REFERENCE

Legal and policy trends

Impacting people living with HIV and key populations in Asia and the Pacific 2014–2019

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2014–2019

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Foreword

In 2015, 193 United Nations Member States agreed on the 2030 Agenda for Sustainable Development. This included a goal of ending the AIDS epidemic by 2030 and leaving no one behind through a multisectoral, rights-based, people-centred approach that addresses the determinants of health.

Despite these commitments, laws and policies that perpetuate stigma, discrimination, violence and other rights violations remain significant barriers. This report describes the legal and policy developments from 2014 to 2019 in the Asia and Pacific region. Legal and policy obstacles continue to undermine an effective HIV response among vulnerable populations, limiting access to prevention, testing, treatment and care services.

People living with HIV in Asia and the Pacific continue to face stigma and discrimination often embedded in laws and policies. The overly broad application of criminal law to HIV non-disclosure, exposure and transmission raises both serious human rights and public health concerns. Five countries in the region still impose HIV-related travel restrictions on people living with HIV. In at least 11 other countries, HIV tests are mandatory for some entry, residence and travel permits. At least 14 countries require compulsory HIV testing for some groups. This does not include testing for blood and human tissue donation.

In a positive development, the introduction of comprehensive HIV legislation in India and the Philippines are standout achievements. In both cases, success came out of meaningful engagement with stigmatized and marginalized populations that play a key role in an effective HIV response. Governments in the region have also shown interest in replicating these successes.

India's Supreme Court decision that decriminalized same-sex relations in 2018 was a landmark decision for the region and globally. The Court ruled that criminalization of any consensual sexual relationship between two adults violates constitutional rights to equality, freedom of expression, and privacy. In many other countries, however, the legal environment for gay men and other men who have sex with men remains hostile and, in some cases, has deteriorated over the past few years. Criminalization of consensual same-sex sexual conduct between men impedes HIV responses by deterring access to HIV testing and treatment services.

Legal recognition of transgender people is vital to combat stigma and ensure people can enjoy equal access to health services. In Pakistan, transgender people saw the Transgender Persons Act enacted in 2018. Transgender people may now express their gender according to their gender identity; that choice is reflected in their legal identity. Other countries have less supportive legal and policy frameworks. In some cases,

criminal laws are broadly applied, and penalties are imposed on transgender people for expressing their gender identity through dress or appearance.

Sex work in most countries in the region remains prohibited. In some countries, however, sex work is quasi-legal and subject to official oversight through licensing, registration with the police or local health authorities, or other types of regulation. In New Zealand and parts of Australia, sex work is decriminalized. In Australia, sex work was decriminalized in Australia's Northern Territory following the Sex Industry Act 2019. In 2019 China abolished highly punitive compulsory detention for sex workers. In some countries, such as Fiji, Myanmar and Papua New Guinea, there are mounting calls for reform. Other countries, on the other hand, have seen regression to punitive laws and law enforcement practices, forcing sex workers to go underground and increasing the risk of HIV transmission.

There has been a resurgence of harsh laws and policies for drug control in some Asian countries. Governments continue to apply criminal punishments rather than public health approaches. In many cases, corporal punishment is used as a penalty for drug use, and the death penalty is in place for drug offences in at least 14 countries in Asia. Approaches also include the use of punitive laws against people who use drugs, impeding the implementation of effective prevention measures such as needle and syringe programmes and opioid substitution therapy. All countries in the region impose criminal or administrative penalties for possession of drugs for personal use. Some countries are making exceptions, such as the decriminalization of cannabis and kratom for medical use in Thailand, and for cannabis use in some parts of Australia. Detention for people who use drugs ostensibly for "treatment and rehabilitation" remains a common intervention in Asian countries, despite the lack of evidence backing abstinence-based programmes.

The trend towards a harsher, more punitive environment in the region around key population groups at higher risk of HIV has in some countries culminated in wide-scale use of extrajudicial measures. This includes the resort to extrajudicial and summary execution of people alleged to be involved in drugs and the impunity for security forces involved. Unfortunately, this has all too often been accompanied by official endorsement of such extrajudicial measures.

We hope this report will give the reader a better understanding of laws and policies that hinder an effective HIV response in Asia and the Pacific, and that the evidence will lead to the reform of harmful laws and policies, the structural barriers essential to ending AIDS by 2030.

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Introduction

This report provides a summary of key developments in the legal environment for HIV responses in Asia and the Pacific. It is the product of a desk review conducted for UNAIDS and the United Nations Development Programme (UNDP) in 2019. The report highlights key trends and developments in laws affecting people living with HIV and key populations in Asia and the Pacific over the five-year period 2014–2019. It updates the legal and policy review conducted in 2016 for UNAIDS, UNDP and the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) *(1)*.

A database of laws of the 38 Member States of ESCAP was created as part of this review. The database identifies laws that are either punitive or enabling for people living with HIV and key populations in Asia and the Pacific. A summary of the findings is presented in Annex 1.

An enabling legal environment for ending AIDS by 2030

Current global targets agreed by the United Nations aim to end the HIV epidemic as a public health threat by 2030. The UNAIDS 2016–2021 Strategy: On the Fast-Track to End AIDS calls for availability of effective and appropriate HIV and health services and commodities in an enabling social, legal and policy environment, and the meaningful engagement of key populations in the response *(2)*.

The 2016 United Nations General Assembly High-level Meeting on Ending AIDS focused the world's attention on the importance of this Fast-Track approach to the HIV response. The meeting issued a political declaration that includes specific recommendations on removing legal and policy barriers to the HIV response. These recommendations are reproduced in Annex 2.

The 2030 Agenda for Sustainable Development was agreed by the United Nations General Assembly in 2015 and envisages a world of universal respect for human rights and human dignity, the rule of law, justice, equality and non-discrimination *(3)*. In agreeing the 2030 Agenda, governments pledged that no one will be left behind. The 2030 Agenda states: "recognizing that the dignity of the human person is fundamental, we wish to see the goals and targets met for all nations and peoples and for all segments of society. And we will endeavour to reach the furthest behind" *(3)*. Leadership from governments in removing legal and policy barriers to effective HIV responses among key populations is key to ensuring Member States are able to achieve the goals and targets of the 2030 Agenda.

At the regional level, the 2015 Asia-Pacific Intergovernmental Meeting on HIV and AIDS resulted in the Asia Pacific Regional Framework for Action on HIV and AIDS beyond 2015 *(4)*. In 2018, a review of national progress in meeting the commitments

contained in this Regional Framework took place during the Asia-Pacific Regional Expert Group Meeting on Reviewing Implementation of Commitments from the Asia-Pacific Intergovernmental Meeting on HIV and AIDS Beyond 2015 *(5)*.

Key populations at the frontline of HIV epidemics in Asia and the Pacific

In this report, the term "key populations" is used to refer to gay men and other men who have sex with men, transgender people, sex workers and their clients, people who use drugs, and people deprived of liberty. These key populations are at higher risk of acquiring or transmitting HIV in most countries in Asia and the Pacific, and their engagement is critical to a successful HIV response. In some cases, a person at higher risk of HIV may belong to more than one key population, which can compound the person's vulnerability to HIV.

Key populations are more likely to engage in HIV prevention efforts and access HIV services if legal environments protect against stigma, discrimination and violence rather than reinforce them. By contrast, punitive laws and policies that target HIV transmission, non-disclosure and exposure, consensual same-sex sexual conduct between adults, gender expression, sex work and drug use, and legal and policy frameworks and practices that fail to protect the rights of people living with HIV, women, girls and key populations, increase risk and act as major barriers to services for the people who need them most.

There is a large body of international evidence demonstrating that decriminalization and introduction of protective and enabling laws result in significant health benefits to key populations by reducing stigma and supporting improved access to health and HIV services *(6–11)*. Supportive, non-discriminatory laws and policies also enable key populations to participate openly in planning and delivering HIV services, which ensures services are accessible and acceptable to their communities *(12)*. Offering HIV services to key populations in ways that are consistent with good public health practices and grounded in a human rights-based approach results in improved uptake of services and marked reductions in the spread of HIV *(13)*. Decriminalization also enables more accurate measurement of the size of key populations, allowing countries to better know their HIV epidemics and respond accordingly *(14)*.

Enabling legal environments are necessary to ensure access to a comprehensive package of HIV treatment and prevention services, including condoms, harm reduction services (such as needle and syringe programmes and opioid-substitution therapy for people who use drugs), prevention of vertical (mother-to-child) HIV transmission services, and innovative approaches such as pre-exposure prophylaxis (PrEP) and HIV self-testing. PrEP can reduce the risk of acquiring HIV through sexual transmission by more than 90% if used as directed, and HIV self-testing can significantly increase the number of people who find out their status, particularly among those least

reached by existing services *(15, 16)*. Use of these new approaches has the potential to revolutionize HIV prevention across Asia and the Pacific *(15)*. Enabling legal environments are also essential to encourage people at highest risk to be tested for HIV, and to ensure that people who test positive for HIV are able to access treatment without delay, can adhere to treatment regimens, and are not lost to care.

Enabling laws are required if the region is to remain on the Fast-Track to end AIDS by 2030 and to achieve the global 90–90–90 targets, whereby 90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are accessing treatment, and 90% of people on treatment have suppressed viral loads. These targets are key to ending AIDS, because an undetectable viral load prevents both AIDS-related illness and onward transmission of HIV.

A significant recent development in the medical management of HIV has been the adoption of the treat-all approach. In 2015 new evidence confirmed that use of antiretroviral therapy soon after diagnosis of HIV results in better clinical outcomes compared with delayed treatment and also increases the preventive impact of treatment *(17)*. The World Health Organization (WHO) published guidelines in 2016 recommending initiation of antiretroviral therapy for all people diagnosed with HIV, regardless of the state of their immune defences at that point *(17)*. Since 2016 most countries in Asia and the Pacific have either changed or are in the process of changing their national HIV treatment policies to align with these new WHO recommendations *(18)*.[1] Implementation of this important policy shift, however, is undermined by laws and law enforcement practices that deter people from attending for HIV testing and from remaining engaged with treatment services.

New medical responses to HIV, including the treat-all approach, PrEP and self-testing, require enabling legal environments to realize their full potential. It is in this context that a focus on improving the legal environment for HIV responses is critically important.

1 The following countries in Asia and the Pacific have adopted the 2016 WHO guidelines: Afghanistan, Bangladesh, China, India, Lao People's Democratic Republic, Malaysia, Nepal, Papua New Guinea, Samoa, Sri Lanka and Vanuatu. The process of adoption is ongoing in Kiribati, the Marshall Islands, Micronesia (Federated States of), Myanmar, Pakistan, Philippines, Tonga and Tuvalu.

Key developments in the legal environment for HIV responses

Comprehensive human rights-based HIV laws

UNAIDS and the Office of the High Commissioner for Human Rights (OHCHR) recommend that states adopt human rights-based legal frameworks as the most effective approach to managing HIV responses *(19)*. Laws that respect, protect and fulfil the human rights of people living with HIV and key populations are effective because they are empowering and affirm human dignity. They enable HIV prevention and treatment interventions to reach people from key populations who are often difficult to reach because, among other barriers, they are criminalized by laws relating to sex work, sexual conduct, gender identity or drug use.

A number of countries have responded by enacting comprehensive HIV legislation.[2] The national HIV laws passed in India and the Philippines are a standout achievement of the past five years. Both countries introduced comprehensive new HIV legislation confirming a human rights-based approach to managing their HIV epidemics. These laws address multiple aspects of the national HIV response in a single law, including legal frameworks for prevention, testing, treatment, discrimination, legal redress mechanisms, national leadership and coordination mechanisms. They provide useful models for other countries in the region. In both cases, these achievements occurred after extensive stakeholder consultations and community debates about the appropriate legal response to managing a public health challenge affecting some of the most stigmatized and marginalized populations of these countries.

India's first comprehensive national HIV law

India's HIV and AIDS (Prevention and Control) Act 2017 commenced operation in 2018. This is India's first HIV-related national legislation that addresses the HIV response through the application of human rights principles. This act protects from discrimination, breach of confidentiality and non-consensual HIV testing. It also establishes formal mechanisms for inquiring into complaints and providing redress for people with grievances for discrimination and other unlawful conduct. The act provides protection to people living with HIV and people who live with them.

The act prohibits discrimination in employment, health care and education; insurance; use of any goods, accommodation, services or facilities; movement; the right to reside, purchase, rent or occupy any property; and the opportunity to stand for or hold

2 It is important to note that not all proposed national AIDS bills are compliant with human rights. Some include mandatory testing for different groups, or criminalize HIV exposure, disclosure or transmission. The meaningful engagement of people living with HIV and key populations is an essential component to ensure a bill compliant with human rights.

public or private office. It prevents unfair treatment, isolation and segregation in a governmental or private establishment in whose care or custody a person may be. The act also prohibits propagation of hatred or violence towards people living with HIV.

Complaints of discrimination or other violations of the act may be made to an ombudsman's office to be established by each state government, which must deal with the complaint within 30 days. Detailed rules relating to the handling of complaints by health-care services and other establishments were issued in 2018.

Although this act represents a very important achievement in India's national HIV response, its enactment was long delayed. The process for drafting the Bill dated back to 2002. Furthermore, immense challenges remain in relation to implementation. For example, despite the prohibition of mandatory HIV testing, civil society organizations report that women are often pressured to undergo HIV testing before they can access health services, and it remains Indian Government policy to require HIV testing of military recruits *(18)*. Implementation requires state governments to establish dedicated offices to handle complaints and for health-care services to designate complaints officers, and yet there are limited resources available at the state level for such initiatives.

The Philippines revises its national HIV law

The Philippine HIV and AIDS Policy Act[3] enacted in 2018 updated the country's 1998 national law on HIV with strengthened protections for people living with HIV. The new law reconstitutes the Philippine National AIDS Council as the body responsible for the oversight of implementation of the national AIDS plan *(20)*. The act addresses gaps in the law. It ensures protection of the basic human rights of people living with HIV, including affordable access to health services without fear of discrimination. Since stigma is also a product of misinformation, the law includes support for education and awareness. It also prohibits bullying and discrimination based on actual, perceived or suspected HIV status, while protecting against breach of confidentiality and non-consensual HIV testing.

New legal restrictions apply to the use of social media. It is unlawful to commit an act of bullying based on actual, perceived or suspected HIV status, including bullying on social media and other online portals. It is unlawful for a person whose work involves delivering HIV services to disclose a person's HIV status without that person's consent. It is unlawful for social media and other media to disclose the name, picture or any information that would reasonably identify a person living with HIV without that person's consent.

Treatment coverage in the Philippines remains low, with only 44% (37 51%) of people living with HIV on antiretroviral therapy in 2018 *(21)*. Notably, the act embeds HIV in universal health care by tasking the Department of Health to develop a benefits package including HIV medication and diagnostics for inpatients and outpatients *(22)*.

The act is an important milestone for the Philippine national HIV response, but many human rights issues affecting key populations continue to be neglected. Although there is supportive legislation relating to HIV testing and treatment, key populations in

3 The Implementing Rules and Regulations of Republic Act 11166 were adopted by the Philippine National AIDS Council on 12 July 2019.

the Philippines remain highly stigmatized, and Government responses to the rapidly expanding epidemics among gay men and other men who have sex with men and transgender people are proving inadequate to stem the rapid rise in new infections *(23)*. The national crackdown on drug use and the drug trade, commonly known as the "war on drugs", has resulted in thousands of extrajudicial killings. It has also had a devastating effect on the HIV response for people who use drugs and other key populations, rendering it difficult or impossible for them to access services *(24)*. Section 12 of the Comprehensive Dangerous Drugs Act prevents the establishment of needle and syringe programmes by prohibiting the possession of needles and syringes. The Philippine Anti-illegal Drugs Strategy launched in 2018 emphasizes enforcement of criminal laws and compulsory drug treatment services but has no harm reduction component.

Advocacy for comprehensive rights-based HIV laws in Myanmar and Pakistan

Other governments in Asia have shown interest in drafting new comprehensive HIV laws similar to those enacted in India and the Philippines. UNAIDS and UNDP have supported government partners and civil society stakeholders in Myanmar and Pakistan to engage in consultations on draft legal frameworks for their HIV responses.

In Myanmar, consultations were held concerning the development of a human rights-based national HIV law from 2014 to 2017, and a bill was drafted as a basis for consultations *(25)*. In 2018 the Legal Affairs and Special Issues Assessment Commission was key in moving the draft HIV law process forward. In 2019, under the leadership of the Ministry of Health and Sports, several review meetings were convened to improve the draft law, which included the participation of relevant stakeholders.

In Pakistan, public health legislation is a matter for provincial governments. The Province of Sindh passed the Sindh HIV and AIDS Control, Treatment and Protection Act in 2013, which includes human rights-based measures relating to testing, discrimination and confidentiality. Since 2013 United Nations agencies and civil society partners in Pakistan have advocated for similar comprehensive HIV laws to be introduced in Islamabad Capital Territory and the province of Punjab, but progress has been slow. Many of the issues raised by such legislation are politically controversial, and there has been resistance to rights-based approaches from some stakeholders. Further, the Province of Sindh has been very slow to implement the AIDS law that it passed in 2013 *(26)*. In 2019 the Sindh High Court ordered the provincial government to establish a commission for HIV prevention and control, in response to a petition filed by individuals and civil society organizations concerned about the undue delay in implementing the provincial AIDS law *(26)*.

Enabling legal environments for HIV testing

Accelerating the early uptake of HIV testing and treatment among key populations is critically important to national efforts to meet the Sustainable Development Goals (SDGs) target of ending AIDS by 2030. Maximizing the number of people who are diagnosed early after acquiring HIV ensures they receive the treatment needed to prevent the disease developing and the onward transmission of HIV to others. HIV testing should be supported by laws that require informed consent, confidentiality of test results, and access to testing for young people at high risk of HIV *(27)*.

In 2017 WHO and UNAIDS issued a joint statement on HIV testing services, highlighting that "all HIV testing services must adhere to the WHO '5 Cs'—consent, confidentiality, counselling, correct status and connections" *(27)*.

HIV testing is a choice. Everybody should be given the opportunity to test for HIV, but a person's decision to take an HIV test must always be voluntary. People being offered testing for HIV must give informed consent. This means they need to be informed of the process for testing and confirming the results, the services available depending on the results, and their right to refuse testing without consequences. Mandatory, compulsory or coerced testing is never appropriate, regardless of whether that coercion comes from health-care providers, partners, family members, employers, law enforcement officials or others.

The only situations where UNAIDS and WHO support mandatory HIV testing are:

- Screening for HIV and other bloodborne infections of all blood destined for transfusion or the manufacture of blood products.
- Screening of donors before all procedures involving the transfer of body fluids or body parts, such as artificial insemination, corneal grafts or organ transplant.

Testing services must be confidential, meaning the test results and the content of discussions between the person tested and the testing provider, counsellor and other health-care workers will not be disclosed to anyone else without the consent of the person being tested.

Mandatory HIV testing

The legal and policy environment for HIV testing in Asia and the Pacific is complex, and countries often have conflicting or contradictory laws, policies and practices. On the one hand, most countries have national HIV testing policies that commit to principles of consent and confidentiality. On the other hand, many countries that have such policies also have laws that single out certain categories of people for mandatory HIV testing. The desk review undertaken in 2019 found that in at least 20 countries, mandatory HIV testing is reported to occur in some groups other than in relation to blood or human tissue donation. In many countries, courts have the ability to require compulsory HIV testing on a case-by-case basis subject to the evidentiary standards required. The following countries require an HIV test for the listed groups:

- Australia: military recruits, residency applicants.
- Brunei Darussalam: pregnant women, people deprived of liberty, people in the country's drug rehabilitation centre.
- China: people deprived of liberty, civil service recruits, some visa applicants.
- Fiji: military recruits, some visa applicants.
- India: military recruits.
- Indonesia: premarital testing in some districts, some visa applicants.
- Kiribati: seafarers and trainees at the national marine training centre.
- Malaysia: people deprived of liberty, premarital testing.
- Mongolia: people deprived of liberty, military recruits, people undergoing surgery.

- Myanmar: military recruits.
- Nepal: people undergoing surgery, people in drug treatment centres.
- New Zealand: some visa applicants.
- Papua New Guinea: some visa applicants, people leaving the country to work or study overseas.
- Republic of Korea: entertainment workers, applicants for some employment permits.
- Samoa: some visa applicants.
- Singapore: national servicepeople, some visa applicants.
- Sri Lanka: some visa applicants.
- Tonga: some visa applicants.
- Tuvalu: some visa applicants.
- Viet Nam: pilots, security and military personnel.

There are strong legal protections against mandatory or compulsory HIV testing in Cambodia,[4] New Zealand[5] and the Philippines.[6] Non-consensual, mandatory or compulsory HIV testing is prohibited by law in these countries, and mandatory HIV testing is restricted to blood and human tissue donors and other exceptional categories justified on reasonable grounds. There are also laws restricting compulsory HIV testing in Australia,[7] Fiji[8] and India,[9] although it remains a mandatory requirement for military recruits in these countries *(28, 29)*. Indonesia[10] and Timor-Leste[11] have laws prohibiting mandatory HIV testing in employment but not for other purposes. Non-consensual, mandatory or compulsory HIV testing is prohibited (other than for blood or human tissue donation) in the Lao People's Democratic Republic, Micronesia (Federated States of—Pohnpei state), Pakistan (Sindh Province), Papua New Guinea, the Philippines and Viet Nam.

Independent access to HIV testing for young people

There is increasing recognition among health authorities of the importance of encouraging young people to access HIV testing *(30)*. The Philippines and Thailand continue to see high prevalence of HIV among some subpopulations of young people, particularly young gay men and other men who have sex with men and transgender people living in urban areas. In response, these countries have revised their HIV testing laws or policies to support more young people to access HIV testing services.

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4 Cambodia Law on the Prevention and Control of HIV/AIDS 2002, Arts 19 and 20.

5 New Zealand Human Rights Act 1993, s. 65.

6 Philippine HIV and AIDS Policy Act of 2018 (Republic Act 11166), Arts 29 and 30.

7 Australia Disability Discrimination Act 1992, ss. 5 and 6.

8 Fiji Employment Relations Act 2007, s. 38(2) and HIV/AIDS Decree 2011, s. 28(2).

9 India HIV and AIDS (Prevention and Control) Act 2017, s. 5.

10 Indonesia Decree of the Minister of Manpower and Transmigration on HIV/AIDS Prevention and Control in the Workplace, No: Kep. 68/Men/2004, Art. 5.

11 Timor-Leste Labour Code (Law 4 of 2012), Art. 72.

In the Philippines, an increasing number of people aged 15–24 years are being diagnosed with HIV. Until 2018 parental consent for HIV testing was required for people aged under 18 years. A study on Philippine gay men and other men who have sex with men found that 86.5% of participants had their sexual debut before age 18 years, with the average age being 15 years; this means the great majority of gay men and other men who have sex with men are sexually active for a long time before they turn 18 years *(31)*. The age of consent for HIV testing prevented men aged under 18 years who have sex with men from knowing their HIV status and accessing treatment if required, because they were highly unlikely to seek parental consent for an HIV test as it would reveal their sexuality *(31)*.

In response to such concerns, the Philippine HIV and AIDS Policy Act includes new provisions supporting young people to access HIV testing independently. The act provides that a child may consent to an HIV test without requirement for parental or guardian consent if the child is aged 15 years or over. If the child is aged under 15 years, parental or guardian consent is not required if the child is pregnant or engaged in high-risk behaviours and the test is conducted with the assistance of a licensed social worker or health worker. If the child is aged under 15 years and either the child's parents refuse consent or cannot be found, then consent can be provided by a social worker or health worker with the child's assent. This is a critical measure given the accelerating spread of HIV among young Philippine gay men and other men who have sex with men over the past five years and provides a helpful legislative model for other countries to consider.

In Thailand, a key development was an amendment introduced in 2014 to the Clinical Guidelines for HIV Testing and Counselling, which provides that parental consent is not required for HIV testing of people aged under 18 years *(32, 33)*. A person aged under 18 years can consent to HIV testing if they have the capacity to understand the information related to HIV and the meaning of a positive test result. In relation to the disclosure of test results, if a minor is assessed as not capable of understanding the process of testing, then parental or guardian involvement is required and the test results will be reported to the parent or guardian.

Countries where the law enables people aged under 18 years to access HIV tests without parental involvement or parental consent in certain circumstances include Australia, Fiji, the Lao People's Democratic Republic, the Marshall Islands, Micronesia (Federated States of—Pohnpei state), Papua New Guinea, New Zealand and Viet Nam. The minimum age of independent consent ranges from 12 years in Papua New Guinea; to 14 years in the Lao People's Democratic Republic, the Marshall Islands and Micronesia (Federated States of—Pohnpei state); to 16 years in Viet Nam. In Australia, Fiji[12] and New Zealand there is no set minimum age of consent; instead, health-care workers are required to assess the capacity of the young person to understand the meaning of having an HIV test *(34, 35)*.

Such provisions are consistent with the WHO adolescent HIV testing guidance *(36)* and the recommendation of the United Nations Committee on the Rights of the Child *(37)*:

12 In Fiji, a young person can consent if they are "capable of understanding the meaning and consequences of an HIV test": Fiji HIV/AIDS Decree, s. 29(2)(b).

In accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests... States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services.

Enabling legal environments for pre-exposure prophylaxis

A key development in HIV prevention over the past five years has been the introduction of PrEP. Since 2015, UNAIDS and WHO have recommended that all people at substantial risk of HIV infection should be offered PrEP as an additional prevention choice. Along with HIV testing, expanding access to PrEP for key populations is regarded as a key strategy to end AIDS in Asia and the Pacific by 2030.

Used correctly, PrEP is a highly effective means for reducing HIV transmission. It requires access to specific antiretroviral medicines that act in combination to prevent HIV transmission. If taken correctly and consistently, PrEP can almost entirely eliminate the risk of acquiring HIV.

Regulatory and policy measures are required to facilitate access to PrEP for people at substantial risk of HIV. A key step is for PrEP medicines to be registered for use in HIV prevention by the national medicines regulatory authority in each country, which is essential before the medicines can legally be sold for the purpose of PrEP. The combination antiretroviral medicines used in PrEP are often already registered for therapeutic uses, but not for prevention purposes.

Across the region, an increasing number of countries are adopting policies that enable PrEP access for key populations and other people at substantial risk of HIV. Five years ago, there was very low PrEP availability in Asia and the Pacific. The situation is rapidly evolving, and it is anticipated that there will be significant improvements in PrEP availability in the coming years.

In 2019 PrEP could be obtained from sites in Australia, Cambodia, China, India, Malaysia, Nepal, New Zealand, the Philippines, the Republic of Korea, Singapore, Thailand and Viet Nam. In some other countries, including Indonesia, Myanmar, Pakistan and Sri Lanka, PrEP was endorsed in principle by government policy but pilot or demonstration projects had not commenced by the end of 2019. Branded or generic formulations of antiretroviral medicines used as PrEP have regulatory approval for use in HIV prevention in Australia, India, New Zealand, the Philippines, the Republic of Korea, Thailand and Viet Nam.

Laws affecting people living with HIV

Criminalization of HIV transmission

The overly broad application of criminal law to HIV non-disclosure, exposure and transmission raises serious human rights and public health concerns. The Global Commission on HIV and the Law, UNAIDS, UNDP, United Nations human rights treaty bodies, the United Nations Special Rapporteur on the right to health, and WHO, among others, recommend that states should avoid introducing HIV-specific laws and

instead apply general criminal law provisions and restrict the application of the criminal law to cases of intentional transmission where transmission has actually occurred *(6, 19, 38–41)*. Criminal or public health legislation should not include specific offences against the deliberate or intentional transmission of HIV, but rather should apply general criminal offences to these exceptional cases.

Contrary to these recommendations, since 2015 several Asian countries have enacted HIV-specific criminal offences rather than relying on general criminal law provisions. For example, in Mongolia a new penal code commenced in 2017 that includes an HIV-specific offence for disease transmission.[13] Under this law, a person who intentionally infects another person with HIV shall be punished with imprisonment for one to five years.

Nepal's Parliament passed a provision for intentional transmission of HIV under its new criminal code in 2017.[14] A person who commits this offence is liable to imprisonment for up to 10 years and a fine not exceeding 100 000 rupees. Where HIV is transmitted with negligence or recklessness, the offender shall be liable to imprisonment for up to 3 years and a fine not exceeding 30 000 rupees. This is an example of overly broad application of the criminal law, as it is an HIV-specific offence that extends beyond intentional conduct to include negligent transmission.

Viet Nam's Penal Code 2015 criminalized HIV transmission with severe penalties of up to life imprisonment for deliberate HIV transmission.[15] Even threatening to transmit HIV to another person is an offence under Viet Nam's Law on HIV AIDS Control of 2006.[16]

UNAIDS urges states to limit any application of criminal law to truly blameworthy cases where it is needed to achieve justice. The concerns raised by the overly broad criminalization of HIV can be addressed in part by limiting the application of criminal law to cases of intentional transmission—whereby a person knows their HIV-positive status, acts with the intention to transmit HIV, and does in fact transmit HIV. UNAIDS has expressed concern at the continued application of criminal law beyond intentional transmission to cases involving unintentional HIV transmission, non-disclosure of HIV status, or exposure to HIV where the virus was not transmitted *(42)*. As noted in an expert consensus statement on the science of HIV transmission in the context of criminalization, many cases of prosecution happen in cases where risk of transmission is incredibly low, if not zero, such as biting, spitting, or where condoms are correctly worn or the individual has an undetectable viral load. The statement went on to say that in the absence of transmission of HIV, the harm of HIV non-disclosure or exposure is not significant enough to warrant criminal prosecution *(43)*. Non-disclosure of HIV-positive status and HIV exposure should therefore not be criminalized.

13 Criminal Code 2015, Art. 15. The Code became effective on 1 July 2017 after it was adopted by the Mongolian Parliament on 3 December 2015.

14 Criminal Code Act 2017, s. 105.

15 Penal Code 2015, Arts 148 and 149.

16 Law on HIV AIDS Control 2006, Art. 8.

HIV-related travel restrictions

In the early years of the epidemic, HIV-related travel restrictions were imposed by many countries due to ignorance about the nature of HIV transmission and lack of understanding of the adverse public health and human rights impacts of travel restrictions. Over time most countries have removed or relaxed HIV-related travel or migration restrictions, but they still exist in Brunei Darussalam, Malaysia, Maldives, the Marshall Islands and Singapore. In these countries, applicants for some visas or residency permits are required to have an HIV test, and people who test positive are automatically denied the relevant visa or permit *(44–48)*.

What are HIV-related travel restrictions?

The term "HIV-related travel restrictions" is used by UNAIDS to refer to restrictions on entry, stay and residence where:

- HIV is a formal and explicit part of the law or regulation.
- HIV is referred to specifically, apart from other comparable conditions.
- Exclusion or deportation occurs because of HIV-positive status only.

In addition to these countries, the desk review confirmed that 11 other countries in the region require a mandatory HIV test for applicants for some entry or residence permits (Australia, China, Fiji, Indonesia, New Zealand, Papua New Guinea, Republic of Korea, Samoa, Sri Lanka, Tonga, Tuvalu) *(49–59)*. In 2018 the Government of Vanuatu indicated that it required HIV tests for applicants for residence or work permits, but it is unclear whether this remains the case *(60)*.[17]

In most cases where countries impose mandatory HIV testing for visa or residence applicants, an HIV test is required to identify people who may be a financial burden on the domestic health system or are considered to be a potential public health threat. In such cases, people living with HIV are generally not automatically denied entry based solely on their HIV status but are treated similarly to other people with health conditions that are costly to treat or considered a public health risk, and the applicant may be denied entry or residence based on financial or public health criteria. Such provisions are problematic when they fail to consider the individual circumstances of the applicant.

Mandatory HIV testing requirements can result in arbitrary exclusion of people living with HIV from visa application processes. This sometimes occurs when procedures for applying for visas involve imposition of requirements by organizations engaged with assisting in processing applications from migrant workers in the applicant's country of origin.

17 Vanuatu's Immigration Act s. 37 requires applicants for visas to "Not be suffering from a contagious or other disease, or a mental condition, which makes their presence in Vanuatu a risk to the health of the community in Vanuatu".

For example, citizens of some countries seeking to work in the Republic of Korea may be required to undergo an HIV test as part of the visa and employment permit application process. These tests are usually undertaken in the country of origin before departure to the Republic of Korea. Under the Republic of Korea's Employment Permit System, employers in the manufacturing, agriculture, livestock, fisheries, construction and service sectors can enter into employment contracts with foreign workers who are certified to be in good health and free from communicable diseases. When applicants register their interest with local organizations in their country of origin, they are required to pass a Korean language test. The website of the language school in the Philippines that offers the approved test to local people seeking to work in the Republic of Korea states that people living with HIV are disqualified from taking the language test and therefore will be ineligible to apply for the visa *(61)*.

Similarly, Indonesia's National Agency for the Placement and Protection of Indonesian Workers requires applicants seeking employment in the Republic of Korea under the Employment Permit System to undergo a medical examination, including an HIV test *(62)*. Applicants for the Republic of Korea's H-1 working holiday visa for entertainment workers and other holiday workers are also required to undergo an HIV test in their country of origin *(63)*.

Laws affecting gay men and other men who have sex with men and transgender people

Legal status of consensual same-sex sexual conduct

Laws that criminalize consensual same-sex sexual conduct between men are highly stigmatizing and impede HIV responses by deterring gay men and other men who have sex with men from attending HIV prevention, testing and treatment services *(7)*. The link between laws and health outcomes for gay men and other men who have sex with men and transgender people has been demonstrated in numerous studies *(64, 65)*.

Of great significance to the Asia region and internationally, India's Supreme Court decision that decriminalized same-sex relations in 2018. In the judgment in the case *Navtej Johar v. Union of India*, the Supreme Court partially struck down section 377 of the Indian Penal Code, which criminalized "carnal intercourse against the order of nature". This section of the Penal Code was inherited from the colonial era and is replicated in the penal codes of other former British colonies in Asia and the Pacific. The Supreme Court declared that criminalization of any consensual sexual relationship between two adults violates the constitutional rights to equality, freedom of expression and privacy. In its decision, the Supreme Court read down section 377 by excluding consensual acts in private between adults from the criminal offence of "unnatural" intercourse. The harmful impact of criminalization of same-sex relations on HIV responses in India was emphasized in the Supreme Court's judgment as follows *(66)*:

Section 377 has had far-reaching consequences for this "key population", pushing them out of the public health system. Men who have sex with men and transgender persons may not approach State health care providers for fear of being prosecuted for engaging in criminalized intercourse. Studies show that it is the stigma attached to these individuals that contributes to increased sexual risk behaviour and/or decreased use of HIV prevention services. The silence and secrecy that accompanies institutional discrimination may foster conditions which encourage escalation of the incidence of HIV/AIDS. The key population is stigmatized by health providers, employers and other service providers. As a result, there exist serious obstacles to effective HIV prevention and treatment as discrimination and harassment can hinder access to HIV and sexual health services and prevention programmes.

Under our constitutional scheme, no minority group must suffer deprivation of a constitutional right because they do not adhere to the majoritarian way of life. By the application of Section 377 of the Indian Penal Code, men who have sex with men and transgender persons are excluded from access to healthcare due to the societal stigma attached to their sexual identity. Being particularly vulnerable to contraction of HIV, this deprivation can only be described as cruel and debilitating. The indignity suffered by the sexual minority cannot, by any means, stand the test of constitutional validity.

Health experts expect decriminalization in India to have significant positive health outcomes. Consensual same-sex sexual conduct had previously been decriminalized in India in the period 2009–2013, from the date the Delhi High Court ruled that section 377 was unconstitutional until the date a higher court overruled the Delhi High Court decision.[18,19] A study conducted during this period found that the High Court's ruling in favour of decriminalization resulted in an increase in the self-esteem and confidence among gay men and other men who have sex with men and transgender people, a reduction in harassment of these groups by authorities, and a perception of an increase in acceptance by their families *(67)*.

In other countries in the region, the criminalization of consensual same-sex sexual conduct between men continues to be challenged through the legal system. Three legal challenges were filed to challenge the constitutionality of Singapore's section 377A of the Penal Code, based on the argument that the provision is a violation of rights to privacy, personal liberty, human dignity and equal protection. Singapore's High Court dismissed these appeals in March 2020.[20] These challenges followed from an earlier attempt to challenge the provision in 2014, where the Court of Appeal held that section 377A of the Penal Code was constitutional and did not infringe constitutional rights.[21]

In some countries, protective laws have been introduced, including antidiscrimination laws and "hate crime" laws that recognize the vulnerability of people to discrimination

18 See https://data.unaids.org/pub/externaldocument/2009/20090702_section_377_en.pdf.

19 See https://main.sci.gov.in/jonew/judis/41070.pdf.

20 See https://www.supremecourt.gov.sg/news/case-summaries/ong-ming-johnson-v-attorney-general-and-other-matters-2020-sghc-63.

21 Lim Meng Suang v. Attorney-General [2014] SGCA.

and violence due to their sexual orientation, gender identity or gender expression. Examples of protective legislation for gay men and other men who have sex with men and transgender people include the following:

- In the Philippines, over 20 local ordinances have been introduced to prohibit discrimination based on a person's actual or perceived sexual orientation, gender identity or gender expression since 2003.
- Mongolia's new Criminal Code, which commenced in 2017, includes harsher sentences for murder motivated by sexual orientation[22] and criminalizes discrimination against people because of their sexual orientation or gender identity.[23]
- In Thailand, antidiscrimination protections were extended to transgender people for the first time by the passing into law of the Gender Equality Act 2015.[24]
- The 2015 Nepal Constitution included the right to non-discrimination on the basis on their preferred gender identity, the recognition of the right to social justice for sexual orientation and gender identity minorities and the right to citizenship based on gender identity.[25]
- Nepal's Safe Motherhood and Reproductive Health Rights Act 2018 also includes protective provisions for transgender people and sexual minorities. The act prohibits discrimination including on the grounds of sexual and gender identity in the provision of family planning, reproductive health, safe motherhood, safe abortion, and emergency obstetric and newborn care services.[26]

In many other countries, the legal environment for gay men and other men who have sex with men and transgender people remains hostile and, in some cases, has deteriorated over the past five years. For example:

- Afghanistan's new Penal Code 2017 includes two offences for consensual sex between men. The Penal Code 2017 includes sodomy as a specific offence punishable with two years' imprisonment, and the offence of *tafkhez* (nonpenetrative sex between men), which attracts a lesser penalty of imprisonment for six months to one year.[27]
- Section 377 of the Bangladesh Penal Code 1860 criminalizes same-sex sexual conduct but has rarely been enforced. In 2017, however, the Rapid Action Battalion, an elite security force, raided a community centre where a gay social gathering was taking place. It was the first time that section 377 was relied on as a reason for such a raid, although due to lack of evidence prosecutions for the offence did not proceed against the men who were detained in the raid. The raid took place at a time when many gay men had gone into hiding after the brutal murder in 2016 of two men associated with the publication of *Roopbaan*, the first gay magazine in Bangladesh *(68)*.

22 Mongolia Penal Code 2015, Art. 10(1).

23 Mongolia Penal Code 2015, Art. 14(1).

24 Thailand Gender Equality Act 2015 (B.E. 2558).

25 Nepal Constitution 2015, Arts 12, 18 and 42.

26 Nepal Safe Motherhood and Reproductive Health Rights Act 2018, s. 29.

27 Afghanistan, Penal Code 2017, Arts 647–9.

- Brunei Darussalam commenced implementation of the Syariah Penal Code Order 2013 from April 2019. Section 82 of the Code provides that sex between men is punishable with death by stoning, or whipping with 100 strokes and imprisonment for a year. In response to international criticism of this provision, a moratorium on the death penalty for this offence was announced by the Sultan of Brunei Darussalam in May 2019 and remains in place.[28] In addition to this offence, consensual same-sex sexual conduct between men is criminalized by section 377 of the Brunei Penal Code. In July 2017, section 377 was amended to increase the maximum penalty from 10 to 30 years' imprisonment, with whippings. The existence of such harsh penalties is highly stigmatizing and means the penalties for consensual same-sex sexual conduct are the same as for the offence of rape *(70)*.

- Police in Indonesia are increasingly applying a range of laws against gay men and other men who have sex with men and transgender people, and there has been an unprecedented crackdown by police and religious groups against lesbian, gay, bisexual and transgender people. There have been reports of arrests under antipornography laws and other public order laws. There has been a series of reports of arbitrary and unlawful raids by police and Islamist groups on private gatherings of lesbian, gay, bisexual and transgender people *(71, 72)*. In Aceh province, gay men have been subjected to arrest and humiliating punishments under the province's *Qanun Jinayat* (Sharia criminal code). For example, in July 2018 two gay men received 87 strokes of the cane administered in public in front of a mosque for the Sharia offence of *liwat* (gay sex) *(73)*.

- Since 2018 community groups have reported increased discrimination, harassment and violent hate crimes against the lesbian, gay, bisexual and transgender community in Malaysia. Police and religious authorities raided the country's oldest gay and lesbian bar in 2018. The raid was justified by authorities as an effort to stop lesbian, gay, bisexual and transgender culture from spreading in society. Authorities urged members of the public to lodge complaints against other gay venues *(74)*.

The legal environment for gay men and other men who have sex with men and transgender people remains challenging in the Pacific island states and territories. Several Pacific island countries retain colonial era provisions in their crimes acts or penal codes that criminalize consensual same-sex conduct between adults, including Kiribati, Papua New Guinea, Samoa, the Solomon Islands, Tonga and Tuvalu. Palau decriminalized consensual same-sex sexual conduct in 2014, when a new Penal Code was introduced *(75)*. Nauru did the same in 2016, with the introduction of a new Crimes Act.[29]

A significant development in Papua New Guinea was the publication of a study on HIV and key populations in 2018 *(76)*. The study found that prevalence of HIV among gay men and other men who have sex with men and transgender people was 8.5% in the capital Port Moresby, and that there are high levels of stigma. Almost one in two gay men and other men who have sex with men and transgender people in Port Moresby (48%) and Lae (45%) felt the need to hide their sexual practices or gender identity when accessing sexual health services. In Port Moresby 13.6% and in Lae 8.7%

28 The Syariah Courts Criminal Procedure Code Order 2018 was passed in March 2018, enabling the Syariah Penal Code Order to be enforced from 2019 (69).

29 Nauru Crimes Act 2016.

reported being blackmailed by someone because of their sexual practices or gender identity. The report of the study called for reinvigoration of efforts to decriminalize homosexual conduct in Papua New Guinea.

Criminalization of gender expression

In some countries criminal penalties are applied to transgender people merely for expressing their gender identity by their dress or appearance. Some laws within the region are broadly interpreted, and criminal offences can be enforced against transgender people for gender expression in Brunei Darussalam, Indonesia, Malaysia *(77)*, Myanmar and Sri Lanka.[30] There is a criminal offence for female impersonation in Tonga, although this is not actively enforced.[31]

Brunei Darussalam introduced sharia law offences for transgender expression in 2013.[32] Section 198 of the Syariah Penal Code of Brunei Darussalam, which commenced operation in 2019, criminalizes anyone who "dresses and poses" as the opposite sex in a public place "without reasonable excuse", with a penalty of up to 3 months' imprisonment and a fine of up to B$1000. Where this is done for "immoral purposes", the penalty is increased to up to a year's imprisonment and a fine of up to B$4000.

In Indonesia there are many provincial and city *perda* (bylaws) that penalize "immoral behaviours", "vagrancy" and "public nuisance".[33] These are used to target *waria* (transgender women) for police harassment and arrest. For example, in Yogyakarta, the city's bylaw on vagrancy allows local public order officers to arrest *waria*, homeless people, children living on the streets, and female sex workers for "public nuisance". Following such arrests, *waria* are sent to assessment camps, where they have reportedly experienced violence *(85, 86)*. In Indonesia's Aceh province, the provincial legislation, including *Qanun Janayat* (Sharia criminal code) and relevant bylaws, also include provisions that can be used to target gender expression. In 2018 media reported that *waria* were being targeted by police, many had lost their jobs, and some had moved to other provinces to escape enforcement of Aceh's Sharia criminal code *(86, 87)*. In 2018 media reported that the Jakarta Social Agency classified *waria* as people with "social dysfunctional traits", which has led to many *waria* being rounded up and detained in rehabilitation centres *(80)*.

In Malaysia 14 states criminalize men who dress as women. In 2014 the Putrajaya Court of Appeal declared a provision in the state's Sharia law, which criminalized "cross-dressing" to be unconstitutional. This decision was overturned, however, by

30 Sri Lanka Penal Code ss 399 and 402. Although no laws specifically criminalize transgender people, the offence of "cheat[ing] by personation" under s. 399 of the Penal Code is used to target transgender people for arrest, based on the assumption that assuming a new gender demonstrates the intent of cheating others.

31 "It is an offence for a male person who, while soliciting for an immoral purpose, in a public place with intent to deceive any other person as to his true sex, to impersonate or represents himself to be a female. Upon conviction, be liable to a fine not exceeding $ 1,000 or to imprisonment for a period not exceeding one year or to both such imprisonment and such fine" (Tonga Criminal Offences Act (Cap. 18), s. 81(5)).

32 In 2015 a Bruneian civil servant was fined under the Syariah Penal Code for cross-dressing in a public place *(78)*.

33 For example, Pariaram city: Regional Regulation on Peace and Order of Kota Pariaram No. 10/2018, Art. 25 regulates the activities of transgender women and those whose activities disturb public order *(79–84)*.

the Federal Court on a technicality, and laws against "cross-dressing" remain in force in Malaysia's states and federal territories. Transgender people regularly face violence and abuse, including arrest and jail, as they are considered to be violating Sharia law provisions against cross-dressing *(88)*.

In Myanmar the Police Act 1945 criminalizes people found with their face covered or disguised, and this law has been used by police to harass or arrest transgender people *(89, 90)*.[34]

In Sri Lanka, although no laws specifically criminalize transgender people, the offence of "cheating by personation" under Section 399 of the Penal Code has been used to target transgender people for arrest and detention in police cells *(91)*.

In many other countries in the region, transgender people are targeted by police under public order offences. For example, a study published in 2019 reported frequent police harassment of transgender women in an Indian community. Transgender participants in the study described how police officers ignored their claims for protection. Participants were physically harassed, dismissed and ridiculed when they sought justice, and were also falsely accused, leading to arrests, verbal harassment and physical abuse *(92)*.

Legal recognition and protection of transgender people

Legal recognition of transgender people is necessary to combat stigma, to ensure their dignity is respected, and to ensure they enjoy equal access to health services. Transgender communities are advocating for the right to self-identify without the requirement to undergo surgery or other medical measures as a precondition for recognition *(93)*. International experience indicates that legal recognition of transgender status based on self-identification leads to a reduction in stigma and discrimination, resulting in greater health and education outcomes *(94–96)*.

The law provides for change of gender markers on passports or other identity documents without a requirement to undergo gender-reassignment surgery[35] in New Zealand[36] and Pakistan. In Australia the law provides for change of gender markers on passports without a requirement to undergo gender-reassignment surgery. State and territory laws also enable birth certificates to be changed without a requirement to undergo gender-reassignment surgery, with the exception of Queensland and New South Wales *(98)*.

In a significant development for the region, Pakistan enacted the Transgender Persons (Protection of Rights) Act in 2018, which provides for legal gender recognition based on self-identification. According to this act, transgender people may express their

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34 Myanmar Police Act 1945, s. 35(c).

35 The term "gender-reassignment surgery" is used instead of "gender-affirming surgery" or "gender-affirming health care". The process where states permit only the modification of gender markers on identity documents in cases of forced or otherwise involuntary gender-reassignment surgery, sterilization or other coercive medical procedures does not align with the concept of gender-affirming surgeries. The umbrella term "gender-affirming health care" typically refers to biomedical, surgical or health interventions that a transgender person voluntarily chooses to undertake in order to align their physical body and their gender identity.

36 The Family Court of New Zealand can make a declaration if a person is living with a gender identity other than the one on their birth certificate and they have had medical treatment (not necessarily full reconstructive surgery) to change the gender on their birth certificate *(97)*.

gender according to their own self-identification, and they may have their gender identity reflected on their documents, including national identification cards, passports, drivers' licences and education certificates. Although the act establishes the important principle of self-identification, it is unclear how this will be implemented in practice by different Government agencies *(99)*. The act also recognizes the fundamental rights of transgender people to inheritance, education, employment, vote, hold public office, health, assembly, and to access public spaces and property.

Other countries have less supportive legal frameworks. In some countries, governments either have no legal procedure to change gender markers on passports or other documents or allow for change of gender markers only in limited circumstances or on the condition that the person undergoes gender-reassignment surgery or complies with other prohibitive conditions. The law provides for change of gender for transgender people in limited circumstances or on condition that the person undergoes gender-reassignment surgery and other prohibitive conditions in eight countries in the region (China, India, Japan, Mongolia, Republic of Korea, Singapore, Sri Lanka, Viet Nam) *(100)*. In some cases, sterilization is required (e.g. Japan, Republic of Korea). In China, change of gender is subject to very strict conditions, including gender-reassignment surgery that results in sterilization, confirmation that the person is heterosexual, lack of a criminal record, and written approval from the person's work unit or educational institution *(101)*.

In India the Transgender Persons (Protection of Rights) Act 2019 was passed by parliament in 2019. This legislation followed the landmark Supreme Court judgment of *NALSA v. Union of India* (2014), which recognized the right of transgender people to "decide their self-identified gender" as male, female or third gender, and which directed India's central and state governments to recognize them based on self-identification. The act provides comprehensive antidiscrimination provisions and measures for the welfare of transgender people. The act enables a transgender person to obtain a certificate of identity as a transgender person, which is issued by a district magistrate *(102)*. The act has been criticized, however, because gender-reassignment surgery is a precondition for change of legal gender *(103)*. Although the act does not require surgery as a necessary precondition of identification as "transgender", surgery is required if a transgender person wishes to change their gender marker on legal documents from male to female or from female to male. The act defines a transgender person as:

> a person whose gender does not match with the gender assigned to that person at birth and includes trans-man or trans-woman (whether or not such person has undergone sex reassignment surgery or hormone therapy or laser therapy or such other therapy), person with intersex variations, genderqueer and person having such sociocultural identities as kinner, hijra, aravani and jogta.

In Japan the Supreme Court found that a law requiring transgender people to be sterilized in order to obtain legal documents reflecting their gender identity was constitutional in 2019 *(104)*.

The Republic of Korea has imposed strict conditions for legal recognition of transgender people, including gender-reassignment surgery and sterilization, but in some cases these conditions have been challenged successfully through the courts. A 2013 ruling by the Seoul Western District Court provided legal recognition to a transgender person without the requirement to undergo genital surgery. The court ruled that requiring surgical reconstruction violated constitutional rights to dignity, the pursuit of happiness and self-determination. In 2017 the Cheongju District Court applied this reasoning in another case, ruling that requiring genital surgery conflicts with constitutional rights to pursue happiness and self-determination and fails to respect diversity and minority rights *(105)*.

In some countries the law states that change of gender is possible, but the specific procedure for change of legal gender is unclear because regulations have not been introduced (e.g. Bangladesh, Indonesia, Malaysia, Nepal, Philippines, Viet Nam). In Viet Nam the Government passed a law in 2015 that recognized in principle the right of transgender people to change their civil status if they undergo gender-reassignment surgery, but the Government is yet to pass a law establishing the procedures that must be followed in such cases *(106, 107)*. A draft law on gender affirmation expected to clarify these procedures has been discussed but is yet to be submitted to the Viet Nam National Assembly for review.

There has also been progress in legal recognition of transgender people in Nepal, where the country's new Constitution of 2015 recognizes the right of Nepalese citizens to obtain a citizenship certificate in their correct gender identity. Nepal's Supreme Court ruled in 2017 that transgender people can change their name to reflect their gender identity and their legal gender marker, although in most cases the gender marker for Nepalese transgender people is limited to a third gender option rather than a change from male to female or from female to male.[37] Nepal has not codified the procedure for changing gender, however.

Laws affecting sex workers

There is a range of different legal approaches to sex work across the region, from strict prohibition (in most countries), to regulation and legal toleration, and full decriminalization. Sex work is decriminalized in New Zealand and parts of Australia, but it is generally prohibited elsewhere in the region. In some countries, sex work at certain sites is quasi-legal and subject to different forms of official oversight through licensing, registration with police or local health authorities, or other types of regulation that permit sex work in limited circumstances. For example, although sex work is criminalized in Bangladesh, India, Japan, the Philippines and Singapore, it is often tolerated by the police in certain areas.

37 Sunil Babu Pant and others v. Government of Nepal, Supreme Court of Nepal (21 December 2007); and Sunil Babu Pant and others v. Government of Nepal, 070-WO-0287, Supreme Court of Nepal (January 2017).

An international review of more than 800 studies and reports on human rights violations against sex workers identified widespread abuses, including physical and sexual violence from law enforcement, clients and intimate partners; unlawful arrest and detention; discrimination in accessing health services; and forced HIV testing. Abuses were most profound in places where sex work is criminalized *(108)*. Criminalization of sex work has been found to have a significant negative effect on the health and well-being of sex workers, increasing vulnerability to violence, HIV, stigma and discrimination *(109–111)*. It impedes access to health care services, including effective HIV prevention and treatment services *(108, 112, 113)*.

A mathematical modelling study found that decriminalization of sex work would avert 33–46% of HIV infections over a 10-year period in concentrated and generalized HIV epidemics, through its sustained effects on violence, policing and safer work environments *(114, 115)*. Reducing stigma and discrimination also enables the health-care system to reach sex workers with HIV, sexual and reproductive health services *(114, 116)*.

Evidence from New Zealand, where sex work has been decriminalized since 2003, indicates that sex workers in decriminalized settings report improved workplace safety, emotional health, and access to health and social care, and that the police and sex workers collaborate effectively to reduce violence *(117, 118)*. A review of the legal status of sex work in New South Wales, Australia found that decriminalization removed police corruption, netted savings for the criminal justice system, and enhanced health promotion and safety of the sex industry *(119)*.

Evidence suggests that HIV infection rates are reduced when sex workers are able to organize themselves within their communities; to protect themselves from violence, force and exploitation; to demand safer sex from their clients; and to have access to health information services and commodities *(6, 109)*. In some countries, health authorities cooperate with local sex worker communities in red-light areas to support access to HIV services, but authorities in other countries take a more hard-line, zero-tolerance approach.

China ends compulsory detention of sex workers

In December 2019 the National People's Congress of China voted to abolish compulsory detention for sex workers. This highly punitive system for policing sex work had been in place for almost 30 years *(120)*. Under the compulsory detention system, police had the power to detain sex workers and their clients for up to two years in compulsory "shelter and education" centres. Although compulsory detention has been abolished, sex work still remains illegal in China, with punishments of up to 15 days in administrative detention and fines of up to 5000 yuan.[38]

Australia reforms sex work laws

Sex work in Australia is regulated by state and territory laws. As a result, a patchwork of eight different legislative models has evolved. These models include registration or licensing laws in the Australian Capital Territory, Queensland and Victoria;

38 Public Security Administrative Punishments Law 2006, Art. 66.

criminalization in South Australia; partial criminalization in Tasmania and Western Australia; and decriminalization in New South Wales and the Northern Territory.

The most significant recent development in Australia's sex work laws was the decriminalization of sex work in the Northern Territory as a result of the passing of the Sex Industry Act 2019 *(121)*. The act enables sex workers to access the same health and safety rights and protections that apply to other workers under labour laws. Decriminalization under the act provides a framework that promotes the welfare and occupational health and safety of sex workers, protects them from exploitation, and prohibits the employment of people aged under 18 years in sex work.

When the Bill was presented to the Northern Territory Parliament, it was accompanied by a Statement of Compatibility with Human Rights, which emphasized the benefits that flow from removing sex work from the criminal law *(122)*:

> The trafficking of women and the exploitation of female sex workers are, more often than not, the conduct of criminal enterprise that takes advantage of the lack of government oversight, and isolated, vulnerable women... By treating the sex industry like any other business or industry, criminal elements will find it increasingly challenging to hold sway over the industry and exploit or traffic women.

The Northern Territory legislation provides a model for other jurisdictions seeking to implement decriminalization. Decriminalization of sex work is supported by Australia's Eighth National HIV Strategy 2018–2022, which notes that "decriminalization of sex work is linked to the reduction of HIV" *(123)*. As at January 2020, however, decriminalization had been achieved only in the Northern Territory and New South Wales, which became the first Australian jurisdiction to implement decriminalization in 1995.

There are ongoing campaigns seeking the full decriminalization of sex work in South Australia, Tasmania, Victoria and Western Australia *(124)*. A bill proposing decriminalization failed to pass the South Australian Parliament in November 2019 *(125)*. A new bill proposing decriminalization is to be introduced to the South Australian Parliament in 2020. In Victoria the Government responded to the passing of the Northern Territory Bill by announcing a parliamentary inquiry into decriminalization of sex work, which is to be conducted in 2020 *(126)*.

In Western Australia the act of selling sex is not illegal, but brothels and soliciting are criminalized. The 2017 Law and Sex Worker Health study surveyed 354 sex workers in Western Australia *(127)*. The study identified a range of harms caused by the criminalization of sex work in Western Australia, including criminalization being used as an excuse for abuse by clients of sex workers; reluctance of sex workers to go to the police if they are survivors of assault or other crimes; and the hidden nature of sex work, which hinders access to health services. The study noted that decriminalization allows a focus on workplace health and safety in brothels and massage parlours, and reduces stigma and discrimination experienced by sex workers. The report recommended that sex work should be fully decriminalized *(127)*.

Tasmania decriminalized private sex work offered by people working alone or in pairs in 2005, but brothels remain criminalized. The Tasmanian branch of the Australian

Labor Party passed a motion in support of full decriminalization of sex work in 2017,[39] but the Liberal Party (which currently holds power in Tasmania) does not support full decriminalization.

Indian sex workers fear punitive law enforcement

In India sex work is tolerated by police in certain areas. Sex worker-led organizations operating in these areas seek cooperation from local health authorities and police in efforts to address HIV and sexual health needs while also minimizing exploitative practices such as trafficking and involvement of minors in sex work *(128–130)*.

As a result of concerns about the need to strengthen India's law against human trafficking, the Government of India drafted the Trafficking of Persons (Prevention, Protection and Rehabilitation) Bill 2018. Sex worker organizations have mobilized in opposition to the Bill because of concerns that it focuses too heavily on a criminal justice approach and that "raid and rescue" operations could be applied against sex workers who have not been trafficked. Sex worker groups have raised concerns that the Bill could result in police crackdowns that could be harmful to the health and human rights of sex workers.

According to Sangram, a sex worker-led advocacy organization *(131)*: "the Bill will end up further criminalizing and incarcerating persons who are not trafficked in the name of prevention, rescue and rehabilitation" *(132)*. Two United Nations Rapporteurs issued a statement cautioning that the "over-broad and vague nature" of some of the Bill's provisions could lead to blanket criminalization of activities that do not necessarily relate to trafficking, and that "the proposed Bill seems to promote 'rescue raids' by the police, and the institutionalization of victims in the name of rehabilitation, rather than applying appropriate screening methods and standard operating procedures for the identification and referral of victims or potential victims of trafficking and social integration programmes which are respectful of their rights" *(133, 134)*.

The Anti-Trafficking Bill was passed by India's lower house of Parliament (Lok Sabha) in 2018, but subsequently lapsed.

Indonesia's campaign to close down all red-light areas

In Indonesia, sex work has been regulated in certain areas by local officials of some municipalities since the 1970s. This model of sex work regulation became known as the *lokalisasi* model. It allowed for public health interventions at many of these specific localities, including regular testing for sexually transmitted infections and HIV, condom promotion and HIV prevention education. However, most *lokalisasi* have been closed down over the past decade.

The *lokalisasi* at Kramat Tunggak in Jakarta was demolished in 2000 to create the Jakarta Islamic Centre. The extensive Dolly *lokalisasi* in Surabaya was home to over 10 000 sex workers before it was closed in 2014 *(135)*.

The Ministry of Social Affairs aimed to close all *lokalisasi* to realize a "prostitution-free" Indonesia in 2019 *(136, 137)*. As of November 2019, it was reported that the Government of Indonesia had closed approximately 162 of the 169 known *lokalisasi*

39 Motions passed at the 2017 Australian Labor Party Tasmanian State Conference, Georgetown, 1–2 July 2017.

(138). At that time, there were fewer than 10 *lokalisasi* still in operation, located in Bangka Belitung, Bengkulu, Central Kalimantan (Palangkaraya), Maluku (Ambon), North Sumatra, Papua (Mimika) and West Kalimantan (Ketapang) *(138)*.

HIV prevention organizations are concerned that the closure of *lokalisasi* will make it more difficult for sex workers to access HIV prevention and sexual health services. Closure of designated sex work areas has resulted in sex work shifting to hidden premises, often operating covertly as online businesses *(136, 139)*.

Republic of Korea's police crackdown on sex workers

The Republic of Korea has seen systematic and widespread crackdowns on sex workers. The National Assembly passed antitrafficking laws in 2004 that criminalized sex workers who cannot prove they have been trafficked into sex working.[40] In 2016 the Constitutional Court upheld the criminalization of sex work by the 2004 antitrafficking laws *(141)*. The majority of the nine justices of the Constitutional Court held that voluntary engagement in sex work is no different from forced sex trafficking because it involves a violation of human dignity by selling your body for financial gain.[41] Three judges issued dissenting opinions opposing criminalization. One justice found that the criminalization of sex work was fully unconstitutional because it violated rights to privacy, equality and sexual self-determination.[42] Sex worker organizations have spoken out against the majority judgment, arguing that criminalization creates barriers for sex workers to access police, social and health services *(142)*. Since this court decision, there have been a series of crackdowns on sex workers, with several sex work areas shut down by police in 2018 and 2019 *(143, 144)*.

Mounting calls for reform of sex work laws in Fiji and Papua New Guinea

In 2014 the first large-scale quantitative research on sex workers in Fiji was published by UNAIDS *(145)*. The research confirmed that sex work in Fiji appears to be less structured than in other countries, with no organized brothels. Sex workers in Fiji tend to operate in a casual manner, conducting business as the opportunity arises. The most common places participants reported operating from was the street, followed by bars, nightclubs and restaurants. Concerns over confidentiality appeared to be the biggest potential barrier to accessing sexual health services. Sex workers feared they might be identified as sex workers by attending sexual health clinics. Over a third of sex workers reported being physically assaulted by clients in the previous 12 months, and 13% reported being raped by a client in the previous 12 months. The report recommended that action be taken to address stigma, discrimination and human rights violations, including encouraging the Government of Fiji to decriminalize sex work because decriminalization would assist sex workers to better negotiate safer sex practices with clients. Other recommendations included delivery of training to law enforcement

40 Two laws were passed in 2004: Act on the Prevention of Prostitution and Protection of Victims Thereof, Statutes of South Korea, Act No. 7212 (22 March 2004); and Act on the Punishment of Procuring Prostitution and Associated Acts, Statutes of South Korea, Act No. 7196 (22 March 2004). Act No. 7196 Chapter II Article 21 criminalizes prostitution *(140)*.

41 Constitutional Court of Korea (2016), Case on the Punishment of Commercial Sex Acts [2013 Hun-Ka2].

42 Ibid.

agencies on legal rights of sex workers to eliminate inappropriate harassment and exploitation by police.

Amnesty International conducted research on sex work in Papua New Guinea based on interviews conducted with sex workers in Mount Hagen and Port Moresby in 2015. The report concluded that police abuses of sex workers are widespread and called for reform of sex work laws and an end to police abuses *(146)*. Another significant development was the publication of a study on HIV and key populations in 2018, which found HIV prevalence of 15% among sex workers in Port Moresby. The report of this study also called for reform of criminal laws, including those affecting women, gay men and other men who have sex with men, and transgender sex workers *(76)*.

Laws affecting people who use drugs

Criminalization of drug use stigmatizes people who use drugs and deters them from accessing health and HIV services *(147, 148)*. Widespread abuses of human rights of people who use drugs increase their vulnerability to HIV and negatively affect delivery of HIV programmes. These abuses include denial of health services, discriminatory access to HIV treatment, abusive law enforcement practices, and coercive methods ostensibly intended as "rehabilitation" or "treatment" for drug dependence *(147–149)*. Arrests for possession of drugs or syringes, confiscation of syringes, compulsory urine testing, and police surveillance of harm reduction services impede access to services such as needle and syringe programmes and opioid-substitution therapy services, and deter people who use drugs from carrying syringes, leading to increased HIV risk from sharing of needles and syringes *(11, 149, 150)*.

The negative health impacts associated with the strict enforcement of the criminal justice approach to drug control can be reduced by decriminalization and public health measures. Globally, it is reported that there have been reductions in transmission of HIV and other bloodborne viruses in countries that have implemented full or partial decriminalization of drug use. In response to mounting evidence of the benefits of a public health approach, the United Nations has revised its policy on drugs and called for decriminalization of drug use. The United Nations System Common Position on Drug Policy, adopted in November 2018, commits to supporting Member States in implementing truly balanced, comprehensive, integrated, evidence-based, human rights-based, development-oriented, sustainable responses to the world drug problem *(151)*. It calls for a rebalancing of drug policies towards health and human rights and promotes "measures aimed at minimizing the adverse public health consequences of drug abuse, by some referred to as harm reduction" and "alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use".

Despite the efforts of United Nations agencies towards a greater focus on public health, governments across the region overwhelmingly prefer drug control laws that apply a strict criminal justice approach rather than a public health approach. In many cases, corporal punishment is applied as a penalty for drug use, and the death penalty is available for drug offences in at least 14 countries in Asia (Bangladesh, Brunei Darussalam, China, Democratic People's Republic of Korea, India, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Pakistan, Republic of Korea, Singapore, Thailand, Viet Nam).

All countries in the region impose criminal or administrative penalties for possession of drugs for personal use. Some jurisdictions make exceptions for certain drugs. For example, cannabis and kratom were decriminalized for medical use in Thailand in 2018 *(152)*, and cannabis use is decriminalized in some parts of Australia.[43]

In 2019 the Government of Malaysia announced it was considering options for decriminalizing possession of small quantities of drugs for personal use, while maintaining its compulsory drug treatment system *(154)*.

There has been a resurgence of hard-line drug control laws and policies in some other Asian countries. Such approaches involve imposition of punitive laws against people who use drugs. Punitive laws and law enforcement practices impede efforts to reach people who use drugs with the harm reduction measures, such as needle and syringe programmes and opioid-substitution therapy, required to prevent epidemics of HIV and other bloodborne viruses. Relatively few countries are investing in scaling up these harm reduction programmes as part of their national HIV or drug control responses. A global review of the coverage of harm reduction interventions identified East Asia and Southeast Asia as regions where injecting drug use is well established but with poor coverage of needle and syringe programmes and opioid-substitution therapy.[44]

Crackdown on drugs escalates in Bangladesh, Cambodia, Philippines and Sri Lanka

Mass arrests and human rights violations against people who use drugs have been reported as a result of the escalation of the crackdown on drugs by governments in Bangladesh, Cambodia, the Philippines and Sri Lanka *(156, 156)*.

In the Philippines, the crackdown on drugs commenced in 2016 and has expanded into areas beyond Manila, including to the provinces of Bulacan, Cavite and Laguna and the cities of Cebu and General Santos *(158, 159)*. In 2019, 11 United Nations human rights experts called for an investigation into extrajudicial killings associated with the so-called "war on drugs" *(156)*. The Commission on Human Rights of the Philippines has estimated the number of these killings could exceed 27 000 *(242, 160)*. The Commission on Human Rights of the Philippines reported that impunity had been virtually guaranteed because of the President's pronouncements that police officers responsible for killing people suspected of involvement in the drug trade would not face prosecution *(161)*.

The Cambodian Government began its campaign against illicit drugs in 2017, leading to mass arrests of people who use drugs and reports of more than 8000 people detained in 2017 *(162, 163)*. In the first 9 months of 2019 alone, the anti-drug police reportedly arrested over 15 000 people *(164)*. Some Cambodian health organizations have raised concerns that the crackdown has made it more difficult to reach people with drug treatment services, because people who use drugs have gone into hiding fearing arrest *(165)*.

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43 The Australian Capital Territory, the Northern Territory and South Australia have decriminalized cannabis by applying civil penalties if a person meets certain eligibility criteria (153).

44 Globally, less than 1% of people who inject drugs live in countries with high coverage of both needle and syringe programmes (more than 200 needles and syringes distributed per person who injects drugs) and opioid substitution therapy (more than 40 people on opioid-substitution therapy per 100 people who inject drugs) (155).

In 2018 the Government of Bangladesh deployed the Rapid Action Battalion, a specialized police unit, against people who use drugs. The Battalion has been accused of killing over 200 people during the so-called "war on drugs" *(161)*. The United Nations High Commissioner for Human Rights has condemned extrajudicial killings and urged authorities in Bangladesh to bring perpetrators of serious human rights violations to justice *(166)*.

In 2018 Sri Lanka's President Sirisena announced his intention to bring back the death penalty for drug offences and to replicate the Philippines' hard-line approach to drug control in Sri Lanka, including mobilizing the military in the crackdown on drugs. In 2019 President Sirisena confirmed death sentences for four people convicted of trafficking in drugs, despite a moratorium on capital punishment that has been in place since 1976. Sri Lanka's Supreme Court has delayed the imposition of the death penalty on these offenders until at least March 2020, in response to a petition from Sri Lanka's Human Rights Commission and nongovernmental organizations *(167–170)*.

Extrajudicial killings condemned as a serious human rights violation

"The extrajudicial targeting of persons suspected of illicit drug-related activity is not only a breach of the three international drug control conventions, it also constitutes a serious breach of human rights, including due process norms as contained in the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights, and is an affront to the most basic standards of human dignity"—International Narcotics Control Board (171).

Compulsory centres for people who use drugs

According to a 2017 report in the *Lancet*, approximately 600 000 people who use drugs are detained in compulsory drug detention centres in Asia *(172)*.

Detention of people who use drugs ostensibly for the purpose of "treatment and rehabilitation" remains a common intervention in Asian countries that align with the "war on drugs" approach. This is despite the lack of evidence of effectiveness of abstinence-based programmes provided in these centres in treating drug dependency or preventing a return to drug use after release *(173, 174)*.

The United Nations Office on Drugs and Crime (UNODC) confirms that this approach has not resulted in sustained treatment outcomes or rehabilitation but rather has been associated with increased HIV risks, added stigma and discrimination, and significant deviations from evidence-based best practices in drug dependence treatment *(175)*. Detainees are typically held in administrative detention, often without due legal process, clinical assessment of drug dependency, or informed consent. Evidence-based drug dependency treatment such as opioid-substitution therapy is rarely provided, and reports of human rights violations, including physical abuse and forced labour, are common *(176)*.

Based on a comprehensive review of the evidence and after two regional consultation meetings, UNAIDS and partners recommended in 2015 that Asian countries transition from compulsory centres to voluntary community-based treatment and support services *(175)*. Twelve United Nations agencies[45] have called for the closure of compulsory drug detention and treatment centres *(174)*. The Global Fund to Fight AIDS, Tuberculosis and Malaria ended funding for HIV services in drug treatment centres in Viet Nam in 2014 *(177)*.

Based on information available to UNAIDS in 2019, it was found that the following 10 Asian countries maintain compulsory centres for people who use drugs operated by government agencies: Brunei Darussalam,[46] Cambodia, China, Indonesia,[47] Lao People's Democratic Republic, Malaysia, Philippines, Singapore,[48] Thailand and Viet Nam *(186–188)*. Centres operating in these countries were found to meet the definition of "compulsory centres" of the 2012 United Nations Joint Statement on Compulsory Drug Detention and Rehabilitation Centres. In these centres, due process rights are limited or absent, and multiple human rights violations have been documented.

Eleven other countries have compulsory systems for treatment and rehabilitation that operate treatment centres that have some of the features of compulsory centres for people who use drugs. Nongovernmental organization, faith-based or private compulsory centres where human rights abuses have been reported exist in four countries (India, Myanmar, Nepal, Pakistan). Hundreds of private treatment centres operate with little to no governmental supervision in South Asia. These rehabilitation centres are described by the Asian Network of People who use Drugs as "compulsory and labour-intensive camps that are mostly run by untrained staff" *(189)*. In seven other countries (Afghanistan, Bangladesh, Bhutan, Maldives, Mongolia, Republic of Korea, Sri Lanka) there are punitive systems for compulsory treatment or rehabilitation, but there is insufficient information regarding human rights abuses, substandard conditions or absence of due process rights to conclude that the centres fully meet the definition of the 2012 United Nations Joint Statement.

A 2018 study estimated that in 2014, over 450 000 people were detained in 948 compulsory rehabilitation facilities in Cambodia, China, the Lao People's Democratic Republic, Malaysia, the Philippines, Thailand and Viet Nam *(187, 188)*; the study did not include estimates for Brunei Darussalam, Indonesia or Singapore. People were typically detained for treatment and rehabilitation for 3–24 months. The study found that although two countries decreased the number of compulsory detention centres,

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45 International Labour Organization; Joint United Nations Programme on HIV/AIDS; Office of the High Commissioner for Human Rights; United Nations Children's Fund; United Nations Development Programme; United Nations Educational, Scientific and Cultural Organization; United Nations Entity for Gender Equality and the Empowerment of Women; United Nations High Commissioner for Refugees; United Nations Office on Drugs and Crime; United Nations Population Fund; World Food Programme; World Health Organization.

46 The Al-Islah Rehabilitation Centre run by the Narcotics Control Bureau is a compulsory centre where there are broad grounds on which detention may be ordered under the Misuse of Drugs Act, with a six-month minimum detention period *(178)*.

47 Compulsory centres are run by the National Narcotics Bureau and residents are detained for up to six months *(179–182)*.

48 People who are dependent on drugs are detained at the men's or women's Drug Rehabilitation Centre at Changi Prison Complex for between six months and three years (Misuse of Drugs Act, Chapter 185, Revised edition 2001) *(183–185)*.

most countries increased the number of people detained. Thailand and Viet Nam had the largest declines in detainees *(188)*.

In Viet Nam in 2013, the Government committed to gradually reduce reliance on compulsory detoxification and adopted a transition to the Decision on Drug Rehabilitation Renovation Plan for 2013–2020, which aims at diversifying drug dependence treatment models, scaling up community-based voluntary treatment services, and reducing the number of people held in compulsory centres. In 2013 Viet Nam started to reform its drug treatment services by converting some of its compulsory centres to voluntary treatment clinics *(186)*. The Government's drug treatment policy focuses on diversifying drug dependence treatment models; increasing community-based and voluntary treatment centres; and reducing the number of people in compulsory rehabilitation centres—the so-called "06 centres".[49] It is unclear how much of this transition has been achieved or will happen in the coming years. There are concerns that many 06 centres will remain as part of the national system until at least 2030 and that the promising community-based treatment model may retain coercive aspects, such as police supervision and punitive response to relapse. UNODC reported in 2018 that there were 6 compulsory treatment centres in Viet Nam, 75 mixed facilities with compulsory and voluntary treatment, and 18 facilities offering methadone and voluntary treatment *(190)*.

By contrast, China's drug control system still favours detention for compulsory treatment, with hundreds of thousands of people who use drugs detained in compulsory treatment centres every year *(191)*. According to China's Ministry of Justice, China had 370 compulsory drug treatment centres at the end of 2018, and the number of registered people who use drugs was 214 300 *(192)*.

In Malaysia there were 22 compulsory centres for people who use drugs housing 7000 people in 2016 *(172)*. People who use drugs are detained for two years in these centres. The centres have no legal oversight and use unproven measures such as spiritual programmes, exercise, counselling and job-related training. Patients are supervised for 18 months after their release *(172)*. A comparison of the outcomes of detention in compulsory centres and voluntary treatment in Malaysia was published in 2016. At Malaysia's voluntary treatment centres, people are medically assessed at the time of entry on to methadone and then allowed to use a variety of treatments, including psychosocial counselling and recreational activities. According to the study, people with chronic opioid use disorders are more likely to relapse and do so sooner if they are treated in a compulsory drug detention centre rather than a voluntary drug treatment centre using methadone maintenance therapy *(172)*.

Harm reduction programmes for people who use drugs

Opioid-substitution therapy is becoming more widely available in the region, particularly in East and Southeast Asia. Opioid-substitution therapy involves medically supervised oral administration of drugs such as methadone or buprenorphine as a substitute for injecting opioids such as heroin. It is an effective HIV prevention intervention for people who use drugs because it reduces unsafe injecting.

49 06 centres are compulsory treatment centres for people who use drugs that have operated in Viet Nam since the 1980s as an extension of the "re-education through labour" system.

Opioid-substitution therapy for people dependent on drugs is available at sites in Afghanistan, Australia, Bangladesh, Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, New Zealand, Thailand and Viet Nam *(162)*. In some of these countries, availability is limited; for example, in 2018 opioid-substitution therapy was available at 8 sites in Afghanistan, 5 sites in Bangladesh, 2 sites in Cambodia and 15 sites in Nepal. By comparison, by 2018 Viet Nam had scaled up its national programme to 316 sites *(21)* and China to 767 sites *(162)*.

In India, although there is a legal framework for opioid-substitution therapy and there were 212 sites in 2018 *(162)*, there remains weak policy support for opioid substitution and harm reduction at the national level *(192–194)*. In Pakistan an opioid-substitution therapy pilot has been conducted, but there are currently no sites *(195)*. Opioid-substitution therapy is supported by Government policy in Thailand, but there is limited availability *(196, 197)*. In Singapore, methadone maintenance therapy is available only to pregnant women who are drug-dependent and a small number of elderly opium-dependent people attending the National Addictions Management Service *(198–200)*. In Bhutan and Mongolia, opioid-substitution therapy is supported by government policy but is not yet available *(162)*.

Although opioid-substitution therapy has become more available in many parts of Asia, needle and syringe programmes remain politically controversial across much of the region. There are some success stories, however, and needle and syringe programmes are provided through government-approved programmes in Afghanistan, Australia, Bangladesh, Cambodia, Indonesia, Malaysia, Myanmar, New Zealand and Viet Nam *(162)*; however, there is lack of government support in Brunei Darussalam, Japan, the Lao People's Democratic Republic, the Maldives, the Philippines, Singapore, the Republic of Korea and Sri Lanka *(162)*.

There is partial or ambiguous government support for needle and syringe programmes in China (some provinces have programmes, but there is no national programme) *(201, 202)*,[50] India (conflicting policy statements) *(203, 204)*, Malaysia (programmes operate but possession of injecting equipment remains illegal) *(205)*,[51] Mongolia *(206)*, Nepal (only a few programmes operate in selected districts) *(207)*, Pakistan[52] and Thailand[53] (some programmes but no enabling legal framework: there is a lack of investment in programmes, but programmes are available in only 12 locations nationwide, with 3 Government services distributing clean needles and syringes and 14 programmes operated by nongovernmental organizations *(208)*).

Needle and syringe programmes have been discontinued in the Lao People's Democratic Republic and the Philippines. Support from the Australian aid programme for needle and syringe programmes in the Lao People's Democratic Republic was

50 Ambiguous government support is indicated by factors such as conflicting policy statements on needle and syringe programmes from health authorities and law enforcement authorities, or where programmes are technically illegal and lack an enabling legal framework. Partial government support is indicated by support restricted to certain provinces or districts, as distinct from a national programme funded from national budgets.

51 Malaysia Dangerous Drugs Act s. 30.

52 Possession of drug use equipment is prohibited and liable to confiscation under Section 32 of the Control of Narcotics Substance Abuse Act of 1997 (Pakistan).

53 Sections 57 and 58 of the Narcotics Act 1979 (Thailand) criminalize supply of needles or syringes to people who use drugs.

discontinued in 2014 after funds were provided for the implementation of a pilot programme in the districts of Houaphanh and Phongsaly provinces *(209)*. The only documented instance of a programme in the Philippines was through the Big Cities Project implemented in Cebu City, where needle distribution was included among services provided at the city's Social Hygiene Clinic. It closed in 2016 due to political pressure *(162)*.

Viet Nam invests in expanded national harm reduction programme

Viet Nam's Ministry of Health has demonstrated strong political will to implement and scale up innovative harm reduction programmes *(162, 210)*. Opioid-substitution therapy programmes were first piloted in Hai Phong province in 2008 and have been significantly expanded since then. The Government, with support from partners, provides methadone maintenance therapy for people who inject drugs in all 63 provinces, covering a total of 52 075 people *(21)*. Opioid-substitution therapy has proven to be extremely cost-effective in Viet Nam. Based on data from 2012–2015, funding a person who injects drugs to stay in a rehabilitation facility costs the local government 2.5 times more than the cost of providing opioid-substitution therapy for a year *(211)*. A policy of decentralizing methadone maintenance therapy to the commune level was introduced in 2015. The policy aims to ensure sustainability of the national programme as international financial support reduces and to increase accessibility of opioid-substitution therapy by mitigating time and travel constraints for patients.[54] The Government promotes the use of needle and syringe programmes: approximately 22 million needles and syringes funded by external partners were distributed through civil society organizations in 2018 *(212)*.

A Government review found inconsistencies between Viet Nam's national HIV legislation, which includes support for harm reduction interventions, and its punitive legislation on drug control. These inconsistencies pose challenges to the further scale-up of opioid-substitution therapy, needle and syringe programmes and other harm reduction interventions *(213)*.

Nepal's national opioid-substitution therapy programme

In Nepal opioid-substitution therapy has been elevated to the status of a national programme under the Ministry of Health, implemented in accordance with country-specific policy documents that align with internationally accepted standards. Opioid-substitution therapy is provided at public hospitals and by nongovernmental organizations *(214)*. Nepal relies heavily on international assistance, however, and the Government's financial contribution to the programme is small, meaning the sustainability of opioid-substitution therapy programmes is uncertain *(162)*. Moreover, opioid-substitution therapy has yet to be given legal recognition as a drug-dependence programme, which would assist in the scale-up of the programme.

54 Viet Nam Ministry of Health, Minister of Health Decision No. 3509/QD-BYT, 21 August 2015.

Myanmar's new National Drug Control Policy recognizes harm reduction

Myanmar's National Drug Control Policy 2018 proposes that the Government promotes and expands a comprehensive package of harm reduction interventions according to UNAIDS, UNODC and WHO technical guidelines. The Policy recommends consideration of decriminalization of drug use. The Policy includes five key policy areas: supply reduction and alternative development; demand and harm reduction; international cooperation; research and analysis; and compliance with human rights. In addition to law enforcement and criminal justice efforts, it includes health and social policy responses. Major changes in the Policy include the adoption of a harm reduction approach to drug use and a focus on human rights as a crosscutting issue. A new policy of initiating antiretroviral therapy for all people living with HIV attending an opioid-substitution therapy centre has great potential to improve access to HIV treatment for people who use drugs in Myanmar.

Myanmar's Narcotics Drugs and Psychotropic Substances Law was amended in 2018 to reflect the policy shift towards managing drug use as a health issue. The most significant change was the removal of the compulsory obligation for people who use drugs to register with the Ministry of Health and Sports. In so doing, prison penalties for simple drug use were abolished in an attempt to facilitate access to health services. Although the Law retains punitive provisions for possession of drugs, which can still result in lengthy imprisonment, alternative options to imprisonment such as treatment, rehabilitation and community service are now available.

Thailand makes first steps towards drug law reform

Thailand demonstrated leadership in drug law reform in 2017, reducing penalties for drug possession, trafficking and production, and abolishing the mandatory death penalty for selling drugs. The amendments clarify that lesser penalties apply for drug possession for the purposes of consumption rather than possession with intent to distribute; increase the quantity of drugs that a person must possess for drug trafficking penalties to apply; expand judicial discretion; and stipulate a higher burden of proof for supply-related offences. The aim of these reforms was to reorient efforts to treat drug dependence as a health problem. Ministerial responsibility for drug treatment has shifted from the Ministry of Justice to the Ministry of Public Health. The Government introduced further reforms in 2018 when use of cannabis and kratom for medical and research purposes was decriminalized, and is considering further proposals to reform drug laws *(188)*. Following decriminalization of cannabis for these purposes, the Government invested in a medical marijuana facility housing 12 000 plants that will be used in the production of over 1 million bottles of cannabis oil by February 2020 *(215)*.

Laws affecting people deprived of liberty

The prevalence of HIV, hepatitis B virus, hepatitis C virus and tuberculosis is higher in prison populations than in the general population, mainly because of the criminalization of drug use, which means that in many countries a significant proportion of the prison population are people who use drugs *(176)*. UNAIDS recommends that people deprived of liberty have access to a comprehensive package of HIV prevention and treatment interventions, including condoms, opioid-substitution therapy, prison-based needle and syringe programmes and antiretroviral therapy *(216)*.

Reducing the rates of incarceration of people who use drugs is an effective way of reducing infections in people deprived of liberty and the broader community *(176)*.

Concerns about high rates of incarceration of people who use drugs has caused the Government of Malaysia to reconsider its drug policies. In Malaysia, 56% of the people in prison are incarcerated for drug-related offences, and around 90% reoffend after release. In 2019 the Malaysian Government announced it is considering options for decriminalizing possession of small quantities of drugs for personal use so that people who use drugs can be referred to health services rather than imprisoned *(217)*.

There are few examples of countries in Asia and the Pacific where laws enable provision of harm reduction services to prevent HIV and other bloodborne viruses in prison settings. Prison-based harm reduction services for people who use drugs are rare in Asia and the Pacific outside of Australia and New Zealand. Where services are available in prison settings, they are often inferior in quality compared with services in the community *(218)*.

Availability of antiretroviral therapy in prisons

It is essential that people deprived of liberty have reliable access to antiretroviral therapy, both to maintain their own health and to restrict onward transmission of HIV to other people in prison. Antiretroviral therapy is increasingly available to people deprived of liberty living with HIV. Thailand has provided antiretroviral therapy to people deprived of liberty since at least 2005, and Malaysia since 2008 *(219, 220)*. By 2018 antiretroviral therapy was reported to be available to people deprived of liberty in some or all parts of Afghanistan, Australia, Bangladesh, Cambodia, China, Indonesia, Malaysia, Myanmar, New Zealand and Thailand *(162, 219, 220)*. In India access to antiretroviral therapy is limited for people deprived of liberty, but it is being scaled up in some states *(221, 222)*. In Viet Nam antiretroviral therapy is available in selected prisons, with 3867 people in prison receiving therapy in 2018 *(21)*.

Availability of condoms in prisons

Of the countries reviewed, an unambiguous policy and practice of making condoms available to people deprived of liberty exists only in Thailand. Over 100 000 condoms were distributed in prisons in Thailand in 2018 *(223)*. In Thailand, there is support for condom access in prisons as part of the service package for people in prison defined by the National Operational Plan on AIDS 2015–2019 *(224)*.

There is some policy support for provision of condoms in prisons in eight other countries in the region, but with restricted distribution (Afghanistan *(225)*, some states of Australia *(226)*, Indonesia *(223)*, New Zealand *(227)*, Pakistan *(228)*, Palau,[55] Papua New Guinea *(229)*, Philippines *(230, 231)*). In Fiji, although condoms are not available in prisons, there is policy support for provision of condoms and lubricants to people in prison in Fiji's National HIV Strategy 2016–2020.

Opioid-substitution therapy in prisons

A study found that people accessing methadone in a voluntary setting reduced their risk of post-release relapse by 84%, whereas the people in a compulsory drug detention centre quickly relapsed *(232)*. People deprived of liberty have varying degrees of access to opioid-substitution therapy in some prisons in Afghanistan, Australia, China (Macao Special Administrative Region), India, Indonesia, Malaysia, New Zealand and Viet Nam *(162)*.

55 Palau reported 90 condoms were distributed to people in prison based on a UNAIDS 2016 dataset.

In Afghanistan UNODC has provided technical assistance to the Ministry of Public Health for developing opioid-substitution therapy and condom programmes in seven prisons *(233)*. There is policy support and partial implementation of opioid-substitution therapy in two prisons in India[56] *(234)* and two prisons in Viet Nam (implementation commenced in 2015 but was not expanded *(218, 235)*). In Cambodia, Maldives and Myanmar there is policy support to opioid-substitution therapy in prisons, but implementation has not commenced.[57] Where opioid-substitution therapy is available in prisons in Asia, stigma and discrimination associated with drug use and HIV deter people from accessing it *(236–238)*.

Needle and syringe programmes in prisons

There are no prison-based needle and syringe programmes in Asia or the Pacific, despite evidence of effectiveness as a health intervention from other regions, in particular Europe *(239)*. A plan to establish such a programme in a prison in the Australian Capital Territory was abandoned in 2015 after opposition from staff *(240, 241)*.

It should be noted that globally, not one instance of syringe-related violence has been reported as a result of a prison-based needle and syringe programme *(242)*. An overview of international evidence on prison-based needle and syringe programmes found they contribute to the prevention of HIV and other bloodborne viruses *(239)*. Anecdotal evidence suggests additional benefits, including decreased risk behaviour, fewer drug-related abscesses, decreased incidence of psychological disorders requiring treatment, increased uptake of other harm reduction services, improved knowledge of infectious diseases among inmates, and almost no drug overdoses *(239)*.

One study assessing the effectiveness of a prison needle and syringe programme in Spain found the prevalence of HIV decreased from 21% to 8.5% over 10 years *(243)*. As only 10 countries globally have maintained prison-based needle and syringe programmes,[58] there are gaps in the evidence and it will be important to pilot programmes in the specific conditions of each country to assess feasibility and effectiveness.

In the absence of clean injecting equipment, in many prison settings used syringes are shared by multiple people to inject drugs, resulting in rapid spread of HIV and other viruses. Clean needles and syringes are usually unavailable. It is more difficult to smuggle needles and syringes into prisons than it is to smuggle drugs. Sometimes, people deprived of liberty resort to injecting drugs using unsafe items such as animal bones or ballpoint pens *(244, 245)*.

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56 India's central rules of the Mental Healthcare Act 2017, Schedule on Minimum Standard for Mental Health Care in Prisons mandates availability of opioid-substitution therapy *(193)*. In Punjab prisons, opioid-substitution therapy is dispensed temporarily as part of drug detoxification *(218)*.

57 In Cambodia the draft methadone maintenance treatment standard operating procedure of the Ministry of Health describes provision of opioid-substitution therapy in prisons, but approval of the standard operating procedure has been pending for several years. The Maldives National HIV Strategic Plan for 2014–2018 included the aspiration to provide opioid-substitution therapy in prisons. Myanmar's National Strategic Plan on HIV and AIDS 2016–2020 states the Government will establish a comprehensive HIV package for people in prison, including "evidence informed drug dependency treatment in prisons".

58 Prison-based needle and syringe programmes operate in Armenia, Canada, Germany, Kyrgyzstan, Luxembourg, Macedonia, Republic of Moldova, Spain, Switzerland and Tajikistan *(218)*.

Conclusion

Enabling legal environments and the Fast-Track to end AIDS in Asia and the Pacific by 2030

As illustrated by this report, the five-year period 2014–2019 has seen uneven progress in efforts to achieve enabling laws and policies for HIV responses among key populations in Asia and the Pacific. The overall context for legislators and policy-makers seeking to advance a human rights-based approach to HIV remains highly challenging. Many countries are experiencing a rise in populism and religious conservatism, with the result that conservative positions on social morality are influencing laws and policies that directly impact key populations, such as punitive responses to drug use, sex work, sexual orientation and gender identity.

This comes at a time when HIV is generally regarded as a lower priority for legislators and policy-makers than it was in past decades. International funding for HIV has reduced dramatically. Many countries in the region have graduated to middle-income status, which restricts the eligibility of these countries to receive grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The priorities of governments and international donors have shifted from the global effort to stop AIDS to achieving broader health goals. There is pressure to integrate HIV services within mainstream health services geared to the general population, which gives rise to the risk of key populations being left behind.

This combination of factors means there is heightened risk that HIV will no longer be considered a policy priority and that, as a result, the public health and human rights impacts of the epidemic will be neglected. Although there have been several significant legislative achievements, such as the national HIV laws enacted recently in India and the Philippines, there is a mounting risk of loss of policy momentum in efforts to address HIV as a human rights issue.

The 2030 Agenda for Sustainable Development presents opportunities to confront this risk of complacency and revitalize national HIV responses. The 2030 Agenda requires attention to multiple goals and targets across the whole of human development and highlights the interconnections between different aspects of development. Ending AIDS by 2030 remains a clear priority of SDG 3 (health), and this will not be attainable unless efforts are also made to achieve the development goals relating to equality, justice and strong institutions (SDGs 5 and 16).

Legal environments and the Economic and Social Commission for Asia and the Pacific Regional Framework for Action to End AIDS by 2030

Addressing legal and policy barriers to HIV responses is one of the three pillars of the ESCAP Regional Framework for Action to End AIDS by 2030, which was adopted at the Asia-Pacific Intergovernmental Meeting on HIV and AIDS in 2015.

In 2018 an expert group meeting was convened by ESCAP and UNAIDS to conduct a mid-term review of progress in implementing the pillars of the Regional Framework *(4)*. In relation to this pillar of the Regional Framework, the expert group meeting made the following recommendations:

- 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, prison 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 that hinder access to health services.

According a priority to these recommendations will assist governments to maintain the focus required to ensure the Fast-Track targets relating to HIV are achieved. Consideration should also be given to the legal and human rights issues highlighted by civil society participants in the expert group meeting. Annex 3 contains the recommendations of civil society organizations to the expert group.

Annexes

Annex 1. Findings of review of laws in Economic and Social Commission for Asia and the Pacific Member States

Table 1.
Punitive laws affecting people living with HIV and key populations

	HIV travel or migration restriction	Offence for HIV transmission, exposure or non-disclosure
Afghanistan	🟢	🟢
Australia	🟠	🟠
Bangladesh	🟢	🟢
Bhutan	🟢	🟢
Brunei Darussalam	🔴	🔴
Cambodia	🟢	🔴
China	🟠	🔴
Democratic People's Republic of Korea		🟢
Fiji	🟠	🟢
India	🟢	🟢
Indonesia	🟠	🔴
Japan	🟢	🟢
Kiribati	🟢	🟢
Lao People's Democratic Republic	🟢	🔴
Malaysia	🔴	🟠
Maldives	🔴	🟢
Marshall Islands	🔴	🔴
Micronesia (Federated States of)	🟢	🟢
Mongolia	🟢	🔴
Myanmar	🟢	🟢
Nauru	🟢	🟢
Nepal	🟢	🔴
New Zealand	🟠	🟢
Pakistan	🟢	🔴
Palau	🟢	🟢
Papua New Guinea	🟠	🔴
Philippines	🟢	🟢
Republic of Korea	🟠	🔴
Samoa	🟠	🟢
Singapore	🔴	🔴
Solomon Islands	🟢	🟢
Sri Lanka	🟠	🟢
Thailand	🟢	🟢
Timor-Leste	🟢	🟢
Tonga	🟠	🔴
Tuvalu	🟠	🟢
Vanuatu	🟠	🟠
Viet Nam	🟢	🔴

Consensual sex between adult men illegal	Sex work in private illegal	Soliciting for sex work illegal	Corporal or capital punishment for drug offences	Compulsory centres for people who use drugs
🔴	🔴	🟠	🟢	🟠
🟢	🟠	🔴	🟢	🟢
🔴	🟢	🔴	🔴	🟠
🟠	🔴	🔴	🟢	🟠
🔴	🔴	🔴	🔴	🔴
🟢	🟠	🔴	🟢	🔴
🟢	🔴	🔴	🔴	🔴
	🔴		🔴	
🟢	🟢	🔴	🟢	🟢
🟢	🟠	🔴	🔴	🟠
🟠	🟠	🔴	🔴	🔴
🟢	🟠	🔴	🟢	🟢
🔴	🟢	🔴	🟢	🟢
🟢	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🟢	🟠
🟢	🔴	🔴	🟢	🟢
🟢	🔴	🟠	🟢	🟢
🟢	🔴	🔴	🟢	🟠
🔴	🔴	🔴	🔴	🟠
🟢	🟠	🟢	🟢	🟢
🟢	🟠	🔴	🟢	🟠
🟢	🟢	🟢	🟢	🟢
🔴	🔴	🔴	🔴	🟠
🟢	🔴	🔴	🟢	🟢
🔴	🔴	🟠	🟢	🟢
🟢	🔴	🔴	🟠	🔴
🟠	🔴	🔴	🔴	🟠
🔴	🔴	🔴	🟢	🟢
🔴	🟢	🔴	🔴	🔴
🔴	🟢	🔴	🟢	🟢
🔴	🟠	🔴	🟠	🟠
🟢	🟠	🔴	🔴	🔴
🟢	🟢	🟢	🟢	🟢
🔴	🟢	🔴	🟢	🟢
🔴	🟢	🔴	🟢	🟢
🟢	🟢	🔴	🟢	🟢
🟢	🔴	🔴	🔴	🔴

●	The law or policy provides an enabling environment for HIV responses
●	Punitive law or policy; there is no enabling law or policy; the law or policy does not provide an enabling environment for HIV responses
●	Partially enabling; enabling but subject to significant limitations; some aspects of the law or policy are punitive
	Information is unavailable or unclear

HIV-specific migration and travel restrictions

●	No HIV-specific travel or migration restrictions; no requirement to undergo HIV test as condition of visa or entry permit
●	HIV-related travel or migration restrictions exist; the term "HIV-related travel restrictions" refers to restrictions on entry, stay and residence where: ► HIV is a formal and explicit part of the law or regulation; ► HIV is referred to specifically, apart from other comparable conditions; and ► exclusion or deportation occurs because of HIV-positive status only
●	Mandatory HIV test requirements are imposed that may result in some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status; the requirement to have an HIV test is compulsory for applicants for some entry or residence permits; in most cases, an HIV test is required to identify people who may be a financial burden on the health system or considered to be a "public health threat"; in such cases, people living with HIV are not automatically denied entry or residence but are treated similarly to other people with health conditions that are costly to treat or considered a risk to public health

Criminalization of HIV transmission

●	No HIV-specific transmission, exposure or non-disclosure offences; HIV transmission is subject to general criminal laws or penal code provisions relating to, for example assault and intentionally spreading disease, but HIV is not specifically listed or identified in the law
●	HIV-specific penal laws criminalize HIV transmission, exposure or non-disclosure, with criminal penalties that include imprisonment; penalties are prescribed in penal codes or crimes acts
●	HIV transmission and failure to take precautions are criminalized under public health infectious disease or sexually transmitted infection laws

Gay men and other men who have sex with men: criminalization of sex between adults

●	Consensual sex between adult men has been decriminalized or is not a criminal offence
●	Consensual sex between adult men is a criminal offence
●	Partial criminalization of consensual sex between adult men, e.g. only in relation to members of the military or where criminalization is partly repealed or ambiguous

Sex work in private is prohibited

●	Sex work in private is not criminalized
●	Sex work in private is prohibited by criminal or administrative law
●	Sex work in private is partly criminalized (e.g. clients are punished but not workers) or criminalized in some parts of the country only

Soliciting is criminalized

●	Soliciting for sex work is not criminalized
●	Soliciting is criminalized
●	Although there is no specific soliciting offence, other offences are enforced for soliciting; Note: in the Federated States of Micronesia, soliciting for sex work is illegal in only two states

Corporal or capital punishment for people who use drugs

●	Penalties for use or possession of drugs do not include corporal or capital punishment
●	Penalties for use or possession of drugs include corporal or capital punishment
●	The position in relation to capital punishment is ambiguous; this includes states where extrajudicial killings are condoned by the state and where the legal status of capital punishment for drug offences is unresolved

Compulsory centres for people who use drugs

●	Countries do not have compulsory centres for people who use drugs
●	Countries have compulsory centres operated by government agencies that meet the definition of compulsory centres for people who use drugs of the 2012 United Nations Joint Statement; in these countries, compulsory centres for "treatment" or "rehabilitation" of people who use drugs exist where due process rights are limited or absent or human rights violations have been documented
●	Countries have compulsory systems for treatment and rehabilitation that operate treatment centres that have some of the features of compulsory centres for people who use drugs as described in the 2012 United Nations Joint Statement; these include countries with: ► nongovernmental organization, faith-based or private centres where human rights abuses have been reported; ► punitive systems for compulsory treatment or rehabilitation but where there is insufficient information (e.g. evidence of human rights abuses, substandard conditions, absence of due process rights) to conclude that the centres fully meet the definition of the 2012 United Nations Joint Statement

Table 2.
Enabling laws and policies affecting people living with HIV and key populations

	Discrimination prohibited against people living with HIV
Afghanistan	🟠
Australia	🟢
Bangladesh	🟠
Bhutan	🔴
Brunei Darussalam	🔴
Cambodia	🟢
China	🟠
Democratic People's Republic of Korea	🔴
Fiji	🟢
India	🟢
Indonesia	🟠
Japan	🟠
Kiribati	🟠
Lao People's Democratic Republic	🟢
Malaysia	🟠
Maldives	🟠
Marshall Islands	🟠
Micronesia (Federated States of)	🟠
Mongolia	🟢
Myanmar	🟠
Nauru	🔴
Nepal	🟠
New Zealand	🟢
Pakistan	🟠
Palau	🔴
Papua New Guinea	🟢
Philippines	🟢
Republic of Korea	🟠
Samoa	🟠
Singapore	🔴
Solomon Islands	🔴
Sri Lanka	🔴
Thailand	🟠
Timor-Leste	🟠
Tonga	🔴
Tuvalu	🔴
Vanuatu	🔴
Viet Nam	🟢

Independent access to HIV tests for young people	Confidentiality of HIV test results	Prohibition of mandatory or compulsory HIV tests
🟠	🔴	🟠
🟢	🟢	🟠
🔴	🔴	🟠
🔴	🔴	🟠
🔴	🟠	🔴
🟠	🟢	🟢
🔴	🟠	🔴
🔴	🔴	
🟢	🟢	🟠
🔴	🟢	🟠
🔴	🟢	🟠
🔴	🟢	🟠
🔴	🔴	🔴
🟢	🟢	🟠
🔴	🔴	🔴
🔴	🔴	🟠
🟢	🟢	🟠
🟠	🟠	🟠
🔴	🟢	🔴
🟠	🔴	🔴
🔴	🔴	🟠
🟠	🔴	🟠
🟢	🟢	🟢
🔴	🟠	🟠
🔴	🔴	🟠
🟢	🟢	🟠
🟢	🟢	🟢
🔴	🟢	🔴
🔴	🔴	🟠
🟠	🟠	🔴
🔴	🔴	🟠
🟠	🔴	🟠
🟢	🟠	🟠
🔴	🔴	🟠
🔴	🔴	🔴
🔴	🔴	🔴
🔴	🔴	🔴
🟢	🟢	🟠

●	Law or policy provides an enabling environment for HIV responses
●	Punitive law or policy; there is no enabling law or policy; law or policy does not provide an enabling environment for HIV responses
●	Partially enabling; enabling but subject to significant limitations; some aspects of the law or policy provide an enabling environment for HIV responses
	Information unavailable or unclear

Legal protections against discrimination on the grounds of HIV status

●	Discrimination against people living with HIV is unlawful in key areas such as employment, education and health care under national legislation; this includes countries where people living with HIV are protected by general human rights or disability laws that include HIV
●	There are no legal protections against discrimination on the grounds of HIV
●	There are partial legal protections against discrimination on the grounds of HIV, including: ► countries with some protections that protect against discrimination in limited circumstances (e.g. employment only, health care only); ► countries with protections that apply only to part of the country; ► countries with laws that prohibit discrimination on the ground of "disability", which may apply to an HIV-related disability but where it is unclear whether there is legal protection for people living with HIV who are well with no symptoms

Independent access to HIV testing for young people

●	The law enables people aged under 18 years to access HIV testing without parental involvement or parental or guardian consent; this includes countries that have set 16 years as the age of consent for HIV testing
●	There is no legal provision permitting adolescents to access HIV testing without parental or guardian consent; either the law prohibits people aged under 18 years from accessing HIV testing unless a parent or guardian consents, or there is no applicable law on age of consent to medical tests
●	People aged under 18 years can access HIV testing in some (restricted) circumstances without parental consent; this includes countries where: ► the child can consent if the parent or guardian cannot be found and it is in the child's best interests; ► legislation applies only in some parts of the country; ► the legal situation is ambiguous and age under 18 years is accepted in practice as the age of consent to testing

Law protects confidentiality of HIV test results

	There are strong legal protections for confidentiality of HIV test results; the law imposes penalties for unauthorized disclosure of HIV status
	There is no law imposing penalties for breach of confidentiality of HIV test results; there are general ethical and professional obligations to protect confidentiality of medical information but no law providing penalties for unauthorized disclosure of test results
	There is partial or weak legal protection of confidentiality of HIV test results, including countries where: ► the law provides for confidentiality of HIV test results in only some parts of the country; ► the duty to protect confidentiality of HIV test results is imposed by law or regulation but with broadly drafted or ill-defined exceptions

Prohibition on mandatory or compulsory HIV testing

	There are strong legal and policy protections against mandatory or compulsory HIV testing
	There is no legal prohibition on mandatory or compulsory HIV testing; laws or policies specify HIV testing as mandatory for certain groups
	There are weak or inadequate legal protections against mandatory or compulsory HIV testing, including countries where: ► there are contradictory laws and policies, and mandatory HIV testing still occurs for specific groups; ► the law prohibits compulsory or mandatory testing in only some parts of the country; ► mandatory or compulsory HIV testing is prohibited in employment but not for other purposes; ► although there is no mandatory HIV testing by government, there is no legal prohibition on mandatory or compulsory testing in private employment, education, health care or other settings

Table 3. Enabling laws and policies affecting key populations

	Transgender people	Sex work
	Legal recognition of change of gender	Sex work regulated and/or permitted in some locations
Afghanistan	🔴	🔴
Australia	🟢	🟢
Bangladesh	🟠	🟠
Bhutan	🔴	🔴
Brunei Darussalam	🔴	🔴
Cambodia	🔴	🔴
China	🟠	🔴
Democratic People's Republic of Korea		🔴
Fiji	🔴	🔴
India	🟠	🟠
Indonesia	🟠	🔴
Japan	🟠	🟠
Kiribati	🔴	🔴
Lao People's Democratic Republic	🔴	🔴
Malaysia	🟠	🔴
Maldives	🔴	🔴
Marshall Islands	🔴	🔴
Micronesia (Federated States of)	🔴	🔴
Mongolia	🟠	🔴
Myanmar	🔴	🔴
Nauru	🔴	🔴
Nepal	🟠	🔴
New Zealand	🟢	🟢
Pakistan	🟢	🔴
Palau	🔴	🔴
Papua New Guinea	🔴	🔴
Philippines	🟠	🟠
Republic of Korea	🟠	🔴
Samoa	🔴	🔴
Singapore	🟠	🟠
Solomon Islands	🔴	🔴
Sri Lanka	🟠	🔴
Thailand	🔴	🟠
Timor-Leste	🔴	🔴
Tonga	🔴	🔴
Tuvalu	🔴	🔴
Vanuatu	🔴	🔴
Viet Nam	🟠	🔴

People who use drugs				
Diversion from prisons to community services	Opioid-substitution therapy provided through government-approved programmes	Young people can access opioid-substitution therapy without parental consent	Needle and syringe programmes provided through government-approved programmes	Young people can access needle and syringe programmes without parental consent
🟠	🟠	🔴	🟠	🔴
🟢	🟢	🟢	🟢	🟢
🟠	🟠	🔴	🟠	🔴
🟢	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🟠	🟠	🔴	🟠	🔴
🟠	🟢	🔴	🟠	🔴
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🟠	🟠	🔴	🟠	🔴
🟠	🟢	🔴	🟢	🟠
🟠	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🟠	🟢	🔴	🟠	🔴
🔴	🟠	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🟠	🔴	🔴	🔴	🔴
🔴	🟢	🟠	🟢	🟠
🔴	🔴	🔴	🔴	🔴
🟠	🟠	🔴	🟠	🔴
🟠	🟢	🟢	🟢	🟢
🔴	🟠	🔴	🟠	🔴
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🟠	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🟠	🟠	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🟠	🟠	🟠	🟠	🟠
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🔴	🔴	🔴	🔴	🔴
🟠	🟢	🟢	🟢	🟠

●	Law or policy provides an enabling environment for HIV responses
●	Punitive law or policy; there is no enabling law or policy; law or policy does not provide an enabling environment for HIV responses
●	Partially enabling; enabling but subject to significant limitations; some aspects of the law or policy provide an enabling environment for HIV responses
	Information unavailable or unclear

Legal recognition of gender change by transgender people

●	Law provides for change of gender markers on passports or other identity documents for transgender people without requirement to undergo gender-reassignment surgery or other prohibitive requirements
●	Law does not provide for change of gender for transgender people
●	Law provides for change of gender for transgender people in limited circumstances or on condition that the person undergoes gender-reassignment surgery or other prohibitive conditions

Sex work regulated and permitted in specific locations

●	Sex work permitted and regulated at certain sites
●	There are no officially tolerated brothels or sex work areas
●	Sex work at certain sites is quasi-legal and permitted in limited circumstances; legal status is ambiguous and tolerated by police within specific areas

Diversion from prisons to community services

●	Country has system for diversion of people who use drugs from prison or detention to treatment or services in the community without threat of legal sanctions for noncompliance
●	No system for diversion of people who use drugs from prison or detention to treatment or other services
●	Country has system for diversion of people who use drugs from prison or detention to treatment or services in the community, but with threat of legal sanctions for noncompliance

Opioid-substitution therapy provided through government-approved programmes

●	Opioid-substitution therapy provided to people who use drugs through government-approved programmes
●	Opioid-substitution therapy not available to people who use drugs through government-approved programmes
●	Partial or ambiguous government support or restricted availability of opioid-substitution therapy for people who use drugs

Young people can access opioid-substitution therapy without parental consent

●	Young people aged under 18 years can access opioid-substitution therapy without a legal requirement for parental consent
●	Consent of a parent or guardian is required for a young person aged under 18 years to access opioid-substitution therapy
●	It is unclear or ambiguous whether consent of a parent or guardian is required for a young person aged under 18 years to access opioid-substitution therapy

Needle and syringe programmes provided through government-approved programmes

●	Needle and syringe programmes are provided to people who use drugs through government-approved programmes
●	Needle and syringe programmes are not available to people who use drugs
●	Partial or ambiguous government support to needle and syringe programmes and restricted availability of needle and syringe programmes to people who use drugs

Young people can access needle and syringe programmes without parental consent

●	Law or policy allows young people aged under 18 years to access needle and syringe programmes without a legal requirement for parental consent
●	There is no legal provision allowing young people aged under 18 years to access needle and syringe programmes without a requirement for consent to be obtained from a parent or guardian
●	It is unclear or ambiguous whether consent of a parent or guardian is required for a young person aged under 18 years to access needle and syringe programmes

Table 4. Enabling laws and policies affecting people deprived of liberty

	Access to opioid-substitution therapy in prisons
Afghanistan	🟠
Australia	🟢
Bangladesh	🔴
Bhutan	🔴
Brunei Darussalam	🔴
Cambodia	🔴
China	🔴
Democratic People's Republic of Korea	🔴
Fiji	🔴
India	🟠
Indonesia	🟢
Japan	🔴
Kiribati	🔴
Lao People's Democratic Republic	🔴
Malaysia	🟠
Maldives	🔴
Marshall Islands	🔴
Micronesia (Federated States of)	🔴
Mongolia	🔴
Myanmar	🟠
Nauru	🔴
Nepal	🔴
New Zealand	🟢
Pakistan	🔴
Palau	🔴
Papua New Guinea	🔴
Philippines	🔴
Republic of Korea	🔴
Samoa	🔴
Singapore	🔴
Solomon Islands	🔴
Sri Lanka	🔴
Thailand	🟠
Timor-Leste	🔴
Tonga	🔴
Tuvalu	🔴
Vanuatu	🔴
Viet Nam	🟠

Access to needle and syringe programmes in prisons	Access to condoms in prisons
🔴	🟠
🔴	🟠
🔴	🔴
🔴	🔴
🔴	🔴
🔴	🔴
🔴	🔴
🔴	🔴
🔴	🟠
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🔴	🔴
🔴	🔴
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🔴	🔴
🔴	🟢
🔴	🔴
🔴	🔴
🔴	🔴
🔴	🔴
🔴	🔴

Access to opioid-substitution therapy in prisons

●	Law or policy supports access to opioid-substitution therapy in prisons
●	Law or policy does not support access to opioid-substitution therapy in prisons
●	Partial or ambiguous support to opioid-substitution therapy in prisons; policy support to opioid-substitution therapy but implementation has not commenced or is very limited in scale

Access to needle and syringe programmes in prisons

●	Law or policy supports access to needle and syringe programmes in prisons
●	Law or policy does not support access to needle and syringe programmes in prisons
●	Partial or ambiguous support for needle and syringe programmes in prisons; programmes being piloted in some prisons

Access to condoms in prisons

●	Unambiguous policy support for condom availability in prisons, and condoms available to people deprived of liberty
●	Condoms not available in prisons; law or policy does not support condom availability in prisons
●	Partial or ambiguous support to condom availability in prisons, including countries where: ► condom availability is restricted to certain facilities or specific circumstances such as conjugal visits; ► condom availability in prisons is supported in principle but is yet to be implemented

Annex 2. Legal commitments of the 2016 United Nations High-level Meeting on HIV and AIDS

Political declaration on HIV and AIDS: on the Fast-Track to accelerating the fight against HIV and to ending the AIDS epidemic by 2030

Resolution adopted by the General Assembly on 8 June 2016.

Promoting laws, policies and practices to enable access to services and end HIV-related stigma and discrimination

63 (a). Reaffirm that the full enjoyment of all human rights and fundamental freedoms for all supports the global response to the AIDS epidemic, including in the areas of prevention, treatment, care and support, and recognize that addressing stigma and discrimination against all people living with, presumed to be living with, at risk of and affected by HIV is a critical element in combating the global HIV epidemic;

63 (b). Commit to strengthening measures at the international, regional, national, and local and community levels to prevent crimes and violence against, and victimization of, people living with, at risk of and affected by HIV and foster social development and inclusiveness, integrating such measures into overall law enforcement efforts and comprehensive HIV policies and programmes as key to reaching the global AIDS Fast-Track targets and the Sustainable Development Goals, and reviewing and reforming, as needed, legislation that may create barriers or reinforce stigma and discrimination, such as age of consent laws, laws related to HIV non-disclosure, exposure and transmission, policy provisions and guidelines that restrict access to services among adolescents, travel restrictions and mandatory testing, including of pregnant women, who should still be encouraged to take the HIV test, to remove adverse effects on the successful, effective and equitable delivery of HIV prevention, treatment care and support programmes to people living with HIV;

63 (c). Commit to intensifying national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV, including by linking service providers in health-care, workplace, educational and other settings, and promoting access to HIV prevention, treatment, care and support and non-discriminatory access to education, health-care, employment and social services, providing legal protections for people living with, at risk of and affected by HIV, including in relation to inheritance rights and respect for privacy and confidentiality, and promoting and protecting all human rights and fundamental freedoms;

63 (d). Underscore the need to mitigate the impact of the epidemic on workers and their families and dependants, workplaces and economies, including by taking into account all relevant conventions of the International Labour Organization, as well as the guidance provided by the relevant International Labour Organization recommendations, including the Recommendation on HIV and AIDS and the World of Work, 2010 (No. 200), and call upon employers, trade and labour unions, employees and volunteers to take measures to eliminate stigma and discrimination, protect, promote and respect human rights and facilitate access to HIV prevention, treatment, care and support;

63 (e). Commit to national AIDS strategies that empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights, including strategies and programmes aimed at sensitizing law enforcement officials and members of the legislature and judiciary, training health-care workers in non-discrimination, confidentiality and informed consent, and supporting national human rights learning campaigns, as well as monitoring the impact of the legal environment on HIV prevention, treatment, care and support;

63 (f). Commit to promoting laws and policies that ensure the enjoyment of all human rights and fundamental freedoms for children, adolescents and young people, particularly those living with, at risk of and affected by HIV, so as to eliminate the stigma and discrimination that they face;

63 (g). Encourage Member States to address the vulnerabilities to HIV and the specific health-care needs experienced by migrant and mobile populations, as well as refugees and crisis-affected populations, and to take steps to reduce stigma, discrimination and violence, as well as to review policies related to restrictions of entry based on HIV status with a view to eliminating such restrictions and the return of people on the basis of their HIV status, and to support their access to HIV prevention, treatment, care and support.

Annex 3. 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 4. Expert general meeting on HIV/AIDS: civil society recommendations

Addressing legal and policy barriers to HIV responses is one of the three pillars of the Economic and Social Commission for Asia and the Pacific (ESCAP) Regional Framework of Action on HIV and AIDS Beyond 2015 held in Bangkok on 27 November 2018. The three pillars were agreed at the 2015 Asia-Pacific Intergovernmental Meeting on HIV and AIDS: (i) access to affordable medicines, diagnostics and vaccines; (ii) legal and policy barriers; and (iii) development of evidence-informed HIV investments cases and sustainability plans. Civil society organizations attending the 2018 expert group meeting provided the following recommendations on legal and policy barriers:

(i) 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.

(ii) 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.

(iii) 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.

(iv) Governments should abandon the "war on drugs" approach and instead apply human rights, public health and harm reduction principles to drug control efforts.

(v) 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.

(vi) Governments should promote alternatives to conviction and punishment for drug use and drug possession offences, including diversion to treatment in the community.

(vii) 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" and "transgender" should be inclusive of diverse genders, gender identities and expressions, and based on self-determination.

(viii) Governments should guarantee legal recognition of gender identity based on self-determination.

(ix) 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.

(x) 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.

(xi) Governments should reform immigration policies that discriminate based on HIV status among migrants, refugees and non-citizens to enable access to treatment and services.

(xii) 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.

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