

/ MEETING REPORT /

*Regional Consultation on Treatment and
Human Rights
REMBRANDT HOTEL / BANGKOK / 28 -
29 SEPTEMBER 2015*

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MULTI-COUNTRY SOUTH ASIA GLOBAL FUND HIV PROGRAMME
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Opening speeches

SESSIONS DAY

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The official opening of the Regional Consultation on Treatment and Human Rights was held in Rembrandt Hotel and included speeches by **Mr. Shiba Phurailatpam**, the director of the Asia Pacific Network of People Living with HIV/AIDS (APN+), Thailand, and **Ms. Anna Chernyshova**, the

programme Manager of Multi-Country South Asia Global Fund HIV Programme from UNDP – Regional Hub, Bangkok - Thailand.

Mr. Shiba Phurailatpam welcomed participants to Bangkok, stating that it was an honor for the committee to host such an important event. He referred to the importance of the meeting and healthcare access challenges facing by PLHIV. He stated that everyday many people were dying because they could not access treatment of HIV. The meeting would draw attention to deliver human rights issues in healthcare settings across seven countries in South Asia region.

Ms. Anna Chernyshova thanked the participants for joining the event, stating that the program was focusing on seven countries of South Asia region. She drew attention to a particular main focus of HIV and Human Rights, with special topic issues on MSM and TG to access HIV/AIDS treatment in health services. She emphasized that health was a fundamental human rights and every person has rights of treatment and access to health service. She gave an example of a PLHIV in India who could not have access to the health treatment once he knew he was HIV positive. The man was stigmatized and expelled from his family, society, and he even lost his job. She referred to the importance of integrating human rights in healthcare access as, for example, in most of countries in South Asia region, homosexuality is criminalized. As the result, HIV positive persons could not have access to treatments, making HIV spread secretly. In this sense, human rights and health is synchronized to each other.

Introduction: Setting Up The Meeting Context

Mr. Paul Cawthorne, Medecins Sans Frontiers, Head of Mission in Thailand (MSF), acted as the facilitator for the event. He warmly welcomed participants on behalf of the committee and set up the framework of the meeting to meet the outcome of the consultation process. He stated that the main objectives of the event were to identify key problems of treatment access for the HIV/AIDS key populations and to work together to address the issues. He discussed the need to consider all barriers to the treatment for PLHIV and also the power relations to the health access. He emphasized a look out to integrate and look of possible funding opportunities to actually implement the ideas that the event would produce.

Country Presentation: Updates on MSM and TG access to Treatment services

The first country to present at this country presentation session was **Afghanistan**, with DR. Mohammad Khan Hedayat, Kabul ART Center Manager, as the country's representative. He started the presentation by explaining the HIV/AIDS background in Afghanistan. The first HIV case in the country was detected in 1989. However, until 2003, civil wars were still presence in Afghanistan. Consequently, there was no access for PLHIV to get treatments. Up to 2014, detected HIB cases were 1694 with total MSM cases were 32 as per August 2015. He continued that NACP in Afghanistan was established in 2003, but it started to be supported by the Global Fund in 2008.

The representative mentioned that in Afghanistan, HIV/AIDS status was low-concentrated with PWID were among key populations at high risk. In 2012, an overall 4.4% of HIV prevalence was among PWID, 0.3%, 0.4%, and 0.7% were among FSW, MSM, and Prisoners respectively. The epidemic was presently under 0.05% among general population. He also stated that NACP Afghanistan had vision to improve life of PLHIV in the country and there would be no new HIV in Afghanistan. NACP Afghanistan

also had missions to strengthen and scale up high quality of HIV access to prevent and cure. The main goal was to maintain low prevalence of HIV/AIDS in Afghanistan. In Afghanistan, there were high-risk people like PWID, FSW, MSM, and Prisoners; vulnerable group like long distance drivers, refugees, migrant workers, and youth; as well as general population. Priority areas for NACP in Afghanistan were covering: Enhancing accessibility, coverage, and quality of HIV prevention; expanding accessibility; making documentation and utilization; and strengthening governance and program management at national and provincial levels.

To achieve the main goal, NACP provided services for key affected population, vulnerable population, and general population in addition to prevention mother to child transmission and post exposure prophylaxes. Throughout the country, there were HIV Services Centers: 10 VCT, 2 ART, 5 PMTCT, 2 male clinics, 1 HIV clinic for truck drivers, 1 HIV clinic and family clinic, and 52 HIV centers in Afghanistan. The ART Centers Services provided: registration of PLHIV, counseling, CD4 counting, and lab exams. Registered cases ART were 794 (On ART 380 / Death 64) with new MSM as per 2015 were 8 cases and 6 cases of death.

The representative mentioned gaps and challenges with target population in Afghanistan. The disease and behavior surveillance system as well lack of politics intervention became the main issue. The challenge was stigma and discrimination; barrier in condoms distribution and inadequate ART centers; majority of target group was mobile; hidden nature of target communities with low geographic coverage; limited geographical coverage; and governmental resource and legal barrier. The recommendations for this country included: training and capacity building of human resources; doorstep delivery of the service through peer education; establishment of community deports; increase of awareness of HIV/AIDS; expansion of HIV prevention; PLHIV networks building.

Ms. Anna Chernyshova appreciated the presentation as she saw a positive sign of Afghanistan of dropping in MSM and TG group. MSM and homosexuality in Afghanistan were still a big issue. She relieved that in the country, MSM and TG groups had now included in the National Strategic Program in Afghanistan.

The second country to present at this country presentation session was **Bangladesh**, with Dr. Nilufar as the representative from a healthcare provider in the country. The representative started the presentation by explaining the HIV/AIDS background in Bangladesh. The country had total population of 160 million people and wrapped by neighboring countries of HIV/AIDS-high like India and Sri Lanka. PLHIV total case was 9500 with first case was found in 1989. HIV infection was increasing every year for cumulative HIV infection and dead. NHC was formed in 1985 as part of national response and reconstituted in 2010. Most of national programs were intervention package especially for sex workers, MSM, TG, and IDU, with intervention in brothels on the street, and hotels. Risk factors were high from needle sharing among IDU, external and internal migration, and also low level of Condom use. The key area in Bangladesh was mainly focuses on preventive actions. So far, there were 7 ART centers across the country and 20 ART more would be built in October, with 89% of PLHIV receiving ART. Save the children built 16 for NARP, 20 for NASP, 5 for TB, and 10 NGO. The diagnostic lab had only a screening function.

Challenges found in the country were continuing and scaling-up effective HIV prevention program, sustaining treatment and ART, and preventing stigma and discrimination. In the country, estimated numbers of MSM were 40,000 – 150,000 (HIV 39, 70% ART) and TG numbers were 10,000-50,000 (HIV 25, 31% ART).

The representative had four questions from other participants:

Q&A – A Representative from Afghanistan

Q: "Who support PLHIV and what kind of support the organizations giving?"

A: "We give treatment from 3 NGO with their own programs. We provide sessions with arranging training and food. PLHIV come from distance.

Q&A – A Representative from Sri Lanka

Q: What is the methodology to estimate MSM and TG population?

A: It has been mentioned in the global report number.

Q&A – A Representative from India

Q: What is the legal privilege given of social protection to PLHIV? Because in India, we have food security, jobs, and so on.

A: Every month they come to ART if they have human rights problem, lawyers can help them. We also have social program.

Q&A – A Representative from Afghanistan

Q: What about stigma and discrimination in Bangladesh and what is the effort to decrease the stigma and discrimination?

A: We have community session meeting program where PLHIV can have public hearing. Bangladesh has anti-discrimination law from the parliament and we have moral courage for the student in the university also.

The **third country** to present at this country presentation session was **Bhutan**. The representative started the presentation by explaining the HIV/AIDS background in Bhutan. The country had HIV prevalence 0.1% in 2013 of 1000 people. The first case was detected in 1993, and not even MSM and TG were detected. Moreover, no officially endorsed size estimation of MSM and TG in Bhutan. MSM had not been coming out. They faced strong fear of stigma and discrimination from family, society, and general population, but experienced no discrimination in public. In healthcare, environment they felt discomfort to talk to healthcare providers. There had been poor awareness from MSM and TG about their HIV status.

The representative explained several achievements in Bhutan: MSM/TG were included as key population in the NSPI; MSA grant in 2012 to put MSM and TG on the table of the discussion to start advocacy and networking (the country also had the Global Fund as its main funding); training of health workers of stigma and STI management among MSM and TG; informal network of LGBTI community had been established; 96 MSM/TG were reached with HIV prevention and 46 were treated; national language to deliver LGBTI terminology; national TV interview for the first MSM and Lesbian; religious leader in Bhutan said sexual orientation had nothing to do with religion.

The country still faced several challenges: criminalization of sodomy as it against the nature with penalties of 1 year sentence in jail; weak network of MSM/TG communities; and inadequate capacity of healthcare training. Way forward, Bhutan aimed to increase networking of MSM and exposed trainings for MSM.

Ms. Anna Chernyshova appreciated the presentation as she saw a wonderful presentation and the breakthrough that Bhutan showed. She emphasized that Bhutan was the only country within South Asia region who worked together with religious leaders (Buddhist monks). Stigma and law still were still there, but the country could become a good example of supporting environment, like the King and religious leaders who had accepted PLHIV. She saw a strong sign from the society and referred to a need to embrace PLHIV. Bhutan was small country with low epidemic, but it showed a positive sign for becoming a good example for other country within the region.

Q&A – A Representative from Afghanistan

Q: "1,000 cases of HIV? How many is the population of Bhutan?"

A: "700,000 as total.

Q&A – A Representative from INDIA

Q: How is HIV prevalence like in Bhutan?

A: "0.1%"

Q&A – A Representative from PAKISTAN

Q: "What about any incentives for PLHIV?"

A: "NGO provides to incentives to PLHIV", from their house to clinics, also for mother to children supplement. However, the incentives are still very small.

Q&A – A Representative from Sri Lanka

Q: "What is the religious issue related to PLHIV?"

A: "Religious groups are Buddhist monastic body with 13 religious leaders concern with HIV. They give positive feedback.

The fourth country to present at this country presentation session was **India**. The representative started the presentation by explaining the HIV/AIDS background in India. In the country, HIV prevalence of MSM was 4.43% and TG was 2%. The government had intervened with some intervention projects and separated component of MSM and TG as target intervention programs. The challenge found in India was that after 2010, HIV response was not very good. New infections were reduced but nobody gave focus in HIV prevention program. There had been low access between MSM and TG groups to get treatment. Since the beginning, the program was dedicated to MSM only. There was huge gap between the prevention and the treatment, and between population identified and population treated. Gap was also found in funding sector due to lack of budget and not getting money on time for the employees engaged in HIV/AIDS sectors. Consequently, they could leave their job for the community. Condoms were not available for enough stock. Government had not got policy for children and Hepatitis C treatment. Failure was also shown in the second line treatment. From the first line to second line treatment, many PLHIV found lack of drugs and access.

The representative mentioned that there had been different estimation between the government and NACP, as the government did not follow up any global policies recommended, like global zero policy and legal protection. However, there were several achievement that NACP gained, like: over 8.5 Lakh people on treatment; 425 ART center across country; some states provide social protection scheme to access treatment in nutrition and free transportation access from home to clinic; HIV Bill and TG Bill was introduced in parliament; the Supreme Court had TG rights in term of discrimination; Indian court

has enforced human rights for PLHIV to access second line treatment; and all state had to, at least, provide one ART center to provide second line treatment.

Q&A – A Representative from PAKISTAN

Q: "Why are there any deficiency found in ARV drugs in India? In Pakistan we have some schemes that can provide all supply."

A: "India is a pharmacy product for generic medicine. However, the stock faces barrier from the government will in political procedures. The situation is more like timing issue in giving the medicine in proper time".

Q&A – A Representative from NEPAL

Q: "Why don't you implement the policies of the government of HIV?"

A: "India is reducing HIV/AIDS budget. Now the authority faces too much difficulty to implement programs. They are struggling by the existing cost".

Q&A – A Representative from NEPAL

Q: "Who will do the scale up in India? What about the willingness from the government?"

A: "The government is not willing to pursue the HIV program. The last budget from Indian government is cut and we have lack program of HIV due to lack of budget. They don't even plan to accelerate any programs".

The fifth country to present at this country presentation session was **Nepal** by Dr Bhesh Raj Pokhrel. The representative started the presentation by explaining the HIV/AIDS background in Nepal. The first case was detected in 1988. HIV prevalence for adults was 0.20% in 2015. Total estimated cases were 39,249 in 2015. Nepal started ART in public hospitals in 2004. Nepal had concentrated HIV epidemic. MSM size was 9497 as per 2014. Out of 39,389 HIV Cases, 8% were MSM. HIV prevalence among MSM groups was 6.8% as per 2012, no data yet for 2015. Heterosexual transmission was the predominant mode. 10,407 PLHIV in total was under ART.

The representative explained that in Nepal, National HIV and STI policy was started in 1995. The vision was to establish Nepal free of HIV/AIDS and STI community. The program aimed to reduce new risk of infection and number of death by following guiding principles of universal program and national investment plan, especially Nepal HIV Investment Plan 2014 – 2016. Components of HIV services in Nepal included behavioral change communication, condom promotion, management of sexually transmitted infections, harm reduction, and HIV testing and counseling. The program covered counseling and testing in 263 sites in 75 districts and ART in 61 centers. MSM and TG as per 2012 was 196,270, HIV prevalence was 3.8% or IBBS in 2012. Moreover, stigma and discrimination still became the social barriers.

In Nepal, some achievements had been granted, especially to LGBTI equal rights. In Nepal, the government gave recognition of the third gender, shown in the citizens' passport. Social justice was also enforced by using human right framework for sexual minority groups, collaborated in Nepal Investment Plan 2014-2016. Some challenges covered funding gap and public harassment. However, fewer complaints against human rights violation were addressed by the community of sex workers and

TG. No specific data found for MSM and TG. Way forward, Nepal aimed to integrate HIV program with human rights perspective.

Q&A – A Representative from PAKISTAN

Q: "What is the reason behind gap of registered data for TG/MSM community?"

A: "It is an on-going program".

Q&A – A Representative from SRI LANKA

Q: "You only mentioned TG as 5% HIV prevalence. Who else? Among IDU use, do you have HIV program?"

A: "PWID is number one. Yes we have several programs in reducing the number of HIV among PWID as well as STD, also detox plus and other implemented programs. Human Rights commission works together with Ministry of Health also.

Q&A – A Representative from BHUTAN

Q: "Who established TG community in Nepal? And how is the acceptance from the community?"

A: "The community who demanded it. Later the government gave positive responses and recognition. BDS society helped to build the community of raising TG issue along with LGBT rights projects and HIV programs with media and network with legal and community people.

Q&A – A Representative from INDIA

Q: "Does Nepal provide second line treatment? What is different between MSM and TG in term of government approach?"

A: "We have meeting in our centers and in the process of making guideline. The government has been so determined to handle this issue and tackles barriers, especially in term of medicine.

The sixth country to present at this country presentation session was **Pakistan** by Dr.Azra Ghayas Abro. The representative started the presentation by explaining the HIV/AIDS background in Pakistan. In the country, NACP had an objective to prevent HIV as transmitted disease by giving research and training with program management. NACP also aimed to give education and implemented the education in all provinces to deliver treatment to as many as key population groups. In general, less than 1% of general population for HIV prevalence or as many as 87,000, and 11% is on ART, 3.1% is MSM and 7.3% of TG. IUD remained the highest. According to IBBS Pakistan, there were more than 23,000 of TG.

The representative delivered progression of HIV in 2005 – 2011. For IDU, the progress was increasing feasibly. However, the progress for MSM and TG was not so significant. Baby became new concern for HIV program. We had huge support program by *zakat mal* or collected money from the Muslim society from all provinces in Pakistan. This meant that everyone could participate. Home-based community program was also running in Pakistan.

In Pakistan, several achievements had been granted, like: recognition of MSM and TG in AIDS strategy and the country had included them in the mapping of HIV/AIDS National Program. ART was scaling up from 2004 to 2014. Pakistan was establishing new centers mostly in hospitals in Karachi. Several issues were still found, like: discrimination, progressing epidemic, registration gap in diagnosing disease, and the government intervention program was still dedicated to pregnant women. Challenges in

Pakistan were social-political aspects in stigma and discrimination, criminalization for homosexual people, lack of research, HIV image that was still shaming for some communities, policies and programs about HIV/AIDS should be further developed, PLHIV network had to be encouraged to support key role in HIV prevention, leadership across all sectors should be fostered and valued through mobilization for HIV support, sustainability would be promoted through existing HIV program, and employers would be assisted to change their policy in employment.

Q&A – A Representative from NEPAL

Q: "What is your planning to reduce harm of stigma and discrimination toward MSM and TG?"

A: "Each province supporting NGO to handle this stigma issue but the government does not support the steps. Further program is supported by The Global Fund".

Q&A – A Representative from INDIA

Q: "Why there is huge gap in Pakistan? Is there any programs who does not engage "sex" for sale?"

A: "The number is taken from festivals in provinces in country and there are available counselor in the spot to have HIV testing. However, there are also some people who are not aware of HIV test. Due to financial problems, people are not coming to the centers, mostly situated in urban area of Karachi. While many people with HIV are from rural area of other provinces.

Q&A – A Representative from AFGANISHTAN

Q: "How the refugee or the *muhajjir* accesses the treatment HIV also for advocacy in Pakistan?"

A: "There is no discrimination, but we don't have either specific data or research yet. Karachi is the hub for people from every province in Pakistan, also for migrants from India and Burma. And I guarantee there is no discrimination for *Muhajjir*.

The last country to present at this country presentation session was **Sri Lanka**. The representative started the presentation by explaining the HIV/AIDS background in Sri Lanka. HIV Situation in Sri Lanka was 1 HIV infection per day and 4 new cases reported per week. In 2014, new cases were high. HIV first case was found in 1987. The proportion of common mode of transmission was by homosexual people. MSM was estimated for as many as 30,000 people. However, no exact preview was available for TG.

The representative mentioned several achievements in the country, like: free health service to PLHIV and STI, and free formula milk for infants born to HIV mother; legal and ethical subcommittee of the National AIDS Committee; countrywide network of STI; implementation of DIVA project; monitoring and evaluation system strengthening; and law enforcement to decriminalized homosexuality. Challenges included moving estimation of MARP's including MSM and TG with difficulty of coverage, as well as variable rate of coming out and continuous nature. Most estimated TG was included in the MSM group and no breakdown was available based on typology. There was still a difficulty to address MARY because of age related legal. LGBT Family needed support and recognition to access care. There was needed consistent condom use among MSM and TG and prevention of Hepatitis B and C among MSM and TG. Moreover, effective Peer education model needed to be tested in different context.

Q&A – A Representative from AFGANISHTAN

Q: "How can you clarify pre-testing challenge?"

A: "It is like to initiate the testing and to make the guidelines also the perspective of the setting to behavioral change."

Sharing Sessions: Community Initiative to address Stigma & Discrimination in South Asia

The session was delivered by **Mr. Sushil Koirala**, the Program Manager of APN+. The idea of this session was to look out PLHIV and their access to treatment after the HIV diagnosis. The session provided a study result of **MATA (Monitoring Access to Treatment Asia)**. The study had 2 principles, implemented in 7 countries in Asia: Bangladesh, Indonesia, Lao PDR, Nepal, Pakistan, the Philippines, Vietnam. The study had two objectives:

- 1) To understand current level of access to the key HIV treatment, care and support services among PLHIV in Bangladesh, Lao, Vietnam, Philippines, Indonesia, Pakistan and Nepal
- 2) To develop baseline to monitor changes in the key HIV treatment, care and support services among PLHIV in Bangladesh, Lao, Vietnam, Philippines, Indonesia, Pakistan and Nepal.

The variables of the study were:

- 1) HIV diagnosis
- 2) Pre-ART care
- 3) Early monitoring of biological markers
- 4) Economic Burden of care
- 5) Reproductive health
- 6) HIV risk behaviors
- 7) Social support
- 8) Stigma & discrimination
- 9) Treatment literacy
- 10) Treatment of Hepatitis C
- 11) Treatment of TB
- 12) ART adherence

Among many reasons, **Mr. Sushil Koirala** mentioned that most reason for people to take HIV Test were due to reference by the doctors with place of initial HIV Test was most likely in the government hospitals. Treatments were not free. Moreover, stigma and discrimination still became barrier for PLHIV to access health service. Type of stigma and discrimination were different in each country and it was related with self-stigma and fear of disclosure. The highest stigma and discrimination was found in Pakistan.

Mr. Sushil Koirala continued that regarding self-reported ART adherence, this was a tricky way. Because the government, for example, the government of Lao PDR, said it had been OK, but in fact, the government had poor access. It seemed that the government was often overlook the data. Finally, the research had several conclusions:

- 1) Low self initiated HIV testing, indication of late diagnosis, Low CD4 at diagnosis
- 2) Poor access to viral load counts – Monitoring of viral load is almost non-existent in 5 out of 7 countries
- 3) Despite large scale funding- cost of care is still a burden
- 4) Level of discrimination varies- but still a significant problem in some countries (like Pakistan)
- 5) Inadequate access to prevention services (Condoms , Needle and Syringes, OST)
- 6) Mixed level of treatment literacy, some countries have lower treatment literacy levels than others.
- 7) Self-reported adherence is lower than 80% in 4 out of seven countries. Less than 50% self-reported adherence in Laos.
- 8) Stavudine was still used in 6 out of 7 countries.

Q&A – A Representative from AFGANISHTAN

Q: "Do religious leaders included in this study?"

A: "For data collection we mainly use peer community.

Q&A – A Representative from NEPAL

Q: "Do you have ethical approval?"

A: "Yes we did and we wanted to do a careful research."

Presentation:

Advocating your Rights: Strategizing Rights Based Approach to better Treatment Access for MSM and TG

This session was presented by **Mr. Ninoslav Mladenovic** from UNDP-BRH, Bangkok. He greeted participants warmly and opened his presentation with an important question: What are human rights? He continued to explain that the definition of human rights are mentioned in the United Nations documents, based on the international standards (the international law) of human rights to advocate our rights. In UN Document, human rights were mentioned to cover many aspect of human life, including rights to health. The definition of rights to health used internationally was based on WHO definition: *"health is a condition of a complete physical, mental and social well-being which does not only mean absence of disease or infirmity"*.

Furthermore, there were key legal aspects of the rights to health:

- 1) The right to health is an inclusive right
- 2) The right to health contains freedoms
- 3) The right to health contains entitlements
- 4) Health services, goods and facilities must be provided to all without any discrimination
- 5) All services, goods and facilities must be available, accessible, acceptable and of good quality

There was inter-relatedness of human rights and health, in term of how to deal with key affect population. This would include freedom of discrimination based on international instrument to the standard of health. There were also common misconceptions about the right to health:

- 1) The right to health is NOT the same as the right to be healthy
- 2) The right to health is NOT only a programmatic goal to be attained in the long term
- 3) A country's difficult financial situation does NOT absolve it from having to take action to realize the right to health

Mr. Ninoslav Mladenovic asked a question about how the Principle of non-discrimination applies to the right to health with addressing HIV-related stigma and discrimination. This would relate with the issue of social perception of HIV, for example, talking about HIV is still a taboo in Afghanistan, also, law criminalizes MSM and TG and that had result in social stigma and violation of human rights and economy chance. In the international human rights law, there are numbers of conventions and many countries had ratified UN Documents for almost all basic rights, including mental and social aspect, like for PLHIV. The rights to health in consensus-reached documents could be found in some documents, like Declaration of Alma-Ata (1978). The document was served as the foundation to understand nowadays rights to primary health access. There were also Declaration of Commitment of HIV/AIDS, Political Declaration on HIV/AIDS, and UNAIDS/UN OHCHR International Guidelines on HIB/AIDS and Human Rights

The Right to Health should be applied to MSM and TG as documented violations towards MSM and TG due to vague or overbroad criminal status and police harassment still existed. In healthcare settings, there were components of sexual health related to MSM and TG:

- 1) Prevention and treatment of STIs and infections of reproductive tract – condom use, immunization programmes, population screening, VCT programmes, partner notification, sexual education, antibiotic treatment.
- 2) Prevention, care and treatment of HIV/AIDS – condoms, education, psycho-social support, ART, harm-reduction programmes among hard-to-reach and vulnerable groups.
- 3) Information, education, counseling about sexuality, sexual and reproductive health, parenthood, gender equality and gender tolerance - sexual education in the schools, youth programmes outside the schools, informal programmes targeting hard-to-reach groups, youth-friendly services, access to contraception (and condoms), counseling centers for sexual and reproductive health.
- 4) Sexual violence and abuse – prevention, education, legal aid, treatment and care of victims of sexual violence, gender perspectives, pedophilia.
- 5) Domestic/family violence – prevention, education, legal aid, treatment and care of victims of domestic/family violence - counseling and transitional centers, gender perspectives.
- 6) Sexual and reproductive rights – awareness raising among the general public, advocacy and policy making, legal regulations, national strategies for sexual and reproductive health.

Mr. Ninoslav Mladenovic also mentioned general obligations and responsibilities on states towards the rights to Health, with the International Covenant on Economic, Social and cultural Rights (article 2), progressive realization, taking steps to realize the rights to health, a proposed framework for structural indicators, and core minimum obligation. He also mentioned three types of obligations of Human Rights:

- 1) The obligation to Respect
- 2) The obligation to Protect
- 3) The obligation to Fulfill

United Nations bodies and specialized agencies (OHCHR/WHO/UNAIDS/UNDP/The World Bank Regional Bodies (UN ESCAP), the private sectors (including pharmaceutical companies), and also the national health system shared the obligations, too. Finally, **Mr. Ninoslav Mladenovic** concluded his presentation by enforcing human rights framework to improve the in-country programming with the overview of best practice example from countries in South Asia region, like India, followed by group-work.

Ms. Anna Chernyshova added information in this session that this program was not intended to push MSM agenda. The main issue was the spreading of HIV among global population. She mentioned that India probably had the most problematic in MSM and TG in HIV discussion as the HIV prevalence was the highest in this country and this issue was not address properly in South Asia. If the stigma and criminalization continued, the HIV between MSM and TG would be even higher. She emphasized the need of more reliable data to be shown to the government as the heading way, especially toward 2020. MSM and TG issue had to be addressed, not because we wanted to promote homosexual relation, but the fact that HIV would be increased among these people. They should not feel afraid to have themselves tested and be treated as other human being as other people in the country.

Community Mobilization, Networking and Partnership

With model of group exercise, the session aimed to provide insights on strengthening MSM and TG community engagement in AIDS response, making more use of their networks and strategizing partnerships with key stakeholders Gov./Dev. Agency, etc. Participants from seven countries in South Asia would be trained to develop a networking and partnership scheme as one of its strategic directions forward. Below is the matrix of the group discussions per country:

Country	Existing MSM and TG Program	Gaps in Existing HIV-Related Health Program for MSM and TG Population	Key Players
Afghanistan	<p>The MSA HIV</p> <p>1) Outreach activities: Awareness on HIV and AIDS, detection and register of new clients and follow up of repeated clients, referral client to MHC and Condom distribution.</p> <p>2) Clinic Based activities: Awareness video of HIV clips, IEC, HIV counseling and testing, STI diagnosis and treatment, stock management, providing reports.</p> <p>3) Follow up of PLHIV: Registration, immediate HIV Case report, HIV client follow</p>	<p>Main Issue</p> <p>1) Stigma and Discrimination against PLHIV</p> <p>2) Low awareness</p> <p>3) The disease and behavior surveillance system with respect to HIV/AIDS in the country remains inadequate for IBBS</p> <p>4) The MSM population groups in the country required increase attention (just two clinics in country)</p> <p>5) Need expansion of program</p> <p>6) Barrier of condom distribution</p> <p>7) Majority of group is mobile</p> <p>8) All PLHIV did not attend the meeting</p> <p>9) Unavailable viral load facility in the country</p> <p>10) Inadequate government resources for HIV response</p>	<p>Government's relevant ministries (Health, Education, Social Justice), UN Agencies, Implementing organization, AIHCR, Parliament, media, religious leaders, MSM, and PLHIV</p>

	<p>up file, refer to ART Center, meeting with PLHIV, and follow up meeting with ART Center.</p> <p>4) Supervision and monitoring: Providing outreach and clinic plans and needs based revision, daily data collection and update the database, surprised and unsurprised monitoring visit from MHC, monthly based collection of reports and quarter based feedback, quarter based monitoring visit and providing report to MHS, management from MHC, community meeting</p>	<p>11) Legal barriers working with target communities</p> <p>12) Not ensure about the long-term project or program for MSM</p> <p>13) Unclear components for MSM projects</p> <p>14) Capacity building and awareness of relevant GOV and NGO</p> <p>15) PLHIV network is not available</p>	
Bhutan	<p>1) Training of health workers on stigma and discrimination reduction package and STI management among MSM/TG</p> <p>2) Buddhist approach to HIV prevention</p> <p>3) Stigma reduction and counseling</p> <p>4) Health workers TOT and Religious leaders TOT</p>	<p>1) Sodomy Law</p> <p>2) Weak network of MSM/TG Community</p> <p>3) Inadequate capacity of health workers to response</p> <p>4) Lack of knowledge among policy makers and MSM/TG is not seen as priority given the limited visibility</p>	<p>Ministry of Health (NACP) for legal barrier</p> <p>Health workers</p> <p>Religious leaders</p> <p>Policy makers</p> <p>LGBTIQ community</p>
Bangladesh	<p>1) Targeted intervention program for MSM and TG</p> <p>2) VCT and STI service (inadequate)</p> <p>3) NGO driven program only</p>	<p>1) Between estimated and reported number between MSM and TG</p> <p>2) No GoB facilities (no testing facility)</p>	<p>Policy makers</p> <p>Community people</p> <p>Healthcare providers</p> <p>NGO, Government sectors.</p> <p>Donors</p>
NEPAL	<p>1) HTC/STI diagnosis and treatment</p> <p>2) S&D reduction program to make awareness and training</p> <p>3) Prevention: TI Program and Condom lubricant</p> <p>4) Treatment: ART, OI Management</p> <p>5) Human Rights advocacy and legal policy, enabling environment</p>	<p>1) Funding gaps</p> <p>2) Lack of awareness among Healthcare Workers among LGBTI</p> <p>3) Healthcare Workers are not well trained on anal and oral STI</p> <p>4) No segregated data on MSM/TG</p> <p>5) Community testing are not yet implemented</p>	<p>The Government – NCASC</p> <p>Donor Agencies (i.e. Save the Children)</p> <p>Civil Society and other stakeholders</p> <p>Community itself</p>
SRI LANKA	<p>1) Legal and ethical subcommittee of the NAC regularly discuss matters related legal issues and access for care</p> <p>2) National HIV Policy includes prevention, treatment and care service for MARP including MSM and TG</p> <p>3) Peer Education</p> <p>4) Government outreach</p>	<p>1) No rational estimation fo TG/MSM</p> <p>2) Changers legal framework</p> <p>3) Sensitization of media</p> <p>4) Proactive intervention by HRC</p> <p>5) Judiciary</p>	<p>NGO</p> <p>Government</p> <p>Media partners</p>

	<p>program under GFMSA</p> <p>5) Implementation of Project DIVA to reduce impact</p> <p>6) Monitoring and evaluation system strengthening</p> <p>7) Early initiation of ART</p> <p>8) Learning modules on rights to health with special emphasis on MARP has been mainstream to post grad students of doctors</p> <p>9) Training of Healthcare Workers on human rights based</p>		
INDIA	<p>1) Government has implemented the targeted program for MSM and TG</p> <p>2) A comprehensive service is provided in Tis program</p> <p>3) Under DIVA project a sensitizing program for stakeholders out, i.e. Law enforcement agency, judiciary and lawyers, policy maker, media fellowship, etc.</p>	<p>1) Community led testing</p> <p>2) Impact of funding crunch, drugs, and diagnosis kits stock out</p> <p>3) Invest on MSM and TG PLHIV Community for activism</p> <p>4) Legal empowerment and Grievance redressed mechanism</p> <p>5) Impact of 377 CBO's community members</p>	
PAKISTAN	<p>1) Implementation of BCC strategy</p> <p>2) Awareness and sensitization of relevant stakeholders</p> <p>3) Advocacy campaign of bureaucracy</p> <p>4) Acceptability and confidentiality</p> <p>5) Social inclusion</p> <p>6) Introducing third line treatment</p>	<p>1) Socially marginalized groups</p> <p>2) Financial issues</p> <p>3) Illiteracy</p> <p>4) Lack of accessibility, knowledge, and psycho social support</p> <p>5) Less sensitization of health professional</p> <p>6) Lack of funding and commitment of priority</p> <p>7) Service of doorstep</p> <p>8) Deficient third part evolution</p> <p>9) No research based evidence regulatory</p> <p>10) Lack of genotyping testing to detect the failure case</p>	

Presentation: Towards Ending AIDS in 2030: Regional Update on Access to Treatment, Fast-Track Targets with Focus on 90-90-90

The Day 2, Tuesday, 29 September 2015, of the Regional Consultation on Treatment and Human Rights was opened by the event's facilitator, **Mr. Paul Cawthorne**. The facilitator went directly to the presentation from **Mr. Tony E. Lisle**, Regional Programme Adviser, UNAIDS Regional Support Team, Asia Pacific.

Mr. Tony E. Lisle mentioned about the accelerated response of HIV/AIDS through community to lead an effective response. He emphasized the need of an investment on community capacity building in indigenous organization, including for MSM and Transgender. This meant the community was taking on the delivery of treatment and testing, also for the work to deliver, the task shifting of medical model from top to down to horizontal way. Particularly in urban area, the young MSM was networking through technology of telephone.

In term of Fast-Track in response, **Mr. Tony E. Lisle** stated that in 2015 to 2030, the world would be against the business as usual, and if we would have new paradigm, including the task management of the community, the new approach of strategic communication by the use of social media. The Fast-Track response targeted across the three key areas: treatment, prevention, and stigma and discrimination (90-90-90). He targeted the program of Ending AIDS by 2030 by introducing Fast-Track response and reducing new infections by 2020:

2020: 90% of PLHIV know their status, receive treatment, have suppressed viral load.

2030: 95% of PLHIV know their status, receive treatment, have suppressed viral load.

Mr. Tony E. Lisle delivered several facts, as below:

- AP Fast-Track target for New HIV infections – 80 000 by 2020 and 33 000 by 2030
- In 2014, there were an estimated 340 000 [240 000 – 480 000] new HIV infections in the region.
- New HIV infections declined by 31% between 2000 and 2014
- However the number of new HIV infections in the region rose by 3% between 2010 and 2014.
- China, India and Indonesia account for 78% of new HIV infections in the region in 2014.
- Treatment scale-up has slowed down between 2013 and 2014, only a 14% increase in number of people receiving ART. (Between 2012 and 2013, there was a 25% increase in number of people receiving ART.)
- About a third of PLHIV are accessing ART.
- With the current pace of scale-up, the region will NOT reach Fast-Track treatment targets by 2020
- Currently, about 3 million people living with HIV are NOT receiving lifesaving antiretroviral therapy.

He also emphasized the need to focus on people left behind as rights were surrounded by local epidemics, communities, commodity security, shared responsibility, and HIV testing. Therefore, stakeholders might also hold responsibilities, such as:

- 1) Prioritize a rapid reduction in new HIV infections
- 2) Focus the response

- 3) Do more for gender equality
- 4) Amplify human rights leadership of the AIDS response
- 5) Front-load, scale up and diversify investment
- 6) Seek opportunities to strategically integrate the response

Mr. Tony E. Lisle mentioned about legal barriers to the HIV response remained in the 38 UN Member States in Asia and the Pacific. Several examples he stated: 18 cases of criminalization of same-sex relations, 10 cases of impose some form of HIV-related restriction on entry, stay, or residence, and 37 cases of criminalization of some aspect of sex work. The challenges then impeded quicker response, as he proposed:

- 1) Increases in multilateral funding are unlikely
- 2) Other external partners are also cutting back
- 3) There is an imbalance between funding for prevention vis-à-vis treatment
- 4) Countries are missing opportunities to make bigger impact
- 5) Civil society and community organizations are vulnerable to funding shortfalls and with the prospect of funding cuts
- 6) More determined regional-level action is needed

Finally, **Mr. Tony E. Lisle** concluded 9 recommendations given to the representatives of South Asia countries:

1. Introduce funding transition plans, supported by bridge funding options
2. Develop country 'investment cases' for HIV
3. Focus resources where most infections are occurring
4. Protect funding for civil society
5. Create an enabling legal environment that supports effective programmes
6. Integrate biomedical interventions into universal health care schemes
7. Develop new financing streams
8. Reduce the costs of HIV drugs and other commodities
9. Ensure reliable future access to affordable HIV drugs

Review Day I

This session aimed to give participants a report of brief summary from the first day meeting on 29th of September 2015.

The meeting was started with the two welcoming talks from **Mr. Shiba Phurailatpam**, the director of the Asia Pacific Network of People Living with HIV/AIDS (APN+), Thailand, and **Ms. Anna Chernyshova**, the programme Manager of Multi-Country South Asia Global Fund HIV Programme from UNDP – Regional Hub, Bangkok - Thailand, who briefly explained why a meeting on human rights and health as such was important to do. The facilitator, **Mr. Paul Cawthorne**, also helped us to set up the meeting context, which mainly concerned about how to identify key problems of treatment access for HIV/AIDS key population, particularly, the MSM and TG population groups. A representative from UNDP even further explained a comprehensive way to Strategizing Rights Based Approach to better Treatment Access for MSM and TG.

Seven countries in South Asia region: Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka became the particular main focus for this meeting. During the country presentation, various facts related to HIV/AIDS status, gaps, challenges, as well as achievements were presented. In general, each country raised human rights issues for MSM and TG population groups in accessing HIV/AIDS treatment, and it was found out that gaps are still found between the human rights and healthcare services.

From the seven countries' presentation in the first day of the meeting, there were some crucial issues regarding gaps in existing HIV-Related Health Program for MSM and TG population groups. There were three similar gap-characteristic shared by seven countries within the South Asia region:

1. Social Gap
2. Financial Gap
3. Legal Framework Gap

The social gap, mostly formed in stigma and discrimination against PLHIV, causing MSM and TG groups to hide their identity and HIV status. This led to the failure to collect PLHIV network to work together as communities, also to the lack of evidence-based research that could share factual data to give the government more reliable data.

The financial gap happened due to the lack of interest from the local government to make HIV response as the nation's budget priority without any supports from international funding and donors. Last, but not least, the Legal Framework Gap that existed in each country to criminalize homosexual people, like, for example, a penalty on Sodomy Act. This exposed MSM and TG groups to human rights violation, not only in healthcare settings, but also in other environment, like employment, school, as well as within the family.

Presentation:

Introduction to Intellectual Property Rights and Implications to Treatment Access Country strategies to increase access to HIV and linkages to related health services, focusing on test and treatment services for MSM and TG population (ways forward).

The session was dedicated as an early exposure for MSM and TG community to IP related issues and how it has impact access to treatment (1st, 2nd and 3rd line ARV and HCV medicines), and what were the roles of community groups in this issue. Participants would understand the significance of public health safeguards presence in the intellectual property laws and policy/regulations.

Presentation from Group Work

Before the presentation, the participants worked in groups by countries to identify their priority issues and strategies to respond and overcome barriers for MSM and TG to scale-up access to HIV and linkages to related HIV services (e.g. HCV, TB, STI, SRH). Each group would present their work to the plenary and responded to questions or comments from others. The presentation was arranged based on alphabetical arrangement of the country's name.

AFGHANISTAN

Key Population or IP Issue	Region or province	Issue at stake (problem)	Reasons and root causes	Needs and priorities	Action needed and/or policy measure	Who will do it / who is responsible	Resources required	Key indicators	Relevant Human Rights standard
MSM/MHRB	Kabul and Balkh	Hidden population and low access to services	<ul style="list-style-type: none"> The practices of MSM is Unlawful according to Sharia & man made laws Lack of awareness about HIV and AIDS Low coverage of specific services for MHRBs in country. 	<ul style="list-style-type: none"> Advocacy with high rank authorities for MHRBs health issues. Standard package for advocacy according to the country context. Expansion and extension of program with long term. Not enough strategic information 	<ul style="list-style-type: none"> Coordination. Advocacy through meetings and trainings. Package of advocacy should adapt to local context. Establishment a new MHC. Research and studies(KAP,IB BS) 	<ul style="list-style-type: none"> UN agencies. Government. Local implementer. 	<ul style="list-style-type: none"> Multi-lateral donors 	Base line indicator and , # of MHRB access to services	National and international
TG	Not applicable								
IP	Country level	No production of ARVs medicine in county	Continues war and low economic situation	<ul style="list-style-type: none"> Capacity building(Trainings) of relevant organization Sustainable, available and affordable treatment of PLHIV. 	To do advocacy and share the evidence information to convince the donor and government to provide resources	<ul style="list-style-type: none"> UN agencies. Government. Local implementers. 	Sustainable Support of Donors	Supply of ARVs for period of project	National and international

BANGLADESH

Key Population or IP Issue	Region or province	Issue at stake (problem)	Reasons and root causes	Needs and priorities	Action needed and/or policy measure	Who will do it / who is responsible	Resources required	Key indicators	Relevant Human Rights standard
<i>e.g MSM or TG</i>	<i>e.g Remote rural areas, capital city</i>	<i>e.g Lack of access to HIV and related health services</i>	<i>e.g Lack of financial and human resources</i>	<i>e.g Access to health care, psycho-social counseling</i>	<i>e.g Development of long-term strategy and action plan</i>	<i>e.g Municipality, Ministry of Health</i>	<i>e.g Municipal budget, Ministry, bilateral or multilateral donor</i>	<i>e.g Developed LTS and AP</i>	<i>e.g National, international.....</i>
MSM	Countrywide	1. Denial attitude of HCP 2. Inadequate services (one stop service) e.g. (HCV, TB, STI, SRH) 3. Inadequate DIC 4. Stigma	1. Lack of awareness 2. Lack of training 3.No GOB facilities	1.Capacity building for HCP 2. Access to health service 3. Community Sensitization 4. Establish one stop service	1.Community awareness 2. Advocacy with different Stakeholders 3. Create enabling environments. 4.360 Community Clinic use as a one stop service.	1. MOHFP 2. DG HS 3. Civil society 4. NHRC	Both financial and others logistic supports needed from GOB & Donors	MSM are award and access to the HS	Ensure Economic, Social and Cultural Rights
TG	Countrywide	1. Denial attitude of HCP 2. Inadequate services. (one stop service) e.g. (HCV, TB, STI, SRH) 3. Inadequate DIC 4. Stigma	1. Lack of awareness 2. Lack of training 3.No GOB facilities	1.Capacity building for HCP 2. Access to health service 3. Community Sensitization	1.Community awareness 2. Advocacy with different Stakeholders 3. Create enabling environments. 4.360 Community Clinic use as a one stop service.	1. MOHFP 2. DG HS 3. Civil society 4. NHRC	Both financial and others logistic supports needed from GOB & Donors	MSM are award and access to the HS	Ensure Economic, Social and Cultural Rights
IP	Countrywide	At present IP is not problems for Bangladesh							

BHUTAN

Key Population or IP Issue	Region or province	Issue at stake (problem)	Reasons and root causes	Needs and priorities	Action needed and/or policy measure	Who will do it / who is responsible	Resources required	Key indicators	Relevant Human Rights standard
<i>e.g MSM or TG</i>	<i>e.g Remote rural areas, capital city</i>	<i>e.g Lack of access to HIV and related health services</i>	<i>e.g Lack of financial and human resources</i>	<i>e.g Access to health care, psycho-social counseling</i>	<i>e.g Development of long-term strategy and action plan</i>	<i>e.g Municipality, Ministry of Health</i>	<i>e.g Municipal budget, Ministry, bilateral or multilateral donor</i>	<i>e.g Developed LTS and AP</i>	<i>e.g National, international.....</i>
MSM	Thimphu (Capital)	Low percentage of MSM accessing HIV and related health services	Self-Stigma and low knowledge of health workers in identifying and working with MSM	Self-stigma reduction psycho-social counseling by peer educators	Networking and Advocacy for MSM and Training of Health workers	Ministry of Health, and LGBTIQ Community Members	MSA Regional Grant	Increase in the percentage of MSM assessing health services	National, International
TG	Thimphu (Capital)	Low percentage of TG accessing HIV and related health services	Self-Stigma and low knowledge of health workers in identifying and working with TG	Self-stigma reduction psycho-social counseling by peer educators	Networking and Advocacy for TG and Training of Health workers	Ministry of Health, and LGBTIQ Community Members	MSA Regional Grant	Increase in the percentage of TG assessing health services	National, International
IP	National	Introduction of Patent Law on pharmaceuticals, Health products and Equipment	WTO Membership	Affordable pharmaceuticals, Health products and Equipment by all	Review of the Draft law by all relevant organizations and agencies	Ministry of Health, MoFA, Judiciary, MoEA and BNP+	National	The draft is properly reviewed and discussed intensively	National International

NEPAL

Key Population or IP Issue	Region or province	Issue at stake (problem)	Reasons and root causes	Needs and priorities	Action needed and/or policy measure	Who will do it / who is responsible	Resources required	Key indicators	Relevant Human Rights standard
<i>e.g MSM or TG</i>	<i>e.g Remote rural areas, capital city</i>	<i>e.g Lack of access to HIV and related health services</i>	<i>e.g Lack of financial and human resources</i>	<i>e.g Access to health care, psycho-social counseling</i>	<i>e.g Development of long-term strategy and action plan</i>	<i>e.g Municipality, Ministry of Health</i>	<i>e.g Municipal budget, Ministry, bilateral or multilateral donor</i>	<i>e.g Developed LTS and AP</i>	<i>e.g National, international.....</i>
MSM		Low disclosure rate and Poor access to treatment	S & D in comm and HFs	Enabling env. through training and raising awareness	Develop guideline and SOP and implement	GoN-NCASC, Community	MoHP, Donors-INGOs, NGOs	Developed guideline and SOPs	Constitution of Nepal, Int'l docs
TG		Exclusion from family, society and state	social stigma and low awareness	Awareness raising, advocacy and legal protection	Develop guideline, SoP and inclusion in edu, health service	MoE, MoHP	GoN, multi and bilateral donors	" "	"
IP		No patent laws in Nepal	Govt 's les priority	Need not to comply with WTO as memb	Incorporate strong IP laws	Mol, MoLJ, & relevant govt agencies	GoN	Developed IP laws	, Production rights, Consumption rights

SRI LANKA

Key Population or IP Issue	Region or province	Issue at stake (problem)	Reasons and root causes	Needs and priorities	Action needed and/or policy measure	Who will do it / who is responsible	Resources required	Key indicators	Relevant Human Rights standard
<i>e.g MSM or TG</i>	<i>e.g Remote rural areas, capital city</i>	<i>e.g Lack of access to HIV and related health services</i>	<i>e.g Lack of financial and human resources</i>	<i>e.g Access to health care, psycho-social counseling</i>	<i>e.g Development of long-term strategy and action plan</i>	<i>e.g Municipality, Ministry of Health</i>	<i>e.g Municipal budget, Ministry, bilateral or multilateral donor</i>	<i>e.g Developed LTS and AP</i>	<i>e.g National, international.....</i>
MSM	Country wide	Lack of awareness on HIV treatments	1. Personal attitudes 2. Trust on health service provider 3. Lack of informal education sys	Patient education sys	Develop patient/community education system	1. Ministry of health 2. CBO	1. Gov. budget allocation 2. Foreign donors 3. Expertise	1. No of programmers 2. Knowledge questions	1. Right to know
TG	Country wide	Transphobia Cultural incompetence of health work force	Lack of awareness on sexual diversity	Normalization of gender diversity	Legal reforms Policy reforms Mainstreaming gender diversity in school education	1. HRCSL 2. MoE 3. MoH	1. Gov. budget allocation 2. Foreign donors 3. Expertise	1. Repeal discriminatory laws 2. Change in school curriculum	1. Right to education 2. Right to health 3. Right to non-discrimination
IP	Country wide	High cost of 2 nd line, 3 rd line drugs	No patency for 2 nd line, 3 rd line drugs	Availability of 2 nd line, 3 rd line drugs	Initiate discussions with relevant parties	1. GoSL/MoH 2. CBO/PLHIV 3. HRCSL 4. WHO	1. Technical assistance	1. discussions carried out 2. Continues supply and availability of 2 nd line, 3 rd line drugs	1. Right to health

INDIA

Key Population or IP Issue	Region or province	Issue at stake (problem)	Reasons and root causes	Needs and priorities	Action needed and/or policy measure	Who will do it / who is responsible	Resources required	Key indicators	Relevant Human Rights standard
<i>e.g MSM or TG</i>	<i>e.g Remote rural areas, capital city</i>	<i>e.g Lack of access to HIV and related health services</i>	<i>e.g Lack of financial and human resources</i>	<i>e.g Access to health care, psycho-social counseling</i>	<i>e.g Development of long-term strategy and action plan</i>	<i>e.g Municipality, Ministry of Health</i>	<i>e.g Municipal budget, Ministry, bilateral or multilateral donor</i>	<i>e.g Developed LTS and AP</i>	<i>e.g National, international.....</i>
MSM		Low disclosure rate and Poor access to treatment	S & D in comm and HFs	Enabling env. through training and raising awareness	Develop guideline and SOP and implement	GoN-NCASC, Community	MoHP, Donors-INGOs, NGOs	Developed guideline and SOPs	Constitution of Nepal, Int'l docs
TG		Exclusion from family, society and state	social stigma and low awareness	Awareness raising, advocacy and legal protection	Develop guideline, SoP and inclusion in edu, health service	MoE, MoHP	GoN, multi and bilateral donors	" "	"
IP		No patent laws in Nepal	Govt 's les priority	Need not to comply with WTO as memb	Incorporate strong IP laws	Mol, MoLJ, & relevant govt agencies	GoN	Developed IP laws	, Production rights, Consumption rights

PAKISTAN

Key Population or IP Issue	Region or province	Issue at stake (problem)	Reasons and root causes	Needs and priorities	Action needed and/or policy measure	Who will do it / who is responsible	Resources required	Key indicators	Relevant Human Rights standard
<i>e.g MSM or TG</i>	<i>e.g Remote rural areas, capital city</i>	<i>e.g Lack of access to HIV and related health services</i>	<i>e.g Lack of financial and human resources</i>	<i>e.g Access to health care, psycho-social counseling</i>	<i>e.g Development of long-term strategy and action plan</i>	<i>e.g Municipality, Ministry of Health</i>	<i>e.g Municipal budget, Ministry, bilateral or multilateral donor</i>	<i>e.g Developed LTS and AP</i>	<i>e.g National, international.....</i>
MSM	Urban	MSM enabling environment	Lack of sensitization	Deficient psycho-social counseling	Develop an integrated/ holistic plan	Ministry of Health/ relevant supporting organization	Government/ donor	Scale up the HTC, Registration/ Treatment	International
TG	Urban	TG enabling environment	Stigma/ Discrimination	Employment	Develop an integrated/ holistic plan	Ministry of Health/ relevant supporting organization	Government/ Donor	Scale up the HTC, Registration/ Treatment	International
IP	Urban	Weak Regulation/ lack of implementation.	Influence of pharmaceutical/ corruption	Advocacy/ Capacity building/ Institutional building	Enforcement of Regulation in a letter & spirit	DRAP	Government/Donor	Affordability, Accessibility / Quality standards	International/ Local

Follow up Actions (mapping opportunities for change and incorporating in e.g. reprogramming approach for 2016; NSPS; in-country WPs; etc.)

The session summarized the consultation process and agreed on opportunities to integrate at country level processes. A set of recommendation of actions to carry out by APN+ and country SRs post meeting, as mentioned below:

Priority Issues	Strategies	APN+ Roles	Country Partners Roles
Capacity Development	Increasing MSM and TG knowledge and understanding on HIV treatment related topics as well as how to advocate for treatment access	Providing TA to country SRs to: <ul style="list-style-type: none"> ▪ Conduct Treatment Literacy and Treatment advocacy Training at country level ▪ Guidance in establishing/strengthening HIV positive self help group for MSM and TG community 	Increasing coverage on building the capacity among MSM and TG community on HIV Treatment Literacy and Treatment advocacy
	Establishing a safe space for HIV positive MSM and TG population		Develop and initiate community self help group for MSM and TG community
Enabling environment	Increasing MSM and TG community knowledge on IP and its relation with treatment access	<ul style="list-style-type: none"> ▪ TA on capacity development process of MSM and TG community on IP and access to affordable medicines ▪ Providing linkage to other CSO or Dev. partners working on IP issues 	Facilitating series of country level training on IP for MSM and TG community
	Advocating for national patent law with comprehensive public health safe guards		Building a coalition/network of CSOs at country level to be engage in policy development related to IP

Closing

The official closing of the Regional Consultation on Treatment and Human Rights included speeches from the event's facilitator, **Mr. Paul Cawthorne** and **Mr. Shiba Phurailatpam**, the director of the Asia Pacific Network of People Living with HIV/AIDS (APN+), Thailand.

Mr. Paul Cawthorne thanked all participants for the fruitful discussions and partnership. **Mr. Shiba Phurailatpam** also expressed his gratitude to the participants for bringing together selected issues at the event of Regional Consultation on Treatment and Human Rights. Mr. Shiba underlined the important links between human rights and health, particularly for the PLHIV to access healthcare treatment.