiated to enable the full achievement of universal access targets.

D. Creating effective and more efficient programmes

63. The 2011 Political Declaration urged countries to commit towards increasing annual global expenditure by 2015 through a series of incremental steps and shared responsibility while recognizing that the estimated expenditure target would be $22 and $24 billion in low- and middle-income countries (para. 88). It also called for countries to play a greater role in undertaking the responsibility of HIV responses, in particular to:

(a) Commit to update and implement, by 2012, through inclusive, country-led and transparent processes, multisectoral national HIV and AIDS strategies and plans, including financing plans, which include time-bound goals to be reached in a targeted, equitable and sustained manner (para. 54);

(b) Increase national ownership of HIV and AIDS responses through greater allocations from national resources and traditional sources of funding, including official development assistance (para. 88).

64. In order to support these country-driven efforts, the 2011 Political Declaration called upon "the United Nations system, donor countries, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the business sector and other international and regional organizations, to support Member States in ensuring that nationally driven, credible, costed, evidence-based, inclusive and comprehensive national HIV and AIDS strategic plans are, by 2013, funded and implemented with transparency, accountability, and effectiveness in line with national priorities" (para. 55).

65. To ensure the provision of a full range of responses for HIV prevention, treatment, care and support, the 2011 Declaration encouraged the active participation and leadership of community organizations run by people living with and affected by HIV, including young people, in the planning, implementation and evaluation of responses, and to partner with local leaders and civil society, including community-based organizations (paras. 56 and 57).

66. Similarly, ESCAP resolution 67/9 called for greater national ownership by substantially increasing support and funding for responses to HIV through domestic budgetary provisions, as well as through the integration of care, support and treatment into national health insurance and social protection schemes. It highlighted the need to establish strategic and operational partnerships at the national and community levels between representatives of public health, law enforcement and civil society and key affected populations to scale up high-impact HIV prevention, treatment, care and support to achieve the universal access target for key populations.

E. Eliminating gender inequalities, abuse and violence

67. The 2011 Political Declaration expressed concern that, globally, women and girls were still the most affected by the epidemic. It also recognized that their ability to protect themselves from HIV would continue to be compromised by physiological factors and gender inequalities and women would bear a disproportionate share of the caregiving burden (para. 21). In recognition of this challenge, the 2011 Political Declaration called to "…eliminate gender inequalities, gender-based abuse and violence; increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection…" and take measures to "…create an enabling environment for the empowerment of women and strengthen their economic independence, and, in this context, reiterate the importance of the role of men and boys in achieving gender equality" (para. 53). These needs, too, were in some measure reflected in ESCAP resolutions 66/10 and 67/9.

V. Conclusion

68. In short, there has been improvement with regard to addressing the regional HIV epidemic, especially in recent years. Gains, however, are fragile and can be reversed without concerted efforts by ESCAP member States. Clearly, at this critical juncture in the evolution of the HIV epidemic, much needs to be done in an accelerated manner given the challenges mentioned above.

69. The 2011 Political Declaration, ESCAP resolutions 66/10 and 67/9, and the initiatives of UNAIDS and its co-sponsors provide member States with the opportunity to address the barriers to universal access. In particular, the 2011 Political Declaration has called for all Member States to revitalize and intensify the comprehensive global HIV and AIDS response through decisive, inclusive and accountable leadership, with a view to achieving Millennium Development Goal 6, in particular, to halt and begin to reverse by 2015 the spread of HIV. It should be borne in mind that the achievement of Goal 6 is also critical to the attainment of the other Goals. The converse is also true in that progress in achieving the other Millennium Development Goals would allow for gains in addressing the HIV epidemic. For example, the elimination of new HIV infections among children and preventing mortality among their mothers has a direct impact on achieving Goal 6, as well as Goal 3 (promoting gender equality and empowering women), Goal 4 (reducing child mortality), and Goal 5 (improving maternal health).

70. Given that 2015 is only four years away, urgent actions by ESCAP member States are critical. Hence, bearing in mind the commitments made in the 2011 Political Declaration and ESCAP resolutions 66/10 and 67/9, the Meeting may wish to consider moving forward on the following key areas:

(a) Redoubling efforts to achieve universal access to HIV prevention, treatment, care and support by 2015 with a view to reversing, by that year, the spread of HIV indicated in Millennium Development Goal 6;

(b) Undertaking greater national ownership of HIV programmes and demonstrating this commitment by formulating, implementing and investing in evidence-based, inclusive, country-led and sustainable national HIV and AIDS programmes that include time-bound goals to be reached in a targeted and equitable manner;

(c) Establishing strategic and operational partnerships at the national and community levels between representatives of public health, law enforcement, civil society and key affected populations to scale up high-impact HIV responses and eliminate stigma and discrimination;

(d) Encourage the leadership and participation of community organizations run by people from key affected populations as well as those living with and affected by HIV including young people in, wherever appropriate, the advocacy, planning, implementation and evaluation of HIV responses;

(e) Addressing laws, policies and practices that impede universal access, including those that perpetuate stigma and discrimination, gender inequalities and gender-based violence;

(f) Strengthening internal systems of data collection and analysis to support the evidence base, which must incorporate all requisite data, such as HIV incidence and prevalence disaggregated by age, sex and mode of transmission as well as disaggregated data for prevention and treatment programme coverage;

(g) Supporting all necessary partnerships comprising ESCAP member States as well as regional and international stakeholders to address the HIV epidemic, such as the undertaking of continuous exchanges of information, research, evidence and experiences;

(h) Undertaking periodic and inclusive intergovernmental reviews at the regional level of national efforts and progress made in their respective countries to combat HIV.

71. Finally, it must not be forgotten that there are significant economic costs to not addressing the HIV epidemic adequately. Not only does the HIV epidemic exact substantial direct financial costs related to treatment and loss of income, it also exacerbates poverty and income inequality due to the erosion of human, social, financial and natural capital, with negative longer term implications on household income, employment, education, gender equality and child and maternal health. This, in turn, points to the crucial need for more explicit and meaningful inclusion of HIV and AIDS within the broader human development agenda.