

**ASIA  
PACIFIC  
CIVIL  
SOCIETY  
& 2008  
UNGASS  
ON HIV  
& AIDS**



**A P C A S O**  
ASIA PACIFIC COUNCIL OF  
AIDS SERVICE ORGANIZATIONS

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& 2008  
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Published by  
Asia Pacific Council of AIDS Service Organizations

Designed by  
Minimus Design

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### **Acknowledgement**

David Stephens is the author of this report. The report was reviewed by a number of external reviewers. Special thanks go to the following persons who provided advice and feedback on the draft of the report: Rathi Ramanathan, Pascal Tanquay, Liang Yang Yang, Loretta Wong, Rico Gustave, and Kem Ley.

Research assistance and coordination was provided by Goh Soon Siew.

Funding for this report was provided by UNAIDS, Geneva under the Civil Society Support Mechanism contract.

The opinions expressed in this publication are those of the respective authors and they are not necessarily that of Asia Pacific Council of AIDS Service Organizations.

We welcome feedback and comments on this report.  
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### **Some Publications by APCASO**

*Microbicides: A MUST HAVE for Women in Southeast Asia Project*, 2006, Kuala Lumpur, APCASO and Global Campaign for Microbicides.

*Preparing Civil Society for Microbicides Advocacy in Southeast Asia*, 2006, Kuala Lumpur, APCASO and Global Campaign for Microbicides.

*Valued Voices. GIPA Toolkit: A Manual for the Greater Involvement of People Living with HIV/AIDS*, 2005, Kuala Lumpur, APN+ and APCASO.

*Training Trainers on Mainstreaming Gender into National HIV/AIDS Programs: A Manual*, Prepared for United Nations Development Fund for Women – East & Southeast Asia Regional Office (UNIFEM – ESEARO), 2005, Kuala Lumpur, APCASO & AP RAINBOW.

*Making UNGASS Work (Second Edition)*, 2004/2005, Kuala Lumpur, APCASO.

*HIV/AIDS and HUMAN RIGHTS – a training manual for NGOs, community groups and people living with HIV/AIDS*, 2002, Kuala Lumpur, APCASO.

*Compact on Human Rights (ACT-HR): The Framework for Community Action on HIV/AIDS*, 1995. Manila, Philippines APCASO.

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# INTRO- DUCTION 4

This review has been commissioned in order to produce a summary analysis of processes and outcomes from the 2008 UNGASS Country Reports. The aim of the review is to provide:

- 1 a general overview of civil society participation in national responses and in the compilation of the reports; and
- 2 an assessment of the accuracy/gaps of each report in terms of civil society experience and knowledge of national responses.

The countries that have provided 2008 UNGASS Country Reports are China, Japan, Mongolia, Republic of Korea, Bangladesh, India, Nepal, Pakistan, Sri Lanka, Cambodia, Laos, Malaysia, Indonesia, Philippines, Singapore, Thailand, Vietnam, Australia, Fiji, Marshall Islands, New Zealand, Federated States of Micronesia, Palau, Papua New Guinea (PNG) and Tuvalu.

The majority of Country Reports note that current UNGASS 2008 reporting has improved significantly from the last round, reflecting improved data collection, increased political commitment and a greater willingness to acknowledge and include the view of civil society partners. Nevertheless the number of reports<sup>1</sup> quality, amount of information and number of indicators reported on – ranging from Singapore’s 5 and Japan’s 7 pages to Papua New Guinea’s 169 pages – indicates that some countries take the reporting process more seriously than others. In other cases, significant geographical areas have been ignored; for example, the China report contains no information or references to Hong Kong, which among other issues means that significant rises in HIV prevalence among men who have sex with men are unreported as is the success of the harm reduction program which has kept HIV prevalence among injecting drug users low for many years (AIDS Concern Hong Kong 2008 and Commission on AIDS in Asia 2008). Myanmar with an estimated 360,000 people living with HIV did not submit a report.

<sup>1</sup> As at 26 March 2008, 25 countries in Asia Pacific had submitted their Country Progress Report on AIDS. This constitutes 67% (25/38) of Asia Pacific countries. In contrast 95% of Eastern Europe and Central Asia, 95% of Latin American and 94% of Sub-Saharan Africa countries submitted their Country Progress Reports on AIDS. In the Oceania region 8 out of 16 countries submitted reports and in the Asia 17 out 22 submitted reports.

<sup>2</sup> UNGASS reports generally distinguish between civil society and the private sector. ICASO has defined the community sector as “Individuals, groups, or associations which are separate from the government and the private sector, and who undertake actions and present views in support of community

In this summary, the term civil society encompasses a spectrum of non-state actors, including international and local non-governmental organizations (NGOs), religious and faith based agencies, academic institutions and a wide range of community based organizations (CBOs)<sup>2</sup>. However, it is important to note that civil society organizations and groups do not necessarily share or advocate for similar approaches to HIV. Faith based organizations (FBOs) play an important role in a variety of HIV interventions including treatment, care and support, but some (noted in UNGASS reports from Indonesia and Philippines) maintain opposition to essential HIV interventions advocated by other organizations, including the provision

and promotion of condoms. A similar scenario applies to NGOs working in the field of drug use.

It is also important to note that, while all of these sectors and organizations are legitimate actors in HIV, specific groups and populations are more affected by HIV – and more vulnerable to infection and to the impact of the policies, programs and resources directed towards the response. These groups are people living with HIV and AIDS (PLHIV), and their families and loved ones, sex workers, drug users, men who have sex with men, transgendered people, women, and members of mobile population groups. The analysis in this summary report does not discount the views and roles of the civil society in its broadest definition; however it does foreground the experiences of the groups and populations most directly affected.

The UNGASS monitoring guidelines note that in countries with concentrated epidemics or sub-epidemics among most-at-risk populations – sex workers, injecting drug users and men who have sex with men – efforts must be made to work with these groups. (UNAIDS, 2007). Ensuring representative participation from the community sector in the UNGASS reporting cycle is necessarily complex. It involves processes of selection and nomination which are often not community controlled, or that marginalise significant groups and populations affected.

To produce this summary, the Country Reports and a brief questionnaire sent to key contacts in the region in order to generate feedback on the UNGASS reports were reviewed. Other sources (for example the Shadow reports produced by Indonesia and Thailand) relevant to the aims of the review were also considered. Finally the review was guided by the findings of the 2005 ICASO research study in 14 countries<sup>3</sup> which evaluated the extent to which governments and the community sector have implemented the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment. The following is a summary of the major findings of the study:

- Knowledge and use of the Declaration of Commitment by policy makers and the community sector is generally low.
- Participation by the community sector in the development, implementation and monitoring of national strategies remains very limited in many countries, including participation in the periodic review of progress on the implementation of the Declaration of Commitment.
- Political leadership is still lacking in most countries. There are significant gaps between what the politicians promise and what they deliver.
- There is a huge gap between what exists on paper in terms of anti-discrimination policies and what happens in reality. Stigma and discrimination are commonplace, and they constitute the major obstacle to the successful implementation of prevention, care, treatment and support services.
- Most developing country governments are spending a very small proportion of national budgets on HIV/AIDS.
- There is little connection between the legally guaranteed right to health and actual access to health, especially for the most vulnerable groups.
- There are large gaps in the services being provided to vulnerable groups.
- Little is being done to promote the empowerment of women and to eliminate the stigma associated with sex work.

members living with or highly affected by HIV and AIDS". ICASO, AfriCASO, and the International HIV/AIDS Alliance, *Coordinating with Communities: Guidelines on the Involvement of the Community Sector in the Coordination of National AIDS Responses*". (May 2007).

<sup>3</sup> Indonesia and Nepal were included in the study.

- The illegal status of sex work and drug use, combined with the high levels of stigma and repressive law enforcement practices, dramatically limit access by sex workers and drug users to basic health and social services.
- While access to anti retrovirals (ARVs) has improved in the last few years in all of the developing countries surveyed, it is still far from what is needed to save millions of lives. (ICASO, 2006)

The conclusions of the ICASO research study illustrate the key issues facing civil society organizations in terms of involvement in the UNGASS process, and more broadly national responses provide a broad set of benchmarks from which to assess progress in the current (2008) round of reporting.

# THE ASIA <sup>6</sup> PACIFIC EPIDEMICS

The region covered by this report comprises nearly two thirds of the global population, ranging from Pakistan in South Asia, New Zealand in Oceania and Japan in East Asia. The diversity of cultural, linguistic, political, economic, social and political formations found within national and often sub-regional boundaries is reflected by the idea of Asian Pacific civil society. Prevalence of HIV in Asia Pacific varies both between and within countries, with very low (Mongolia), to a generalized epidemic in Papua New Guinea. Approximately 9 million people in the region have been infected since the epidemic appeared over 20 years ago. Injecting drug users, sex workers, migrants, transgendered people and men who have sex with men are also all populations with high levels of HIV.

Several countries are experiencing increasing feminization of the epidemic as men infect their wives and sexual partners. While the epidemics in Asia and the Pacific vary both between and within countries they share characteristics centered around unprotected paid sex, sharing of contaminated needles and syringes by injecting drug users and unprotected sex between men. All of these populations remain underserved in current responses (Commission on AIDS in Asia, 2008). The World Health Organization estimates that by late 2006, 280 000 (225 000–335 000) people were on anti-retroviral treatment and coverage was estimated at 19% (WHO, UNAIDS, UNICEF, April 2007).

# UNGASS & INVOLVE- MENT

The Country Reports reviewed do note the involvement of civil society and particularly PLHIV. Innovative use of web based technology was used in China to call for participation in the UNGASS process (see annex 1). The Philippines consultation process and the involvement of civil society agencies have been posted on a web blog<sup>4</sup>. For the first time a regional consultation on harm reduction and drug use took place in 2007 (AHRN, 2007). However, few reports provide details on the efforts made to reach vulnerable populations and provide support for their input. While most reports note that PLHIV, and to a lesser extent other vulnerable groups, were involved or consulted in the development of the UNGASS report, little detail is provided regarding the actual groups involved or the support they received in order to engage in the process (with some exceptions). Shadow reports and key informants contacted in the region also noted that the amount of time available to most civil society organizations to organize input and/or a response to the national report is generally inadequate and leaves little time or space for community consultation.

While there have been substantial improvements in the consultation process with PLHIV from the last round of reporting, this review found that progress has been uneven and that the UNGASS reports provide limited analysis or discussion of the quality of involvement. This is noted in the Shadow report developed by civil society members for Indonesia (Indonesian UNGASS Community Report, 2008), which commented that involvement *'still seemed symbolic or tokenistic in many senses. In some consultation processes, community was only involved in the last phase of the process, so the civil society or community activists were not able to fully contribute to the process itself'*. This complaint was echoed by key informants from other countries. This is a point also noted in the official Indonesian report, but is ascribed to the low capacity of many civil society organizations to engage with national policy and strategy. In some cases, there is unwillingness on the part of local officials to receive input from non-government sources<sup>5</sup>, even contributions from civil society organizations may be ignored.

*'I attended two civil society consultations on UNGASS and had distributed our latest evidence-based report which had a chapter on Malaysia documenting the discriminatory practices of mandatory testing for HIV and other health conditions on migrant workers into destination countries. It was not cited nor were excerpts from the report used.'* <sup>6</sup>

<sup>4</sup> <http://hivmephilippines.blogspot.com/>

<sup>5</sup> A representative from civil society in China, noted that in China SWACO, the government agency responsible for the UNGASS report, *'likes to communicate with government departments more'* than civil society organizations, email communication received March 2008.

<sup>6</sup> Rathi Ramanathan, email communication, March 2008.



It is also important to note that participation among civil society agencies can be uneven. Factors which influence this include the ability of groups and organizations to access resources and government-sponsored HIV support, the influence of more dominant civil society actors (for example, established AIDS Councils which have strong relations with government) and lack of access to international agencies operating in-country.

More practically, some NGOs and CBOs operate in areas remote from urban decision making centers, and many of these are still perceived as lacking in capacity in relation to HIV policy development.

Countries which have established mechanisms of partnership and particularly policy involvement with civil society (for example, in national HIV committees) were able to use these as mechanisms for input into the UNGASS reporting process. These UNGASS reports describe in detail the development of representative civil society structures which allow for properly managed consultation and participation. The process and analysis is detailed and candid regarding the challenges involved in improving the level and quality of involvement. In Nepal, a process was developed that included the drafting of a Road Map for the process of reporting and the establishment of a Task Force to oversee improvements which included representatives of civil society, notably PLHIV and IDU representatives (UNGASS Report Nepal 2008).

Similar accounts were provided in the reports for India and Cambodia. However support for community sector involvement in UNGASS should not necessarily be used as a proxy measure for ongoing participation in national and local HIV policy and planning. In Cambodia 170 NGOs, CBOs and FBOs took part in the UNGASS process, but involvement in HIV policy and planning is still viewed as inadequate, particularly in relation to law and policy monitoring and implementation (Kem Ley, March 2008)

# CON- STRAINTS TO <sup>9</sup> PARTICI- PATION

In general, systemic development of community participation in policy development across the region remains limited, is mostly focused on local action and is not effectively networked with national HIV forums. Opportunities to use the knowledge and experience generated by community involvement to benefit the UNGASS process, or to expand the quality and reach of essential interventions, are being missed. Even where PLHIV groups are being incorporated into national planning and policy processes, a lack of commitment to fully support policy involvement remains. China's UNGASS report estimates that PLHIV groups now number over 400. Nevertheless PLHIV involvement in the national program is referred to in the UNGASS report only in terms of limited contribution to IEC materials, involvement or contribution in the report itself is not covered. The report does note that PLHIV involvement in the national response remains constrained by the absence of a supportive legal framework. In Viet Nam the number of PLHIV groups has expanded to over 75, and many of these are nominally independent from State agencies. PLHIV and civil society groups were consulted during the development of the report, although the absence of a national PLHIV network limits the influence of this sector in the national response. While the report notes that PLHIV have been invited to take part in high level meetings, involvement is limited and they are not represented on high level national HIV committees. More generally, the absence of a supportive legal framework for civil society organizations limits the ability of civil organizations or groups to register and receive funding, and therefore to extend or scale up important community based initiatives.

Community representatives are often expected to take part in high level planning processes but are not supported to build capacity or make the maximum use of their experience or skills. Usually they are not reimbursed for their time. The Indonesian Shadow report notes that involvement is still mainly limited to implementation activities.

'The bulk of participation and involvement of community & community activists is at implementation level with some in the program designing and decision making process. However, it is hard to find involvement in the monitoring & evaluation process, in particular PLHIV involvement and that the involvement of women, particularly positive women often took the form of invitations to take part in AIDS response as testimonial speakers or are invited to meetings without knowing what they can contribute to those meetings.' (Shadow Report Indonesia. 2008)'

Participation of groups from the Pacific (with the exception of PNG where the national network of positive people IGAT Hope is represented on national structures) appears to be very limited, and the reports from this region contained little information on the role of civil society in providing input to the reporting process or more generally in relation to participation in national responses, as the report from Fiji notes.

'While some most-at-risk populations have been represented in the National Strategic Plan, this has been tokenistic at best. In addition, there is minimal gender and HIV and AIDS coverage in the NSP. Six NGOs who are significant stakeholders were excluded from the Country Coordinating Mechanism during the Fiji Global Fund Round 7 process in July 2007. Civil society representation on NACA is currently government appointees and therefore not truly representative of civil society in general.' (UNGASS Fiji Report 2008)

The report also notes that NGOs with views critical or divergent from their Government have been removed from national committees.

# POLITICAL COMMIT- MENT 10

High level and sustained political commitment is a key element in establishing a sustaining comprehensive HIV response. While most countries reported that high level (prime ministerial or presidential) statements on HIV were now a regular feature of political discourse, the commitments reflected by budget allocations and planning across government departments and ministries were much weaker. The clear issue of lack of cross ministerial support from key ministries remains a major barrier to realizing comprehensive political commitment. There are indications in several reports – including Mongolia, Papua New Guinea and Laos

– that the health sector and particularly National AIDS programs struggle to provide strategic leadership and gain the attention of more powerful ministries. The factors identified in the reports include limited strategic capacities of national AIDS Committees, resistance from other sectors (for example, public security) and a failure to turn high level political rhetoric into real institutional and financial commitments.

# HUMAN RIGHTS 11

Few of the UNGASS reports document in any detail the human rights dimensions of HIV/AIDS. This is arguably the most sensitive indicator in the reports and the one which provides an important measure of relations between governments and civil society. The following summary provides extracts from alternative sources which have documented human rights abuses.

The 2007 Report of the UNAIDS Reference Group on HIV and Human Rights Meeting noted a number of areas of concern. Key among these are reports of discrimination against PLHIV in accessing health care, harassment against MSM, drug users and sex workers by local authorities in China, and harassment against men who have sex with men and people who use drugs in India. Provider-initiated testing and counseling has been adopted by several countries in the region and the impact of this approach on existing voluntary counseling and testing remains unclear. This issue is also raised in the UNAIDS Reference Group report as a concern due to the potential for misinterpretation or the potential for use as a justification for mandatory testing and counseling (UNAIDS, 2007).

The report for the Federated States of Micronesia notes that most HIV tests are mandatory 'being conducted during screening of blood donors, on pregnant women, students, food handlers and prior to marriage' (FSM UNGASS Report 2008).

Community based agencies and the constituencies they work for and with (sex workers, MSMS and drug users), are – as the UNAIDS Reference group report makes clear – bearing the brunt of human rights violations. A Shadow report produced by the Thai Treatment Action Group, documents serious human rights violations against drug users in Thailand as a result of the systematic 'war on drugs' initiated by the government in 2003. This is also evident in the widespread policy and practice of mandatory health and HIV testing for migrant workers which is discriminatory, dehumanizing, violates migrants' rights, international guidelines and national law, while serving no public health goals.

National human rights institutions play a limited role in law and policy development. Far fewer are involved in investigating, documenting and prosecuting HIV related human rights violations. This is the case, for example, in India. While human rights have assumed an importance in many national HIV policies and strategies, less effort has been made to translate this commitment into building the capacity of human rights institutions, where they exist, to provide mechanisms to record, document and address cases of discrimination experienced by people living with HIV and other vulnerable populations. Nor have efforts been scaled up to educate members of the judiciary on HIV and human rights, or stigma and discrimination.

While provisions in national equal opportunity or human rights legislation may be interpreted to apply to vulnerable populations, countries without explicit laws which protect and promote the rights of sex workers, MSM, other sexual minorities, drug users, and PLHIV – for example Bangladesh, Indonesia and Pakistan – provide little or no real protection for these populations. In other cases, existing policies or laws remain effective barriers against HIV prevention. In Bangladesh, for example, the condom promotion policy is restricted to married couples, and in many countries the criminalization of sex work and drug use are the most significant barriers to effective HIV interventions and human rights protection.

India still retains a number of laws which impede HIV interventions; for example, criminal statutes such as the Narcotic Drugs and Psychotropic Substances Act, 1985, section 377 of the Indian Penal Code renders homosexuality illegal in India and the Immoral Traffic Prevention Act, 1956 continues to hinder the implementation of effective interventions with IDUs, MSM and female sex workers.

Where a strong and independent judiciary is in place and able to act progressively in relation to HIV and human rights, the impact can strengthen rights protection as well as add the voice of a powerful actor to calls for legislative review and reform. The following excerpt from the Nepal national report illustrates this.

‘Two recent verdicts of Supreme Courts have further strengthened the human rights situation. First one is a directive order to the government to introduce laws that provides equal rights of sexual minorities... and second one was the imperative order to maintain strict confidentiality of all court proceeding and hearings for the cases relating to sexual violence, girl trafficking, HIV/AIDS and children. This move not only indicates the progressive nature of the judiciary system in the country, but also a reflection of social acceptance of sexual minorities.’  
(UNGASS Report Nepal 2008).

# POLICY & LAW, IMPLEMENTATION & MONITORING **13**

Most countries in the Asia Pacific region are now conducting regular reviews and revisions of national HIV/AIDS plans and strategies. Some have enacted HIV specific legislation which gives legal force to these strategies. However, in addition to the need to bring conflicting legislation on drug control, sex work and homosexuality into line with HIV legislation, there is also the need to create stronger implementing mechanisms including monitoring and enforcement of HIV legal provisions that already exist. The importance of this for the creation of an enabling policy environment is underscored by the tension between harm reduction and demand reduction approaches to drug use and the criminalization of sex work noted in many of the 2008 UNGASS reports.

CARAM Asia, a regional network of twenty-seven members covering sixteen countries, conducted research in both origin and destination countries spanning across Asia and the Middle East<sup>2</sup>. The report, *State of Health of Migrants 2007: Mandatory Testing*, reviews existing laws and policies on HIV testing in these sixteen countries and compares them with the requirements of mandatory health testing that migrants who wish to work abroad must undergo.

The main finding of the research is that the practices of mandatory testing for HIV and other health conditions as a screening tool for the entry of migrant workers into destination countries is discriminatory and results in the violation of basic rights. It is discriminatory because it singles out migrants who fill unskilled jobs and come from developing countries for

<sup>2</sup> Destination countries included: Bahrain, Dubai, the Hong Kong Special Administrative Region (China), Japan, the Republic of Korea, Malaysia and Thailand; origin countries included: Bangladesh, Cambodia, Vietnam, India, Indonesia, Nepal, Pakistan, Philippines and Sri Lanka.

mandatory health examinations that include HIV testing; whereas those who may have professional skills or come from developed countries do not have to undergo such testing. Moreover, those who undergo mandatory testing and are found with HIV are denied the right to migrate for work (CARAM Asia, 2007).

# INJECTING DRUG USE 14

The importance of responding effectively to injecting drug use – including legal reform of drug control laws and supporting the involvement of drug users at the policy and program level – cannot be overstated. The epidemics in Asia are still mainly driven by injecting drug use. Evidence for the effectiveness of harm reduction approaches including needle and syringe (N&S) distribution and exchange and substitution therapy has been accumulating for many years. Yet there is still a reluctance to scale up effective harm reduction programs, address legal conflicts, or involve drug users meaningfully in the responses that directly affect them. Coverage of harm reduction programs is also very low, with an actual decline in coverage during the period 2003–2005 in South East Asia from 5% to 3.2% (IHRA, 2008). In many countries, including Viet Nam and China where the majority of HIV infection is still transmitted through injecting drug use, existing drug control laws contain measures used to restrict and interfere with harm reduction and peer outreach activities. A recent report on HIV policy in Viet Nam notes that while the domestic policy environment is strong, it has not paid sufficient attention to the increase in infections among women and girls, nor does it effectively address stigma and discrimination against drug users and sex workers (Kuat Thi Hai Oanh, 2007).

The China UNGASS report provides details on the prevention affecting key populations. However a key weakness is the lack of detail provided on the operation and issues related to needle and syringe (N&S) distribution and exchange for injecting drug users. This is covered in just three lines of the 45 page report and provides no detail other than the numbers of N&S distributed nationally. There is no discussion in the report of the operation of the N&S programs at the local level or the role of security services in supporting or hindering these services. The International Harm Reduction Association (IHRA) reports that,

*'In China, it is estimated that 110 needles are distributed per IDU per year, and that only 7% of people who inject drugs have access to NSP services in areas where they exist.'* (IHRA, 2008)

A report by the Thai AIDS Treatment Action Group (TTAG) (Thai AIDS Treatment Action Group, 2007) documents serious human rights violations

and obstacles to the provision of services for Thai drug users as a result of the 2003 government policy of the 'war on drugs'. The report argues that the effect of the war on drugs, in particular the extra judicial killings that were frequent in the years between 2003 and 2005, has created a climate of fear among drug users who are unwilling to access services. It concludes that many service providers will either refuse access to people who are using or pass personal information on to police authorities. The following quote from an outreach worker illustrates this point.

L., an outreach worker in Chiang Mai, said that alongside fear of being "blacklisted", a chief preoccupation among drug users was that physicians would refuse to provide them with treatment. Most doctors require that people quit drugs before they get ART. Drug users may lie to the doctor if they have no record. Some can't get substitution [medication-assisted] therapy and some people die.' (Excerpt from the TTAG Report Deadly Denial 2007)

Despite signs that countries in the region are becoming more accepting of buprenorphine and methadone maintenance Treatment (MMT), only 9 Asian countries provide some degree of treatment and there are considerable barriers to access including lack of access in rural areas and legal restrictions which inhibit scaling up services (IHRA, 2008). The broader policy environment affecting harm reduction – notably the development of law and policy on narcotics control – is also closed to the participation of drug users, harm reduction organisations and others with experience and insight (AHRN, 2007).

# CUSTODIAL SETTINGS 15

Countries across the region incarcerate people living with HIV or people vulnerable to HIV infection either in prisons or in other closed settings, often for rehabilitation and re-education purposes. The International Harm Reduction Association (IHRA) reports that,

'There is evidence of elevated HIV prevalence amongst prisoners and those held in DRCs in several Asian countries. Of particular concern is the high prevalence rates found amongst prisoners at a national level in Indonesia (20%), where male prisoners account for 3% of people living with HIV in the country, and Vietnam (28.4%), where up to 40% of prisoners in some facilities are living with HIV. Clear evidence of elevated HIV prevalence rates in prisons has also been found in Cambodia (3.1%), China (0–4%), Chinese DRCs (42%) and Malaysia (6%). There is no information available on HCV prevalence rates amongst prisoners or DRC residents in Asia, but rates are likely to be higher than outside prisons.' (IHRA, 2008).



Lack of access to HIV services in custodial settings is unfortunately the norm for the majority. This includes extremely limited access to ARV for those living with HIV, and no access to harm reduction services. In countries with a policy of compulsory drug rehabilitation and high levels of HIV among drug users (for example, Viet Nam, China and Malaysia) the lack of services and the disruption to continuity of care between closed and community settings provides the platform for increasing transmission within these settings and undermines the stability necessary to achieve successful treatment outcomes.

# GENDER 16

Gender based violence against women and girls continues to be a major area of concern in the Asia Pacific region. Discriminatory gender norms and gender based violence both compound and contribute to women's vulnerability to HIV and disproportionately increase the social and economic impact of HIV on women. Women and girls are being trafficked to India in large numbers from Nepal to work in brothels. An estimated 22 to 38% of young Nepalese women trafficked to India and returning to Nepal were found to be HIV positive. Gender based violence and rape is most prevalent in Cambodia, PNG, India, and Nepal and indicated in all countries covered by this review. The increasing trend of women at no obvious or low risk becoming infected with HIV by their lovers or spouses is also a very worrying trend in the pattern of the epidemic in many countries across the region. Programs which address the cultural and social construction of gendered identities and place this within a framework of HIV risk lack government support. The Naz Foundation International in a report released in 2006, notes that,

'In some cultures in South Asia, male-to male sexualities, to a large extent, do not fit the heterosexual/homosexual oppositional paradigm that is so commonly used as a discourse to discuss same sex behavior. Rather the primary pattern appears to be that of a gendered framework with specific orientations and sex roles. This framework reflects a belief in a "man/not-man" duality where the "man" perceives himself as a normative male from the general male society, while the "not-man" perceives himself as a feminized male, self-identifying as a "kothi." Feminized males are heavily stigmatized in the region and are victims of violence and oppression'. (Naz Foundation International, 2005-2006)

# MOBILE POPULA- TIONS 17

Migrant workers still experience high levels of discrimination. Many of these experiences are undocumented, and migrant workers have little or no access to basic health services and less or no access to HIV services. Compulsory testing and deportation of migrant workers by host countries is still a common practice in the region. In Malaysia, female migrant workers are subjected to mandatory screening for more than 15 infectious diseases and conditions including HIV, STDs, tuberculosis, malaria and pregnancy. The Foreign Workers Medical Examination Agency (FOMEMA), a centralized agency in charge of these medical screenings, communicates the results to the Immigration Department which then notifies the employer of the employee's medical status. Should they be found to have tested positive for any of these diseases or be pregnant, they are subject to deportation (UNGASS Malaysia Report).

A regional review of migrant policies across the region by CARAM Asia (Coordination of Action Research on AIDS and Mobility) notes that it is alarming that Cambodia, Indonesia, and Vietnam who are large sending countries do not recognize returnee migrants as at risk population and provide little or no support. Destination countries, Japan, Singapore, and Korea also do not recognize migrants as vulnerable to HIV.

However on a more optimistic note, New Zealand, Malaysia, Bangladesh, Lao PDR, Pakistan, Nepal, Sri Lanka, Thailand and Philippines recognize migrants as a vulnerable group or a bridging population in need of targeted interventions. New Zealand, a destination country for skilled migrant workers, has programs on prevention for refugees and new immigrants, and free access to ARVs, however, it imposes mandatory testing for those seeking long term residency. Malaysia, while recognizing that undocumented migrant workers and refugees are vulnerable populations, has no formalized programs or services in place. Migrant workers are subjected to mandatory testing and then deported, often with no knowledge of their serostatus. It is important to note that only the Philippines has a formalized pre-departure program targeted at prospective migrants. (Ramanathan, 2008).

# ACCESS TO TREATMENT, CARE & 18 SUPPORT

There has been a remarkable scale-up of access to anti retrovirals (ARV) in many countries of the Asia Pacific and this is a major advance since the last UNGASS reporting period. However, the majority of people in need are still not able to access treatment, and access for highly stigmatized groups remains uneven and in some cases significantly disproportionate to their needs. As an example, in Indonesia, just under a quarter of those estimated to be in need are currently on ARV, and this figure drops to 1% for IDU estimated to be in need of ARV. The IHRA – quoting the report “*WHO, UNAIDS, UNICEF (2007) Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*” – estimates that ‘amongst a total of 81,000 people receiving ART across fourteen South and South-East Asian countries, only 1,700 were people who currently or formerly injected drugs’ (IHRA, 2008). In Pakistan, 7.4% of people estimated to be in need are receiving ARV (Pakistan UNGASS report 2008).

Geographical coverage in many countries is also limited. Treatment clinics are situated in major urban centers and not accessible to people in rural and remote areas due to distance and the cost of travel. Other factors include the costs of associated laboratory tests – which often have to be borne by patients – and judgmental and stigmatizing attitudes of health care workers towards people with HIV. Where access is more widely available, as in Cambodia, the issue of data collection regarding drug resistance and access to second and third line regimens requires urgent attention, if the gains from first line ARVs are to be maintained. Sustainable supplies of ARV and the need for national strategies to secure supplies merits little discussion in the reports.

While the need for sustainability of the response is noted in many reports, this is often balanced against the requirement for scaling-up coverage of programs which emphasize a reliance on donor funding rather than sustainable national resource allocation strategies. Several key informants noted the lack of adequate psycho-social support for PLHIV and most of the UNGASS reports were silent on this issue. This reflects the lack of importance

– and the lack of treatment resources and care systems – which are attached to the psycho-social care and support of people living with and affected by HIV/AIDS.

# SUSTAINA- BILITY 19

Reporting by low and middle income countries on sustaining the national response and the role of civil society in building structures and reallocating national resources to secure indigenously sustained HIV/AIDS responses was also a weakness in the UNGASS reports. Some countries, for example Cambodia, note that their successes in preventing HIV infection and treating HIV disease may be in jeopardy if sustainable approaches are not supported (UNGASS Report Cambodia). Given that this is an issue for many of the countries covered in this summary, moves towards national sustainability would appear to merit more discussion in the reports than is apparent. As an example, national contributions to the overall program in Cambodia account for 13% of the total funding of all contributions, including international funding; in Viet Nam, the domestic budget for HIV was 9.4 million US dollars (USD) while international contributions amounted to 51 million USD in 2006, equivalent to 18.5%. Yet while these funding gaps are noted, less is written regarding strategies to bridge them.

# DISCUSSION

Most country reports demonstrated a willingness to acknowledge key areas of weakness in national responses including the need to involve civil society, PLHIV and vulnerable groups, more effectively both in the response and to a lesser extent in the development of the UNGASS reports. However, while the best country reports make this point, it is also clear that the barriers to overcoming the shortcomings identified both in the reports and in the civil society responses to the UNGASS process lie to a large extent outside the health sector and are linked with resource, legal or policy issues, which can only be resolved through higher level political commitment which goes beyond supportive public statements. The systematic exclusion of key civil partners from law and policy processes which profoundly impact on the epidemics of HIV and the human rights of affected groups

– for example drug users and narcotics control – is in need of urgent change.

The epidemics in Asia Pacific overwhelmingly affect populations already vulnerable to HIV and who are stigmatized due to poverty, gender norms or lifestyles and behaviors that place the majority of them beyond the reach of essential prevention, treatment and care services. While there have been impressive improvements in some areas – notably the rapid increase in the number of people able to access to effective HIV treatment – coverage of services overall is low. Deep cleavages created by stigma, gender inequities, and oppressive laws and policies still separate highly marginalized populations from access to essential HIV services. The responses from community sector representatives quoted in this report are clear regarding the essential link between increasing meaningful involvement of vulnerable populations, improving coverage of services and the removal of legal and policy barriers. It is the case in the Asia-Pacific region and globally that successful responses to HIV/AIDS, including advocacy and leadership against stigma and discrimination and treatment and care interventions began in the community sector.

While community responses have too often gone unacknowledged, the sector cannot, without support, provide the capacity to bring these responses to the scale necessary to make the changes in people's lives, which will in turn change the course of the epidemics in the region. The current impact, the patterns of infection, and the future course of HIV all provide compelling evidence from which to fashion a response which creates a meaningful partnership between affected populations, NGOs, CBOs, governments, international agencies and all who are concerned with HIV/AIDS.

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# ANNEX 1: CHINA CIVIL SOCIETY 22 REPORT ON UNGASS

## Issues

Founding an UNGASS CSO Working Group to mobilize CSO involvement in UNGASS Review Process.

## Description

On November 28, 2007, China's UNGASS CSO Working Group (WG) was founded. The members of which included the China Association for STD/AIDS Prevention and Control (Association), China HIV/AIDS Information Network (CHAIN) and AIDS activist Liang Yanyan. The mission of the WG is to mobilize Chinese AIDS CSOs to get involved into the Review Process.

An e-column was created on CHAIN to play a role as information focal point of WG at the first step. UN key documents, ICASO UNGASS Alert, notices on NCPI Part-B and HLM civil society representative accreditation application were posted in a timely way on the column to help the CSOs understand UN DoC, the purpose of the Review and the importance of CSO involvement.

The WG mobilized financial support from UNAIDS China Office to support its activities. At first, it cooperated with UNAIDS to modify the NCPI Part-B questionnaire and call for CSO participation in meetings, by mail and by online survey systems. Finally, 108 CSOs participated in the NCPI Part-B, covering 20 provinces. Secondly, the WG held three consultations respectively on treatment, IDU and CSW to discuss the national gaps with CSO and the key affected population representatives.

## Lessons learned

The WG has made progress on mobilizing CSO involvement because of the following reasons:

- 1 Good membership of the WG. The Association is one of the largest umbrella NGO in China with good reputation. CHAIN is most developed

CS-led AIDS website in China. Liang Yanyan is an eminent AIDS CS advocate.

- 2 During the whole process, the WG has close cooperation with UNAIDS Country Office.
- 3 Information could be distributed in an efficient way.
- 4 CSO consultations could be held to find out the national gap on the response to AIDS.

#### **Next steps**

- 1 The WG plans to invite 1-2 PLHIV representatives to join the WG to commit GIPA.
- 2 The WG will help the accredited CS reps to attend the regional CS Forum and New York HLM.
- 3 During the process, the WG will help to build up further dialogue between Chinese government and CSOs on national gap.

#### **Helpful Links**

UNGASS Review Column: [www.chain.net.cn/ungass](http://www.chain.net.cn/ungass)

China AIDS Association: <http://www.aids.org.cn/>

CHAIN: [www.chain.net.cn](http://www.chain.net.cn), <http://www.chain.net.cn/english/>





Pictures

Online survey on NCPI Part-B:

### 组织基本信息



单位名称			
地址	省	市 (请填写)	
邮编			
组织性质	<input type="checkbox"/> 营利组织 <input type="checkbox"/> 3-9人 <input type="checkbox"/> 10-29人 <input type="checkbox"/> 30-99人 <input type="checkbox"/> 100人以上		
组织人员	<input type="checkbox"/> 1-9人 <input type="checkbox"/> 10-29人 <input type="checkbox"/> 30-99人 <input type="checkbox"/> 100人以上		
负责人		性别	<input type="checkbox"/> 男 <input type="checkbox"/> 女
联系方式 (必填项)	负责人	固定电话	手机
	联系人	固定电话	手机
电子邮箱			
组织创建时间	年 (至少)	参与志愿服务的工作时间	年 (至少)
去年总预算	万元 (人民币)		
您的组织是否团市委级	<input type="checkbox"/> 是 <input type="checkbox"/> 否		
您从事过哪些职业 (可多选, 请勾选所有符合您经历的项目)	<input type="checkbox"/> 工人/农民 <input type="checkbox"/> 社会工作者 <input type="checkbox"/> 特殊教育/聋哑教育 <input type="checkbox"/> 民间组织/基金会/非营利组织 <input type="checkbox"/> 以高技能类职业		
您的工作经历主要集中在哪些方面 (可多选, 请勾选所有符合您经历的项目)	<input type="checkbox"/> 志愿服务项目 <input type="checkbox"/> 在志愿服务 <input type="checkbox"/> 社会工作/社会工作 <input type="checkbox"/> 志愿服务项目/志愿者招募 <input type="checkbox"/> 志愿服务项目/志愿者招募/影响儿童 <input type="checkbox"/> 组织/团队 <input type="checkbox"/> 志愿者 <input type="checkbox"/> 志愿者 <input type="checkbox"/> 志愿者/服务人员 <input type="checkbox"/> 义工 <input type="checkbox"/> 其他 (请注明: )		
您从事志愿服务的年限或服务的总小时数:	A		
您的组织正式工作人员的平均学历是	<input type="checkbox"/> 小学 <input type="checkbox"/> 初中 <input type="checkbox"/> 中专或高中 <input type="checkbox"/> 大学 <input type="checkbox"/> 硕士 <input type="checkbox"/> 博士		
参与志愿服务的岗位或职务 (可多选)	<input type="checkbox"/> 社会志愿者 <input type="checkbox"/> 项目志愿者 <input type="checkbox"/> 义工 <input type="checkbox"/> 志愿服务队长 <input type="checkbox"/> 领队 <input type="checkbox"/> 组织者 <input type="checkbox"/> 其他 (请注明: )		
贵组织是否向民政部门注册或备案或是否是在民政部门注册	<input type="checkbox"/> 是 <input type="checkbox"/> 否		
您的组织是否注册	<input type="checkbox"/> 是 在哪个部门注册的: <input type="checkbox"/> 民政 <input type="checkbox"/> 工商 <input type="checkbox"/> 国家体育总局 <input type="checkbox"/> 其他 (请注明: ) <input type="checkbox"/> 否 是哪个组织的部门: <input type="checkbox"/> 基层组 <input type="checkbox"/> 省级 (含直辖市) <input type="checkbox"/> 市级 <input type="checkbox"/> 区级		
	<input type="checkbox"/> 否		



本次活动网络支持:  中华网, 拉近中国与世界的距离

## News Release

[http://www.chain.net.cn/english//News\\_and\\_Events/Hot\\_Topics/15887.htm](http://www.chain.net.cn/english//News_and_Events/Hot_Topics/15887.htm)

Over 100 NGOs have participated into UNGASS Review Policy Index B.

### **UNGASS Review NGO Working Group (2008-01-08)**

To coordinate and promote civil society participation into UNGASS Review, an UNGASS Review NGO Working Group was established. The current group members include Chinese Association of STD/AIDS Prevention and Control, China HIV/AIDS Information Network (CHAIN) and AIDS activist Liang Yanyan. UNAIDS China Office has given great support to civil society participation during the process.

Up to January 4th 2008, the Review NGO Working Group has received 116 Part-B respondent questionnaires, 106 NGOs has participated into the UNGASS Review process. Out of the questionnaires received, 62 were received from online survey database and mail, 25 were received at NGO AIDS Project Management Training on November 13 2007, 29 were received at "2006-2007 Joint Evaluation Report" Civil Society Meeting.

The Review NGO Working Group gives their deepest acknowledgment to all the NGOs who have participated into the process. Currently, the Review NGO Working Group is analyzing the data received from the questionnaires and writing the initial report. The initial report can be finished in the next week, and will be posted on UNGASS Review column, email groups and websites for public feedback.

To discuss key issues in a deeper way, such as treatment and care, AIDS prevention in the populations who have high risks to AIDS, and civil society involvement, the Review NGO Working Group plan to hold several small panels (less than 15 people) in the next step. The main purpose of the panel is to help improve the initial report and raise suggestions.

For further and future information, please notice the UNGASS column at CHAIN: [www.chain.net.cn/UNGASS](http://www.chain.net.cn/UNGASS)

*We give our acknowledgement to all the NGOs who participated into the Part-B questionnaire.*

# ANNEX 2: CARAM REPORT ON UNGASS 27

## UNGASS review on Asia Pacific

By Rathi Ramanathan

On reviewing countries in the Asia Pacific regions, it is quite evident that Governments in the region need to scale-up efforts to ensure that, migrants, a vulnerable group, be accelerated in order to meet the Universal Access target of 2010. One of the biggest obstacles in universal access is mandatory testing. The policy and practice of mandatory health and HIV testing for migrant workers is discriminatory, dehumanizing and violates migrants' rights. Mandatory testing serves no public health goals and plays no practical role in HIV prevention. Moreover, the policy of mandatory testing for migrant workers contravenes international guidelines and national laws on HIV testing, resulting in a total disregard for the established best practices of consent, confidentiality, counseling and referral to treatment and support services.

Destination countries must provide for HIV/SRH counseling and testing services to non-nationals. Destination countries which are often middle income countries should also ensure that ART coverage is extended to them.

### Trends

It is alarming that Cambodia, Indonesia, and Vietnam who are large sending countries do not recognize returnee migrants as at risk population. Not only would they require follow up testing, support, care on treatment if they are HIV positive but also counseling so as to not infect their spouses.

Destination countries, Japan, Singapore, and Korea also do not even recognize migrants as vulnerable is problematic.

However on an optimistic note, countries like New Zealand, Malaysia, Bangladesh, Lao PDR, Pakistan, Nepal, Sri Lanka, Thailand and Philippines recognize migrants as a vulnerable group or a bridging population that need to be targeted.

New Zealand, a destination country for skilled migrant workers, has programmes on prevention for refugees and new immigrants and free

access to ARVs but it impose mandatory testing for those seeking long term residency.

Destination country, Malaysia, while recognizing that undocumented, migrants workers and refugees were vulnerable populations, have no formalized programmes or services were in place. Migrants workers are subjected to mandatory testing and then deported, often with no knowledge of their serostatus.

Bangladesh does state mobile populations as at risk population but again have no programmes like pre-departure for Bangladeshi migrants going abroad nor reintegration programmes and referral services to support, care and treatment for returnee positive migrants.

Lao PDR acknowledges that returnee migrants are vulnerable but while there are some prevention and VCT services available, universal coverage of ART remains a challenge.

Nepal has recognized migrants as an at risk population and like Lao, offer prevention and VCT services for returnees but like Lao, do not have institutionalised pre-departure programmes. Also like Lao, ARV coverage is limited.

Philippines and Sri Lanka, both sending countries, recognize migrants as a vulnerable group and have programmes targeted at migrants. However, re-integration and referral systems to care, support and treatment, including remains unavailable.

Thailand, both a receiving and sending country has in place prevention services but again, ARV coverage is limited. There is no systematic pre-departures or re-integration programmes and referral services.

Sending countries, Pakistan and India acknowledge migrants as at risk group but have no targeted programmes for migrants.

Australia, Mongolia and China and the Islands of Vanuatu, Micronesia, Marshall Islands, Tuvalu, Palau and PNG are not significant sending or receiving countries for migrant workers.

It is important to note that only Philippines has formalised pre-departure programme targeted at prospective migrants.

### **Best Practices**

#### **Sending Country: Philippines**

Pre-departure programmes are in place for prospective migrant workers. This programme is specifically targeted to migrants and provides an opportunity to educate and inform prospective migrant workers provided in a way that migrants understand, taking into consideration their literacy level. Pre-test counselling includes basic information regarding HIV transmission, prevention, and the specific vulnerability of migrant workers; the process of testing, and the meaning of HIV test results.

#### **Receiving Country: Thailand**

Migrant workers are NOT subjected to mandatory HIV testing. Both

document and undocumented workers are entitled to access to health care system via a public health insurance scheme which means if tested positive they are able to access treatment.

The migrant population has been integrated into the National AIDS Control program since 2005. The migrant health strategy has been a joint effort between the government and civil society to establish a budget allocation, health system and the legal permission to provide health care to all migrant populations and to create a sustainable program at the national level. The strategy includes the 4 aspects of public health approach (health promotion, prevention, treatment and care), the universal access to health, the community and target group participation, the management system and budget allocation. The third policy related to HIV interventions among migrants is that the government has recently signed the agreement for the border health program on 11 December 2007. The target of the border health program is everyone who lives along the Thai border including the Thais, migrants, stateless people, ethnic minorities, and the refugees. The border health program covers all aspects of health care including communicable diseases such as HIV and AIDS interventions. Border surveillance and access to care are also parts of the program.

The serious constraints found in working with migrant laborers were their different languages, cultures, and beliefs about health. Thailand has begun to overcome these obstacles by opening up and emphasizing the participation of the migrant community. In this regard, the migrant community health volunteers and the migrant health workers were developed to play a vital role as educators for migrant laborers to educate them in HIV prevention in their own language, serving as interpreters for the hospital personnel, serving as translator and counselor to the migrant community to help them know their serostatus, function as a coordinator in access to health services for those who need treatment as well as a coordinator in social services, and as a worker to follow up on AIDS patients in the community.

# ANNEX 3:

# AIDS CONCERN HONG KONG REPORT ON UNGASS 30

*Key points from AIDS Concern, Hong Kong in regards to UNGASS report 2008.*

Hong Kong's HIV/AIDS situation is not included in the China UNGASS 2008 Country Report (please refer to China UNGASS 2008 report page 1, footnote 1). The Hong Kong Government also did not submit any report on such. The reasons behind are unknown, but may be due to the political status of Hong Kong as it is not a "country". Civil society is only aware of this situation in end February 2008.

## **HIV/AIDS Epidemic in Hong Kong**

The HIV prevalence has remained low in Hong Kong but is challenged by sharp rises in the reported HIV/AIDS cases in the last few years. As of the end of December 31, 2007, 3,612 people (cumulative) have tested positive for HIV and 934 of them have developed AIDS. In 2004, 2005, 2006 & 2007 there were 268, 313, 373 and 414 new infections recorded respectively. In 2007, 83% reported cases are male and about 65% of the total new cases reported HIV transmission through sexual contact. Despite the steady increase in new cases each year, the prevalence among the general population is low at less than 0.1%, with new infections largely confined to particular vulnerable communities.

New HIV/AIDS reported cases in MSM are on the steep rise and has posed a challenge to HIV prevention and care in Hong Kong. The ratio of sexually acquired HIV infection in heterosexual men to homo/bisexual men has narrow-downed from 4.1:1 in 1998 to 0.7:1 in 2006. Evidence suggests that condom use and testing rate among MSM remain low. The detection of



three HIV clusters has further revealed how quickly HIV is spreading in the local MSM community. In 2006, the Hong Kong first MSM HIV surveillance indicated that the HIV prevalence in MSM (those who attended public cruising venues) is 4.05%.

The increasing cross border (China and other Asian countries) mobility creates an opportunity for interaction between emerging epidemics on Hong Kong and the regional countries. The Guangdong Province now ranks fifth in China for HIV/AIDS cases, while the number of HIV carriers in seven cities in the Pearl River Delta accounted for 72.5% of those infected in the whole province. Two main routes of HIV transmissions are intravenous drug use and sexual contact. With the economic integration of Hong Kong into the Pearl River Delta, new transportation infrastructures will further facilitate people's mobility within the area. The trend of Hong Kong men patronizing the entertainment (sex) industry in cities close to Hong Kong border has become a public health issue as condom use across the border remain low and inconsistent. Hong Kong IDUs report purchasing or consuming drugs in Mainland China and increasing number of female sex workers are coming from Mainland have little knowledge on HIV/AIDS and access to prevention services. The increasing cross border sex and drug trade has fuelled the risk of HIV and STI transmission. Experiences from other countries indicated that emerging epidemics typically begin with a preliminary surge among IDUs, followed by transfer into the sex industry to sex workers and their clients, and eventually into the general female populations. Sub sectors, such as MSM and young people, in this cross border populations has presented the multifaceted prevention needs of the populations.

### **Current Responses to HIV/AIDS**

The overall community responses to HIV/AIDS in Hong Kong remained scattered. There are 7 AIDS specific organizations in Hong Kong and nearly each organization has its unique programme on particular populations. A few mainstream welfare organizations (mainly work with youth and IDUs) have small projects on HIV/AIDS. The competition of resources remains a key barrier to a coordinated response. Besides, sustainability of the programmes posed challenges to both NGOs and communities especially in terms of building experiences and nurturing talents in the field. Multi-sectoral response is rare. We are yet to see a coordinated response from the AIDS NGOs, NGOs and the community.

HIV prevalence in the local IDU community remains low but the reported number of cases has an increasing trend.

Responses from the government still have more rooms to improve. Compare to other countries, the presence of AIDS Trust Fund provided opportunities to the concerned parties in accessing designated funding for prevention and care programmes. The Dept of Health begins to address the MSM issue as a result of the escalating epidemic in the MSM community (but this response is too late and came only when the epidemic is too obvious to ignore). A new Special Project Fund under the AIDS Trust Fund (for MSM programmes) has indicated that resources are available for immediate responses if the government is determined to do so. However, AIDS is still at the low priority at the policy level. In terms of education, Hong Kong still lack of a comprehensive sex education at school and the society is still debating "whether sex education should be taught in school". We see The Education Bureau has prepared various sex education guidelines and



tool kits but we do not see how they are being used and implemented. As a whole, we are yet to see the government possessing the necessary leadership or being proactive in HIV/AIDS.

In terms of care, the provision of Highly Active Anti Retroviral Therapy (HAART), which is highly subsidised by the government, has dramatically reduced the mortality and morbidity of People Living with HIV/AIDS. If the epidemic continues to expand, the health care system has to bear the continuing high costs of additional HAART. The Hong Kong Government is now having a public consultation on a new Health Care Financing Model and we do not know whether the new financing model would affect the current access to HAART.

Stigma and discrimination remains a key barrier in HIV prevention and care, which prevented people from getting tested, access to treatment and disclosure and drive the epidemic into underground. Visibility of People living with HIV/AIDS in the public is extremely minimal due to stigma and (fear of) discrimination. Anti stigma programmes are rare in Hong Kong. Such issue is also not included in the Hong Kong AIDS Strategy 2007–2011.

The lack of research in the epidemic, behaviour and determinants of risky behaviour of the vulnerable communities has prevented us from gaining a better understanding of the epidemic as a whole. From our observation and front-line experiences, we know simply disseminating HIV information is not enough to lead the changes in behaviour and attitude. 22 years after the first AIDS case was discovered in Hong Kong, we now need more intervention approaches that are effective in changing behaviour and attitude. As HIV is primarily transmitted through sexual contact, we are yet to see a greater awareness of integrating HIV prevention and care into a broader sense of sexual health promotion. Besides, the lack of awareness of impact of cultural, socio-economic and psychological factors and their impacts on sexual health and HIV infection has hindered the dynamic development of prevention and care programmes to tackle the issues from various angles.

Despite the above barriers and difficulties, we are seeing new opportunities, which will bring new movements. We are seeing an increasing awareness from the government, particularly the Department of Health, to work more closely with AIDS NGOs and the communities. We can ride on such awareness to explore such collaboration and nurture a model of collaboration among GO, NGO and the communities. Besides, we are witnessing an increase in community participation. Though some forms of participation are token, but there is tremendous opportunity to turn such token participation into a meaningful one.

*The above only represents the view from AIDS Concern.*

APCASO is a network of non-governmental organizations and community-based organizations that implements HIV and AIDS related initiatives in the Asia and Pacific region. The mission of APCASO is to provide and strengthen the community-based response to HIV/AIDS in the Asia Pacific region.



**A P C A S O**  
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