Economic and Social Commission for Asia and the Pacific

Asia-Pacific Regional Expert Group Meeting on
Reviewing Implementation of Commitments from the
Asia-Pacific Intergovernmental Meeting on HIV AIDS Beyond 2015

Bangkok, 27 November 2018

Meeting Report

Contents

I. Background

1. The Asia-Pacific Regional Expert Group Meeting on Reviewing Implementation of Commitments from the Asia-Pacific Intergovernmental Meeting on HIV AIDS Beyond 2015 was organized by the Economic and Social Commission for Asia and the Pacific (ESCAP) in cooperation with the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP) and the United Nations Office on Drugs and Crime (UNODC) on 27 November 2018 in Bangkok.

II. Objectives

2. The Meeting aimed to

(i) Provide countries with an opportunity to report on progress against the Asia Pacific Regional Framework for Action on HIV and AIDS beyond 2015 across its three pillars, namely:

a. Continuing national reviews and multisectoral consultations on legal and policy barriers;

b. Holding national stakeholder consultations to promote access to affordable medicines, diagnostics and vaccines; and

c. Developing evidence-based national HIV investment cases and sustainability plans. This will include sharing of key milestones achieved, lessons learned, local solutions to challenges met, and strategic opportunities and entry points to integrate HIV in other national health and development programs and sustainability plans;

(ii) Share experiences and lessons learned on their own HIV response progress to fast track their responses towards achieving the commitments agreed to in the Regional Framework; and

(iii) Review countries' progress against the outcomes of the 2016 High Level Meeting on HIV where member states agreed to targets for 2020 and 2030.

III. Opening

3. The Meeting was opened by Mr. Kaveh Zahedi, Deputy Executive Secretary of ESCAP; Ms. Karin Hulshof, Regional Director East Asia and the Pacific, UNICEF on behalf of the Co-sponsors of UNAIDS; H.E. Mr. Ratu

Epeli Nailatikau, Former President of Fiji and Chair of the Asia-Pacific High-level Intergovernmental Meeting on HIV/AIDS; H.E. Mr. Ieng Mouly, Senior Minister and Chair of the National AIDS Authority, Cambodia; and Ms. Ikka Noviyanti, Youth LEAD, the Regional Network of Young Key Populations in Asia and Pacific.

4. Mr. Zahedi welcomed the participants by noting that despite the efforts to address the three pillars of the Asia-Pacifc regional framework for action on HIV and AIDS beyond 2015, HIV remained as a serious public health threat in the Asia-Pacific region. He highlighted the continued barriers faced by key populations at higher risk of HIV exposure, men who have sex with men, transgender people, sex workers and people who inject drugs, continuing difficulties in ensuring access to vital medicines and diagnostics, and funding shortfalls for AIDS responses. As a result, many people were still at risk of being left behind in the effort to end HIV as a public health threat. Political will was important in taking the necessary steps to strengthen responses and ensure their inclusiveness, especially in the context of the 2030 Agenda for Sustainable Development. ESCAP, in partnership with UNAIDS and other entities, played an important role in addressing HIV through ESCAP's intergovernmental platform, and he expressed his hope that this would continue.The findings of the Expert Group Meeting would feed into the Fifth Session of the Committee on Social Development.

5. Ms. Hulshof noted the loss of life as a result of HIV and outlined the model of the Joint United Nations Programme on HIV/AIDS as an effective means of combining problem-solving efforts towards shared goals. The region was off-track to meet the Fast Track targets of reducing new infections; despite progress in areas such as ending mother-to-child transmission of HIV, in some countries the number of new infections was rising, with specific key populaitons and younger people especially at risk. The importance of a multi-sectoral response which addressed the needs and rights of key populations and excluded groups was important in ensuring access to HIV care and services through improved access, including by integrating HIV within universal health coverage schemes, and increased financing to meet the fast track targets. She called for political commitment, multi-sectoral responses, enabling environments, increased resources and support for communities.

6. H.E. Mr. Nailatikau noted the progress that had been made since he had chaired the 2015 Intergovernmental Meeting on HIV and AIDS, which had increased understanding of the concept of treatment as prevention. He further outlined the increase in access to testing and treatment and progress in ending mother to child transmission, as well as the growth in adoption of pre-exposure prophylaxis in several countries of the region. It was concerning that several groups were still being left behind by responses. Prevention based on human rights as a means of reaching key populations,

including harm reduction for people who use drugs, empowerment of young people to protect themselves against HIV and access to antiretroviral treatments for young people living with HIV was important. Leadership and political will were key, and the opportunities provided by the integrated approach of the 2030 Agenda for Sustainable Development to address of HIV in an integrated fashion, although there was a need to maintain a specific focus on HIV to ensure that gains were not lost. He closed by calling for reflection for a future framework beyond 2020.

7. H.E. Mr. Mouly outlined the importance of the meeting to take stock of progress and challenges across the three pillars of the regional framework, and called for hope that the region could still meet the 90-90-90 targets of 90 per cent of people living with HIV knowing their status; 90 per cent of them receiving antiretroviral treatment; and 90 per cent of people on treatment achieving viral suppression. He accepted the role of the Chair of the meeting and called for frank discussions of the progress and challenges as a means for building consensus to accelerate progress towards ending HIV as a public health threat in Asia and the Pacific.

8. Ms. Noviyanti, speaking on behalf of civil society, highlighted four key points of concern. Human rights violations and discrimination vis-à-vis people affected by HIVAIDS remained high throughout the region, creating barriers to key populations accessing services. While domestic funding had increased, funding for key population- and community-led intiatives had not kept pace, leading to risks for sustainability of AIDS responses. She further pointed to the risk posed to generic drug access by trade agreements, calling for an intellectual policy framework that was flexible and patient-friendly. She also noted that the space for civil society engagement at national level and through other intergovernmental processes was shrinking. She called for laws which were respectful, not punitive; greater domestic funding for community-led responses; use of TRIPS flexibilities to ensure the affordability of drugs; repeal of laws restricting civil society engagement; and the creation of enabling environments for key populations and people living with HIV.

IV. Panel Session on national HIV investment cases and sustainability plans

9. The meeting considered the progress being made to achieve sustainability of national HIV programmes in the context of the rapidly changing financial landscape. The meeting discussed the challenge of ensuring financial sustainability in an era of shrinking international financial support for HIV. The meeting considered lessons learned from countries that were shifting away from AIDS exceptionalism to a more

integrated approach that delivers HIV services within health systems, as part of the move to Universal Health Coverage.

10. The meeting benefited from a panel consisting of Dr. Phan Thi Thu Huong, Deputy Director, Viet Nam Authority of HIV/AIDS Controller, Viet Nam; Dr. Hettiarachchige Suhashini Rasanja Perera De Silva, Deputy Director General Public Health Services a.i. and Director (Organization Development), Ministry of Health, Sri Lanka; and Mr. Ronivin Pagtakhan, Executive Director, Love Yourself, Philippines. The session was chaired by H.E. Mr. Ieng Mouly, and moderated by Mr. Eamonn Murphy, UNAIDS Regional Director, Asia Pacific.

11. Panellists discussed issues related to integration of HIV services in health insurance; centralized procurement of HIV drugs to achieve cost savings; reorientation of vertical HIV and tuberculosis programmes into decentralized cluster approaches linked to provision of testing at primary health care facilities for greater equality, efficiency and effectiveness; and hybrid funding approaches linking Government financing from the Ministry of Health to civil society initiatives to benefit from community outreach and innovative approaches.

12. In the subsequent discussion, participants considered lessons learned from countries that were integrating HIV into health systems for sustainability. Afghanistan emphasized the importance of integrating HIV services with other health services where there were synergies including sexual and reproductive health. Cambodia reported on a shift to a more integrated and sustainable approach, while maintaining accelerated progress towards the fast-track goal of virtual elimination of HIV in Cambodia by 2025. It was noted that engaging the Ministry of Economy and Finance in this process had been a key ingredient of Cambodia's success.

13. Participants stressed that political factors which made it difficult to sustain domestic funding to civil society organizations needed to be addressed to ensure that key populations had access to services when donor support ends. Transition and sustainability planning was crucial. An area that was highlighted as requiring careful management was the high dependence on external funding of HIV services for key populations. It would be essential to identify options for domestic funding of critical prevention, outreach and stigma reduction services delivered to key populations.

14. In relation to this pillar of the Regional Framework, the meeting recommended that:

- Governments mobilize domestic resources to sustain funding of HIV prevention and treatment services including support to civil society in delivering community-based HIV services.

- Governments include HIV prevention, testing and treatment in Universal Health Coverage.
- Countries engage the whole of Government to ensure sustainable financing of the AIDS response, in particular finance ministries.
- Governments involve civil society as key partners in planning for transition from external to domestic funding of HIV, including representatives of people living with HIV and key populations.

V. Panel Session on access to affordable medicines, diagnostics and vaccines

15. The Meeting benefited from a panel consisting of Ms. Nur'Ain Shuhaila Bt Shohaimi, Deputy Director of Pharmacy Policy and Strategic Planning, Ministry of Health, Malaysia; Dr. Netnapis Suchonwanich, Adviser, Health Intervention and Technology Assessment Program (HITAP) Ministry of Public Health, Thailand; and Mr. Jean-Michel Piedagnel, Head of Drugs for Neglected Diseases Initiative, South-East Asia Office. The seesion was chaired by Dr. Muhammad Iqbal Hussain, Additional Secretary, Ministry of National Health Services and Regulations, Pakistan and moderated by Mr. Håkan Björkman, Executive Coordinator, Global Fund Partnership & Health Programme Implementation Support, UNDP.

16. The panellists discussed experiences relating to compulsory licencing of key drugs to ensure their availability at affordable prices; the accessibility outcomes of inclusion of HIV within social health insurance schemes; and the role of civil society in informing decision makers, and holding industry accountable to ensure accessible medication.

17. In the subsequent discussion, participants from several countries noted that most HIV treatments were provided for free or were heavily subsidized by governments.

18. However, many participants also noted that the high cost of drugs remained a key barrier to access for some newer HIV medicines that were patented. Some diagnostics such as tests for confirming Hepatitis C diagnoses were also noted as being expensive.

19. Participants shared concerns about market failures that resulted in patented drugs and diagnostics being priced by pharmaceutical companies at a level that countries could not afford. This was noted as a particular concern for third and fourth generation antiretroviral HIV medicines and drugs for treating the hepatitis C virus and multidrug-resistant tuberculosis. The problem arose when there was an imbalance between the protection of the rights of industry to receive a return on research investments, and the needs of people to access essential medicines.

Although voluntary licencing intiatives were welcome, they were seen as insufficient to provide the scale of response required.

20. Several participants further discussed the barriers to access to affordable medicines created by intellectual property regimes created by trade agreements and patent laws. Participants highlighted that use of the flexibilities of the World Trade Organization Agreement on Trade Related Aspects of Intellectual Property Rights, known as the TRIPS Agreement had played an important role in supporting access to medicines in countries including Indonesia, Malaysia and Thailand. It was explained that this required strong political will and engagement with trade officials to advocate for use of TRIPS flexibilities. It also required engagement with pharmaceutical industry and collaboration with non-governmental organizations.

21. The meeting considered lessons learned. Participants stressed that HIV prevention and treatment services needed to be included in Universal Health Coverage to help mobilize new health funding from domestic sources and provide an entry point for inclusion of related conditions in Universal Health Coverage including hepatitis C and sexually transmitted infections.

22. Other factors identified as underlying high drug prices included issues of procurement, quality control, capacity, transparency, regulation of monopolies and engagement of ministries across government needed to be addressed.

23. Participants reported that many countries were implementing new approaches that used HIV medicines for both treatment and prevention. The 'test and treat' approach involved provision of treatment immediately after diagnosis. A powerful new prevention tool known as Pre-exposure Prophylaxis (PrEP) was also discussed which involved the use of anti-retroviral drugs to prevent infection. Some countries such as Thailand and Viet Nam explained that they were expanding access to PrEP and several others reported conducting or planning PrEP trials.

24. Another new approach highlighted by participants was the promotion of HIV self-testing. This was found to be an important option to provide for members of key populations who preferred not to attend clinical services for HIV testing because of fear of stigma and discrimination.

25. Use of HIV drugs to prevent mother-to-child transmission was reported by participants to be highly effective and had resulted in Thailand eliminating mother-to-child transmission. However, gaps in coverage of this intervention remained, and international procurement of drugs was challenging in some parts of South and South-West Asia.

26. In relation to this pillar of the Regional Framework, the meeting recommended that:

- Governments review patent legislation, and trade and investment policy, to ensure that it supports use of TRIPS flexibilities to access affordable medicines and diagnostics.
- Governments consider informing ministries responsible for negotiating trade and investment agreements about the impact of 'TRIPS Plus' clauses that restrict access to affordable medicines.
- Ministries of Health invest in strengthening procurement, quality control and supply chain systems for essential medicines.
- Ministries of Health consider scaling up the 'test and treat' approach, PrEP and HIV self-testing.
- Governments consider the recommendations of the UN Secretary General's High-Level Panel on Access to Medicines.

VI. Panel Session on legal and policy barriers

27. The meeting benefitied from a panel discussion including Ms. Loretta Lei Lai Peng, Head of Department of Prevention and Treatment of Problem Gambling and Drug Dependence, Social Welfare Bureau, Ministry of Social Welfare, Macao, China; Dr. Nick Dala, Executive Director, National AIDS Council Secretariat, Papua New Guinea; and Ms. Jannat Ali, Program Director, Sathi Foundation, Pakistan. The Session was chaired by Dr. Endang Budi Hastuti, National HIV/AIDS and Sexually-Transmitted Infection Programme Manager, Ministry of Health, Indonesia and moderated by Mr. Olivier Lermet, Senior Policy Advisor, United Nations Office on Drugs and Crime for Southeast Asia and the Pacific.

28. Panellists focused on the benefits to public health of implementing human rights-based approaches to HIV and AIDS that encouraged people, including adolescents, to present for testing early to ensure that people know their status, can access the information and tools required to prevent HIV transmission, and get treatment when required. Panellists shared experiences such as harm reduction measures including methadone maintenance therapy and needle and syringe programmes which had helped Macao, China to achieve zero new infections among people who inject drugs for the past three years; efforts of Papua New Guinea to reform laws inherited from the colonial era that criminalized sex between men and sex work, so as to create a more enabling legal environment for HIV services; and the lessons learned from Pakistan in introducing a law that gave legal recognition to transgender people and protected them from discrimination.

29. In the subsequent discussions, participants stressed that laws that treated people with dignity and respect enabled people-centred public

health approaches to be implemented. This rights-based approach was highlighted as being particularly important to reach stigmatized key populations. Participants explained that sensitizing political leaders and policy makers about the importance of reaching the most marginalized people in society facilitated progress towards the global targets for ending AIDS.

30. Participants exchanged experiences relating to introduction of harm reduction measures to prevent HIV among people who inject drugs. In countries where harm reduction programmes had been implemented at a larger scale, such as in Australia and Malaysia, they had led to sustained declines in HIV among people who inject drugs.

31. Changes in laws to legalize needle and syringe distribution were highlighted as being helpful in facilitating harm reduction for people who use drugs. The effective implementation of harm reduction approaches required Governments to take a pragmatic approach to ensure that enforcement of drug laws did not interfere with provision of health services. It further required a multisectoral approach engaging law enforcement bodies, health ministries and civil society.

32. High rates of stigma, discrimination and violence were deterring sex workers, men who have sex with men and transgender people from accessing health services. Participants emphasised that punitive laws could be harmful to public health if fear of arrest and imprisonment drove key populations away from health services. Removing criminal penalties relating to consensual sexual conduct between adults was highlighted as a means to facilitate reaching key populations at high risk of HIV with prevention, treatment and care services.

33. The meeting reflected on lessons learned from India about the public health benefits of the recent decriminalization of consensual adult same-sex sexual activity in that country. Participants applauded India's law reform efforts and suggested that they could provide a catalyst for change in other countries across the region.

34. Participants noted that in planning law and policy reforms, it was vital to bring key populations to the table, to enable their communication of the challenges faced by their communities and participate in decisions on laws and policies. For example, it was explained that a transgender woman participated in the national Country Coordinating Mechanism in Pakistan.

35. People living with HIV and the key populations at higher risk of HIV continued to experience high levels of stigma and discrimination across the region. Participants from the Australian Government shared their success in reducing HIV stigma and discrimination, which the Government viewed as an ongoing priority for the whole region. Laws that protected key

populations from discrimination by health services would encourage people to access those services.

36. Undocumented migrants were also identified as a group experiencing legal barriers that prevented access to HIV services and other health services.

37. Participants from Indonesia and Papua New Guinea highlighted the importance of engaging faith-based organizations when seeking support for removal of legal barriers faced by key populations.

38. In relation to this Pillar of the Regional Framework, the meeting recommended that:

- Governments reform laws that criminalize key populations, impose HIV-related travel restrictions and restrict adolescents from independently accessing health services.
- Governments enact legislation that prohibits discrimination and protects key populations from human rights violations.
- Governments encourage partnerships between health, justice, prisons and law enforcement authorities to ensure support for harm reduction services, treatment services and community-based HIV programmes.
- Governments encourage dialogue between the health, justice and public security ministries about the harms caused by punitive laws which hinder access to health services.

VII. Reflections and Next Steps

39. H.E. Mr. Mouly presented a statement, drafted on the basis of the day's proceedings, for presentation to the Fifth Session of the Committee on Social Development (annex I).

40. The Government of Australia requested that the meeting recognize the leadership role that ESCAP has played in ensuring that AIDS remains on the agenda of member States and requested that a new ESCAP Roadmap be developed to guide the AIDS response to 2030.

Annexes

Annex I: Outcome Statement of the Asia-Pacific Regional Expert Group Meeting on Reviewing Implementation of Commitments from the Asia-Pacific Intergovernmental Meeting on HIV AIDS Beyond 2015, 27 November 2018

AIDS is not over in Asia and the Pacific.

The review of the Regional Framework for Action on AIDS beyond 2015 conducted at the Expert General Meeting concluded that our work is far from done. Since 2015, countries have made substantial progress in expanding access to HIV treatment and prevention, but these gains are fragile.

As we plan for the next phase of the response, key ingredients of success will reinvigorate political leadership, allocation of resources to enable the scaling-up of innovative interventions including PrEP and HIV self-testing, a human rights-based approach and partnerships with civil society.

People must continue to be at the centre of our response, including the most marginalized key populations, because it is only by placing them at the centre of the response that we will succeed in ending AIDS by 2030.

In conclusion, the Expert Group Meeting recommends the following to the ESCAP Committee on Social Development:

- In 2019, ESCAP develops a new Roadmap for Action on HIV and AIDS in Asia and the Pacific for the period 2020 to 2030.
- In 2020, ESCAP reviews progress under the existing Regional Framework and adopts the new Roadmap for HIV and AIDS in Asia and the Pacific to 2030.

Annex II: Programme

Asia-Pacific Regional Expert Group Meeting on Reviewing Implementation of Commitments from the Asia-Pacific Intergovernmental Meeting on HIV AIDS Beyond 2015

27 November 2018	
09:00 – 10:00	**Opening** Welcome by Mr. Kaveh Zahedi, Deputy Executive Secretary, ESCAP Welcome by Ms. Karin Hulshof, Regional Director East Asia and the Pacific, UNICEF Opening remarks: • H.E. Mr. Ratu Epeli Nailatikau, Former President of Fiji and Chair of the Asia-Pacific Intergovernmental Meeting on HIV and AIDS beyond 2015 • H.E. Mr. Ieng Mouly, Senior Minister and Chair of the National AIDS Authority, Cambodia and Chair of the Asia-Pacific Regional Expert Group Meeting on Reviewing Implementation of Commitments from the Asia-Pacific Intergovernmental Meeting on HIV and AIDS Beyond 2015 • Ms. Ikka Noviyanti, Youth-Lead
10:00 – 11:15	**Panel Session on national HIV investment cases and sustainability plans** **Chair:** H.E Ieng Mouly, Senior Minister, Chair of National AIDS Authority, Cambodia **Moderator:** Mr. Eamonn Murphy, UNAIDS Regional Director, Asia Pacific **Panellists:** • Dr. Phan Thi Thu Huong, Deputy Director, Viet Nam Authority of HIV/AIDS Controller, Viet Nam • Dr. Hettiarachchige Suhashini Rasanja Perera De Silva, Deputy Director General Public Health Services a.i. and Director (Organization Development), Ministry of Health, Sri Lanka • Mr. Ronivin Pagtakhan, Executive Director, Love Yourself, Philippines Discussion
11:15 – 11:30	**Break**
11:30-12:45	**Panel Session on access to affordable medicines, diagnostics and vaccines** **Chair:** Dr. Muhammad Iqbal Hussain, Additional Secretary, Ministry of National Health Services and Regulations, Pakistan **Moderator:** Mr. Håkan Björkman, Executive Coordinator, Global Fund Partnership & Health Programme Implementation Support, UNDP **Panellists:** • Ms. Nur'Ain Shuhaila Bt Shohaimi, Deputy Director of Pharmacy Policy and Strategic Planning, Ministry of Health, Malaysia • Dr. Netnapis Suchonwanich, Adviser, Health Intervention and Technology Assessment Program (HITAP) Ministry of Public Health, Thailand • Mr. Jean-Michel Piedagnel, Head of Drugs for Neglected Diseases Initiative, South-East Asia Office

	Discussion
12:45 – 14:00	Lunch
14:00 – 15:15	**Panel Session on legal and policy barriers** **Chair:** Dr. Endang Budi Hastuti, National HIV/AIDS and Sexually-Transmitted Infection Programme Manager, Ministry of Health, Indonesia **Moderator:** Mr. Olivier Lermet, Senior Policy Advisor, United Nations Office on Drugs and Crime for Southeast Asia and the Pacific **Panellists:** • Ms. Loretta Lei Lai Peng, Head of Department of Prevention and Treatment of Problem Gambling and Drug Dependence, Social Welfare Bureau, Ministry of Social Welfare, Macao, China • Dr. Nick Dala, Executive Director, National AIDS Council Secretariat, Papua New Guinea • Ms. Jannat Ali, Program Director, Sathi Foundation, Pakistan Discussion
15:15 – 15:45	Break
15:45 – 16:45	**Reflections and Next Steps** Mr. Justin Francis Bionat, Youth Voices Count Statement on behalf of civil society Reading and accepting final statement for presentation to the Fifth Session of the ESCAP Committee on Social Development
16:45 – 17:00	**Closing**

Annex III: Opening remarks on behalf of United Nations Economic And Social Commsion For Asia Pacific by Mr. Kaveh Zahedi, Deputy Executive Secretary, UNESCAP

On behalf of the Executive Secretary of ESCAP, it gives me great pleasure to welcome you to this Expert Group Meeting on Reviewing Implementation of Commitments from the Asia-Pacific Intergovernmental Meeting on HIV and AIDS Beyond 2015, which is being organised as part of our ongoing Social Development Week.

HIV continues to be a major public health threat in our Asia-Pacific region. Over a quarter of a million people become infected with HIV each year. Key populations – men who have sex with men, transgender people, sex workers and people who inject drugs – are at particular risk.

Legal and policy barriers continue to deny individuals – particularly key populations – access to the means to protect themselves from HIV. Key populations are stigmatized and criminalized. In contexts where an atmosphere of discrimination and human rights violations prevail, they and their partners remain at risk from infection.

Many people continue to require essential medicines including lifesaving antiretroviral treatment. Funding for the AIDS response is flatlining and in some places declining. A shortfall in funding jeopardises our achievements thus far and risks an increase in the number of new cases of HIV.

On a more positive note, we have seen major progress. The hundreds of thousands of new cases in 2017 is a third of the infection rate seen in the early years of the epidemic.

Major legislative and judicial reforms in some countries have enabled those previously forced to live in fear of arrest or incarceration to enjoy the same rights and freedoms as everyone else. The overturning of the law criminalising consensual adult same-sex sexual activity in India, the passing of a transgender recognition law in Pakistan and the rollout of harm reduction programmes for people who inject drugs across the region are examples of change that we hope will be a continuing trend across the region.

Thanks to the use of flexibilities in international trade law and innovations in pharmaceutical manufacturing in the region, the treatment gap is shrinking and people living with HIV are accessing ARVs and can live healthy lives.

And more and more countries are using domestic resources up to fund their national AIDS programmes as foreign donors withdraw.

However, we must be clear about where we stand today. Despite the progress we have made, the region is off-track in meet the targets of 90 per cent of people living with HIV knowing their status; 90 per cent of those living with HIV who know their status being on antiretroviral treatment; and 90 per cent of them having a suppressed viral load by 2020.

Despite our efforts to end HIV many people are still being left behind.

Three years ago, Member States met to review their progress on ending HIV as a public health threat in the Asia-Pacific region at the Asia-Pacific Intergovernmental Meeting on HIV and AIDS Beyond 2015. They were clear-eyed about the prospects.

They recognised the progress that had been made, but they understood the challenges. They saw the looming funding transition that meant that AIDS programmes that had relied on external funding needed to move quickly to national support; they saw the need to build capacity to fully

implement the legal changes that protected key populations from discriminatory practices; and above all, they noted the continuing growth of HIV epidemics across the region.

At the close of the Meeting they adopted the Asia Pacific Regional Framework for Action on HIV and AIDS Beyond 2015. This framework for action was based on a broad consensus on the next steps to ending HIV. It highlighted the need to continue efforts to bring an end to stigmatization and discrimination faced by key populations; to undertake consultations to increase access to medicines, taking into account each country's circumstances; and to move towards sustainable national funding for AIDS programmes that focused resources where they were most needed.

Today we will address progress towards commitments made in 2015, and to look into how we can continue to accelerate progress to 2020. There is still time to turn things around. We know the best means to stem the increase in the number of cases. Repealing the laws that stigmatise and discriminate against key populations; targeting our prevention efforts towards these groups; and making use of the flexibilities afforded to us by international trade law to use generic antiretroviral treatments – all of these are possible within existing resources, and we will hear today from many countries in the region who have taken these steps and how they have benefited.

What is needed most of all is political will. To stand up and lead the fight against stigma and discrimination, to defend the rights of key populations; to work with civil society,; and to take the controversial choices that direct resources towards positive impacts, and are not driven by damaging and false stereotypes.

In short, we must take forward the message of the 2030 Agenda for Sustainable Development, and this Social Development Week – to end HIV, we must leave no one behind.

In the past, ESCAP has been the forum where Member States have expressed this will. In 2010, 2011, 2012 and 2015, through ground-breaking resolutions at ESCAP's Commissions and high-level meetings, Member States have reiterated their desire to take the necessary measures to end HIV through the ESCAP platform. In anticipation of the 2030 Agenda's focus, Member States here in ESCAP have led the world in prioritising reaching the furthest behind first, and in recognising that without empowerment of the most vulnerable we cannot hope to bring an end to the harms caused by HIV.

Leveraging ESCAP's normative and convening mandates, its inclusiveness, and our close relationship with civil society, we have built an effective and collaborative mechanism that has helped to catalyse the AIDS response in the region.

Working in effective partnership with UNAIDS, UNDP and UNODC, we have helped to keep the momentum alive at country level, working with Member States and civil society to implement the agreements reached through ESCAP, and then taking these achievements back up to the region for review, as we are doing today. As we look to reform of the development pillar, I believe that this serves as an example of how the UN system can work together effectively to link the national, regional and global levels of action.

As we look forward to 2020, I hope that ESCAP will continue to be a key partner in the crucial task of ending HIV as a public health threat in the Asia-Pacific region. Your outcome today will feed in to discussions taking place as part of ESCAP's Committee on Social Development and I hope they will go further to galvanising action at the national level, and new successes in reaching the goals we have set ourselves.

I wish you all a successful and fruitful day of discussions, and look forward to reviewing the outcome of this meeting.

Annex IV: Opening remarks on behalf of UNAIDS co-sponsors

Ms. Karin Hulshof, Regional Director East Asia and the Pacific, UNICEF on behalf of the Co-sponsors of UNAIDS (UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO, World Bank)

It is my pleasure today to speak on behalf of the UN cosponsoring organisations that make up the Joint United Nations programme on HIV and AIDS (otherwise known as UNAIDS). Let me first thank Mr Eamonn Murphy, Regional Director of UNAIDS Asia Pacific, for offering me this opportunity to welcome you to this very important regional expert group meeting today.

Since the first cases of HIV were reported more than 35 years ago, 78 million people have become infected with HIV and 35 million have died from AIDS-related illnesses.

For almost three decades the UN has been at the forefront of the response to AIDS epidemic. The 11 cosponsoring agencies that form UNAIDS - UNHCR, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO, World Bank and UNICEF - joined forces with governments, bilateral and multi-lateral agencies, the private sector and civil society and have made huge strides towards strengthening and sustaining political commitment towards 2020 Fast Track targets and ending AIDS by 2030.

The UNAIDS family has been, from its inception, a model for United Nations reform. The UNAIDS Secretariat and eleven Cosponsoring agencies work together to deliver results articulated in our Unified Budgetary Results and Accountability Framework. UNAIDS is the only United Nations entity with civil society represented on its governing body.

Crucially, UNAIDS is a problem-solver. It places people living with HIV and people affected by the virus at the decision-making table and at the centre of designing, delivering and monitoring the AIDS response. It charts paths for countries and communities to get on the Fast-Track to ending AIDS. It is a bold advocate for addressing the legal and policy barriers to the AIDS response.

I would like to talk for a few moments about where we are in the AIDS response. Let me start by saying AIDS is not over.

While new HIV infections are declining globally and regionally, the pace of decline is not fast enough. In the Asia-Pacific region, new HIV infections declined by only 14% between 2010 and 2017. Globally we have seen a decline of 18% since 2010.

At this current pace of decline, the region will not reach its Fast-Track target of 90,000 new HIV infections by 2020. We will fall short of the regional target by 170,000 new HIV infections. We need to do more and do it more efficiently.

There is progress is some areas and Asia-Pacific has contributed to some impressive successes. For example, we have seen tremendous progress in eliminating mother-to-child transmission of HIV the region. Both Thailand and Malaysia have been validated for achieving EMTCT and almost all countries have committed to EMTCT in the Asia-Pacific region by 2030.

However, we are seeing an upward trend in new HIV infections - a second wave epidemic - in the region. Rates of new infections are on the rise in Bangladesh, Malaysia, Pakistan and Papua New Guinea. The Philippines has the fastest growing epidemic in the region with a 174% increase in new infections between 2010 and 2017.

And worryingly, this re-emerging epidemic is disproportionately affecting adolescent and young people in the region. In 2017, in Myanmar, young people between the ages of 15 – 24 years accounted for 55% of all new HIV infections. In Indonesia they accounted for 52% of new infections. And in the Philippines, 69%.

Inadequate availability and access to adolescent-friendly HIV and sexual and reproductive health information and services, along with challenges related to poverty, legal and cultural barriers, have significant adverse impact on the lives of adolescents and young people. Evidence shows that those young key populations who are most at risk of HIV infection also have the lowest levels of access to HIV prevention, testing and treatment programmes.

Collectively key populations of all ages (including men who have sex with men, sex workers, people who use drugs, transgender people and clients of sex workers and their partners) account for 84% of new infections in the region. And while Malaysia successfully decreased new infections amongst people who use drugs, they are seeing a rapid increase amongst men who have sex with men. In fact, close to 30% of all new infections in the region are amongst men who have sex with men. This is in part because they lack access to the services and the means to protect themselves and their partners and in part due to punitive laws and criminalized legal environments.

It is clear – AIDS is not over.

Going forward, the region must maximise a focused response on those populations and locations where the epidemic is expanding, while maintaining and intensifying efforts in those areas where infections rates have declined.

Now more than ever, a multi-sectoral response is required to address the multiple vulnerabilities relating to HIV. We must continue to focus on ensuring that everyone has access to the health care services where, when and how they need them. This involves access to HIV testing, to treatment, and to the means to prevent future infection including through access to condoms and to Pre-Exposure Prophylaxis (PrEP). We need to ensure that these services and medicines are sustainably financed and that the legal environment facilitates rather than inhibits access to what is needed – this includes providing mental health services for young people and eliminating the punitive laws that marginalise and exclude those in need of support.

As we move towards building up Universal Health Coverage (UHC) we must continue to focus on providing services for Health – including HIV services.

Guaranteeing access to HIV services will be a critical element of achieving the UHC goals. HIV services including - but not limited to - testing, antiretroviral treatment, access to the means of prevention are essential requirements of a robust system for health and must be part of health benefits packages and available to all.

Where appropriate, integrating HIV services with services for tuberculosis, Hepatitis, and reproductive health not only provides efficiency gains but more importantly creates services that are centered on the person.

Beyond the health system, removing gender and human rights-related barriers, and strengthening community action on health, is critical to improving access to health services for vulnerable and excluded populations. We have good examples of this in the region. Thailand, for example, provides national health insurance to documented migrant workers and is trying to extend those services to undocumented workers. And, later today, we will be hearing about Viet Nam's efforts to scale up health insurance while maintaining quality services for all.

In this climate of shrinking resources, we cannot afford to be complacent. Improved rates of donor expenditure and increases in domestic investments have led to an overall increase in global AIDS spending in 2017. However, annual investments had flatlined for the previous four years between 2012 and 2016.

The balance of AIDS contributions is shifting. While financial resources from international resources are shrinking, AIDS spending from domestic resources have doubled over the past decade. Countries in Asia and the Pacific continue to increase their share of investment in the AIDS response. We greatly applaud the member states represented here for your political commitment and leadership.

Despite this investment, however, there is a significant resource gap - a USD 1.2 billion short fall of the total USD 4.9 billion needed to fast track the response to meet the 2020 targets. Even small donor cuts have big consequences. And in our region in particular we are seeing a retrenchment from some of our most significant donors. We must be looking towards alternative financial sources and to ensuring programme efficiencies.

It is in this climate that we will need to be mindful of the economics of prevention. We have good examples in the region of countries such as in Cambodia, Malaysia, Thailand where Ministries of Health have worked with Ministries of Finance and Planning to build in the HIV and broader health response into the nation's future planning. I look forward to hearing more about Cambodia's financial roadmap during the day.

And finally, as I come to the close of my presentation, I want to remind all of us why we are here today.
The Fast Track targets that Member States in the Asia Pacific region committed to achieve are only 2 years away. At the current trajectory we will fail. We encourage Member States, bilateral and multi-lateral cooperation agencies, private sector and civil society to:

- Re-commit and strengthen political commitment to secure financial and human resources to accelerate the prevention, treatment and care response.
- Continue building on a multi-sectoral integrated approach to HIV and associated comorbidities and co-infections including tuberculosis, Syphilis, Hepatitis B by breaking down silos and opening up under-utilized opportunities to improve health outcomes within the framework of universal health coverage.
- Create enabling environments through affirmative and empowering education, social protection programmes including removal of discriminatory laws, policies and practices. This includes increasing access to healthcare services for vulnerable populations such as migrants, refugees, indigenous people and racial minorities.
- Increase investments in healthcare workers to ensure they can provide quality and person-centered care and to advocate for UHC and health systems strengthening to increase access to comprehensive HIV and other health services for all.
- Finally, communities must be adequately resourced, supported and sustained in all country contexts

Excellencies, Distinguished Delegates, Ladies and Gentlemen, Let me remind you one final time that there is no space for complacency. AIDS is not over. I wish you all the success in your discussion today and look forward to hearing the outcome.

Annex V: Opening remarks, outgoing Chair

H.E. Ratu Epeli Nailatikau, Former President of Fiji and Chair of the Asia-Pacific Intergovernmental Meeting on HIV and AIDS beyond 2015

Excellencies, Distinguished Delegates, Ladies and Gentlemen. Ni Sa Bula Vinaka and welcome to each of you here this morning.

At the outset I wish to express my gratitude to ESCAP for convening today's important meeting to review progress of the Regional Framework for Action on HIV and AIDS beyond 2015.

The Asia-Pacific Intergovernmental Meeting on HIV and AIDS held in this building in 2015 was a landmark event in the regional response. It was an honour and privilege to Chair that meeting and I am very grateful to participate again in today's meeting.

I am keenly looking forward to hearing from the experts who are here with us today to share the lessons learned over the last three years under each of the Three Pillars of the Regional Framework– Pillar 1 on legal and policy barriers, Pillar 2 on access to treatments, diagnostics and vaccines; and Pillar 3 on investment cases and sustainability plans.

The world is constantly changing. In the time since governments and civil society convened in Bangkok for the 2015 meeting, there have been significant developments in science and global health policy that we now need to consider in assessing our progress under the Regional Framework.

Advances in medical science mean that the links between HIV treatment and HIV prevention, and the concept of 'treatment as prevention', are much better understood now than they were three years ago. The science of 'treatment as prevention' informed the 90-90-90 fast track targets that were set at the 2016 UN General Assembly Special Session on AIDS, and gave governments a firm basis on which to set the ambitious goal that governments committed to in 2016, the goal of ending AIDS by 2030.

Asia and the Pacific have made good progress in their AIDS responses since 2015. More people have access to HIV testing and treatment than they did three years ago. Mother-to-child transmission continues to decline. Some countries have introduced pre-exposure prophylaxis, a powerful new prevention tool that uses antiretroviral drugs to prevent HIV transmission among high risk populations.

But progress is fragile and uneven. Some populations continue to be left further and further behind, particularly those who are recognized to be the key populations at greatest risk of HIV. This includes: sex workers, people who use drugs, men who have sex with men and transgender people. As a result, some of these communities have seen new outbreaks in the time since 2015 and HIV diagnoses have rapidly increased. For example, there are now rising epidemics among key populations in the Philippines, Pakistan, Malaysia, Bangladesh and Papua New Guinea.
Prevention is the key to breaking the cycle of HIV transmission. A sharpened focus on human rights and key populations is essential. We must empower young people to protect themselves from HIV. This includes providing harm reduction for people who use drugs, and access to antiretroviral treatment for young people living with HIV.

Greater leadership and investment must follow suit to remove the social and political barriers that keep many beyond the reach of services.

The challenge for us now is to expand further the coverage of testing and treatment services so that the 2030 goals can be realised. This means reflecting on the barriers that prevent access to health

services, including the financial, legal, human rights and policy barriers. It means continuing to battle the stigma that alienates many marginalized people from the health services they need.

We also need to ensure that we understand what is required to sustain political will. In 2015, we heard from many delegations about the importance of focusing attention on programmes directed at key populations. Clarity of focus on services that reach these populations at greatest risk will remain key as we plan for the future. These populations are often demonized and targeted as scapegoats for societies' problems. It will require political courage to ensure the needs and rights of the marginalized are kept front of mind.

The Sustainable Development Goals provide an opportunity, but also a challenge, for the AIDS response. The 2030 Agenda for Sustainable Development calls for an integrated approach to development challenges. The SDGs underscore the need for a whole of government approach that recognizes that AIDS is more than a health issue. The goals draw our attention to the links between health, gender equality, education, decent work, peace, justice and building resilient societies. They emphasize the importance of multisectoral, rights-based, people-centred approaches that address the determinants of health and well-being.

In the health sector, HIV is increasingly addressed in an integrated way alongside a wide range of other conditions. Our efforts to end HIV are connected to other areas, such as tuberculosis, hepatitis, access to medicines, and the increasing threat of anti-microbial resistance. Success will require us to strengthen links across these areas and build resilient and sustainable systems for health, underpinned by principles of human rights and equity. Countries are accelerating their plans for universal health coverage. If managed well, this integrated approach could bring great benefits for HIV responses as they become sustainable within domestic systems for health.

However, this integrated approach poses a potential challenge to AIDS the response. We must maintain our momentum. We need to be vigilant and ensure that the clarity of focus and dedicated effort we have applied to AIDS in the past is not lost. We cannot afford for this to happen at a time when HIV budgets are under pressure from competing health priorities and donors are withdrawing aid to middle-income countries. There is a lot at stake, as I am sure we all agree.

In 2018 we know how to prevent HIV, how to treat it, and to suppress the virus to prevent onward transmission. This knowledge holds the key to ending AIDS by 2030. After we have come so far, we must not lose ground.

In this context I am very grateful for ESCAP for keeping AIDS high on its agenda these past three years. It is now time for all of us to review our work under the Regional Framework, understand our successes and failures, and plan ahead in anticipation of developing a new Roadmap to guide our work when the current Regional Framework concludes in 2020.

HIV MUST remain on our regional agenda through the good work of ESCAP.

I am confident that with the benefit of our collective experiences across this vast region - and under the leadership of a new Chair - we can meet these challenges together.

In this context I will now formally step down as Chair and ask that ESCAP propose a Chair to continue this process to 2020 and beyond.

Annex VI: Opening remarks, incoming Chair

H.E. Mr Ieng Mouly, Senior Minister and Chair of the National AIDS Authority, Cambodia; Chair of the Asia-Pacific Regional Expert Group Meeting on Reviewing Implementation of Commitments from the Asia-Pacific Intergovernmental Meeting on HIV and AIDS Beyond 2015

It is my great pleasure to be here today as the Chair of this mid-term review of progress in implementing the commitments made at the 2015 Asia-Pacific Intergovenmental Meeting on HIV and AIDS Beyond 2015. I offer my sincere thanks to Ratu Epeli Nailatikau, former President of Fiji and Chair of that 2015 event, for his commitment in bringing the Framework for Action developed at the 2015 Intergovernemental meeting to this mid-point review.

The objectives of today's Expert Group Review are to provide all our countries with the opportunity to take stock of our progress, but also to reflect on the challenges that we have encountered in addressing the three pillars of the 2015 Framework of Action on HIV and AIDS Beyond 2015:

- access to affordable medicines, diagnostics and vaccines;
- legal and policy barriers; and
- development of evidence-informed HIV investments cases and sustainability plans

Ladies and Gentlemen, As the Deputy Executive Secretary of ESCAP, Mr. Kaveh Zahedi, so correctly stated, we are at a turning point for ending HIV as a public health threat in the Asia-Pacific region. If we recommit, we still have a chance to meet the goals we have set ourselves:

- 90 per cent of people living with HIV knowing their status;
- 90 per cent of them receiving antiretroviral treatment; and
- 90 per cent of people on treatment achieving viral suppression.

However, if we lose our focus we risk the epidemic once again gaining a foothold, and the number of new cases of HIV rising once more.

Excellencies, Ladies and Gentlemen - I am encouraged by your presence here today as this shows your continuing commitment and the importance you attach to understanding what has been done, learning from each other, and committing to the cause of ending HIV.

I look forward, with great interest, to hearing your views on the success stories concerning our HIV responses around the region, but also the challenges that remain. A frank discussion of these issues can only help our efforts to build consensus, to address our challenges, but will also to help us identify and seize the opportunities that lie ahead so that we can accelerate progress in responding to HIV in Asia and the Pacific.

It is now my pleasure to invite Ms. Ikka Noviyanti to speak on behalf of civil society. Ms. Noviyanti is 21 years old and learned that she was living with HIV while attending university. As a result of her positive HIV test result, she was expelled from school and joined a network of sex workers in Jakarta, learning community organisation and activism skills. Ikka is currently working with Indonesia's National Sex Worker Organisation – OPSI, is on the Board of Fokus Muda (a young key population organisation), and has been instrumental in the development of the female sex worker training module under Indonesia's Global Fund Grant.

Annex VII: Opening remarks on behalf of civil society

Ms. Ikka Noviyanti Youth LEAD, The Regional Network of Young Key Populations in Asia and Pacific

My name is Ikka Noviyanti. I was born and raised in Indonesia- a country diverse in people, culture and language, with over 17,000 islands. I am 25 years old and I am a young sex worker living with HIV. I was diagnosed with HIV in 2013. These past five years, I have been able to walk against the tides of the epidemic because I received treatment on time, correct information, support from my peers, and capacity development training, among others. On the other hand, I have also faced challenges and harsh realities of living with HIV and as a young sex worker.

Today, I'm standing here to speak to you all on both the key challenges and solutions, as I represent the communities and civil societies from Asia and the Pacific.

Mr Chair I have four key issues to present today.

Firstly, human rights violations and discrimination are rampant. Criminalization of people who use drugs, sex workers, men who have sex with men, and transgender people, has been the greatest barrier in accessing services by key populations, including among women, young people and migrants. Unfortunately, our region has seen little to no progress since the adoption of the Regional Framework in 2015.

Today we still see extrajudicial killings, unlawful prosecutions, police harassment, corrective rape, lynching of LGBTQ persons, abuse and brutality of minority groups that are justified by morality based on the regressive laws and policies. This has to stop. This has to stop now. These policies and human rights violations are not only a great threat to the HIV response, but undermines all our basic human rights principles.

Secondly, our region has made significant progress towards domestic investment for the HIV response. However, despite domestic spending for HIV, key population programmes and community-led interventions have not received equal attention. The exclusion of key populations in programmes in national budget priorities and the reduction of donor support pose a serious threat to the sustainability of community-led interventions that are effective in reaching key populations.

Thirdly, trade agreements continue to threaten the access by many countries in our region to generic production of ARVs, a life saving medicine. We need to unite and stand strong to make sure that Intellectual Property Rights laws are flexible and patient friendly, not just industrial friendly. In addition, the governments and service providers need to step up and promote medicines like PrEp, which has been proven |successful| on HIV prevention. The new HIV regimes such as, Dolutegravir and Tenofovir Alafenamide Fumarate (TAF) with low side effects and increased adherence should be made available and affordable for the PLHIV.

Fourthly, we take note of the vibrant engagement of communities and civil society in the HIV response. However, we are alarmed at emerging trends to restrict community and civil society organizations to register, operate, and receive funding. The issue of shrinking democratic space is of great concern, not just at the country level, but even in regional and global intergovernmental platforms such as UN ESCAP.

Mr Chair, in light of these challenges and barriers, we do have concrete proposals and solutions to present. I urge member states to:

- Ensure that laws and policies reflect our basic human right principles. Enact laws that are not punitive, but instead protect and respect our communities.
- Ensure domestic financing for community-led programs, including HIV prevention among key populations. The transition plans should meaningfully engage key populations and people living with HIV.
- Use flexibilities provided in the TRIPS agreement such as compulsory licensing on expensive patented drugs so that generic production is not affected and thereby ensures medicines are at low cost and accessible.
- Repeal laws and policies that restrict the existence and engagement of communities and civil society, including in the HIV response.
- Create enabling environments where each key populations and people living with HIV can live their lives to the fullest.

Lastly, I would like to echo a statement that I heard recently - "People living with HIV and Key Populations have always been central to the HIV response. HIV has brought us together to organize around health for our communities - based on the love we have for each other."

AIDS is not over in the Asia-Pacific region. There is no room for complacency. We must act now!

Annex VIII: Executive summary of community and civil society inputs

This section summarizes community and civil society inputs to the review of progress under each Pillar of the Regional Framework for Action on HIV and AIDS. It summarizes responses to a survey distributed to community and civil society organizations in October 2018, and submissions provided by regional networks to the Coalition of Asia-Pacific Regional Networks on HIV/AIDS (7 Sisters) in November 2018.

Roadmap to 2030

The Economic and Social Commission for Asia and the Pacific (ESCAP) should define a new Roadmap for the next decade with a greater focus on action, not just consultations and reviews.

The new Roadmap to 2030 should focus on specific priorities essential to ending AIDS by 2030 (e.g., scaling up 'treatment as prevention' and PrEP approaches), commit to human rights protection for key populations as a cross-cutting theme for all Pillars, ensure that the 95-95-95 targets are met, allocate sufficient and sustainable domestic resources, and include a Pillar on community and civil society participation and engagement.

A forward-looking and action-oriented Roadmap for the future of the region's HIV/AIDS response is essential for achievement of the interlinked Sustainable Development Goals in Asia and the Pacific. The Roadmap should align and coordinate with broader efforts in support of the 2030 Agenda for Sustainable Development to ensure that HIV/AIDS remains a key priority for the region.

IMMEDIATE PRIORITIES

Pillar 1: Legal and policy barriers faced by key populations

- An end to brutal police crackdowns and extrajudicial killings of key populations.
- Accelerated efforts to decriminalize key populations and enact and enforce laws that protect key populations from violence and discrimination.

Pillar 2: Access to medicines, diagnostics and vaccines

- Universal implementation of the 'test and treat' approach which provides treatment to people with HIV upon diagnosis, regardless of CD4 count.
- Provision of PrEP at scale for key populations.
- Ensure governments support access to generic medicines through the use of TRIPS flexibilities and that trade agreements do not include TRIPS-plus provisions.

Pillar 3: Financing and sustainability

- Transition planning must recognize the imperative to ensure sustainable funding of community organizations to deliver HIV services to key populations. Failure to place key populations at the centre of transition and sustainability planning will result in failed HIV responses.

KEY FINDINGS

Pillar 1: Legal and policy barriers faced by key populations

There has been patchy progress in improving the legal and human rights situation of key populations.

Most respondents confirmed only slight improvements in addressing legal and policy barriers.

There is political resistance to removal of harsh criminal penalties for drug use and sex work. Enforcement of drug laws is highly punitive. Extrajudicial killings are reported from Bangladesh and the Philippines. This 'war on drugs' approach is ineffective in preventing drug use, compounds HIV vulnerability of marginalized communities and is associated with gross human rights violations.

In most countries, transgender people cannot obtain identification documents that reflect their gender identity. Transgender people's dignity, equality, privacy and security are compromised because their gender identity and expression are not recognized through legal and administrative processes.

Many countries criminalize transgender people's gender expression, either through criminalizing 'cross-dressing' or by enforcement of other penal provisions relating to immorality, public indecency, vagrancy and loitering. Other forms of criminalization that marginalize transgender people include the criminalization of sex work, same-sex sexual activity, and begging.

There has been a lack of progress in removing HIV-related travel restrictions, in part due to the negative narrative migration has taken.

Many countries have laws that prevent adolescents from independently accessing HIV testing, condoms, harm reduction services, and other health services.

However, there were also some important examples of legal and policy progress since 2015:

- The new Philippine AIDS Act was passed in 2018 to overhaul the legal framework on HIV, expanding human rights protection for people living with HIV, providing key populations access to redress mechanisms, and removing legal barriers to HIV services for young people.
- India also passed a comprehensive law prohibiting HIV-related discrimination. This law came into force in 2018, and a redress mechanism has also been established to assist enforcement.
- Homosexuality was decriminalized in India as a result of a Supreme Court ruling in 2018.
- Laws protecting the rights of transgender persons were passed in India (2016) and Pakistan (2018), and Nepal's 2015 Constitution recognizes the rights of gender and sexual minorities.
- In parts of this region, there has been some significant progress in guaranteeing the right to legal gender recognition, including through Supreme Court decisions in India and Nepal. Supreme Court judgments or cabinet decisions in Bangladesh, India, Nepal and Pakistan recognize third gender status. A new Civil Code gave transgender people the right to register their change of gender in Viet Nam in 2017.
- There is progress in removing legal barriers to harm reduction services in India and Myanmar. Myanmar's drug law was updated in 2017 to end mandatory registration of people who use drugs and introduce diversion to treatment services. Myanmar also drafted an AIDS Bill prohibiting discrimination.

Recommendations

- *Criminal penalties relating to homosexual conduct, sex work and drug use should be abolished. Law enforcement should focus on protecting key populations against violence, exploitation and discrimination. Governments should recognize and address the severe negative health and human rights impacts of criminalizing sex work, same-sex sexual activity, drug use, irregular migration and begging.*
- *Governments should ensure laws are enacted to protect and promote the personal security and rights of people living with HIV, key populations and vulnerable groups, including those not recognized as citizens and with sensitive social status such as migrants, refugees and stateless people, especially their access to basic services, social welfare, and employment, and to prohibit any form of*

discrimination. Legal redress mechanisms should be put in place and made accessible in cases of violations of personal security and any kind of discrimination.

- *Police and other law enforcement agencies should partner with health authorities to support provision of health services to key populations, including through peer-based outreach. Enforcement of criminal laws relating to sexuality, drug use and sex work should not drive key populations away from health services.*
- *Governments should abandon the 'war on drugs' approach and instead apply human rights, public health and harm reduction principles to drug control efforts.*
- *Governments should close compulsory drug detention centres and implement voluntary, evidence-informed and rights-based health and social services for people who use drugs in the community.*
- *Governments should promote alternatives to conviction and punishment for drug use and drug possession offences, including diversion to treatment in the community.*
- *Governments should ensure that transgender people are protected under human rights and anti-discrimination provisions of the constitution and relevant laws. Gender, gender identity and gender expression should be prohibited grounds for discrimination. Definitions in laws and policies of terms such as 'gender', 'gender identity', 'gender expression', 'transgender' should be inclusive of diverse genders, gender identities and expressions, and based on self-determination.*
- *Governments should guarantee legal recognition of gender identity based on self-determination.*
- *Governments should harmonize non-discriminatory national HIV policies with immigration policies to ensure that non-citizens have the right to remain and have full access to HIV services and treatment.*
- *Laws and policies should recognize the evolving capacity of children and adolescents to understand and independently consent to harm reduction, HIV and sexual health services. Governments should ensure that sexual and reproductive health services especially HIV testing, counselling, treatment and care are youth-friendly, accessible and affordable for young key populations.*
- *Governments should reform immigration policies that discriminate based on HIV status among migrants, refugees and non-citizens to enable access to treatment and services.*

Pillar 2: Access to medicines, diagnostics and vaccines

Although governments have committed on paper to the 90-90-90 targets, most respondents reported that access to medicines and diagnostics had either only slightly improved or not improved at all. Examples of progress since 2015 in expanding access included:

Several countries reported that access to HIV medicines is being considered in the context of their government's commitment to Universal Health Coverage (UHC). Bhutan, Thailand and India have taken important steps towards inclusion of HIV in UHC, while others are in the planning stage (e.g. Myanmar).

Least Developed Countries are now able to take advantage of the extended World Trade Organization transition period for introducing pharmaceutical patents (January 2033). This will allow ongoing access to affordable generic HIV medicines in these countries during the transition period.

Government funding of antiretroviral therapy (ART) has supported expanded access to medicines in Myanmar.

From 2018, India is providing free HIV viral load testing and expanded government-funded health insurance for all poor families.

There is also expanded access to hepatitis medicines in some countries (e.g. India and Myanmar).

PrEP is a new and highly cost-effective HIV prevention tool that was not available in 2015. Evidence confirms that PrEP has the potential to revolutionize HIV prevention among key populations. When

PrEP is implemented at scale, it contributes to substantial reductions in HIV transmission at a population level. PrEP is already available in Thailand, but elsewhere most governments have not yet included it in their national HIV plans and programmes. In Australia, PrEP has been subsidized by government and is universally accessible.

Recognizing the importance of ensuring treatment for co-infections, in 2017 the government of Malaysia issued the world's first compulsory license on a treatment for hepatitis C virus, sofosbuvir.

Recommendations

- *A commitment to implement scaled-up PrEP programmes targeted at key populations should be given a high priority in national HIV/AIDS strategies as an essential addition to the HIV prevention package. Antiretroviral drugs (Truvada or generic equivalents) should be approved for use as PrEP within national health insurance schemes.*
- *Governments should support community-based HIV testing and treatment delivery models to ensure greater coverage of key populations and hard to reach vulnerable groups so that countries can meet their 90-90-90 and 95-95-95 targets.*
- *National HIV/AIDS strategies should implement WHO recommendations on PrEP and linking people diagnosed with HIV to treatment regardless of CD4 count. HIV testing and treatment should be included in Universal Health Coverage programmes that mobilize new health funding from domestic sources.*
- *Governments should amend their patent laws to ensure inclusion of the full range of TRIPS flexibilities including rigorous patentability criteria, preventing evergreening, and patent oppositions by public interest groups including people living with HIV, easy to use compulsory license provisions and parallel and personal import of medicines. In particular, LDCs in the region should urgently adopt (through law or government order) the pharmaceutical transition period of 2033.*
- *Governments must commit to using these TRIPS flexibilities to ensure access to generic versions of current and new treatment for HIV, Hepatitis C and Tuberculosis for adult and paediatric treatment, including ARVs, Directly Acting Antivirals (DAAs) and MDR-TB medicines recognizing that generic competition often enables drastic price reductions, improves availability for current and new diagnostics, treatment and vaccines and contributes to financial sustainability of treatment programmes i.e. Pillar 3.*
- *Governments must reject all TRIPS-plus demands in ongoing free trade agreement (FTA) negotiations including in the ongoing Regional Comprehensive Economic Partnership (RCEP) Agreement negotiations as well as those with developing countries like the European Union. These TRIPS-plus demands hamper the ability of countries to use TRIPS flexibilities and should be rejected to ensure government commitments under SDG Goal 3b, the 90-90-90 targets and regional and international commitments on HIV and AIDS.*
- *Ensure that laws and policies focus on eliminating discrimination and violence against key populations in health care settings.*
- *Develop national clinical guidelines for gender-affirming health services building on international guidance from the World Professional Association for Transgender Health and the World Health Organization, and the Asia Pacific Trans Health Blueprint.*

Pillar 3: Financing and sustainability

Transitioning to domestic financing of national HIV responses poses a threat to programmes for key populations, which continue to rely heavily on external support from international donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Most respondents reported some improvements in financial sustainability since 2015. However, there is very slow progress in the transition to domestic financing.

In some countries the government is contributing more from domestic budgets to cover treatment costs. However, governments are less willing to use domestic budgets for work with key

populations or to fund community organizations or civil society organizations perceived as controversial.

Recommendations

- *Governments must increase public spending for their HIV, tuberculosis and hepatitis responses. This includes ensuring sufficient investment in services for key populations and human rights programmes for law reform and access to justice. Governments should also use all legal and policy tools at their disposal (including TRIPS flexibilities mentioned in Pillar 2) to decrease costs of medicines and diagnostics.*
- *Governments should provide civil society organizations and key population networks access to domestic funding for outreach activities, community mobilization, advocacy, stigma and discrimination reduction and prevention activities and core operational costs.*
- *Government should commit to fund innovative HIV prevention approaches under national HIV/AIDS strategies including pre-exposure prophylaxis (PrEP), HIV self-testing and voluntary partner notification. A high priority should be given to scaling up PrEP among key populations at high or medium risk of HIV given the significant savings to health budgets of this intervention.*
- *Governments should involve representatives of key populations in planning for transition from external to domestic funding of HIV. Governments need to plan for domestically financed programmes that reach key populations to ensure these populations have ongoing access to health services and protection of their human rights when donor support ends. Government should also ensure that there are existing legal mechanisms to allow for the transfer of public funds to CSOs that implement interventions for various health responses, including HIV.*
- *Governments should ensure that the integration of HIV services into their universal health coverage frameworks is inclusive of key populations and should not lead to the defunding of community-led interventions.*
- *Planning of HIV services should be based on reliable data. Few countries collect reliable data on young key populations and transgender people. This results in lack of dedicated funding for HIV services targeting these populations and failure to include them in policy and planning discussions at the national level. Governments and development partners should disaggregate data based on sex, gender and age and make it available for national policy and planning processes. Both countries of origin and destination should recognize migrants or those who have returned from migration and are living with HIV and include them in HIV services planning at the national and local levels.*

Community engagement and gender

Over 2/3 of respondents reported some improvements to community engagement, gender responsiveness and gender inclusivity since 2015. However, most respondents reported only slight improvements.

Recommendations

- *Key populations should be meaningfully engaged in health governance. Governments should observe the following elements for meaningful community engagement:*
- *Representation of key populations and vulnerable groups in the bodies responsible for planning, implementing and evaluating HIV/AIDS responses;*
- *Transparency in decision making processes and implementation of national HIV/AIDS strategies including creating accountability mechanisms that enable representatives of key populations to provide feedback on national programme areas that impact on effective programme implementation.*
- *Young people from key populations should be provided with enabling platforms so that they can engage meaningfully in national HIV responses.*
- *Returned migrants and their communities affected by HIV also need representation in National planning in countries of origin especially when they comprise a significant percentage of the population living with HIV.*

- *Governments should support organizations of sex workers, people who use drugs, gay men, MSM, transgender people and migrants to mobilize their communities to implement peer-led HIV prevention, treatment, legal protection and community empowerment measures.*
- *Governments should promote and protect the freedom of association of sex workers, people who use drugs, gay men, MSM, transgender people and migrants, and ensure laws and polices do not infringe the rights of community-based organizations representing these populations to register and operate under national laws.*
- *Governments should ensure gender responsive planning and budgeting approaches are applied in HIV programming.*
- *National strategies on HIV and national strategies on violence and discrimination against women should be linked, so that the vulnerabilities of marginalized women (including sex workers, women who use drugs, transgender women, migrant women and key populations and their intimate partners) to gender-based violence and HIV are understood and addressed.*

Community and civil society inputs to the survey on review of progress

Substantive civil society and community inputs were received from the following:

Regional organizations:
Asia-Pacific Network of People Living with HIV/AIDS (APN+); International Drug Policy Consortium (IDPC); APCASO; Asia Pacific Transgender Network (APTN); APCOM Foundation, Youth LEAD; Youth Voices Count; CARAM Asia; Coalition of Asia Pacific Regional Networks on HIV/AIDS (7 Sisters)

Australia	Australian Federation of AIDS Organisations (AFAO); Family Planning NSW (FPNSW)
Bangladesh	IDPC
Bhutan	Lhak-Sam (BNP+)
Cambodia	HIV/AIDS Coordinating Committee of Cambodian NGOs (HACC); Khmer HIV/AIDS NGO Alliance (KHANA); IDPC
Fiji	UNAIDS Youth Alliance for Sexual and Reproductive Health Rights
India	Swasti; Indian Drug Users Forum
Indonesia	ACASO; Youth LEAD; APTN
Malaysia	Malaysian AIDS Council; APTN
Marshall Islands	Gay community member
Myanmar	Myanmar Positive Group; Radanar Ayar Association; Drug Policy Advocacy Group; PLHIV community member; Burnet Institute Myanmar
Nepal	Blue Diamond Society; Suruwat; Youth LEAD; APTN
Papua New Guinea	Kapul Champions
Pakistan	Association of People Living with HIV Pakistan; Youth Association for Development; Humraz Male Health Society
Philippines	Association of Transgender Men of the Philippines; Youth Voices Count Philippines; International Community of Women Living with HIV (ICWAP); National Council of Churches in the Philippines; IDPC; APCASO
Singapore	APTN; Gay PLHIV community, Singapore
Thailand	Youth LEAD; Planned Parenthood Association; MAP Foundation
Viet Nam	APTN; LGBT community member

Annex IX: Participants list

AFGHANISTAN

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AUSTRALIA

Mr. Paul Stephens, Deputy Head of Mission and Permanent Representative to ESCAP, Australian Embassy, Bangkok

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Mr. Md Hafizur Rahman Chowdhury, Deputy Secretary, Health Services Division, Ministry of Health and Family Welfare, Dhaka

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H.E. Mr. Ieng Mouly, Senior Minister and Chair of the National AIDS Authority, Phnom Penh

H.E. Khindareth Chhim, Deputy Secretary General, National AIDS Authority, Phnom Penh

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