



People Living with HIV Stigma Index

Asia Pacific Regional Analysis | 2011





This report is dedicated to the people who participated in the PLHIV Stigma Index Surveys but have since lost their lives to AIDS.

You remind us of the urgent need for universal access to comprehensive HIV prevention programmes, treatment, care and support. We will strive to do better.

Disclaimer: All reasonable care has been taken in the production of this report. Neither the author nor UNAIDS can be held responsible for any inaccuracies or misstatement of fact beyond their control.

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Cover photos: UNAIDS / O.O'Hanlon / S.Noorani

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EXECUTIVE SUMMARY

This report provides findings from the rollout of the People Living with HIV Stigma Index (PLHIV Stigma Index) in nine countries in Asia and the Pacific (Bangladesh, Cambodia, China, Fiji, Myanmar, Pakistan, Philippines, Sri Lanka, Thailand). It provides the first large-scale regional comparison of standardized human immunodeficiency virus (HIV)-related stigma indicators. The findings and interpretation represent an extraordinary effort by people living with HIV, organizations of people living with HIV, and supporting domestic and international agencies.

The PLHIV Stigma Index has two key aims:

1. **To increase the evidence base for policies and programmes to reduce HIV-related stigma and discrimination:** The PLHIV Stigma Index aims to document HIV-related stigma and discrimination and to provide a mechanism for comparison of experiences in different settings and across time. Findings can then inform responses to HIV.
2. **To ensure the Greater Involvement of People Living with HIV and AIDS principle (GIPA principle) is enshrined in local, regional and national responses to HIV:** The PLHIV Stigma Index aims to empower individual people living with HIV, their networks and local communities by ensuring people living with HIV are at the centre of the process.

Summary of key findings

HIV-related stigma is pervasive in the lives of people living with HIV.

Stigma marks people as different and as disgraced. It denies an individual's dignity, respect and right to fully participate in their community. Stigma manifests in discriminatory and sometimes violent treatment of people living with HIV, their families and others affected by HIV. It can place limits on education, work, housing and health care. It may restrict travel, prevent participation in religious or cultural ceremonies, and trigger verbal or physical violence, isolation or complete ostracism. It may also affect personal and family life, including the opportunity to marry and to bear and raise children.

Stigma may be experienced, expressed or enacted by people who are the target of stigmatizing attitudes or by people seeking to lay blame and set themselves apart.

Stigmatizing attitudes frequently take the form of discrimination. Great social harms are also perpetuated by the expression of broadly (i.e. not individually) targeted stigmatizing attitudes, with comments such as "People with HIV should be jailed" and "People with HIV are immoral", particularly if such comments are repeated across different settings over time. For many people living with HIV, the anticipation of discrimination prohibits social inclusion and participation even when actual instances of discrimination are infrequent.

Stigma may be internalized and experienced as shame or guilt, or externalized as discrimination. It may lead to reduced self-confidence, loss of motivation, withdrawal from social contact, avoidance of work- and health-based interactions, and abandonment of planning for the future. The negative consequences for the individual are clear, but such responses to internalized stigma also undermine familial and community networks and facilitate a great waste of states' social capital.

HIV-related stigma and discrimination continue to occur in all national settings, although they manifest differently and in varying degrees in different locations. HIV-related stigma and discrimination frequently work to entrench existing social inequalities and intersect with other forms of stigma, including discrimination based on gender, sexuality, ethnicity and stigmas associated with particular behaviours and activities.

Stigma and discrimination have profound implications for HIV prevention, treatment, care and support. They reduce an individual's willingness to be tested for HIV, to disclose their HIV status, to practise safer sex and to access health care. Stigma impedes the efforts of services to reach people most in need of prevention, treatment and care. It impacts an individual's capacity to acknowledge and manage their own HIV infection, affecting their physical and psychological well-being and quality of life. Moreover, the social acceptability of stigma and discrimination affects governments' willingness to take the measures required to minimize HIV transmission and to guarantee protection of human rights.

In the nine participating countries, HIV-related stigma and discrimination were evidenced across all areas of life, including in the key areas described below. Even when respondents had not experienced direct discrimination, they had a generalized fear of discrimination and thus modified their behaviour accordingly.

1. Family

The PLHIV Stigma Index found that many people living with HIV are without a "safe" home environment, and the likelihood of hurtful, stigmatizing events is ever present. HIV stigma-based exclusion was reported within many family environments (3–26%¹). Many respondents also reported psychological pressure, manipulation and harassment by their spouse, with reference to their HIV status (10–36%). Evidence of unsafe family environments was reflected in the data on domestic violence perpetrated by spouses and other family members with whom HIV-positive people reside.

Individuals' internalized HIV-related stigma has contributed to people isolating themselves from family or friends "because of" their HIV status (6–58%). Reasons for the significant variations in range are not understood. The Sri Lanka report (which recorded 19% of people with HIV isolating themselves from family or friends because of their HIV status) makes an interesting observation, suggesting the "low" rate of respondents' familial/social isolation may correspond to low levels of disclosure to family and friends.

All countries reported that the majority of respondents' husbands, wives or partners were aware of their HIV-positive status, although significant variation was recorded (62–94%). Accordingly, 6–38% of spouses were not aware of their partner's HIV status.

In some instances, respondents' HIV-positive status had been disclosed to their spouse or partner without their consent (1–13%). Most spouses/partners were supportive when they learnt of their partner's HIV diagnosis (49–78%), although a minority of spouses/partners were not supportive (3–25%).

There were many instances of adult family members having been told of respondents' HIV-positive status without consent (1–30%). Most family members were supportive (46–62%), but significant proportions of people living with HIV faced discrimination from family members (6–27%).

1 Percentage figures in brackets reflect the percentage of country survey responses indicating experience of the aforementioned stigma. For example, these data reflect 3% of respondents in Cambodia (the lowest recorded response) and 27% of respondents in Pakistan (the highest recorded response).

Internalized stigma was apparent in relation to marriage, with large numbers of people living with HIV choosing not to marry (more than 75% of respondents in Bangladesh) despite marriage being a cornerstone of personal and cultural relationships and a requirement for social acceptance. Further investigation is needed to understand this issue better.

2. Community

Large numbers of people continue to experience various forms of stigma and discrimination in community interactions, with friends and neighbours exhibiting high rates of discrimination compared with other categories of people.

Many people living with HIV were reticent to let their friends or neighbours know of their HIV status, but there were frequent instances of respondents' HIV-positive status being disclosed to friends and neighbours without respondents' consent (9–50%).

All countries reported that a significant proportion of respondents were aware they had been gossiped about (26–78%). Such gossip, which indicates respondents' actions may fail to comply with community norms, is alienating and decreases a sense of belonging to the local community.

Exclusion from social gatherings was reported by respondents in all countries (4–31%). Such exclusion facilitates loss of power, respect and identity through the removal or diminishing of community roles and social standing. Internalized stigma may have contributed to many people isolating themselves from family and friends (6–58%) or deciding not to attend social gatherings (9–55%) "because of" their HIV status.

The intersection of community-based HIV stigma and other sites of stigma is suggested by data on housing: between 5% and 20% of respondents had been forced to move or had been unable to rent accommodation during the previous 12 months as a result of their HIV-positive status. Given the low likelihood of people disclosing their HIV-positive status in relation to housing, it seems that gossip within the community is the likely cause of discrimination, with disastrous results.

The strongest source of community support for many people living with HIV was found to be the emotional, physical and referral support provided by other people living with HIV and networks of people living with HIV.

3. Employment

Stigma and discrimination were the key factor – or had played a part in – respondents' loss of employment or income (16–50%), being refused the opportunity to work (9–38%), or being refused promotion or the nature of work changing (8–52%). Many respondents had also decided to stop work (3–38%) or decided not to apply for a job or promotion (10–31%).

Four countries provided data on how disclosure of HIV status had been received in work and employment settings. In three of the four locations, employers and managers, co-workers and clients were more likely to be supportive or to not change their behaviour, although in all locations discrimination was clearly noted: from employer and managers (13–55%), from colleagues (15–50%) and from clients (0–50%).²

² The clients sample is based on low numbers of responses: China (50), Philippines (8) and Thailand (55). In Fiji, neither of the two respondents with clients had experienced discrimination.

In a number of countries, employment was named as a key reason for undertaking HIV testing, particularly in the Philippines, Sri Lanka and Pakistan (45%, 27% and 15%, respectively). In Sri Lanka, of the 27% of respondents who had received employment-related testing, 78% reported being tested without consent. In many instances, high rates of employment-related testing are likely linked to migration for work (and travel restrictions imposed on people living with HIV).

4. Education

Stigma and discrimination appear to have less impact on education than on work and accommodation, although education of people living with HIV and their children continues to be affected in many locations (0–6%). These data, however, may underrepresent the presence of HIV-related stigma in educational settings, as most people had not informed their teachers of their HIV status. For example, data from China state that 36% of people living with HIV under the age of 25 years said their teacher had shown a “discriminatory” or “very discriminatory” attitude after discovering their HIV status. Many people had decided to stop work or education as a result of their HIV status (3–47%).

5. Health care

HIV-related stigma reduced respondents’ access to health care (4–33%). Of great concern is that countries reporting data on the issue of health-care avoidance found that despite needing medical care, many people living with HIV avoided clinics (7–35%) and hospitals (7–25%) because of their HIV-positive status. Further analysis is needed to understand these trends.

In most settings, health-care workers were supportive upon learning of a respondent’s HIV-positive status; a significant percentage was not supportive, however (3–29%). Similarly, many respondents did not have constructive discussions with health-care professionals about their HIV-related treatment options (37–90%) or other subjects (49–81%).

- **Confidentiality**

There were many instances where health-care workers were told of respondents’ HIV-positive status without consent from the respondents (4–41%). In all countries, some respondents believed their medical and health records were not confidential (3–26%); in some cases, that belief was based on their experience of confidentiality breaches in a health-care setting. Far greater numbers of respondents were unsure of, or doubted the confidentiality of, their medical and health records (8–64%).

In Sri Lanka, anecdotal evidence was noted suggesting that disclosure of HIV status by hospital workers to a person’s village or community is associated with ostracization, physical assault and damage to property.

- **Access to antiretroviral treatment**

At least half of all respondents were currently on antiretroviral treatment (50–90%). Many others believed they could access antiretroviral treatment if desired, although these data may reflect many respondents being linked to PLHIV support organizations. In most settings, respondents were taking medication for opportunistic infections (38–77%).

- **HIV testing**

Respondents reported taking an HIV test for a range of reasons. Significant populations reported an HIV test following having HIV-related symptoms, family members testing

positive, or illness or death of family members. This may suggest that people wait for external cues before they take an HIV test. In some locations, HIV testing was influenced by gender, associated with pregnancy or associated with employment.

In all populations except Cambodia, a significant proportion of respondents had not been tested voluntarily. In China, Bangladesh and Sri Lanka, the majority of respondents (more than 60%) had been tested without their consent.

Pre- and post-HIV test counselling was not the norm in most countries. Only Cambodia (93%) and Myanmar (60%) offered pre- and post-test counselling to the majority of respondents. In many instances, respondents received no pre- or post-test counselling (8–68%).

- **Family planning, and sexual and reproductive health**

Many respondents were denied family planning (2–38%) or sexual and reproductive health services (2–20%). Many respondents had not received counselling about their reproductive options (12–66%). In some instances, provision of antiretroviral treatment was conditional – i.e. based on the use of contraception (7–20%). Many people were advised by a health-care professional not to have children after they were diagnosed with HIV (17–79%).

Some respondents had been coerced by a health professional into being sterilized (2–29%). Other respondents had been coerced into terminating pregnancies. These actions are contrary to the guidelines of the International Federation of Gynecology and Obstetrics, which state that people living with HIV should not be discouraged from becoming pregnant. They are also contrary to the human right to attain the highest standard of sexual and reproductive health, and the right to decide freely and in an informed manner the number, spacing and timing of children and to be provided the information and means to do so.

Some women reported being forced or coerced into particular methods of giving birth or into particular infant feeding practices.

6. Religion

Some respondents experienced exclusion from religious activities (less than 1% to 16%). Importantly, these data are not a direct reflection of the degree to which exclusion is practised by religious leaders, as exclusion is also influenced by the proportion of any population likely to participate in religious ceremonies, the frequency with which the respondent may wish to participate (given that the question measures exclusion during the previous 12 months), and whether the respondent had disclosed their HIV-positive status. Five countries presented data³ on the reactions of religious leaders to HIV disclosure, which suggested relatively low levels of stigma and discrimination.

Given the centrality of religious beliefs and practices in many people's lives, faith-based stigma should not be disregarded. Reported data fail to reflect the influence of faith-based prejudices on community members' values and consequently the practice of stigma and discrimination. Some responses point to the role of morality and faith-based beliefs in stigma and discrimination. Respondents reported their belief that others' expressions of stigma were based on religious beliefs and moral judgements (1–8%), belief they should not associate because HIV is shameful (11–20%), and disapproval of lifestyle (4–11%).

³ Based on low numbers of respondents.

7. Gender

In most instances where sex-disaggregated data were provided, countries reported that larger numbers of female than male study participants had low levels of education or access to income from full-time employment. Countries reported that significantly more women were aware of being the subject of gossip. It is not clear, however, whether this is because women are predisposed to community judgement and gossip due to gender biases and inequalities or whether women are more aware of gossip occurring. In locations providing sex-disaggregated data, women were more likely than men to be the targets of verbal insults, harassment, threats and physical assault. Further research is needed to better understand whether a community is predisposed to judgement and gossip due to gender bias and equality or whether women are more aware of gossip occurring.

Reasons for HIV testing were informed by gender, and gendered experience of access to voluntary testing was reported in some locales. For example, in Bangladesh, 49% of women reported volunteering for HIV testing compared with only 25% of men. In Cambodia, which reported high rates of voluntary testing, little gendered variance in voluntary testing was reported.

Summary of country report recommendations

A number of countries made specific observations and recommendations arising from the PLHIV Stigma Index findings:⁴

1. Develop greater understanding of HIV-related stigma and discrimination.
2. Ensure stigma interventions are embedded in cohesive national HIV policy and programmatic responses.
3. Improve legal and policy responses to HIV-related stigma and discrimination.
4. Strengthen policy and practice to reduce HIV-related stigma and discrimination in health-care settings.
5. Increase initiatives to reduce HIV-related stigma and discrimination within families.
6. Increase initiatives to reduce HIV-related stigma and discrimination within work and employment settings.
7. Increase public and community education about HIV, ensuring such efforts include the goal of reducing HIV-related stigma and discrimination.
8. Increase the capacity of support groups and networks for people living with HIV.
9. Recognize the intersection of HIV-related stigma and discrimination and other forms of stigma, discrimination and disadvantage.
10. Ensure the GIPA principle is embedded in anti-stigma and discrimination policy and practice.

⁴ For a full list of recommendations, refer to individual country reports.

1. UNDERSTANDING STIGMA

Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.

UN Secretary-General Ban Ki-moon⁵

Stigma marks people as different and as disgraced, denying individuals' dignity, respect and the right to fully participate in their community. It may impede access to education, work or much needed health care. It may also preclude marriage and the opportunity to bear and raise children. It may prohibit temporary or longer-term migration for work or for other reasons, and it may prevent participation in religious or cultural ceremonies. Stigma may also trigger verbal or physical violence, isolation or complete ostracism.

Stigma is based on socially defined norms of behaviour, moral judgements and fear (perhaps of contagion or simply of difference). Although socially constructed, it frequently has tremendous personal effects. Stigma can be both internalized as shame or guilt, and externalized as discrimination. HIV-related stigma and discrimination continue to occur in all national settings, although they manifest differently and in varying degrees in different locations. They frequently work to entrench existing social inequalities and intersect with other forms of stigma, including discrimination based on gender, sexuality, ethnicity and stigmas associated with particular behaviours and activities.

Stigma has profound implications for HIV prevention, treatment, care and support. For example, HIV-related stigma and discrimination may reduce an individual's willingness to be tested for HIV, to disclose their HIV status, to practise safer sex, to access health care and to take antiretroviral drugs. Stigma also impedes proactive efforts to reach people most in need of prevention, treatment and care. Although these factors significantly impact on an individual's capacity to acknowledge and manage their own HIV infection, affecting their physical and psychological quality of life, they also undermine HIV prevention efforts and influence the course of HIV epidemics. Moreover, the social acceptability of HIV-related stigma and discrimination in many settings affects governments' willingness to take the (sometimes "brave") strategic measures required to minimize HIV transmission and to guarantee protection of human rights.

As HIV-related stigma and discrimination are not innate or static, they may change over time, the likelihood being that both stigma and discrimination decrease as community understanding of HIV and access to effective treatments increase. Even so, HIV-related stigma and discrimina-

⁵ Ban Ki-moon op-ed: The stigma factor. *Washington Times*, 6 August 2008.

tion remain in many settings where human rights are formally embedded through legislation and practice, and HIV treatments have been accessible for years.⁶ Proactive efforts are required to identify the basis for stigmatizing attitudes; to differentiate its expression by location, by population, and by its intersection with other forms of disadvantage and discrimination; and to expedite the development and rollout of effective remedies to reduce stigma and discrimination against all people living with HIV.

Measuring HIV-related stigma and discrimination

Many governments and agencies have developed strategies and (often short-term) projects to reduce stigma and discrimination in national or local settings. International agencies too have funded anti-stigma initiatives and, more recently, sought to communicate understanding of effective programmatic responses⁷ as a means to improve effectiveness of future anti-HIV stigma efforts.

In recent years, a number of agencies and academics⁸ have turned their attention to the measurement of stigma and discrimination experienced by people living with HIV so that their experiences may be better understood, more clearly articulated and strategically targeted by anti-stigma initiatives. Many of these stigma measurement efforts, although supported by international agencies, have been led by organizations of people living with HIV. One such initiative is the People Living with HIV Stigma Index (PLHIV Stigma Index), the subject of this report. Two other international stigma measurement initiatives merit particular mention, AIDS Discrimination in Asia and Human Rights Count!.⁹

▶ AIDS Discrimination in Asia

The first regional documentation of HIV-related stigma and discrimination in Asia (then described as “AIDS-related discrimination”) was undertaken between July 2001 and November 2002 by the Asia Pacific Network of People Living With HIV/AIDS (APN+). The AIDS Discrimination in Asia project included interviews in four countries – India (302 people interviewed), Indonesia (42 people interviewed), the Philippines (82 people interviewed) and Thailand (338 people interviewed) – and generated both qualitative and quantitative data.

6 Notably, preliminary results from the People Living with HIV Stigma Index (2009) found that 17% of respondents living with HIV in the United Kingdom of Great Britain and Northern Ireland had been denied health care and 21% had experienced verbal harassment or assault relating to their HIV-positive status during the previous 12 months.

7 See, for example, UNAIDS (2007). Also important was the South Asia Regional Development Marketplace funding of HIV stigma-related grants between 2008 and 2010, in particular the programme design, which included (the provision of technical expertise, monitoring and evaluation, and) a commitment to communicating examples of best practice (see Appendix 1).

8 For a summary of recent academic literature, see MacQuarrie et al (2009).

9 See also Hermann & Leach (2005).

AIDS Discrimination in Asia found that HIV-related stigma and discrimination were prevalent in every sector of society, with some 80% of respondents reporting discriminatory experiences, including discrimination in the health sector (54%), community (31%), family (18%) and the workplace (18%). The project also found that women were significantly more likely than men to experience HIV-related discrimination within their family and community.

A unique aspect of AIDS Discrimination in Asia was its conception as an action-based peer-led study. It was initiated and driven by people living with HIV and it aimed to deliver useful data on HIV-related stigma *and* to build the capacity of people living with HIV to advance a rights-based response to HIV and AIDS and address human rights abuse in a resilient manner.

People living with HIV undertook targeted training and conducted interviews with 764 of their peers living with HIV. Interviewers described the process of training and data collection as empowering, saying it equipped them to respond to future human rights violations, provided them with skills and self-confidence in carrying out research, and strengthened their networks. The consultative and participatory nature of the research, while documenting interviewees' experiences of stigma and discrimination, also worked to increase their awareness of their rights.

AIDS Discrimination in Asia was the precursor to the PLHIV Stigma Index.

► Human Rights Count!¹⁰

Recently, the Global Network of People Living with HIV (GNP+) developed a new tool to enable networks of people living with HIV to lead the process of systematically documenting HIV-related human rights violations, which frequently intersect with HIV-related stigma and discrimination. Increasing interviewers' and interviewees' understanding of rights, and empowering individuals and networks to assert those rights, is fundamental to the aims of Human Rights Count.

Following extensive consultations with people living with HIV and other human rights organizations, GNP+ developed a structured form to elicit quantitative and qualitative data regarding violations of human rights. Information is collected, verified and analysed through regional or national focal points of networks of people living with HIV, facilitating ownership and strong links with national and regional campaigns.

In 2009–2010, pilot projects in Kenya, Nigeria and Zambia identified experiences of rights violations from 53 respondents in Kenya, 40 respondents in Nigeria and 28 respondents in Zambia. Since the pilot phase, the tool has been used to identify experiences of rights violations from 75 respondents in Canada, 90 respondents in the United States of America, 120 respondents in Namibia and 270 respondents in Swaziland.

10 See <http://www.gnpplus.net/en/programmes/human-rights/human-rights-count>.

During 2010, APN+, in partnership with national networks in Nepal and Indonesia, documented 200 human rights violations in Indonesia and 30 violations in Nepal. Evidence gathered will inform advocacy campaigns against human rights violations.

► Developing consensus on indicators of HIV-related stigma and discrimination

Until recently, efforts to measure HIV-related stigma and discrimination have been relatively isolated (organization- or academic-driven) and ad hoc, with minimal collective stakeholder effort to review the usefulness of existing tools or to develop a standard set of global indicators for assessing HIV stigma and discrimination. The absence of an agreed set of standardized global stigma indicators is a key barrier to the scale-up of HIV stigma interventions.

Global-level indicators (including standardized country- and population-level measures) could provide consistent measurement of the nuances and trends of stigma and its impact on key populations at risk of infection. Such indicators could also measure the impact of stigma-reduction programmes on stigma and health outcomes and be useful in determining the effectiveness of investments in HIV stigma-reduction programmes and services by national governments, nongovernmental organizations (NGOs) and affected populations. Standardized global indicators would also provide evidence to drive increased strategic advocacy for stigma-related interventions.

Parallel to development and implementation of the PLHIV Stigma Index, efforts are ongoing to reach consensus on and implement globally consistent methods of measuring stigma. In November 2009, a number of organizations¹¹ held a technical meeting with the aim of:

- achieving consensus on key areas to be measured when assessing HIV-related stigma, including the stigmatizing of groups most affected by the HIV epidemic;
- prioritizing a minimum set of measures to assess each area;
- identifying gaps where new measures must be developed or improved;
- agreeing upon next steps for testing proposed measures and indicators.

Based on the consensus recommendations of that meeting, a 16-member Stigma Indicator Working Group of stigma measurement experts and programme implementers was established to revise existing measures and create new measures to inform national- and global-level reporting.¹² In short, the Working Group aimed to develop a set of indicators to measure HIV stigma and discrimination for inclusion in broader data collection and reporting mechanisms, for example the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) reporting

11 GNP+, the International Center for Research on Women, the International Planned Parenthood Federation (IPPF), the Johns Hopkins Bloomberg School of Public Health and the Joint United Nations Programme on HIV and AIDS (UNAIDS).

12 Reports of work undertaken to further that process include Global Network of People Living with HIV (2010) and International Planned Parenthood Federation (2010).

system, the Demographic and Health Survey, and the United States President's Emergency Plan for AIDS Relief (PEPFAR).

► Special Session of the United Nations General Assembly on HIV/AIDS

The 2001 UNGASS provided an opportunity for United Nations (UN) Member States to define feasible goals to address pressing social issues. In 2001, a Special Session on HIV/AIDS was held, and the Declaration of Commitment on HIV/AIDS was drafted and adopted by 189 Member States. Commitments were made in a range of areas, including human rights.

The 2001 Declaration of Commitment on HIV/AIDS recognizes the harms of HIV-related stigma and states that:

- the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and ... it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS;
- stigma, silence, discrimination and denial, as well as lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must ... be addressed.

The Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS required governments to develop national HIV strategic plans that include laws and regulations to eliminate discrimination and guarantee the human rights of people living with HIV, including members of vulnerable groups, and to develop strategies to combat stigma and social exclusion connected to epidemics. In the 2011 Political Declaration on HIV/AIDS, Member States adopted new targets further strengthening commitments to people living with HIV and ending stigma and discrimination.

Every 2 years, signatory countries are required to report on the progress made towards meeting their commitments. Progress is evaluated against specific quantitative indicators and through the National Composite Policy Index (NCPI), which includes a number of questions regarding policies, laws and plans, including questions relating to human rights, anti-discrimination laws and programmes to reduce HIV-related stigma and discrimination.

In 2010, a review of the UNGASS reporting system was undertaken, including a review of indicators related to the enabling environment. In the report regarding the enabling environment, two main gaps in the UNGASS reporting system were highlighted, one of them being the need for quantitative indicators on stigma¹³ (i.e. both experiences and expressions of stigma). The review process attempted to identify possible stigma indicators for inclusion but found that

13 The other gap was quantitative data on intimate partner violence.

although “stigma is a critical barrier in effective national AIDS responses, and ... it should be tracked formally in the main UNGASS indicator set”, a specific indicator could not be included because “weaknesses in existing and proposed stigma indicators precluded their inclusion ... [however] ... a formal stigma indicator should be included in the next year or two, once the weaknesses [can] be properly addressed.”¹⁴

The way forward

Research has confirmed that HIV-related stigma is globally prevalent, widely pervasive and highly damaging. Evidence from diverse countries suggests that expanding the response to stigma and discrimination could improve the duration and quality of life of people living with HIV, and optimize investments in HIV prevention, care and treatment. Although many individuals, organizations and governments have worked diligently to reduce HIV-related stigma and discrimination, actions at the scale necessary to impact the pandemic are lacking.

The urgency of measuring stigma and discrimination (as well as efforts to counter stigma and discrimination) is now well established. Many countries, however, do not attempt to measure stigma,¹⁵ and the global community is without agreed indicators or mechanisms to facilitate formalized reporting from national governments or national HIV community-based organizations.

The results of the PLHIV Stigma Index represent an extraordinary effort by people living with HIV, organizations of people living with HIV, and supporting domestic and international agencies to get this issue on the agenda. It is hoped this report will contribute to greater recognition of the damage that stigma causes, both at the individual level and at the epidemic level; to increased efforts to entrench stigma measurement and countermeasures in national and international responses; and to fundamental involvement of people living with HIV in anti-stigma initiatives at all levels of the response.

14 Enabling Environment Working Group (2010).

15 It is estimated that only 70 countries currently track stigma with an existing stigma indicator (Enabling Environment Working Group, 2010).

2. THE PEOPLE LIVING WITH HIV STIGMA INDEX

The process of working with the index is just as important as the results.¹⁶

The PLHIV Stigma Index has been developed as a joint initiative of several organizations, including:

- ▶ the Global Network of People living with HIV (GNP+);
- ▶ the International Community of Women Living with HIV/AIDS (ICW);
- ▶ the International Planned Parenthood Federation (IPPF);
- ▶ the Joint United Nations Programme on HIV/AIDS (UNAIDS).

In 2006, a team of eight people living with HIV from organizations for people living with HIV in Kenya, Trinidad and Tobago, India and Lesotho piloted a draft version of the PLHIV Stigma Index questionnaire with more than 60 people living with HIV. Since then, the PLHIV Stigma Index survey has been undertaken in 27 countries, with work progressing in 22 other countries¹⁷ and work at the preparatory planning stage in a further 20 countries. Final reports have been received from nine countries in the Asia Pacific region: Bangladesh, Cambodia, China, Fiji, Myanmar, Pakistan, the Philippines, Sri Lanka and Thailand.

The People Living with HIV Stigma Index User Guide and the PLHIV Stigma Index: Standards for Country Rollout provide guidelines for effective rollout of the PLHIV Stigma Index process in different national settings and facilitate regional data comparability. The methodology and research design in each country have differed slightly, according to domestic priorities and capacity, but each study has maintained core commitment to the prescribed PLHIV Stigma Index process and the rigour and sensitivity demanded of each individual interview.

Overview of country rollout

Rollout of the PLHIV Stigma Index in nine countries in the Asia Pacific Region has allowed the first large-scale regional comparisons of standard indicators (Table 1). A similar process is being undertaken with the results of the PLHIV Stigma Index from Africa and eastern and central Europe during 2011.

¹⁶ See <http://www.stigmaindex.org/9/aims-of-the-index/aims-of-the-index.html>.

¹⁷ Including Tamil Nadu in India, Malaysia, Nepal, Papua New Guinea, Viet Nam and "the Pacific".

Table 1: Overview of country rollout

Bangladesh	
Data collected	2008
Sample size	238 people (plus additional qualitative survey of 31 people)
Local partner organizations	Ashar Alo Society Mukto Akash Bangladesh Confidential Approach to AIDS Prevention GEON Health Foundation
Survey team	10 people living with HIV and 10 anthropologists trained to work in pairs of 1 person living with HIV and 1 anthropologist 3 training sessions (funded by Bangladesh School of Public Health, Family Planning Association of Bangladesh and UNAIDS), including mock interviews and role plays
Cambodia	
Data collected	2010
Sample size	397 people (plus additional qualitative survey of 37 people)
Local partner organizations	Cambodian People Living with HIV/AIDS Network Khmer HIV/AIDS NGO Alliance
Survey team	Interviewers and supervisors – people living with HIV who are active members of self-help groups and provincial networks of people living with HIV 5 teams (1 per province) consisting of 10 members (2 supervisors and 8 interviewers) Interviewers received 4 days' training
China	
Data collected	2009
Sample size	2096 people
Local partner organizations	Marie Stopes Positive Talks Project Institute of Social Development Research, Chinese Central Party School UNAIDS China
Survey team	Implemented by members of the Positive Talks Project network: 30 researchers provided with training and capacity development
Fiji	
Data collected	2009
Sample size	45 people
Local partner organizations	Fiji Network for People Living with HIV AIDS (FJM+) Fiji School of Medicine Research Unit
Survey team	Interviews conducted by 2 key members of FJM+
Myanmar	
Data collected	2009
Sample size	324 people
Local partner organizations	Myanmar Positive Group Myanmar Marketing Research & Development Co. Ltd
Survey team	12 people living with HIV trained as enumerators and 4 PLHIV trained as supervisors 5-day training programme included training on interviewing technique, sampling methodology and data management, including data quality assurance

Pakistan	
Data collected	2009–2010
Sample size	833 people
Local partner organizations	Association of People Living with HIV & AIDS in Pakistan
Survey team	Interviewer – people living with HIV from respective community-based organizations
Philippines	
Data collected	2009
Sample size	80 people (plus additional qualitative survey of 6 people)
Local partner organizations	Pinoy Plus Association in collaboration with a team of researchers from numerous groups of people living with HIV (Positive Action Foundation Philippines, Inc., Babae Plus, Sister Plus, Crossbreeds, Pinoy Young Positives and Mindanao Advocates)
Survey team	Researchers – 8 people living with HIV who underwent 3-day basic training on research techniques
Sri Lanka	
Data collected	2009–2010
Sample size	99 people
Local partner organizations	Lanka+ (Sri Lankan network of people living with HIV) Positive Hopes Alliance (Sri Lankan network of people living with HIV) National STD and AIDS Control Programme UNAIDS Colombo Family Planning Association of Sri Lanka Positive Women's Network
Survey team	All 7 interviewers participated in a 3-day training course
Thailand	
Data collected	2009
Sample size	233 people
Local partner organizations	Thai Network of People Living with HIV/AIDS
Survey team	13 team members engaged in training (mock interviews, role plays, coaching) throughout a series of workshop and participation in a 20-day data collection trial

^aAdditional support to that provided by international partners: GNP+, ICSW, IPPF and UNAIDS.

PLHIV Stigma Index aims

The PLHIV Stigma Index has two key aims:

1. **To increase the evidence base for policy and programmatic interventions to reduce HIV-related stigma and discrimination:** The PLHIV Stigma Index provides a mechanism to collect stigma- and discrimination-related information about the experiences of people living with HIV and the remedies available to them as a means to:
 - ▶ document and broaden understanding of the stigma- and discrimination-related experiences of people living with HIV;
 - ▶ consider the extent of, and the variables that influence, the experience of HIV-related stigma and discrimination in a particular country;
 - ▶ compare the experience of HIV-related stigma and discrimination across different national settings;
 - ▶ measure change over time, particularly the focus, severity and frequency of HIV-related stigma and discrimination;
 - ▶ provide an evidence base for policy change and programmatic interventions. Findings from the PLHIV Stigma Index can then be used as an advocacy tool to improve the rights of people living with HIV.

2. **To ensure the Greater Involvement of People Living with HIV and AIDS principle (GIPA principle) is enshrined in local, regional and national responses to HIV:** The PLHIV Stigma Index has been developed and implemented by and for people living with HIV. Since the early pilot workshops, domestic PLHIV networks have frequently taken the lead in the PLHIV Stigma Index survey process, with research teams including partners from local academic institutions and other experts advising on research design and sampling strategy appropriate to the specific domestic context. The PLHIV Stigma Index process locates people living with HIV at the centre of the process and aims to empower individual people living with HIV, and their networks and local communities, by facilitating increased awareness of stigma and discrimination and possible remedies to address it:
 - ▶ **Interviewers:** All interviewers are people living with HIV, so interviews are peer-based. In addition to training on stigma and discrimination, interviewers learn skills in interview techniques, facilitating participatory group discussions, recording case studies, dealing with difficult emotional situations, and referral for advice or counselling. Interviewers have the opportunity to apply these theoretical understandings and build their skills through the interview process.
 - ▶ **Interviewees:** The interview process includes interviewer and interviewee sitting side by side, both with copies of the survey, to minimize power imbalance while recording and sometimes discussing (often shared) experiences of living with HIV.

The interview process allows the interviewee the opportunity to ask questions and to be given information about the experience of stigma and discrimination and remedies to address it.

- ▶ **Peer support networks and organizations of people living with HIV:** The PLHIV Stigma Index process facilitates expansion of networks of people living with HIV, partnerships between national partners, development of staff and members' capacity to engage in policy analysis and advocacy, and identification of priority areas for advocacy and support to people living with HIV.

PLHIV Stigma Index process

The PLHIV Stigma Index survey requires a number of basic quality-control mechanisms to be in place:

- ▶ **Interviewees must provide informed consent:** Informed consent to the collection and processing of personal data can be provided only after a person has been informed fully of the nature of the study, who is involved in it, how the data will be processed and stored, and the prescribed use of the data. Interviewers are required to explain that a person is free to refuse to be interviewed, to withdraw from the interview at any time, and to refuse to answer any particular question.
- ▶ **Data must be kept confidential:** Completed questionnaires must *not* record individuals' names. Instead, interviewees must be given discrete codes, with a centralized list of interviewees and their codes available only to the team leader. That list must later be destroyed.
- ▶ **Surveys must be translated into community languages:** Appropriate translations of key concepts such as stigma and discrimination must be discussed by key partners and agreement reached on appropriate translation. Surveys must then be translated from English into the interview language and translated back into English by a different translator to confirm accuracy.
- ▶ **Interviewers must be fully trained:** Interviewers must be fully trained in the concepts, the interview process and the research methodology (usually through attending a 3-day workshop) before commencement of interviews.¹⁸
- ▶ **Referral should be made where appropriate:** Interviewers must be provided with a list of possible referral agencies and have received instruction about what services agencies are able to provide.
- ▶ **Data-checking quality-control mechanisms must be in place:** A number of quality-control mechanisms must be in place, including a requirement for team leaders to check surveys as soon as they are returned so that any inconsistencies can be addressed as soon

¹⁸ The financial and technical support of UNAIDS (frequently through civil society partnerships) has been key in ensuring the provision of these essential training programmes.

as possible, if necessary, through a follow-up interview with the interviewee. Data must be entered twice (once each by two data-entry people) to ensure consistency and hence accuracy.

The PLHIV Stigma Index requires that agencies do their utmost to maximize potential findings by ensuring their sampling is as targeted and broad as possible. Countries have been instructed to attempt to survey a sample of people living with HIV that is diverse and large enough to capture the main features of the population as well as divergence from the main features. Furthermore, the PLHIV Stigma Index process has aimed to survey sample populations large enough to enable some generalization to be made.¹⁹

Understanding data contained in this report

The PLHIV Stigma Index has facilitated collection of an enormous amount of data, rich in content, to improve national, regional and international responses to HIV. Country reports have synthesized many of these data into accessible formats and have logically reported against key national and local criteria. Variation among national reporting has, however, facilitated minor limitations to reporting comparability and has affected the reporting of data in this report. When reviewing report data, it is important to note the following:

- ▶ **Not all countries asked all questions:** The PLHIV Stigma Index questionnaire formed the basis of all countries' research, but some country teams modified the pro forma questionnaire to establish a set of questions appropriate to their local context. Where specific countries did not ask specific questions (and consequently did not provide data), they have been excluded from comparative charts. Where countries reported a 0% response to a specific question, that response has been included.
- ▶ **Not all countries provided full reports on all questions:** Some countries did not provide a full data set in their country reports; for example, a country may have reported only the most common response to a survey question with four response options. In instances where this impacted on the comparative data, those countries have been excluded from comparative charts. Where countries reported a 0% response to a specific question, that response has been included.
- ▶ **There was a lack of standardized reporting:** Although the PLHIV Stigma Index includes a pro forma questionnaire and quality-control mechanisms relating to participant and data management processes, it does not have a standard reporting template.²⁰ Country reports may record percentages against the indicator they think most important given their national context, but unless the variables being measured are described fully the meanings










¹⁹ An overview of demographic data is provided in Appendix 2.

²⁰ Although, as noted above, this is under active consideration by the international partnership.

of the percentages provided are not always clear. For example, some country reports record a percentage response relating to pregnant women accessing antiretroviral treatment (e.g. 23%), but it is not always apparent whether that percentage reflects (i) the percentage of pregnant women living with HIV at the time of pregnancy, or (ii) the percentage of all pregnant women or (iii) the percentage of all women. Similarly, some questions allow interviewees to provide more than one answer, and so it is not always clear whether percentages relate to (i) the percentage of respondents, or (ii) the percentage of respondents excluding those who indicated “not applicable” or (iii) the percentage of responses, given that in some instances respondents provided more than one answer to certain questions. In such instances, efforts have been made to work back through all the available data and either check the figures or recalculate the figures to gain comparability. When this has not been possible, the data have been removed or issues of comparability have been explained.

- ▶ **Sample sizes were small:** In the Asia Pacific region, country samples are currently not sufficiently large to be representative of entire national populations of people living with HIV. Significant effort has been made, however, to ensure that key affected populations have been included. Even so, in some instances, the numbers of people surveyed are very small. For example, in most countries, very few people were in an educational setting and even fewer people had disclosed their HIV-positive status, and so formal “measurement” of discrimination in educational settings was not possible. Instead, responses show that in some instances teachers who were aware of students’ HIV-positive status were supportive, were discriminatory, or did not appear to change their attitudes or behaviours. Similarly, data relating to pregnant women are not able to show the prevalence of stigma and discrimination in health-care settings but do demonstrate that some health-care providers have treated pregnant women living with HIV appropriately while others have responded poorly.
- ▶ **The data are not finalized:** A number of countries are in the final stages of checking data but have generously made their penultimate country reports available as a means to facilitate a broader sampling of countries across the Asia Pacific region for this report. It is anticipated that if any alterations are made, then they are likely to be very small, reflecting a change of only 1–2%.
- ▶ **Triangulation of data:** Frequently, data are most useful when detailed and able to demonstrate nuance, for example variations of experience by age or urban/rural location, or triangulated by age across domestic regional settings. Given the breadth of this report, which includes comparison of the experiences of people living with HIV across nine countries, analysis is provided only on basic indicators. Further detailed analysis, including triangulation of data, is provided in many country reports and has been evaluated by country offices working on the PLHIV Stigma Index.

- ▶ **Use of charts:** This report uses charts to represent the data visually:
 - ▶ **Colour coding:** To facilitate quick visual identification of country data, each country has been allocated a specific colour code, which is used consistently throughout the report:

 Bangladesh	 Cambodia	 China	 Fiji	
 Myanmar	 Pakistan	 Philippines	 Sri Lanka	 Thailand
 - ▶ **Bar charts:** Bar charts in this report reflect the frequency with which respondents have experienced particular indicators. In most instances, countries have been ranked from highest to lowest. Although these charts clearly reflect PLHIV Stigma Index responses, the rankings (while they may be indicative) do not reflect the actual frequency of experience of entire country-based PLHIV populations. Most importantly, any comparison of one jurisdiction with another should be undertaken with considerable caution.
- ▶ **Accuracy of data:** All efforts have been made to ensure the data provided in this report accurately reflect the data provided in the PLHIV Stigma Index country reports, which in turn have endeavoured to reflect the data recorded at the country level.

3. PLHIV STIGMA INDEX REGIONAL SUMMARY

Section 2A: Experience of stigma and discrimination from other people

This means that no one likes us. People are afraid of us. They don't consider us as human beings.

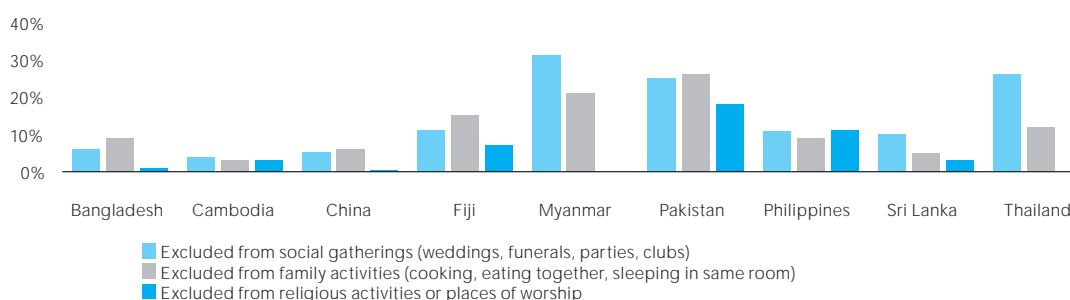
Cambodia

The PLHIV Stigma Index country reports suggest that large numbers of people continue to experience various forms of stigma and discrimination in familial and community interactions across the region. Stigma and discrimination, and the resulting isolation from community and other harms experienced by people living with HIV, militate against realization of the enabling environment required to facilitate individuals' disclosure of HIV status before taking part in high-risk activities, uptake of testing and treatment, and the full and productive participation of people living with HIV in their communities.

HIV-based exclusion from family, religious and community activities

Respondents from all countries had been excluded from family, religious and community activities during the past 12 months (Figure 1).²¹

Figure 1: HIV-based exclusion from family, religious and community activities in past 12 months



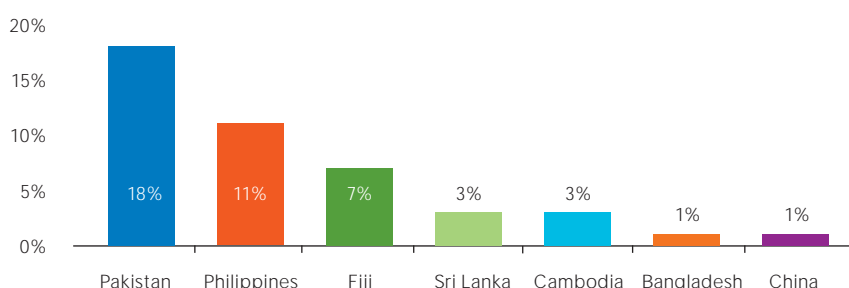
Based on responses to Section 2A:1a–3b.

21 Figure 1 is based on responses to Section 2A:1a–3b. Question 2A asked respondents whether they had been excluded from family, religious or community activities and whether that exclusion was based on: 1. HIV status, 2. (An)other reason(s), 3. HIV status and other reasons, 4. Not sure why. The charts relating to section 2A aim to reflect exclusion informed by HIV-related stigma and so combine data from answers 1. HIV status and 3. HIV status and other reasons.

Religious activities

The PLHIV Stigma Index found that some respondents had experienced exclusion from religious activities (Figure 2). Reports ranged from less than 1% of respondents (China, Bangladesh) to 16% (Pakistan).

Figure 2: Exclusion from religious activities or places of worship in past 12 months (prevalence by country)



Based on responses to Section 2A:2a and 2b.

Importantly, these data are not a direct reflection of the degree to which exclusion is practised by religious leaders, as the data are influenced by the proportion of the population likely to participate in religious ceremonies, the frequency with which respondents wish to participate in religious ceremonies (given that the question measures exclusion during the past 12 months), and whether respondents had disclosed their HIV-positive status.

The available data may also underrepresent the extent of stigma associated with religion. For example, the Thai report notes:

Though the questionnaires revealed that [95%] of the respondents were not hindered from joining religious activities, field records exhibited large-scale prevalence of religion-based stigma. Even religious leaders were not allowed to perform religious ceremonies for them. Or if allowed, the procedures must be minimized. This has caused people who believe in life after death to feel that the souls will suffer in another world. (p. 71).

Given the centrality of faith-based beliefs and practices in many people's lives, even low levels of faith-based stigma must not be discounted. Moreover, these data fail to reflect the influence of faith-based beliefs and faith-based prejudice on community members' values and, consequently, the practice of stigma and discrimination in other settings. For example, when respondents were asked the basis of others' HIV-related stigma and discrimination (Question 13), some cited religious beliefs and moral judgements (Fiji 8%, Philippines 6%, Thailand 5%).

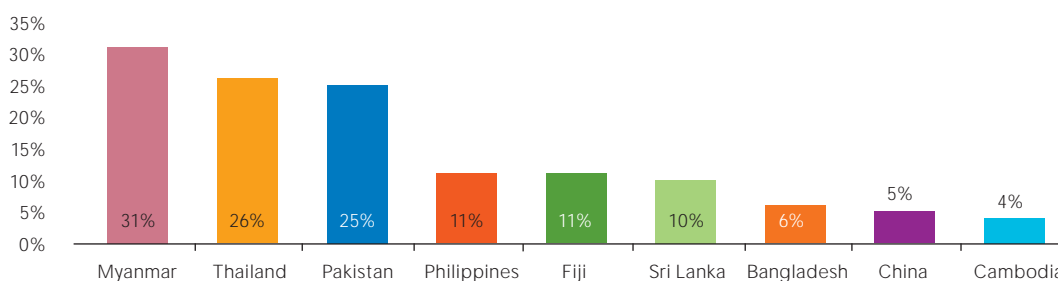
Social activities

Since I have not job and not a good man [using drugs], plus I am positive, they [neighbours] said let me die.

Cambodia

Exclusion from social gatherings was reported by respondents in all countries, ranging from 4% (Cambodia) to 31% (Myanmar) (Figure 3).²²

Figure 3: Exclusion from social gathering and activities in past 12 months (prevalence by country)



Based on responses to Section 2A:1a and 1b.

The implications of such exclusion extend beyond the experience of a specific event, which may be hurtful and stigmatizing in itself. Such exclusion facilitates loss of power, respect and identity through the removal or diminishing of community roles and social standing. It excludes individuals from key meaningful milestones of daily life and locates them outside their community. It is isolating and may exacerbate the person's ongoing isolation and reluctance to engage in social activities or other productive activity in the future.

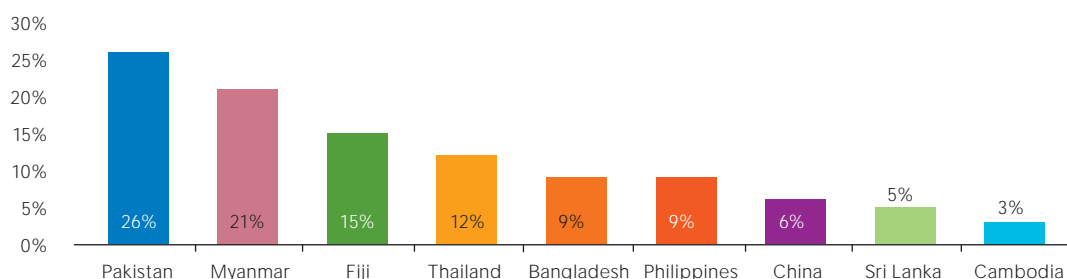
Family activities

Of particular concern is the reporting of high levels of stigma-based exclusion within family environments, ranging from 3% (Cambodia) to 26% (Pakistan) (Figure 4). In some instances, respondents reported they were "often" excluded from family events (e.g. in Myanmar, 15% had often been excluded during the past 12 months).²³ This suggests that many people living with HIV are without a "safe" home environment and are living in an environment where the likelihood of hurtful stigmatizing events is ever present. The physical consequences of exclusion may also be profound in environments where the sharing of food or household implements is a basic strategy to manage poverty.

²² These findings compare with 12% of respondents in the AIDS Discrimination in Asia report being excluded.

²³ These findings compare with 18% of respondents in the AIDS Discrimination in Asia report.

Figure 4: Exclusion from family activities in past 12 months (prevalence by country)



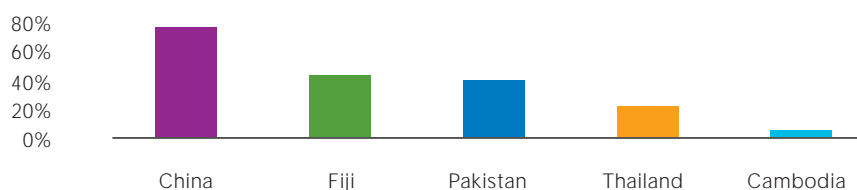
Based on responses to Section 2A:3a and 3b.

Exclusion of people living with HIV from family activities suggests that the impact of HIV on families is far broader than simply issues arising from a person's ill health (e.g. health-care costs, reduced or no capacity to work to produce income, other people losing income to provide care). Such stigma in family-based settings suggests a breakdown in family units and marginalization of people living with HIV by family members. Two countries reported directly on discrimination (as well as exclusion) by family members: In Myanmar, 25% of respondents had experienced discrimination from their own family members within the past 12 months, with approximately half of these experiencing such discrimination often. In the Philippines, more than 20% of respondents had experienced discrimination from members of their own household as a result of their HIV status within the past 12 months; for 10% of respondents in the Philippines such discrimination occurred a few times, but for 5% of respondents such discrimination occurred often. In both Myanmar and the Philippines, rates of discrimination exceeded rates of exclusion.

That many people living with HIV are without a safe family environment is evidenced further by data recording significant levels of violence by spouses and other family members with whom people living with HIV reside (see Figure 14 later in this document).

The reasons for family members exercising discrimination are likely to be multifarious, but it is important to note that many families experience real disadvantage as a result of a family member's HIV infection. Countries recorded many instances of respondents' family members experiencing stigma and discrimination related to respondents' HIV status (Figure 5).

Figure 5: Discrimination of family members related to respondents' HIV status in past 12 months



Based on responses to Section 2A:12.

Intersecting reasons for exclusion

Further consideration of the PLHIV Stigma Index data suggests that people living with HIV are excluded from family, religious and community events more frequently than the preceding data suggest. In some countries, such as Thailand, HIV status was identified as the primary reason for exclusion (Figure 6). In other countries, such as Cambodia, respondents less commonly reported HIV as the reason for exclusion (Figure 7). Notably, some countries have clearly reported the basis of “other reason” for exclusion being related directly to behaviours or “identities” associated with HIV transmission risk (Figure 8).

Figure 6: Reason for exclusion: Thailand

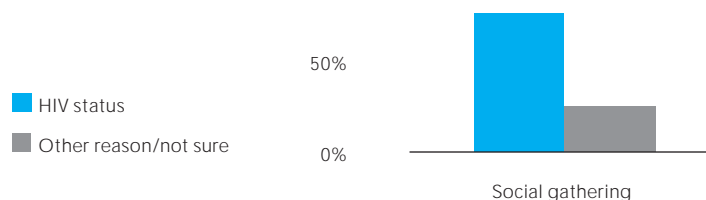


Figure 7: Reason for exclusion: Cambodia

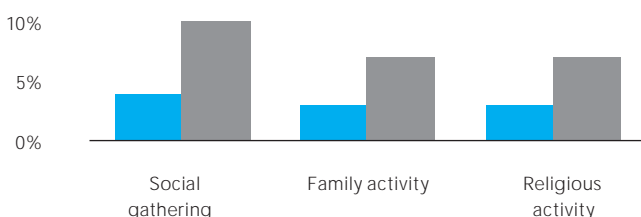
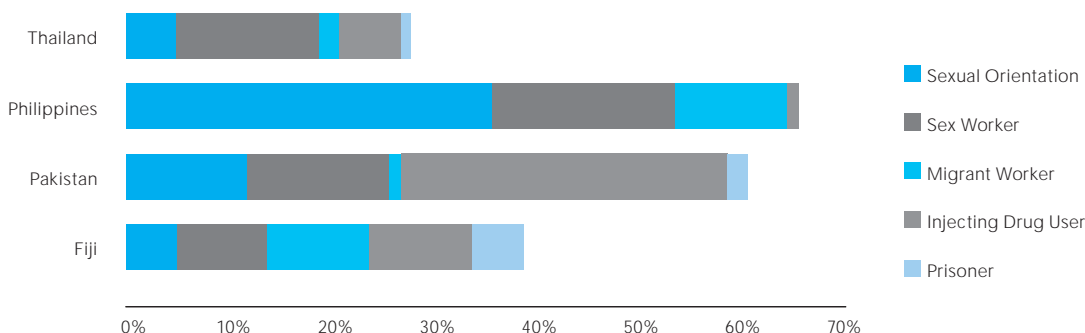


Figure 8: Reasons for stigma and discrimination “other than HIV status”

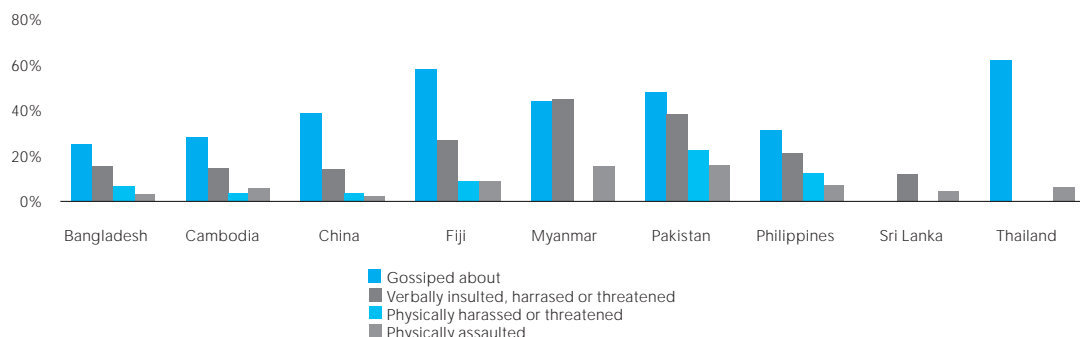


Based on responses to Section 2A:8.

Gossip, harassment, threats and assault

Respondents in many locations reported being the subject of gossip or the target of verbal and physical insult, harassment and threats (Figure 9).

Figure 9: Stigma and discrimination in past 12 months

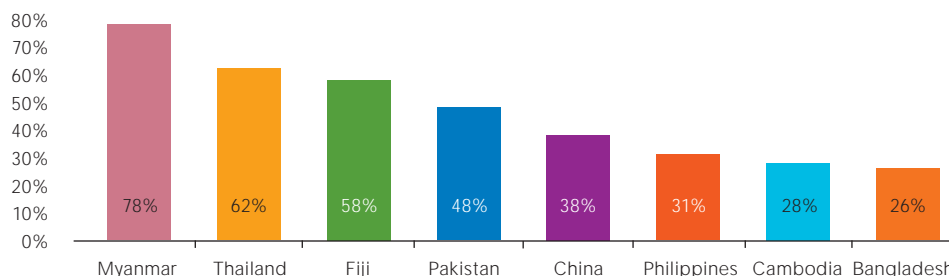


Based on responses to Section 2A:4a–7b.

Gossip

All countries reported that a significant proportion of respondents were aware they had been gossiped about, ranging from 26% (Bangladesh) to 78% (Myanmar) (Figure 10). Such experience alienates people living with HIV and decreases their sense of belonging to their local community, because gossip indicates that their actions and their lives fail to comply with community norms.

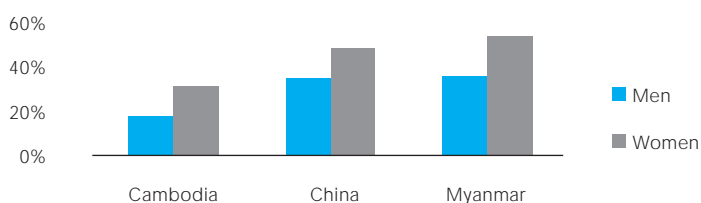
Figure 10: Gossiped about in past 12 months (prevalence by country)



Based on responses to Section 2A:4a.

In most instances where gender-disaggregated data were provided, countries reported that significantly more women than men were aware of being the subject of gossip (Figure 11), although it is not clear whether this is because women are predisposed to community judgement and gossip due to gender biases and inequalities, or whether women are more aware of gossip occurring.

Figure 11: Subject of gossip specific to HIV in past 12 months

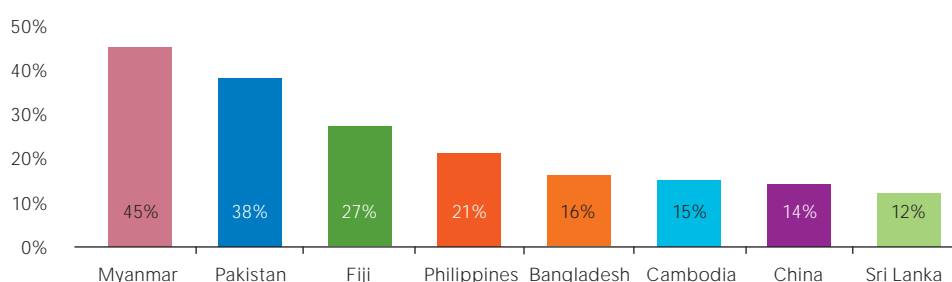


Based on responses to Section 2A:4a and 4b.

Verbal insults, harassment and threats

Many respondents indicated that they had been verbally insulted, harassed or threatened, ranging from 12% (Sri Lanka) to 45% (Myanmar) (Figure 12). In countries locations that provided data, this experience was gendered, with women being targeted more often than men.

Figure 12: Verbally insulted, harassed or threatened in past 12 months (prevalence by country)

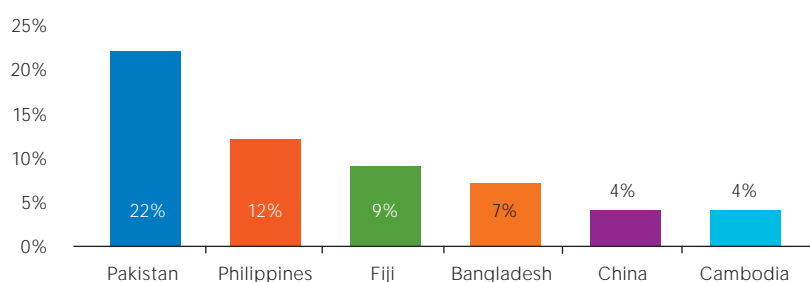


Based on responses to Section 2A:5a.

Physical harassment and threats

All countries providing data identified instances of people living with HIV being physically harassed or threatened in response to their HIV status (Figure 13), although at far lower levels than verbal harassment or gossip. Reports of physical harassment and threats ranged from 4% (Cambodia) to 22% (Pakistan).

Figure 13: Physically harassed in past 12 months (prevalence by country)



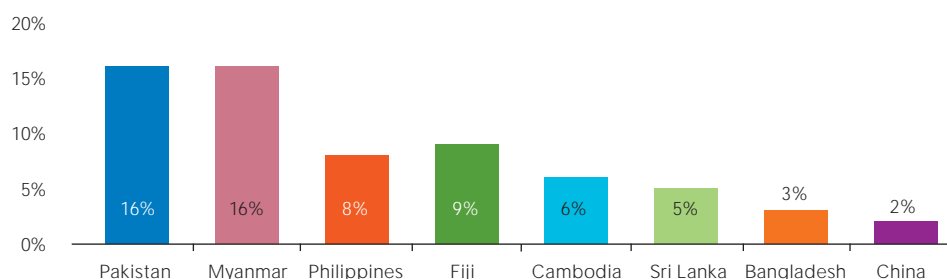
Based on responses to Section 2A:6a.

Physical assault

All countries identified instances of people being assaulted as a result of their HIV status (Figure 14), although the percentage of people living with HIV who had experienced HIV-related assault in the past 12 months was generally lower than for the above three categories, ranging from 2% (China) to 16% (Pakistan).²⁴

24 These findings compare with 5% of respondents in the AIDS Discrimination in Asia report.

Figure 14: Physically assaulted in past 12 months (prevalence by country)



Based on responses to Section 2A:7a.

Gendered nature of insults, harassment and assaults

Countries that provided gender-disaggregated data recorded that women were more likely than men to experience insults, harassment and assaults, both in relation to their HIV-status and as a response to other unidentified factors (Figures 15 and 16).

Figure 15: Gendered nature of insults, threats and assaults: Cambodia

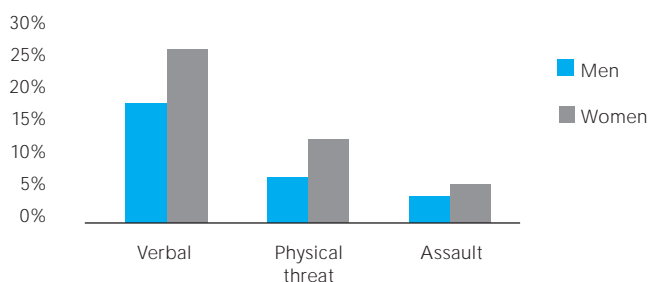
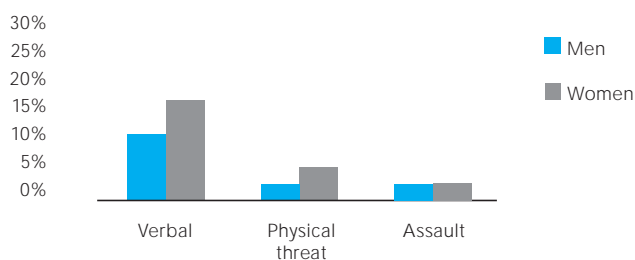


Figure 16: Gendered nature of insults, threats and assaults: China

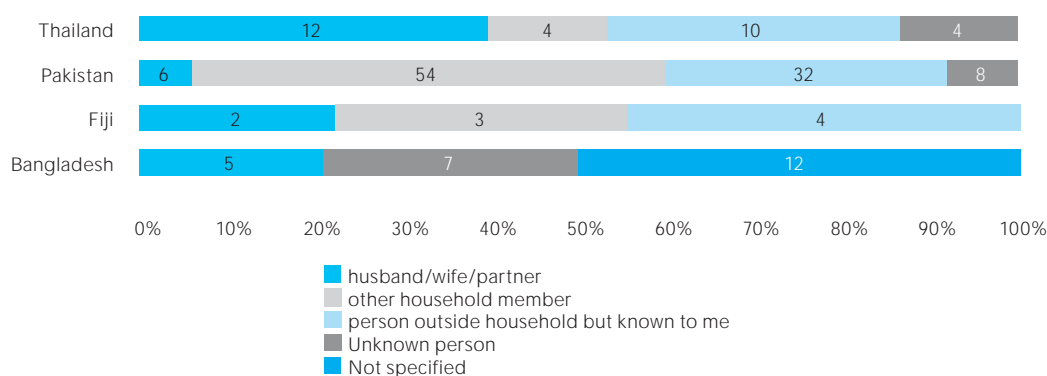


Perpetrators of assault

The PLHIV Stigma Index asked all respondents who had experienced assault during the past 12 months to identify (by category) the perpetrator of the assault. Bangladesh, Fiji, Pakistan and Thailand provided transparent reports showing that people living with HIV were at greater risk of assault from a person within their household than from anyone else: assaults by spouses or other household members totalled more than 50% in each instance (Figure 17). Again, the family

home remains a major location of stigma- and discrimination-based harm for many people living with HIV.

Figure 17: Perpetrators of physical assault



Based on responses to Section 2A:7c.

Although the intersection of HIV status and domestic (or family) violence is underresearched, Millennium Development Goal 6A noted that there “is mounting evidence showing a link between gender-based violence and HIV”. As stated in the Bangladesh report:

Gender discrimination seemed to be an added burden on the shoulders of female [people living with HIV]. Female participants described being thrown out of their in-laws’ houses, tortured and having their inherited properties and money taken away etc. even in cases where in-laws knew that the participant had been infected with HIV through her husband. Female participants also felt the added pressure from in-laws to become pregnant since they did not know of their sons’ and daughter-in-laws’ positive status. Participants reported that family members verbally discriminated against them when they could not participate in family activities or perform their daily tasks and chores.

More research is needed to understand and address the ways in which a person’s HIV-positive status increases their vulnerability to domestic violence or perpetration of violence in many different national settings. What is clear is that domestic violence remains acceptable and unsurprising in many locations. As noted in Thailand’s report, of the 30 respondents who had been the subject of domestic violence:

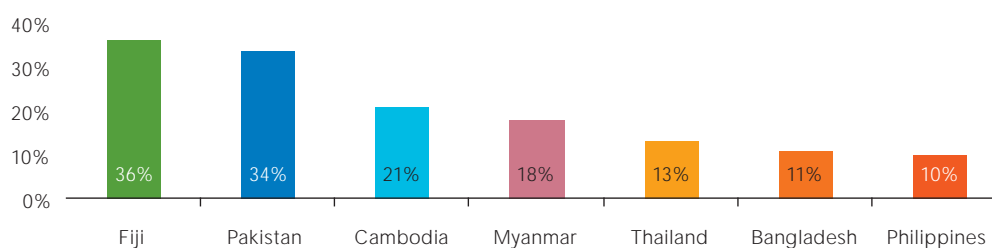
15 thought physical assault was not based on HIV status as the occurrences involved 6 heterosexual couples, 4 family members and 10 acquaintances. These people had close relationships that could allow for physical violence.

Similarly, the Sri Lanka report states:

Domestic abuse is underreported in Sri Lanka, and Sri Lankan culture shares the region's traditional apathy towards domestic abuse and intimate partner violence. ... In fact, the research team through discussion suggests that people would attempt to justify it based on punitive grounds, especially if the individual is perceived to bring shame on the family due to HIV status.

Many people living with HIV also reported psychological pressure, manipulation and harassment by their spouse focused on their HIV status, ranging from 10% (the Philippines) to 36% (Fiji) (Figure 18). This finding confirms the family home as a key site of stigma, manipulation and family violence.

Figure 18: Psychological pressure or manipulation by husband, wife or partner in past 12 months



Based on responses to Section 2A:9.

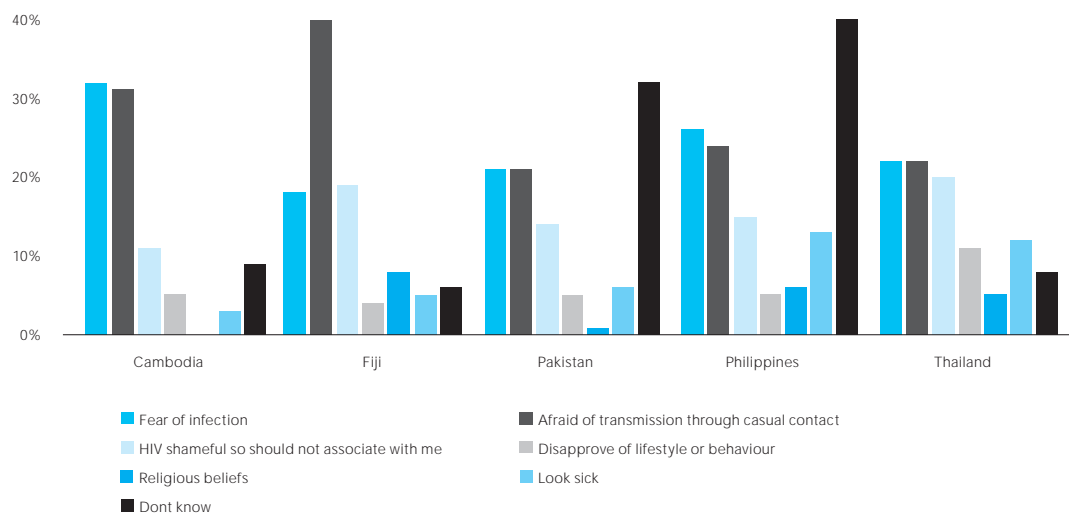
Reasons for discrimination

The PLHIV Stigma Index asked respondents who had experienced stigma or discrimination during the past 12 months to consider the reasons people had discriminated against them.

Fear of infection

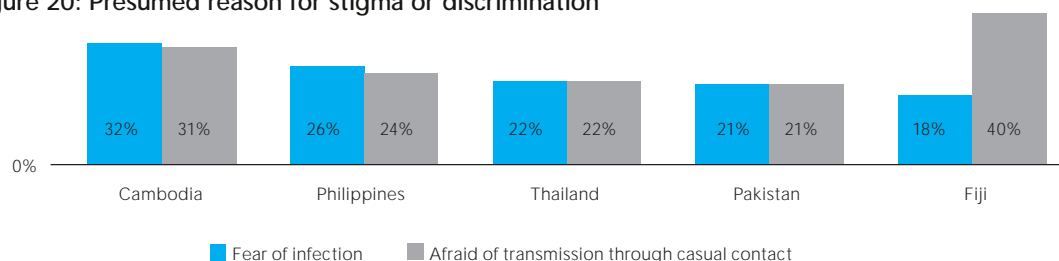
As shown in Figure 19, PLHIV Stigma Index responses suggest that fear of infection, including infection through casual contact, remains a leading trigger for stigma and discrimination. Respondents estimated that experiences of stigma and discrimination had been caused by fear of infection, ranging from 18% (Fiji) to 32% (Cambodia), and from fear of transmission through casual contact, ranging from 21% (Pakistan) to 40% (Fiji) (Figure 20).

Figure 19: Presumed reason for stigma or discrimination



Based on responses to Section 2A:13.

Figure 20: Presumed reason for stigma or discrimination



Based on responses to Section 2A:13.

I did not know anything about HIV before I tested positive myself. I just knew that people who have this condition die. Immoral people get this disease. I have also heard that train carriages that HIV positive people travel on are burnt later [to avoid contagion spreading]. I have heard all this from people and on television.

Bangladesh

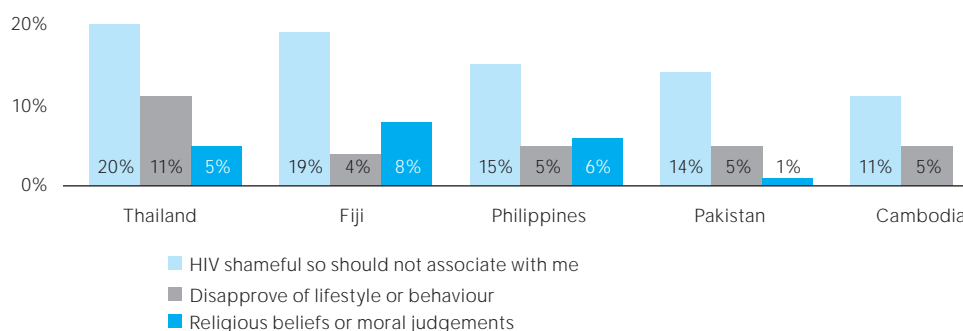
These findings suggest the importance of effective education on transmission risk, both to minimize HIV transmission risk behaviours and to reduce stigma and discrimination experienced by people living with HIV.

Morality

Responses also point to the role of morality and faith-based beliefs in stigma and discrimination, particularly disapproval of lifestyle and behaviour and religious beliefs or moral judgements (Figure 21). For example, individuals experienced the following judgements:

- ▶ Should not associate because HIV is shameful: ranging from 11% (Cambodia) to 20% (Thailand).
- ▶ Disapproval of lifestyle: ranging from 4% (Fiji) to 11% (Thailand).
- ▶ Religious beliefs and moral judgements: ranging from 1% (Pakistan) to 8% (Fiji).

Figure 21: Presumed reason for stigma or discrimination



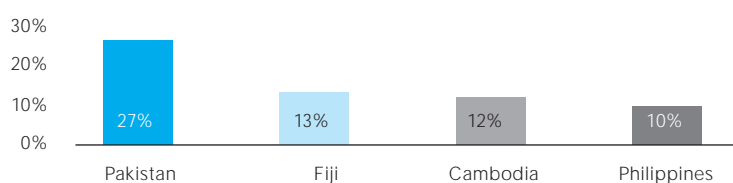
Based on responses to Section 2A:13.

The data show that morality and religious beliefs continue to play a role in informing stigma and discrimination.

Discrimination by people living with HIV

The PLHIV Stigma Index revealed that discrimination is not only practised by people who are HIV-negative. In the four countries that provided data, more than 10% of respondents indicated that they had experienced discrimination by other people living with HIV (Figure 22).

Figure 22: Discrimination by other people living with HIV in past 12 months



Based on responses to Section 2A:11.

It is unfortunate that, despite the personal experience of living with HIV and the attendant stigma and discrimination it attracts, some people living with HIV at times discriminate against others in similar circumstances. The PLHIV Stigma Index questionnaire did not explore the reasons for such discrimination and whether it occurred in response to another person's HIV infection, their membership of a marginalized population, or other reasons. Further research is needed to understand and address the issue of people living with HIV discriminating against other people living with HIV.

Section 2B: Access to work and health and education services

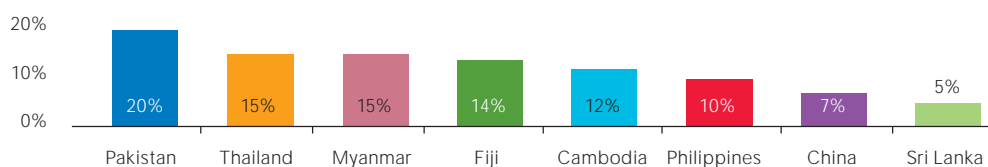
Section 2B of the PLHIV Stigma Index found that stigma and discrimination adversely affect the lives of many people living with HIV by reducing their access to secure housing, fair work (income), education and health care.

Right to housing

HIV infection directly impacted on respondents' ability to secure accommodation, and consequently undermines their right to housing as prescribed by Article 25 of the Universal Declaration of Human Rights. Adequate housing is essential to human dignity: Without adequate housing, many other basic human rights are compromised, including the right to family life and privacy, the right to freedom of movement, the right to assembly and association, the right to health and the right to development.

The PLHIV Stigma Index found that many people living with HIV, ranging from 5% (in Sri Lanka) to 20% (in Pakistan), had been forced to move or had been unable to rent accommodation during the past 12 months as a result of their HIV-positive status (Figure 23).²⁵

Figure 23: Forced to change or unable to rent place of residence in past 12 months



Based on responses to Section 2B:1. The response from Thailand may include actions for reasons other than HIV.

Right to work

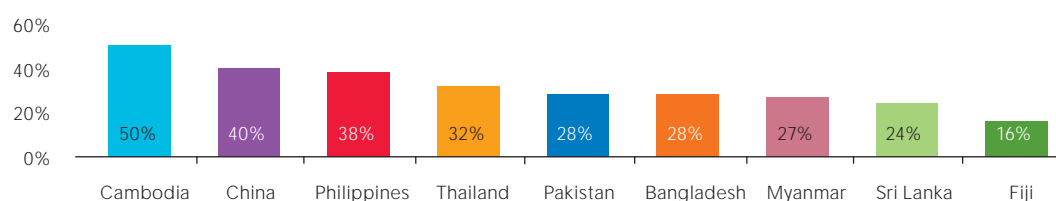
Article 23 of the Universal Declaration of Human Rights describes the human right to work, and “full and productive employment and decent work for all” is specifically named as a Millennium Development Goal. Discrimination against people living with HIV is denying many people the right to work, and the consequences can be profound. For example, Cambodia’s report refers to the findings of Cambodia’s Socio-economic Impact Study, which found that:

27% of people living with HIV who were earning an income before their diagnosis were no longer earning an income because of their HIV status. And for those still earning an income, their income had dropped by 50%. ... household[s] [of people living with HIV] with smaller revenues ... end up selling their land or house to pay health care bills and other necessities that leads them into a cycle of poverty.

²⁵ These findings compare with 10% of people in the AIDS Discrimination in Asia report being forced to change their place of residence.

The PLHIV Stigma Index revealed that HIV had significantly affected people's ability to secure and retain employment, and their employment and career progression.²⁶ Between 16% (Fiji) and 50% (Cambodia) of respondents had lost their job or other form of income during the past 12 months (Figure 24).

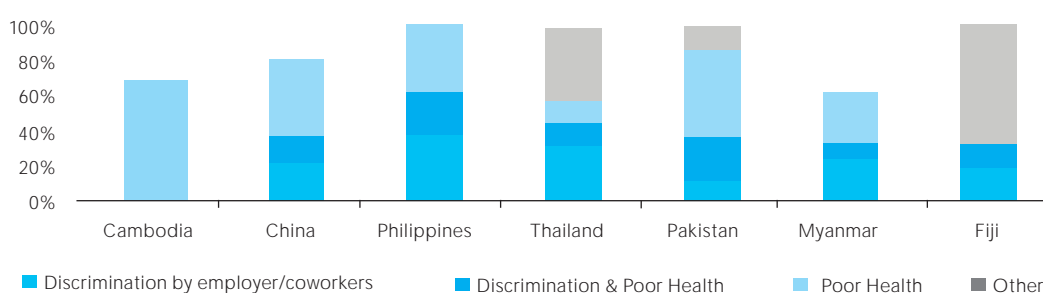
Figure 24: Loss of job or other form of income in past 12 months



Based on responses to Section 2B:2a.

Although many respondents attributed their loss of employment or income to poor health, discrimination was the key factor or played a role in many other respondents' loss of income or employment (Figure 25 and Table 2).

Figure 25: Reason for loss of employment or work



Based on responses to Section 2B:2b.

Table 2: Reasons for employment loss

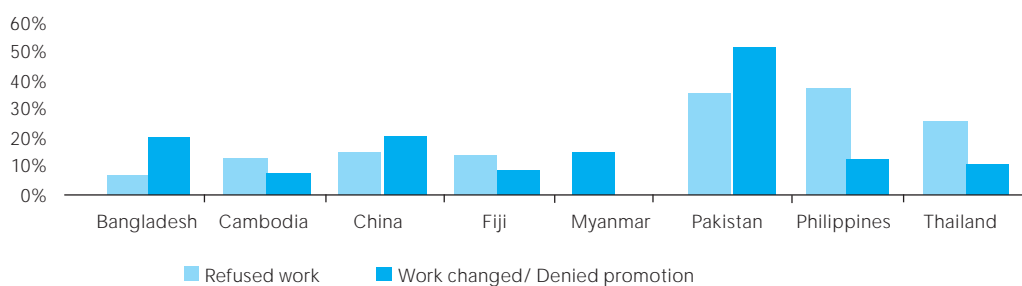
Left employment as result of	"Discrimination" only (%)	"Discrimination" and "Combination of discrimination and poor health" (%)
China	22	39
Fiji	19	31
Myanmar	24	33
Pakistan	11	25
Philippines	38	63
Thailand	31	45

²⁶ AIDS Discrimination in Asia reports that one in six people had experienced some form of discrimination in the workplace.

The profound impact of discrimination on work opportunities was not limited to discrimination by employers and co-workers in formal employment settings. For example, the China report notes that “more than a third of those who reported being unemployed or losing income because of HIV-related discrimination were self-employed or farmers”. The Cambodia report notes that “selling products is often difficult for HIV-positive people and their families due to stigma and discrimination, which continues to occur in the community”.

The PLHIV Stigma Index revealed that significant proportions of people living with HIV had been refused the opportunity to work, ranging from 9% (Bangladesh) to 38% (Philippines) (Figure 26). Similarly, many people living with HIV had been refused promotion, or the nature of their work had changed, ranging from 8% (Cambodia and Fiji) to 52% (Pakistan).

Figure 26: Refusal of work or promotion, or change of nature of work because of HIV-positive status in past 12 months



Based on responses to Section 2B:3 and 4.

The PLHIV Stigma Index does not ask questions to identify whether “work” refers to work in the respondent’s home country or a destination country (i.e. it does not indicate whether the respondent had migrated for work). Migration for work is very common to and from countries within the Asia Pacific region, and many former migrant workers were included in survey populations. For example, the Sri Lanka report notes:

during the dissemination of key [PLHIV Stigma Index] findings to approximately 30 HIV-positive people from three networks in Sri Lanka, every single member spoke of a link to migrant work. They were either migrant workers themselves, or had a spouse or partner who was a migrant worker.

The experiences of migrant workers can be disaggregated at the country level, but in this regional context it must be noted that in many instances diagnosis of HIV in destination countries may lead to incarceration and subsequent deportation.²⁷ It may also deny the opportunity to earn funds to repay debts incurred in order to migrate to take up the initial offer of employment, pushing people living with HIV and their families further into poverty. Such consequences may occur regardless of whether the individual’s HIV-positive status posed any risk to other individuals or public health.

27 See Annex 3.

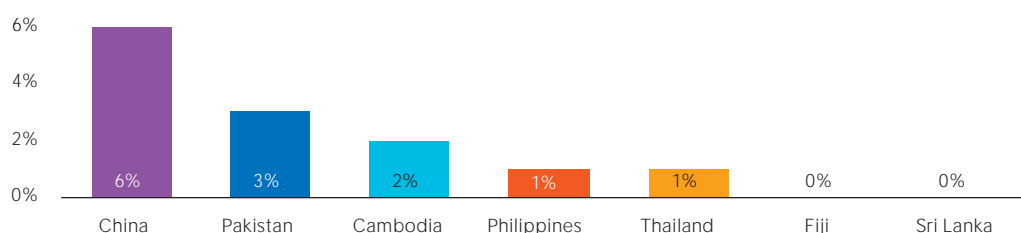
Police were sent to my shop three or four days after I was found positive. I hid for 10 to 12 days but then the police caught me and kept me in the prison hospital. They notified my shop owner who later arranged for my air ticket. The police kept me in chains like a common criminal. They opened the chains when they put me on the plane [to be deported].

Bangladesh

Right to education

Article 26 of the Universal Declaration of Human Rights describes the human right to an education, and all children's completion of primary education is specifically named as a Millennium Development Goal. The PLHIV Stigma Index found that stigma and discrimination appear to have less impact on the participation of people living with HIV in educational settings, compared with work and accommodation,²⁸ but the education of people living with HIV, and their children, continues to be affected in many locations (Figure 27).

Figure 27: Prevented from attending educational institution in past 12 months



Based on responses to Section 2B:5.

These data do not, however, provide a full picture of HIV-related discrimination in educational settings. For example, data from China (collected later in Section 3B: Disclosure and confidentiality) show that 36% of people living with HIV aged under 25 years said their teacher had shown a “discriminatory” or “very discriminatory” attitude after discovering their HIV status.

Three of the five countries reporting relevant data recorded instances of respondents' children being dismissed, suspended or prevented from attending educational institutions because of their parent's HIV status:

- ▶ China recorded that the children of 9% of people living with HIV interviewed had been prevented from attending school as a result of stigma and discrimination.
- ▶ Cambodia recorded that the children of 10% of people living with HIV interviewed had been prevented from attending school as a result of stigma and discrimination. This figure

²⁸ These findings are consistent with those of AIDS Discrimination in Asia which found ‘there were fewer violations within the sphere of education than in other areas. Some 2% of the sample said they or their child(ren) had been denied admission into an educational establishment because of their HIV status.

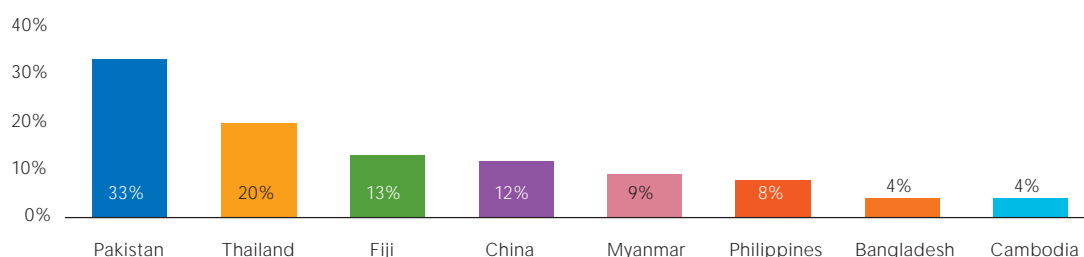
differs from findings from Cambodia’s Socio-economic study, which found comparable school enrolment of children from HIV-affected and non-affected households, although children from HIV-affected households were more likely to miss school or repeat a grade.

- ▶ Pakistan reported that 55 children had been denied access to school, with 41 children being denied access to school more than once.
- ▶ Bangladesh identified that 1 child of the 238 people interviewed (not all of whom had children) had been prevented from attending school as a result of stigma and discrimination.
- ▶ The Philippines found no instances of children being denied access to school as a result of stigma and discrimination.

Right to health care

The PLHIV Stigma Index shows that HIV-positive status reduced respondents’ access to health care, ranging from 4% (Cambodia and Bangladesh) to 33% (Pakistan) (Figure 28).

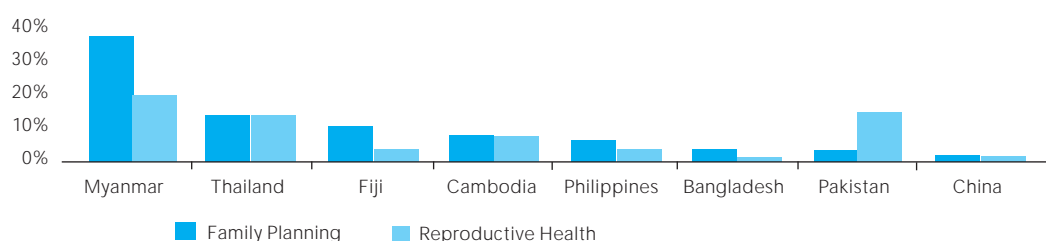
Figure 28: Denied health services (including dental care) because of HIV status in past 12 months



Based on responses to Section 2B:7.

Respondents were denied both family planning, ranging from 2% (China) to 38% (Myanmar), and sexual and reproductive services, ranging from 2% (China and Bangladesh) to 20% (Myanmar) (Figure 29), although a significant range in responses was recorded throughout the region.

Figure 29: Denied family planning and sexual and reproductive health services in past 12 months



Based on responses to Section 2B:8 and 9.

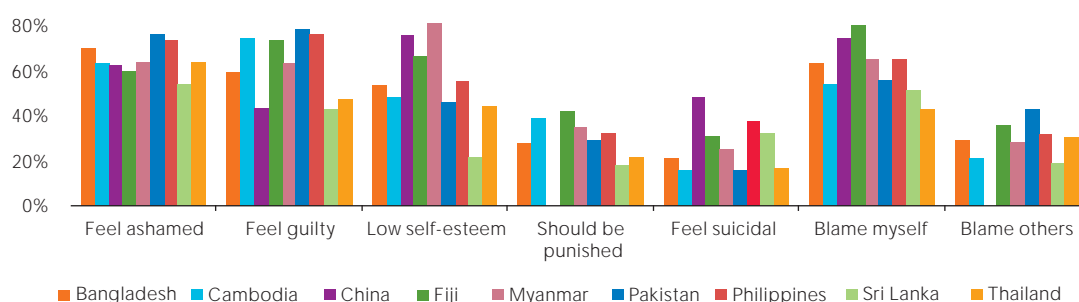
Further data on access to health care are provided throughout the report.

Section 2C: Internalized stigma (way you feel about yourself and your fears)

Sense of self

The PLHIV Stigma Index found disturbingly high levels of internalized stigma manifesting as shame, guilt and self-loathing. It also found that most people living with HIV blamed themselves for their own HIV infection. Figure 30 and Table 3 are based on “responses” with respondents able to provide multiple responses.

Figure 30: Internalized stigma



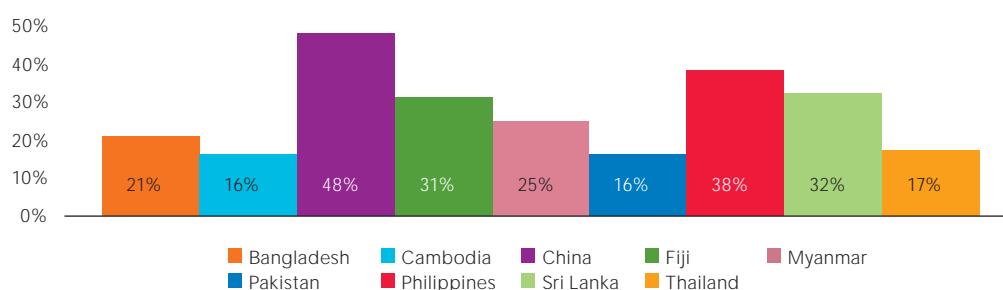
Based on responses to Section 2C:1.

Table 3: Internalized stigma recorded by people living with HIV

Experience of internalized stigma	Shame	Guilt	Low self-esteem	Feel should be punished	Feel suicidal	Blame myself	Blame others
High end of range	76% (Pakistan)	76% (Philippines)	81% (Myanmar)	42% (Fiji)	48% (China)	80% (Fiji)	36% (Fiji)
Low end of range	54% (Sri Lanka)	43% (Sri Lanka and China)	22% (Sri Lanka)	18% (Sri Lanka)	16% (Cambodia and Pakistan)	51% (Sri Lanka)	19% (Sri Lanka)

Of particular concern is the significant number of respondents who stated they feel suicidal (Figure 31).

Figure 31: Percentage of respondents feeling suicidal in past 12 months



Based on responses to Section 2C:1.

I felt like killing myself and my two kids many times because after having this disease, a lot of things started to happen to me which I never thought possible.

Bangladesh

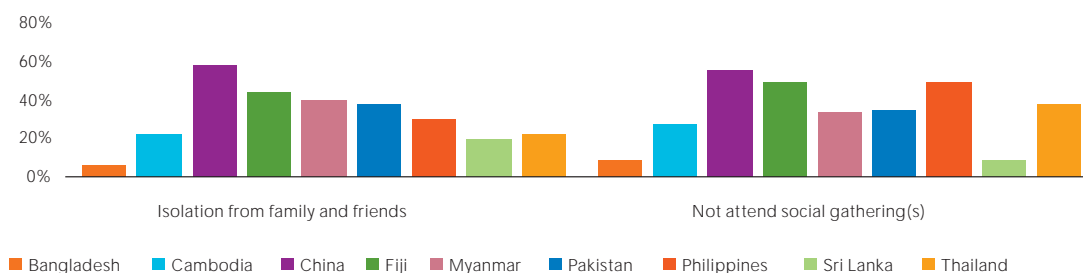
So far, I don't want to be alive.

Cambodia

Expressions of internalized stigma: social and familial isolation

Internalized stigma impacts on people’s daily life, affects the ways in which people cope with their HIV-positive status, and finds behavioural and practical expression. Many people isolated themselves from family and friends, from 6% (Bangladesh) to 58% (China), or decided not to attend social gatherings, from 9% (Bangladesh and Sri Lanka) to 55% (China), “because of” their HIV status (Figure 32).

Figure 32: Social isolation: decisions based on HIV-positive status in past 12 months



Based on responses to Section 2C:2.

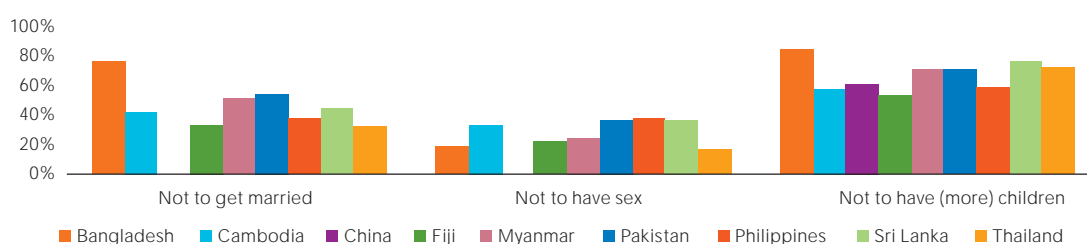
Reasons for the significant variations in range are not understood, but the Sri Lanka report suggests that the low rate of respondents’ familial and social isolation may correspond to low levels of disclosure to family and friends – hence more people felt able to attend social gatherings when others were unaware they were living with HIV.

Expressions of internalized stigma: sex, marriage and reproduction

Article 16 of the Universal Declaration of Human Rights recognizes the right to marry and found a family, regardless of race, nationality or religion, because “the family is the natural and fundamental group unit of society and is entitled to protection by society and the State”. The PLHIV Stigma Index, however, found that large numbers of people living with HIV were choosing not to marry (more than three-quarters of respondents in Bangladesh).

In many cultures, marriage is a fundamental foundation of personal and cultural human relationships, and yet large numbers of people are now making choices that will permanently exclude them from cultural acceptance (Figure 33).

Figure 33: Sex, marriage and reproduction: decisions based on HIV status in past 12 months



Based on responses to Section 2C:2.

Choosing not to have sex

Many people living with HIV are choosing not to have sexual relationships, from 17% (Thailand) to 38% (Philippines), despite sex being a normal part of human life, wide-scale evidence for healthy consensual sexual practice facilitating a sense of well-being, and safe sexual practice precluding HIV transmission risk.

Deciding not to marry

Many people living with HIV are choosing not to marry, from 32% (Thailand) to 77% (Bangladesh), despite HIV infection not precluding marriage per se. Further work is needed to explore strategies to facilitate options for people living with HIV to marry and to have children. These may include increased HIV prevention education, including the understanding that (safe) sexual relations may occur without the risk of transmission, and increased uptake of effective treatments, as these significantly decrease transmission risk even when condoms are not used or are not used correctly.

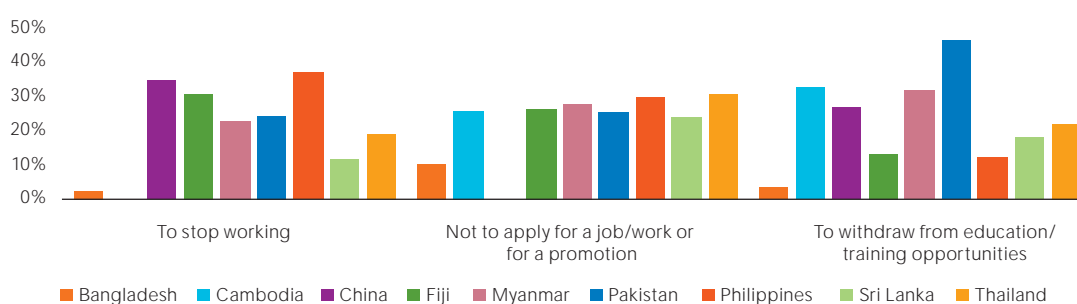
Deciding not to have (more) children

In all countries, more than half of people living with HIV interviewed had decided they would not have (more) children as a result of their HIV-positive status, from 53% (Fiji) to 85% (Bangladesh); the PLHIV Stigma Index records that in some instances such decisions were coerced. The PLHIV Stigma Index did not, however, measure the extent to which these decisions were based on stigma compared with other reasons that might influence such decisions, such as fear of failing health, fear of bearing HIV-positive children, and fear of dying while one's children are young.

Expressions of internalized stigma: work and education

The PLHIV Stigma Index found that many people had decided, as a result of their HIV status, to withdraw from work, from 3% (Bangladesh) to 38% (Philippines); to not apply for a job or promotion, from 10% (Bangladesh) to 31% (Thailand); or to withdraw from education and training, from 3% (Bangladesh) to 47% (Pakistan) opportunities (Figure 34); that is, they made the decision rather than having the decision directly imposed upon them.

Figure 34: Impact on work: decisions made as a result of HIV-positive status in past 12 months



Based on responses to Section 2C:2.

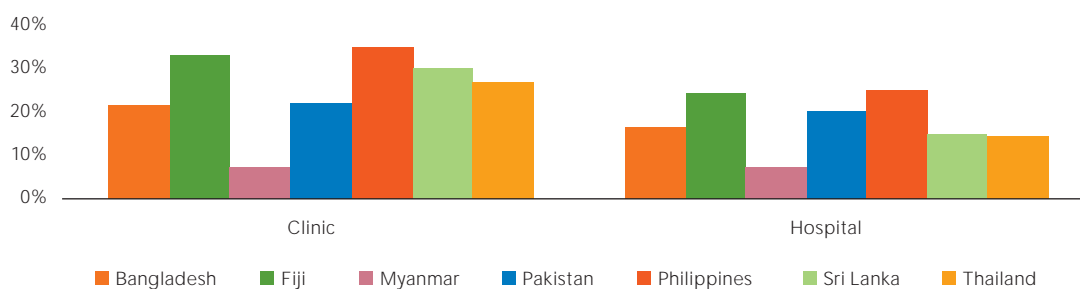
Note that China did not report people who had “decided” to withdraw from work or training opportunities but reported on those who were worried about withdrawing from work or training opportunities.

The PLHIV Stigma Index did not ask respondents to identify the extent to which stigma had informed their decisions compared with other reasons, such as failing health.

Expressions of internalized stigma: decision to avoid necessary healthcare

Of great concern, countries reporting data on avoidance of health care found that many people living with HIV avoid clinics and hospitals because of their HIV-positive status, despite needing access to medical services (Figure 35): From 7% (Myanmar) to 35% (Philippines) avoided going to a clinic when they needed to, and from 7% (Myanmar) to 25% (Philippines) avoided going to a hospital when they needed to.

Figure 35: Avoided health care when needed: decisions made in response to HIV in past 12 months

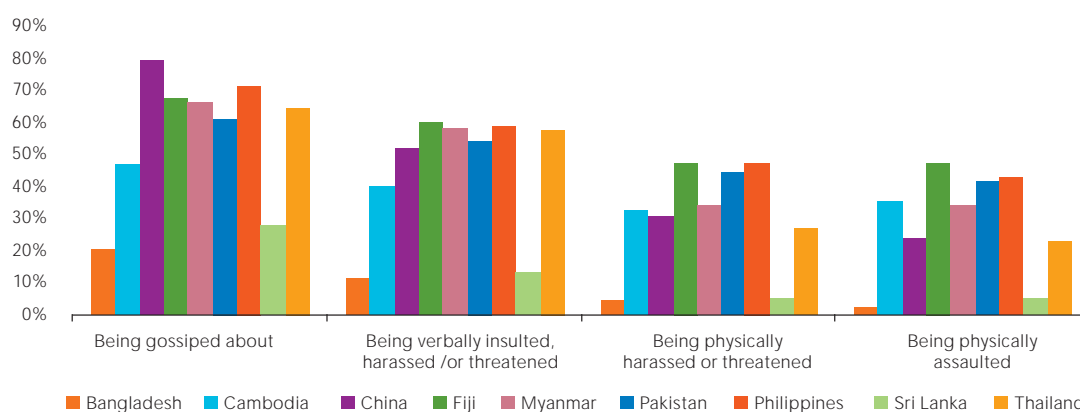


Based on responses to Section 2C:2.

Fear of gossip, harassment and assault

The PLHIV Stigma Index reported that many people were scared of gossip, verbal insults and threats, and physical assault (Figure 36). The data suggest that many people live in fear of physical manifestations of stigma and discrimination – fear that is likely to be far more pervasive and frequent than actual instances of gossip, threat, harassment and assault.

Figure 36: Feared gossip, threat, harassment and assault in past 12 months



Based on responses to Section 2C:3.

Section 2D: Rights, laws and policies

Awareness of laws and policies

The Declaration of Commitment on HIV/AIDS is an international agreement signed by 189 governments at the United Nations General Assembly Special Session on HIV/AIDS in 2001. The Declaration affirms that:

the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS.

The Declaration notes that “stigma, silence, discrimination and denial, as well as a lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must also be addressed”.

The PLHIV Stigma Index found that most respondents had not heard of the Declaration of Commitment on HIV/AIDS, although survey results varied considerably in a few specific locations. Awareness of the Declaration of Commitment on HIV AIDS was as follows:²⁹

- ▶ Bangladesh: 9%
- ▶ Cambodia: 85%
- ▶ Fiji: 18%
- ▶ Myanmar: 5%
- ▶ Pakistan: 1%
- ▶ Philippines: 80%
- ▶ Sri Lanka: 0%
- ▶ Thailand: 43%

Bangladesh, Fiji, Pakistan and Myanmar recorded low numbers of respondents being aware of the Declaration of Commitment on HIV/AIDS. Sri Lanka, which found none of the 99 respondents were aware of the Declaration, notes that the poor knowledge of laws and policies was predictable, particularly in the context of Sri Lanka having no laws or policies related specifically to HIV.³⁰

Cambodia recorded a high rate of awareness (85%), although the Cambodia report suggests this finding is "surprising and somewhat unreliable", as it is likely that both respondents and interviewers confused the declaration with the Cambodia AIDS Law, which came into force in late 2002. The relatively high Thai response rate (43%) may be informed by the question having been rephrased as awareness of "any HIV-related declarations protecting the rights of positive people". The report from the Philippines did not suggest reasons for the high positive response rate in the Philippines (80%).

Of the people who had "heard of" the Declaration of Commitment on HIV/AIDS, a smaller number had "ever read or discussed" its content. A number of countries also reported on respondents' awareness of domestic laws (Table 4).

29 Based on responses to Section 2D.1a.

30 Sri Lanka also notes that if the PLHIV Stigma Index is undertaken again, the process would "need to consider including knowledge of basic rights, and existing laws and policies under which HIV-positive people can find recourse".

Table 4
Awareness of people living with HIV of national laws, policies and plans

Country	Law, policy or plan	Aware (%)	Read or discussed (%)
Bangladesh	Not named	0.4	0
Cambodia	Prevention and Control of HIV/AIDS in Cambodia 2002	80	68
Fiji	HIV Decree	31	22
Myanmar	Not named	1	
Philippines	RA8504: The Philippine AIDS Prevention and Control Act of 1998	85	85
Sri Lanka	National Strategic Plan (HIV) 2007–2011 (no domestic law or policy)	13	5
Thailand	National Health Security Act 2002	72	79

Based on responses to Section 2D:2a and 2b.

We used to see it through the media in the community such as newspaper and radio aimed to reduce stigma.

Cambodia

The Cambodia report notes that the high result rate may have been influenced by the fact that more than 90% of the people living with HIV who were interviewed were members of a network of people living with HIV, with 66% of them working or volunteering on projects or programmes providing assistance to people living with HIV. They may have been aware of, read or discussed the law, or they may have been embarrassed to admit non-awareness. The high response rate might simply also reflect national efforts led by the National AIDS Authority to disseminate the law through media and communities with active participation from AIDS activists and networks of people living with HIV. It may be useful to explore further why certain jurisdictions have generated high levels of awareness of legal remedies among their populations of people living with HIV so that these models may be considered in other settings.

Experience of discrimination through institutional and formal mechanisms

In those countries providing data, most respondents indicated that they had not experienced HIV-related discrimination through the formal mechanisms described: forced medical procedure, denial of health or life insurance, immigration-related HIV disclosure, detention, quarantine, isolation, segregation, or arrest for HIV-related charge:

- ▶ Cambodia: 87%
- ▶ Fiji: 76%

- ▶ Philippines: 45%
- ▶ Thailand: 55%

There were, however, instances of violations in institutional settings.

My uncle notified the police and other highly placed people in our community about my physical condition. They took my two children and me away and kept us locked in a room in the office for disabled people for 1 month and 2 days. During this time nobody spoke to us or fed us regularly.

Bangladesh

Five countries reported incidents of forced disclosure related to immigration: Cambodia, Fiji, Myanmar, Pakistan and Philippines with rates between 1% (Philippines) and 6% (Pakistan), although these are percentages of the total respondent population rather than of people who travelled or sought a change of residency or nationality (Table 5).³¹ Many countries continue to require HIV disclosure as a means to deny entry to people living with HIV, despite there being no public health rationale for many of these restrictions, particularly restrictions related to short-term entry (see Annex 5).

Table 5: Experience of discrimination through institutional and formal mechanisms related to forced disclosure for migration

	Detained, quarantined, isolated or segregated (%)	Forced disclosure of HIV status on entering another country (%)	Forced disclosure of HIV: residency/nationality (%)
Cambodia	3	2	4
Fiji	2	4	–
Myanmar	10	3	–
Pakistan	3	6	–
Philippines	4	1	
Thailand	8	–	–

Based on responses to Section 2D:3.

Table 6: Experience of discrimination through institutional and formal mechanisms related to health care and insurance

	Forced medical and health procedure (including HIV testing) (%)	Denied health or life insurance (%)
Cambodia	12	4
China	20 ^a	12
Fiji	11	7

³¹ These findings compare with 5% of respondents from the AIDS Discrimination in Asia report.

	Forced medical and health procedure (including HIV testing) (%)	Denied health or life insurance (%)
Myanmar	5	-
Pakistan	11	8
Philippines	59	4
Thailand	14	21

Based on responses to Section 2D:3.

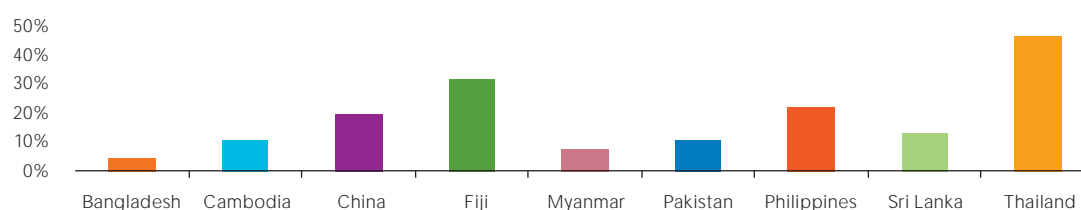
^aChina also reported that 12% of respondents had been forced to submit to a medical or health report, although it is not clear whether there is overlap between the two categories.

Although most respondents indicated that they had not experienced HIV-related discrimination through the formal mechanisms, Table 6 records respondents' experienced forced medical and health procedures (including HIV testing) and denied health and life insurance, ranging from 4% (Cambodia) and 5% (Myanmar) to 21% (Thailand) and 59% (the Philippines).

Abuse of rights

The PLHIV Stigma Index records respondents' experience of rights abuse (Figure 37). Reports of such abuses ranged from 5% (Bangladesh) to 47% (Thailand). The reason for such variation, which may or may not include increased reporting facilitated by increased awareness of human rights, should be explored further.

Figure 37: Abuse of rights as a person living with HIV in past 12 months



Based on responses to Section 2D:4a.

Legal redress

The PLHIV Stigma Index survey asked respondents who had experienced abuse whether they had attempted legal redress, and whether their efforts had been successful (Table 7).

The data show that most people who experienced rights abuses did not attempt redress through legal mechanisms. Of the people who did attempt legal redress, most had not been successful within 12 months.

Table 7: Rights abuses and remedies during past 12 months

	Experienced rights abuse (%)	Number of respondents who experienced rights abuse	No. attempted legal redress ^a	Matter resolved	Matter still in process of being solved	Nothing happened or matter not solved
Bangladesh	5	12 of 238	1	1	–	–
Cambodia	11	43 of 397	29	10	5	4
China	20	400 of 2096 (approx.)	110	22	Not provided	75
Fiji	32	14 of 45	2	–	1	2
Myanmar	8	22 of 324	“Few”	Figures not available	Figures not available	Figures not available
Pakistan	11	97 of 833	22	5	3	14
Philippines	22	18 of 80	3	1	–	1
Sri Lanka	13	13 of 99	5	0	2	3
Thailand	47	110 of 233	25	17	4	4

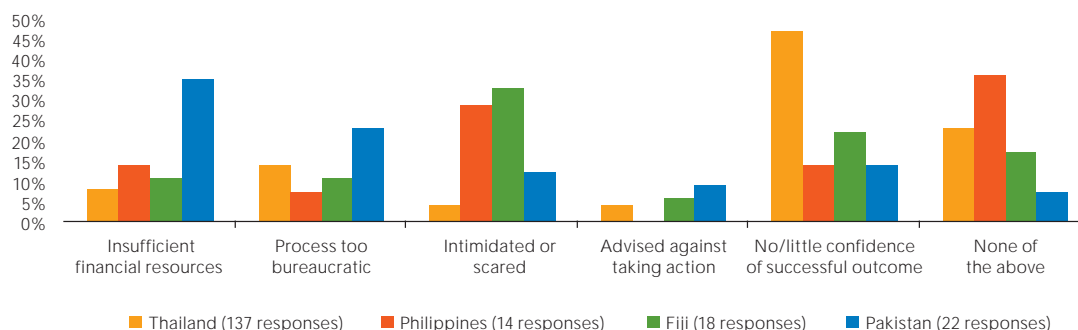
Based on responses to Section 2D:4a, 4b and 4d.

^aSome respondents may have commenced more than one action for legal redress.

The PLHIV Stigma Index questioned respondents who had not sought legal redress about why they had not done so (Figure 38). Although many countries did not provide full data, their reports make important observations:

- ▶ **Sri Lanka:** People living with HIV “have had poor experiences with HIV and law ... people had no confidence in the system and were afraid of being subject to further stigma and discrimination in seeking legal redress for violation of rights”.
- ▶ **Myanmar:** Respondents demonstrated “little confidence in the outcome or stated they felt intimidated by the process”.
- ▶ **China:** The primary reason respondents did not attempt legal redress was “a lack of faith in the possibility of success”.
- ▶ **Cambodia:** The main reasons for not attempting legal redress were insufficient financial resources and uncertainty about where and from whom to seek help.
- ▶ **Bangladesh:** “Insufficient financial resources” was given as the reason the majority (4 of 11) respondents did not seek legal redress.

Figure 38: Reasons for respondents not seeking legal redress following human rights abuses



Multiple responses allowed Based on responses to Section 2D:4e.

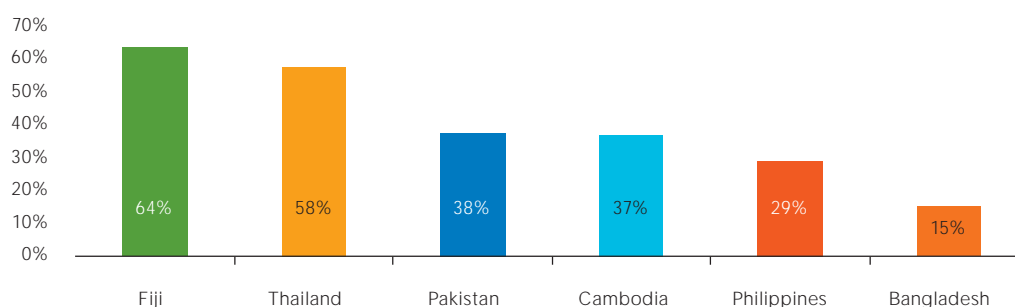
Note that Fiji allowed multiple answers to this question, so Fiji's figures are somewhat inflated compared against other countries' figures; however, the figures are still relevant to considering barriers within Fiji.

Section 2E: Effecting change

Confronting stigma and discrimination

From the countries providing data, it is clear that some people living with HIV are able to confront, challenge and educate people who stigmatize and discriminate against them (Figure 39). There was, however, substantial variation between rates in different countries, ranging from 15% (Bangladesh) to 64% (Fiji).

Figure 39: Confronted, challenged or educated someone who was stigmatizing or discriminating in past 12 months



Based on responses to Section 2E:1.

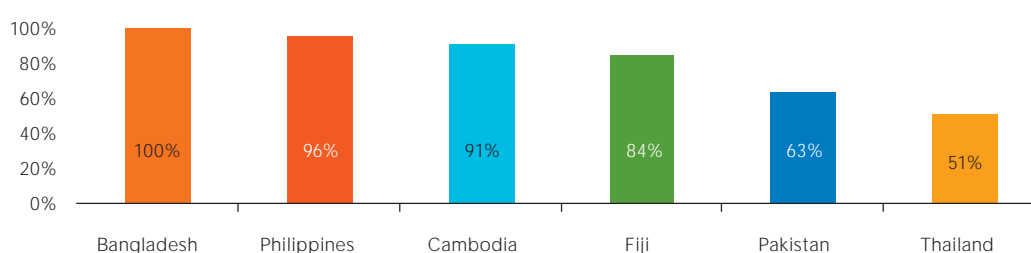
The Philippines report notes concern that:

barely 28% had the courage to confront, challenge or educate someone who was stigmatizing and/or discriminating against them. This is indeed a cause for concern because even though most of them are knowledgeable of their rights as PLHIV, only three in ten would dare to challenge those who had violated their rights.

Awareness of support organisations

Respondents were asked whether they were aware of organizations and groups they could approach for help if they experienced stigma or discrimination. The majority of respondents replied “yes”, ranging from 51% (Thailand) to 100% (Bangladesh) (Figure 40). This high response rate is probably informed by respondents being in contact with organizations undertaking the PLHIV Stigma Index survey.

Figure 40: Knowledge of organizations and groups to approach in cases of violation



Based on responses to Section 2E:2a.

The PLHIV Stigma Index asked the respondents who knew about support agencies what kinds of support agency they were aware of (Table 8).

Table 8: Support groups and networks of/for people living with HIV

	Bangladesh (238 respondents) (%)	Cambodia (358 respondents) (%)	China (%)	Fiji (38 respondents) (%)	Pakistan (558 respondents) (%)	Philippines (77 respondents) (%)	Thailand (%)
Support group for people living with HIV	99 %	83%	68%	87%	71%	90%	81%
Network of people living with HIV	–	55%	73%	80%	49%	38%	73%
Local non-governmental organization	82%	72%	26%	26%	41%	65%	41%
Faith-based organization	–	18%	4%	45%	1%	22%	21%
Legal practice	–	6%	42%	18%	1%	4%	27%
Human rights organization	–	8%	–	29%	8%	14%	24%
National non-governmental organization	–	–	–	16%	4%	23%	21%

	Bangladesh (238 respondents) (%)	Cambodia (358 respondents) (%)	China (%)	Fiji (38 respondents) (%)	Pakistan (558 respondents) (%)	Philippines (77 respondents) (%)	Thailand (%)
National AIDS Council	–	9% ^a	26 ^b	42%	26%	20%	15%
International nongovernmental organization	–	8%	8%	10%	11%	20%	8%
United Nations organization	–	4%	13%	37%	20%	23%	6%
Other	–	–	2%	3%	4%	18%	5%

Based on responses to Section 2E:2b. Responses in this table relate to responses from people who were aware of support organizations, except in the case of Thailand, where responses relate to the total number of survey respondents.

^aProvisional AIDS office.

^bDenoted as "governmental organization".

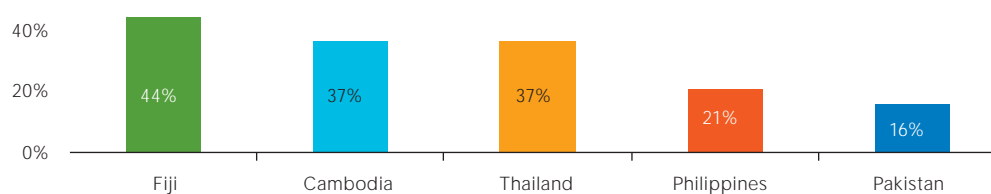
The fundamental role of support groups and networks for people living with HIV was clearly recorded. As noted in China's report:

PLHIV support groups and networks were the most well recognized groups. Government and other agencies should continue to support PLHIV groups as they constitute a very important source of support for people living with HIV.

Seeking help from support organizations

A number of countries reported that respondents had sought help from organizations after being stigmatized or discriminated against, ranging from 16% (Pakistan) to 44% (Fiji) (Figure 41).

Figure 41: Sought help from organizations when stigmatized or discriminated against in past 12 months



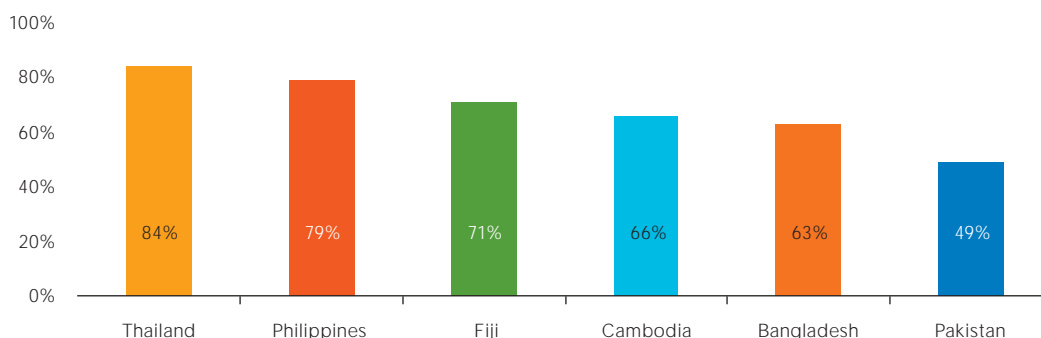
Based on responses to Section 2E:3.

In all instances, the majority of respondents who had been stigmatized or discriminated against did not seek support. The Philippines is an important case in point, with the Philippines report noting “although most respondents knew where to seek help [some 96%], only two in ten sought help from PLHIV community networks or organizations”.

Providing support

The PLHIV Stigma Index found high levels of support being provided by respondents (Figure 42). In all countries providing data, the majority of respondents were involved in providing support to other people living with HIV, ranging from 49% (Bangladesh) to 84% (Thailand).

Figure 42: Provided support for other people living with HIV in past 12 months



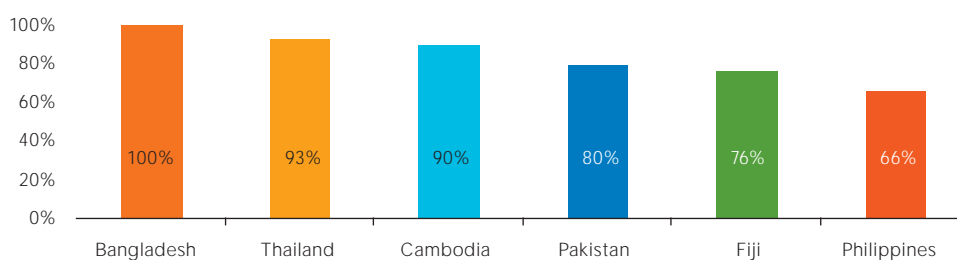
Based on responses to Section 2E:5a.

Of the people providing support, emotional support was predominant, for example in Bangladesh (83%), Cambodia (84%), Fiji (94%) and the Philippines (98%). The Thailand report notes that support provided between friends living with HIV was mainly moral support, counselling and sharing of experiences. Respondents also provided physical support, for example in Cambodia (31%), Fiji (49%) and the Philippines (37%), and referral to services, for example in Cambodia (58%), Fiji (37%) and the Philippines (35%).

Being a member of a support group

Respondents were asked whether they were a member of a support group for people living with HIV. Most were, ranging from 66% (Philippines) to 100% (Bangladesh) (Figure 43).

Figure 43: Membership of a support group for people living with HIV in past 12 months



Based on responses to Section 2E:6.

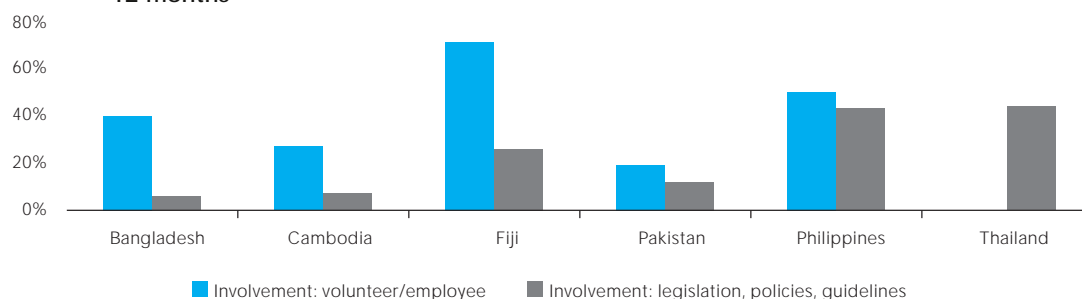
The high rates of membership of support groups for people living with HIV are not necessarily representative of people living with HIV throughout PLHIV Stigma Index target countries, however, but more likely reflect the PLHIV Stigma Index process. That is, groups for people living with HIV led the identification of potential subjects, and were central to the process. What is clear, however, is that many of the people who were members of support groups for people living with HIV were able to access emotional and physical support. Moreover:

besides the support among friends within these networks it was revealed that participation within these groups (governmental or private) allowed opportunity for people living with HIV to be involved in the effort to improve the law, policy and practice related to HIV/AIDS.

Thailand

In some of the countries providing data, involvement in the development of HIV-related legislation, policies or guidelines was limited (e.g. Cambodia, Bangladesh). In other countries, particularly Thailand and the Philippines, more than 40% of respondents had been involved in the development of legislation, policies or guidelines (Figure 44).

Figure 44: Involvement in projects and law reform to assist people living with HIV in past 12 months



Based on responses to Section 2E:7 and 8.

The Thailand report suggests that such involvement “increased the confidence of groups and networks to advocate for better policy and structural reform”. The Pakistan report also points to the importance of involvement of people living with HIV in law reform, noting:

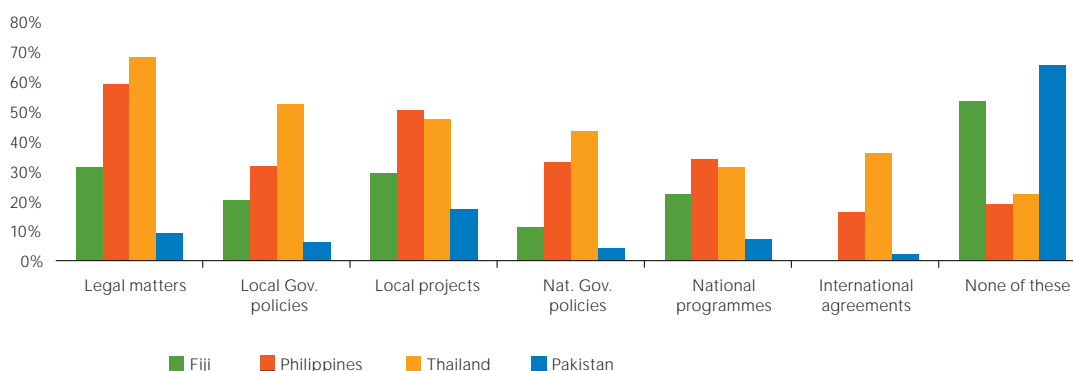
This is a big concern as people living with HIV are not being involved in the decision making process affecting them. It can [/should] be taken [up] with the governmental as well as nongovernmental organizations to involve people living with HIV so that they can decide about the policies and legislations affecting them. It would be also an empowering tool.

Notably, the involvement of people living with HIV in the development and reform of HIV-related laws, policies and guidelines is fundamental to implementation of the GIPA principle.

Power to influence decisions

Of the four countries that provided data, a higher proportion of respondents in Thailand reported belief in their power to influence law and policy compared with respondents in other countries (Figure 45). Responses from Fiji suggest that respondents believed their greatest potential influence was at the local government level.

Figure 45: Belief of people with HIV that they have power to influence decisions



Based on responses to Section 2E:9.

The Bangladesh report provided only one piece of data in relation to this question: that only 14.3% of respondents believed they had the power to influence decisions regarding legal and rights matters affecting people living with HIV (column 1 in Figure 45). The Sri Lanka report, which did not report specific data on the above areas, provided a summary of respondents' general disempowerment related to legal and policy processes:

While the HIV-positive community does feel that they have a stake in effecting change either through policy (5%) or through working on HIV prevention programmes (17%), 47% feel they have no power to influence any decision related to the community, and prefer to remain silent.

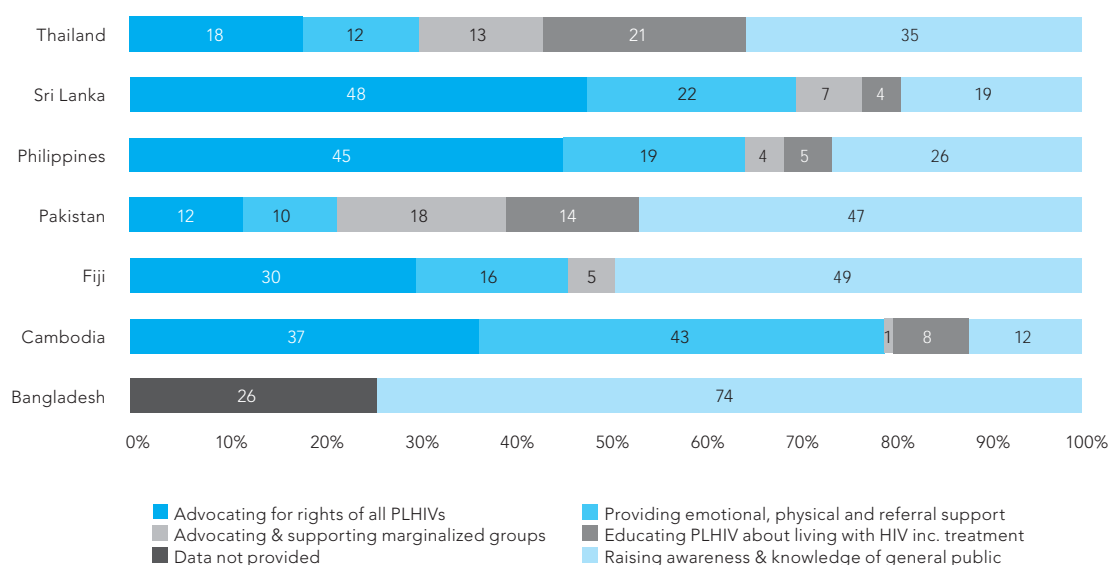
Priorities in addressing stigma and discrimination

Respondents were asked to nominate the single most important thing that organizations should be doing to address stigma and discrimination, based on a list of five alternatives:

- ▶ advocacy for rights for people living with HIV;
- ▶ emotional, physical and referral support for people living with HIV;
- ▶ advocacy for rights of and support for marginalized groups;
- ▶ educating people living with HIV about living with HIV;
- ▶ raising HIV awareness and knowledge among the general public.

Across the region, the two alternatives with the greatest percentage of respondents were advocacy for rights for all people living with HIV and education of the general public about HIV and AIDS (Figure 46). Advocacy for rights of people living with HIV was named the priority by approximately one-third of respondents in Fiji and Cambodia, and by approximately half of respondents in the Philippines and Sri Lanka. Raising awareness of HIV and AIDS among the general public was the priority of the majority of respondents in Bangladesh (74%), Fiji (49%), Thailand (35%) and Pakistan (47%). Provision of emotional, physical and referral support was the priority of the majority of respondents in Cambodia (43%) and was a priority for significant numbers of people (10–22%). Advocating and supporting marginalized groups and educating people living with HIV about HIV were rated poorly as priorities in most countries, although it is not clear whether this is because these alternatives are of low priority or whether they are already being undertaken to some effect.

Figure 46: Identified priorities of people living with HIV for actions to address stigma and discrimination



Based on responses to Section 2E:10.

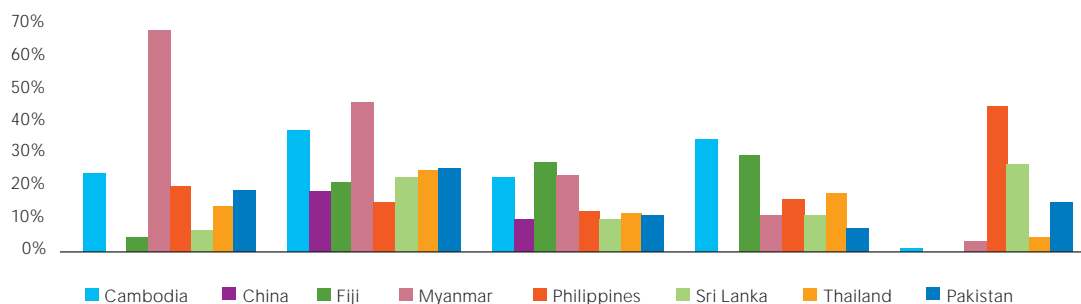
Section 3A: Testing and diagnosis

Motivation for HIV testing

The PLHIV Stigma Index asked respondents to identify the reasons why they decided to have an HIV test (with multiple responses allowed) (Figure 47). Respondents reported testing for a range of reasons, including “wanting to know”. Significant populations reported testing following HIV-related symptoms, following family members testing positive for HIV, and following illness or death of family members, all of which may suggest late presentations for testing. The

Philippines, Sri Lanka and Pakistan reported high rates of testing in relation to employment (45%, 27% and 15%, respectively). China reported that many respondents were tested for HIV as part of a mandatory check, including tests carried out at the time of hospitalization.

Figure 47: Reasons for testing for HIV

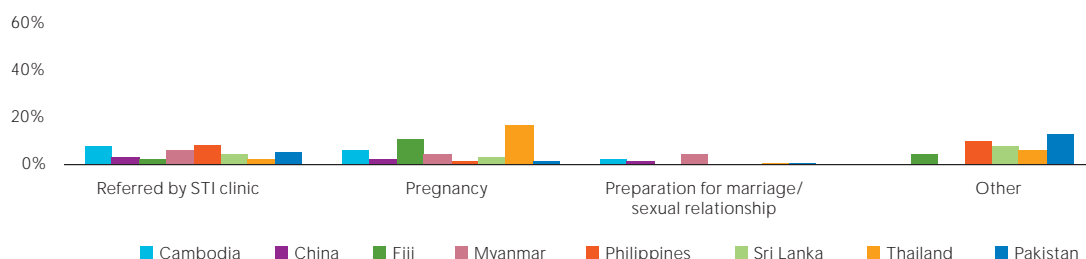


Based on responses to Section 3A:1.

Under the category “ Illness/death of family member”, Myanmar’s response relates only to “ death of spouse/partner/ family member” .

Some respondents tested after being referred for HIV testing by a sexually transmitted infection (STI) clinic (ranging from 2% to 8%), in preparation for marriage or commencing a sexual relationship (from 0% to 5%), or in relation to pregnancy (from 1% to 17%) (Figure 48).

Figure 48: Reasons for testing for HIV (generally low rates of response)



Based on responses to Section 3A:1.

The above data suggest that, in some locations at least, HIV testing is:

- ▶ **Influenced by gender:** The Cambodia and Myanmar reports suggest reasons for HIV testing being highly gendered (Table 9). These findings reflect the 2002 data from AIDS Discrimination in Asia, which found that “Men were more likely than women to be referred for testing because they had HIV-related symptoms (37% v 10%), whilst women were much more likely than men to be tested because their partner had tested positive (42% v 11%)”.
- ▶ **Associated with pregnancy:** The PLHIV Stigma Index data suggest that pregnancy is frequently a trigger for HIV testing. The data in Figure 48 underrepresent the prevalence of HIV testing during pregnancy (Cambodia 6%, China 2%, Fiji 11%, Myanmar 4%, Philippines 1.3% Pakistan 1%, Sri Lanka 3%, Thailand 17%) because they reflect responses

of men and women, including women who are no longer of childbearing age. Data were not available on whether antenatal HIV testing was provided with the mother's full consent.

- ▶ **Associated with employment:** In the Philippines, the most frequent reason for respondents testing for HIV was employment (45%). This figure is not explained but may be influenced by HIV testing preceding overseas employment, and the very large numbers of Filipinos (approximately 1 million) who migrate through employment channels to work outside the Philippines each year. (Notably, Republic Act RA8504 prohibits the imposition of HIV testing as a precondition for employment.) AIDS Discrimination in Asia also found high rates of testing for employment in the Philippines (more than a third of respondents). There are numerous issues associated with HIV testing for overseas employment, including the possibility of testing becoming “automatic” without provision of pre- and post-test counselling or other safeguards to ensure that consent to testing is voluntary, and issues of confidentiality, including the management of sensitive health information.

He applied in an agency that would help him look for a job opportunity overseas. He was asked to go to a diagnostic clinic for medical examinations. ... When he arrived in the clinic for the results ... it took some time before they could locate his results because they had posted them [on] the bulletin board. Although there [was] nothing that pertains to HIV on the form, he had his picture on it and “For confirmatory”. ... People in the clinic would stare at him every time they passed. He went back to the agency ... withdrew his application and he told the agency manger the reason why he [was] withdrawing Without his permission, [the agency manager] called the doctor in the laboratory and discussed his case in front of him.

Philippines

In Sri Lanka, 27% of respondents had been tested for employment, but 78% of these report being tested *without consent*. The Sri Lanka report refers to earlier work in the United Nations Development Programme (UNDP)/UNAIDS Report on HIV Vulnerabilities of Migrant Women, which found:

Blood and urine tests (for HIV and pregnancy, respectively) are mandatory for legally migrating women prior to their departure. The test results are provided directly to the agents, and many of the interviewed women admitted to being in the dark about the nature of these tests.³²

- ▶ **Reflects late presentation of HIV infection:** The Cambodia report notes high rates of people being referred for testing due to HIV-related symptoms, because family members test positive, or following the illness or death of a family member. The qualitative discussions strongly confirmed the quantitative findings that “most testing was late and due to

32 UNDP (2009).

illness or death of their partners or from referral when they were very ill”. The Cambodia report notes that “stigma and discrimination remains an impediment to HIV testing and diagnoses. Part of the reason why people don’t get tested is because they are afraid that their neighbours or relatives might know their status”.

Table 9: Motivation and reasons for testing

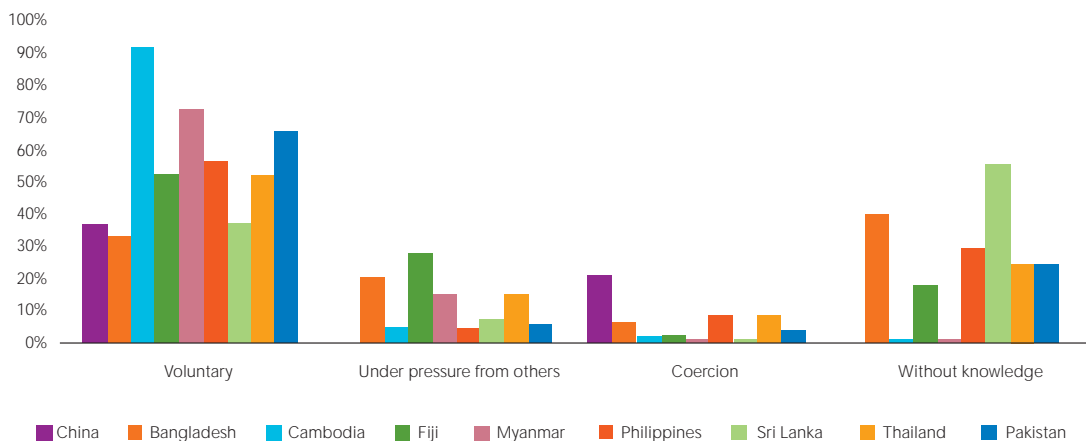
Reason for testing for HIV	Men (%)		Women (%)	
	Cambodia	Myanmar	Cambodia	Myanmar
Just wanted to know	26	70	23	68
Referral due to suspected HIV-related symptoms (e.g. TB)	47	60	33	32
Spouse/partner/family member HIV-positive	17	11	26	36
Illness or death of spouse/partner/family member	20	–	41	–
Death of spouse/partner/family member	–	6	–	15
Referral by clinic for STIs	12	6	6	7
Preparation for marriage or sexual relationship	3	6	3	4
Pregnancy	–	1	–	8

Multiple answers allowed. Based on responses to Section 2A:1.

Voluntary HIV testing

In all populations except Cambodia, a significant proportion of respondents were tested involuntarily (Figure 49). In fact, the majority of respondents (more than 60%) in China, Bangladesh and Sri Lanka had been tested without their consent. In Sri Lanka, some 64% of respondents described their HIV test as not being voluntary, despite Sri Lanka’s National Strategic Plan 2007–2011 Respect for Human Rights stating “HIV testing without prior informed consent is never acceptable (unless anonymous unlinked for screening purposes)”.

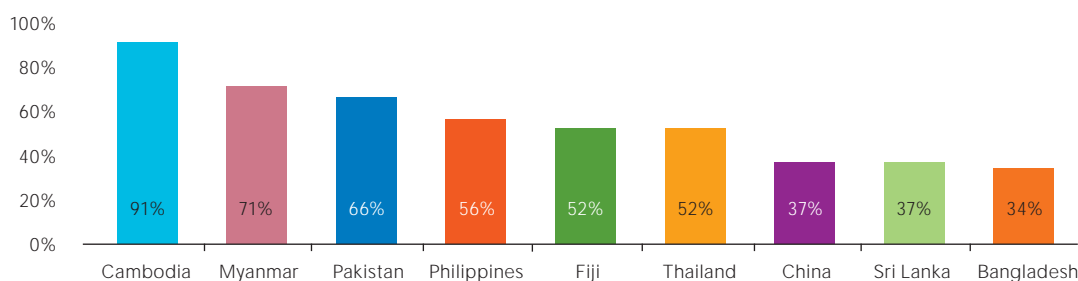
Figure 49: Influence on decision to be tested for HIV



Based on responses to Section 3A:2.

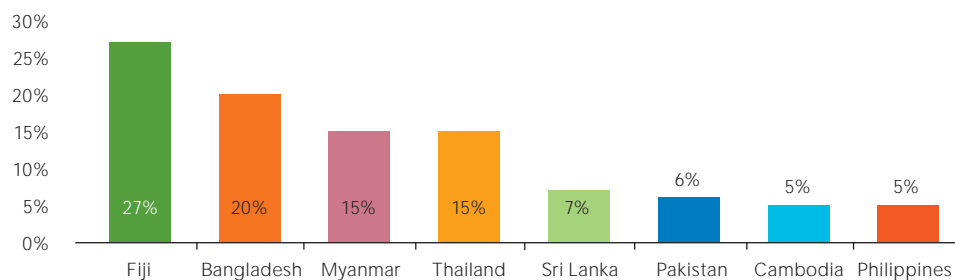
The above findings are not dissimilar from testing practices considered in the AIDS Discrimination in Asia research, in which 45% of respondents said they were not ready to be tested for HIV when the test was done and nobody explained the reasons for the test before it was done (Figures 50–53).

Figure 50: Prevalence of voluntary HIV testing in past 12 months



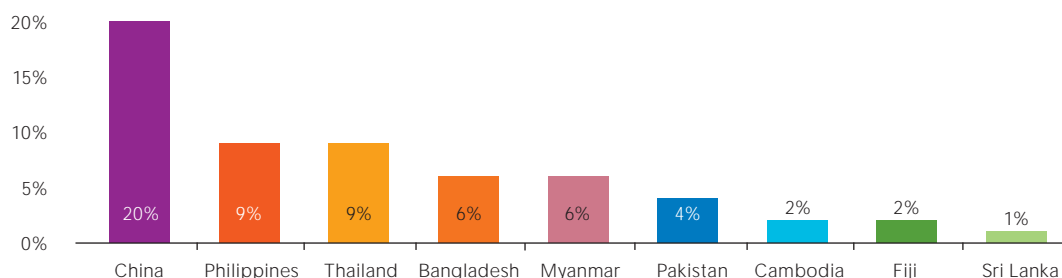
Based on responses to Section 3A:2.

Figure 51: Prevalence of pressure to be tested for HIV in past 12 months



Based on responses to Section 3A:2.

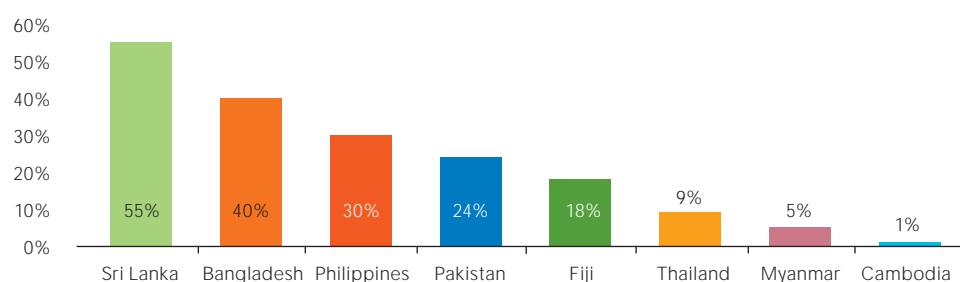
Figure 52: Prevalence of coercion to be tested for HIV in past 12 months



Based on responses to Section 3A:2.

AIDS Discrimination in Asia reports one in every eight respondents reported being coerced into taking an HIV test.

Figure 53: Prevalence of testing for HIV without respondent's knowledge in past 12 months



Based on responses to Section 3A:2.

Intersecting areas of stigma and discrimination: testing

- ▶ **Injecting drug use:** The PLHIV Stigma Index data indicate that access to voluntary testing is affected by numerous factors that relate to stigma and discrimination. For example, in Myanmar, voluntary HIV testing was reported by approximately 70% of all respondents but by only 50% of respondents who inject drugs. People who inject drugs reported almost twice the rate of testing under pressure (26%) and four times the rate of being testing without being informed (approximately 20%).
- ▶ **Gender:** A number of country reports recorded notable gender disparities in relation to voluntary testing; for example, in Bangladesh, 49% of women living with HIV volunteered for HIV testing compared with only 25% of men (Figure 54). Gender-informed access to voluntary HIV testing was not reflected in all locales; for example, in the Cambodia report, which reported high rates of voluntary testing, there was little gendered variance in the experience of people living with HIV (Figure 55).

Figure 54: HIV testing: Bangladesh

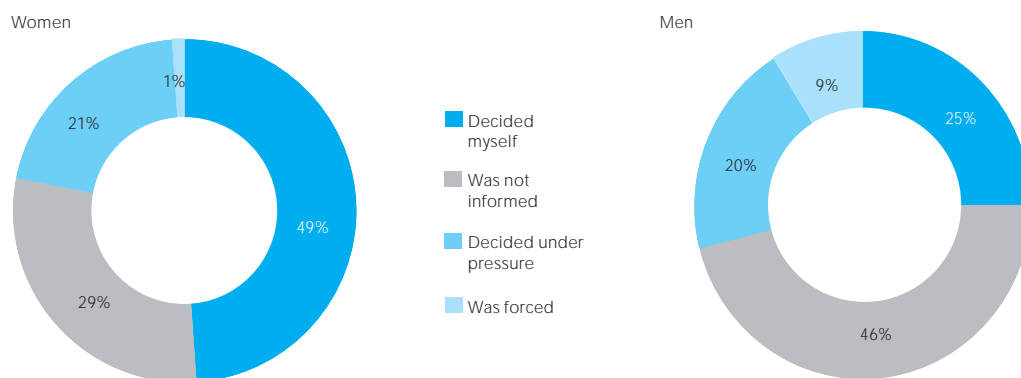
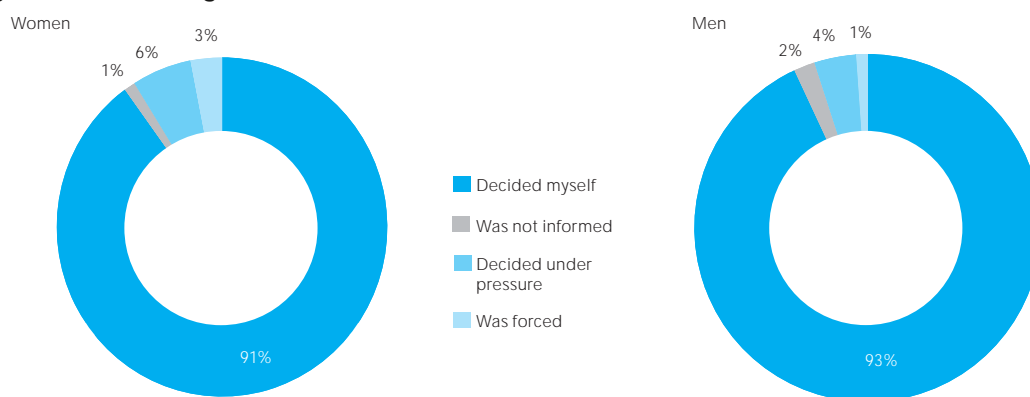


Figure 55: HIV testing: Cambodia



Based on responses to Section 3A:2.

HIV counselling

He was asked to submit to a laboratory test as a procedure for his blood donation in the same hospital where he was working ... The medical technologist who took his blood specimen found out that he is HIV-positive and in turn informed the doctor assigned to the blood bank. The doctor did not inform [the respondent] of the result directly but went on to inform the doctor/owner of the hospital. ... [The respondent] was the last to know, and only knew about the result of his diagnosis because people at work were already talking about him.

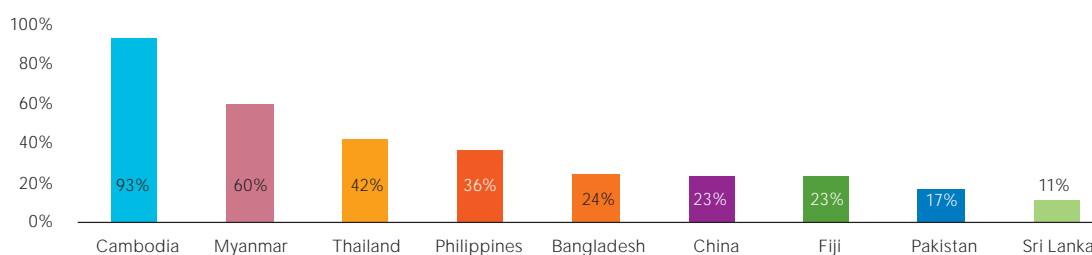
Philippines

The PLHIV Stigma Index found that pre- and post-HIV test counselling is still not the norm.³³ Only Cambodia (93%) and Myanmar (60%) offered pre- and post-test counselling to the majority of respondents (Figure 56). The Bangladesh report recorded a clear gender difference in access

³³ AIDS Discrimination in Asia provides basic 2002 data on pre- and post-testing counselling in India, Thailand, the Philippines and Indonesia. The majority of people in all countries received no pre-test counselling, and only 53% of respondents received post-test counselling; 20% received no information whatsoever about HIV and AIDS when they were told of their HIV-positive diagnosis.

to pre- and post-test counselling, with 19% of women but 11% of men receiving both pre- and post-test counselling.

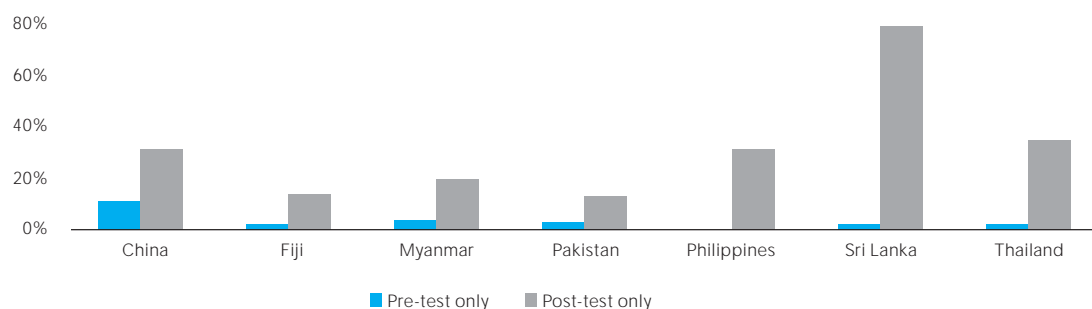
Figure 56: Offered pre- and post-test counselling in past 12 months



Based on responses to Section 3A:3.

In all locales, some respondents reported receiving either pre- or post-test counselling (except in the Philippines, which reported no incidents of pre-test counselling only) (Figure 57). These data suggest that post-test counselling only is far more common than pre-test counselling only.

Figure 57: Offered either pre-test or post -test counselling in past 12 months

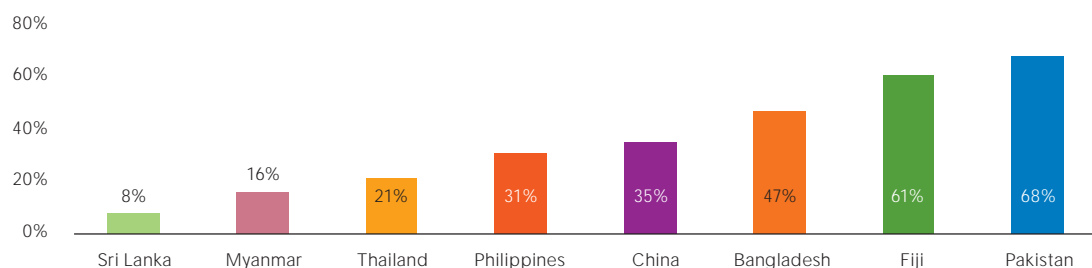


Based on responses to Section 3A:3.

These figures can be added to those in Figure 56 to calculate the total number of people receiving pre-test or post-test counselling.

In many instances, people living with HIV received no pre- or post-test counselling at all, ranging from 8% (Sri Lanka) to 68% (Pakistan) (Figure 58).

Figure 58: Offered neither pre-test nor post-test counselling in past 12 months



Based on responses to Section 3A:3.

Section 3B: Disclosure and confidentiality

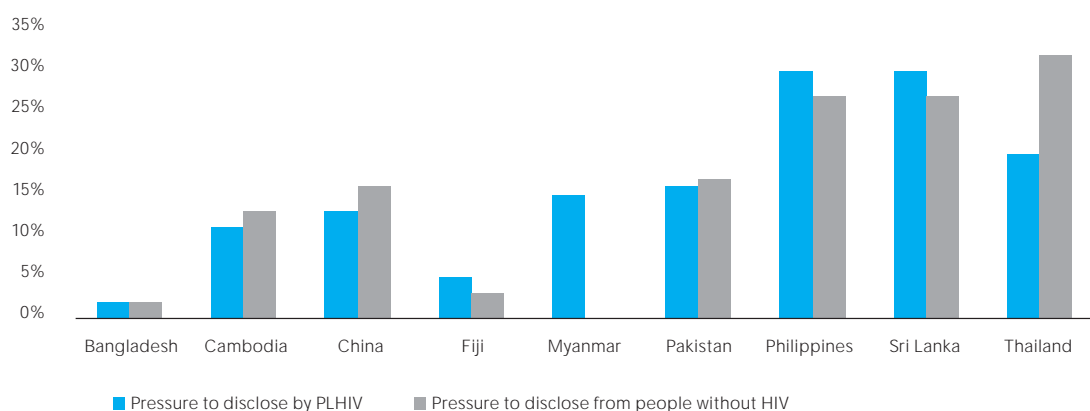
Factors affecting disclosure

The PLHIV Stigma Index asked respondents to reveal how people in their family and community became aware of their HIV-positive status. Not all people living with HIV had disclosed their HIV-positive status to family members (see below). As noted in the China report, “these figures are an indication of the gravity of stigma surrounding HIV, with such high proportions of people living with HIV feeling unable to tell even those closest to them about their HIV infection”.

Pressure from others to disclose

The PLHIV Stigma Index found that many people living with HIV had experienced direct pressure to disclose their HIV-positive status to other people, both from people living with HIV and groups and networks of people living with HIV, ranging from 2% (Bangladesh) to 16% (Philippines), and from people not living with HIV, ranging from 2% (Bangladesh) to 32% (Thailand) (Figure 59).

Figure 59: Pressured to disclose HIV status in past 12 months



Based on responses to Section 3B:2a and 2b.

Generally, similar numbers of people had experienced pressure to disclose their HIV-positive status from people living with HIV and from people not living with HIV, except in Thailand, where pressure from people not living with HIV was experienced by approximately 50% more people (20% from people living with HIV compared with 32% from people not living with HIV). Pressure to disclose was very low in Bangladesh and Fiji (experienced by less than 5% of respondents) and was highest in the Philippines, Sri Lanka and Thailand (experienced by 25–30% of respondents).

The Cambodia report notes that some of the pressure from people not living with HIV may have resulted from health-care providers and home- and community-based care services. The report states “it is a dilemma that people living with HIV have to disclose their status in order to access care and support services”.

People’s responses to HIV disclosure

The PLHIV Stigma Index questionnaire asks respondents to rank the responses of different categories of people on discovering the respondent’s HIV-positive status. This section provides responses related to disclosure to:

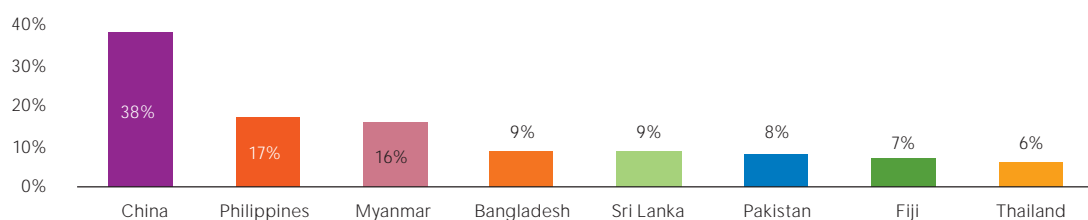
- ▶ the respondent’s partner;
- ▶ other adult family members;
- ▶ children in the respondent’s family;
- ▶ the respondent’s friends and neighbours;
- ▶ the respondent’s employers, colleagues and clients;
- ▶ religious leaders;
- ▶ health-care workers;
- ▶ teachers;
- ▶ other people living with HIV.³⁴

Respondents were asked to rank people’s reactions according to whether they had been: 1. Very discriminatory, 2. Discriminatory, 3. No different, 4. Supportive, 5. Very supportive or 6. Not applicable. For the purposes of this section, categories 1 and 2 have been combined as “discriminatory” and categories 4 and 5 have been combined as “supportive”.

Reaction of partner

In all settings, the majority of the respondents’ partners were aware of their HIV-positive status, ranging from 62% (China) to 94% (Thailand) (Figure 60).

Figure 60: Partner does not know respondent’s HIV-positive status



Based on responses to Section 3B:1.

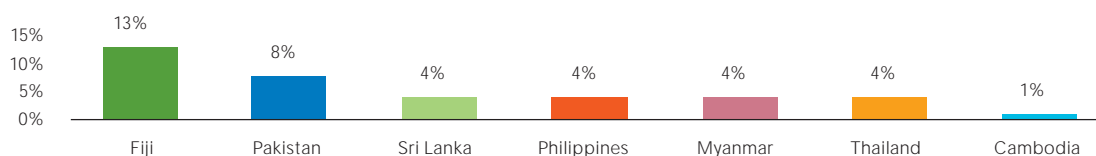
34 The PLHIV Stigma Index also seeks responses in relation to partners who inject drug, community leaders, government officials and the media. Country responses are not consolidated in this report but are recorded in some individual PLHIV Stigma Index country reports.

He asked his boyfriend an indirect question, “What if you have an HIV-positive boyfriend? What will you do?” His boyfriend was quick to answer that he will leave him right away. His boyfriend believes that HIV is transmitted by touching and associating with people living with HIV. His boyfriend even called the person living with HIV a pest.

Philippines

In some instances, the respondent’s HIV-positive status had been disclosed to their partner without the respondent’s consent, ranging from 1% (Cambodia) to 13% (Fiji) (Figure 61).

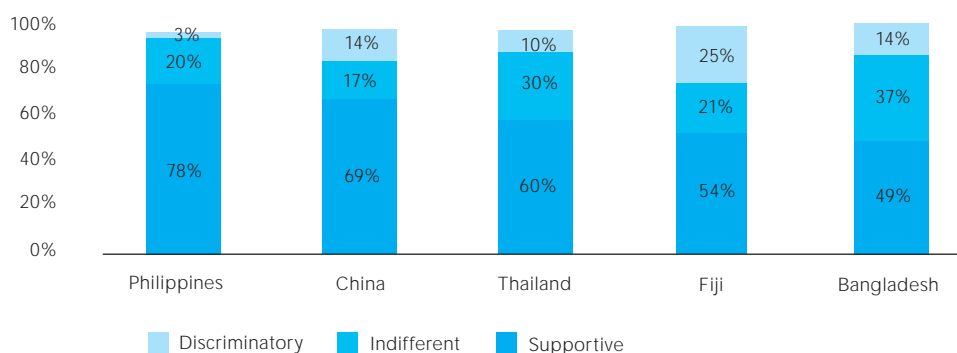
Figure 61: HIV status revealed to partner without respondent’s consent



Based on responses to Section 3B:1.

The PLHIV Stigma Index found that most respondents’ partners were supportive on discovering the respondent’s HIV diagnosis, ranging from 49% (Bangladesh) to 78% (Philippines) (Figure 62). Although the Myanmar report did not provide specific data, it notes that respondents were more likely than not to have encountered supportive responses.

Figure 62: Partner’s response to disclosure of HIV status



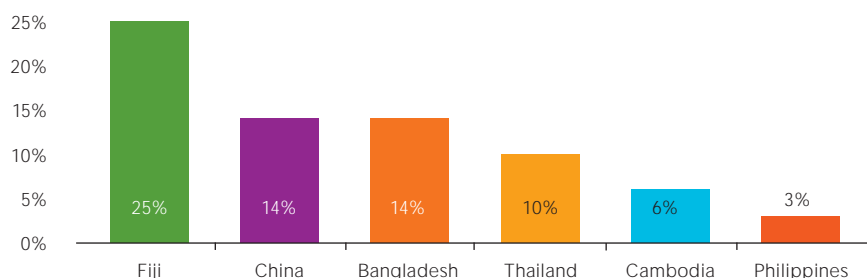
Based on responses to Section 3B:5.

This chart reflects responses relating to people who were aware of their partner’s HIV-positive status and does not show percentages of the whole respondent population.

Data from Bangladesh refer only to partners of respondents who “willingly” told their partner of their HIV-positive status.

Across the region, a minority of partners were not supportive, from 3% (Philippines) to 25% (Fiji) (Figure 63).

Figure 63: Discriminatory reactions from partner on discovering respondent's HIV-positive status



Based on responses to Section 3B:5.

I informed my wife when I knew after my marriage that I am HIV-positive. She spread it. She filed a case against me in court ... My brother, father and I were charged in a women-torture lawsuit. I was imprisoned for three months. My brother and father were imprisoned for 20 days. My elder sister was also imprisoned.

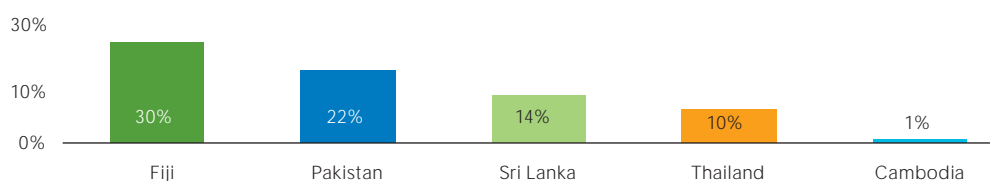
The data in this section must be interpreted with some caution. They record a supportive response only from people who were aware of their partner's HIV-positive status. There is an unexplored question of whether people are less likely to disclose their HIV-positive status if they anticipate a discriminatory or very negative response from their partner, whether their partners' responses are in fact likely to be discriminatory or very negative, and how lack of disclosure (and hence the absence of a response) in such circumstances may skew the data. This question is referenced in the Bangladesh report, which states:

Out of 238 people living with HIV, almost 50% willingly told their husband/wife/partner about their HIV status; but some of them (22 out of 238) did not disclose their status. Among those who willingly told their spouses, 49% received supportive behaviour ... while 14.4% received discriminatory behaviour:

Bangladesh does not provide data on people whose partners found out their HIV-positive status by means other than "willing" disclosure.

Reaction of family members

Figure 64
HIV status revealed to adult family members without respondent's consent

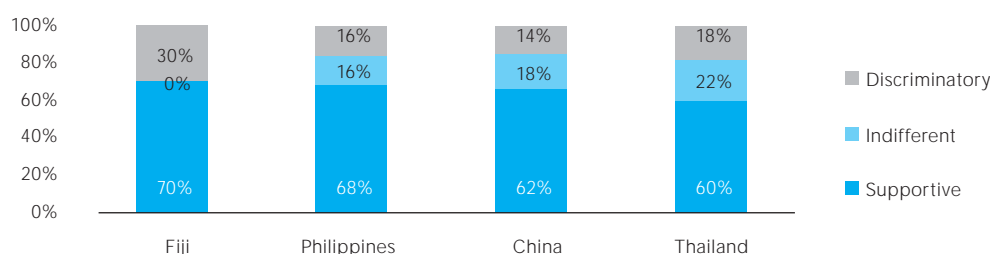


Based on responses to Section 3B:1.

The PLHIV Stigma Index found that some adult family members had been told of the respondent's HIV-positive status without the respondent's consent, ranging from 1% (Cambodia) to 30% (Fiji) (Figure 64).

The PLHIV Stigma Index found that most family members were supportive on discovering the person's HIV diagnosis, ranging from 46% (Philippines) to 62% (China and Fiji); however, significant proportions of people living with HIV faced discrimination from family members, ranging from 6% (Cambodia – not included in Figure 65) to 27% (Fiji).

Figure 65: Reactions of other adult family members to disclosure of respondent's HIV status



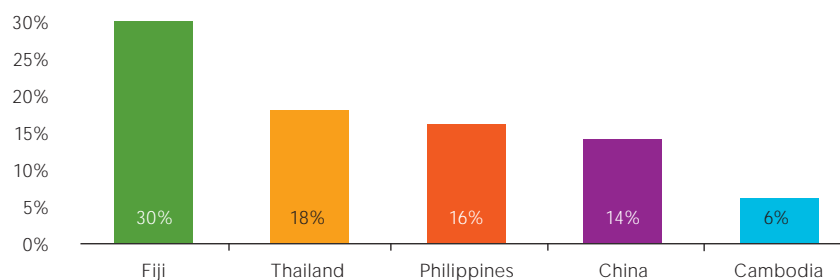
Based on responses to Section 3B:5.

This chart reflects responses relating to respondents' adult family members who are aware of respondents' HIV-positive status and does not show percentages of the whole respondent population.

The Cambodia report notes that 6% of respondents had experienced discriminatory reactions from adult family members when told of the respondent's HIV status (Figure 66). The Bangladesh report notes that of the 42% of respondents who willing told family members of their HIV-positive status, 8% faced very discriminatory behaviour. During the survey process, and as shown in the data, it was clear that many respondents did not want their family members to know their HIV-positive status. For example, the Sri Lanka report notes:

The research team reported that respondents requested interviews not at their homes or even the general vicinity, but at public places including bus stands, parks, tea shops, often after dark, to ensure that their families remained unaware of what was taking place.

Figure 66: Discriminatory reactions from other adult family members aware of respondent's HIV-positive status



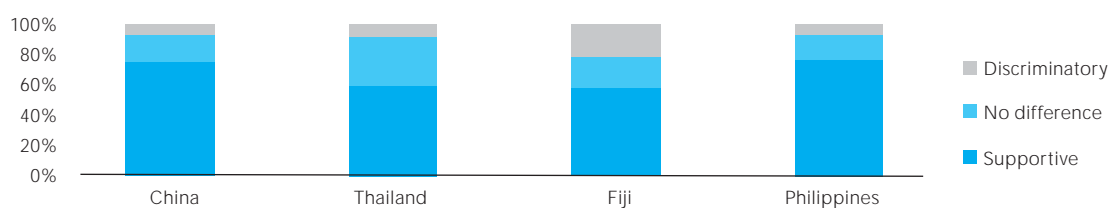
Based on responses to Section 3B:5. Reaction of children

The PLHIV Stigma Index asked respondents whether or not their children were aware of their HIV-positive status. The countries that provided data showed that in many instances the respondents' children were not aware of their HIV-positive status:

- ▶ Bangladesh: more than 50% not aware;
- ▶ Thailand: 50% not aware;
- ▶ Fiji: 34% not aware;
- ▶ Philippines: 33% not aware.

Respondents were asked to record the responses of their children on discovering the respondent's HIV-positive status (Figure 67). The ages of the children concerned were not collected.

Figure 67: Children's reactions to disclosure of respondent's HIV status



Based on responses to Section 3B:5.

This chart reflects responses relating only to respondents' children who were aware of the respondents' HIV-positive status and does not show percentages of the whole respondent population.

Fiji's response of 11% represents only five children.

Reaction of friends and neighbours

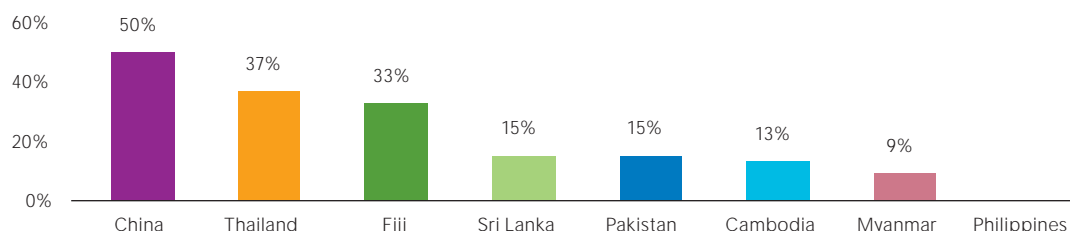
I disclosed my status before. Since I got stigmatized and discriminated, it is better not to disclose. ... I was aware that ... [my neighbours] gossiped about me everywhere.

Cambodia

The PLHIV Stigma Index reveals that in many instances people living with HIV were reticent to let their friends or neighbours know of their HIV status. For example, the Sri Lanka report states that 73% of respondents believed their friends and neighbours to be unaware of their HIV-positive status.

In many instances, the respondent's HIV-positive status had been disclosed to their friends and neighbours without the respondent's consent, ranging from 9% (Myanmar) to 50% (China) (Figure 68).

Figure 68: HIV status revealed to friends or neighbours without respondent's consent



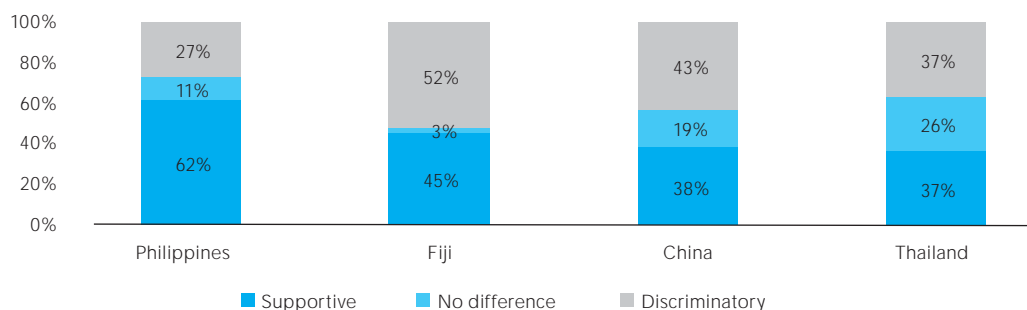
Based on responses to Section 3B:1.

My neighbours did not talk to me after I tested positive. I couldn't bathe in the same pond as them. They turned their faces away when they saw me. They did not allow me to keep my clothes with theirs. I couldn't drink water from the same tube well. I was asked to send someone else from my house to fetch water.

Bangladesh

Friends and neighbours exhibited high rates of discrimination compared with many other categories of people considered in the PLHIV Stigma Index (Figure 69).

Figure 69: Friends' and neighbours' reactions to disclosure of respondent's HIV status

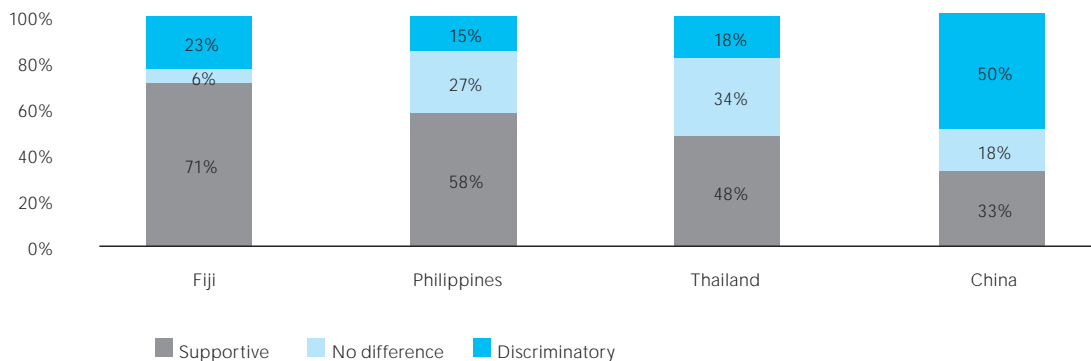


Based on responses to Section 3B:5.

Reaction of employers, co-workers and clients

The PLHIV Stigma Index survey asked respondents how their HIV disclosure had been received in relation to employment (Figures 70–72). In Fiji, the Philippines and Thailand, employers/managers, co-workers and clients were usually supportive or did not respond to the respondent differently, although some discrimination was noted. In China, the number of respondents experiencing discriminatory behaviour was similar to the number of respondents who did not experience discriminatory behaviour.

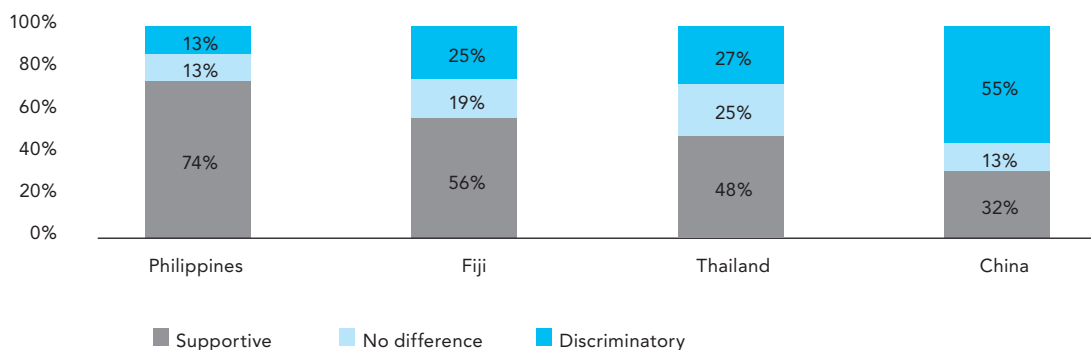
Figure 70: Colleagues’ reactions to disclosure of respondent’s HIV status



Based on responses to Section 3B:5.

This chart reflects responses relating to respondents’ colleagues who were aware of the respondents’ HIV-positive status and does not show percentages of the whole respondent population.

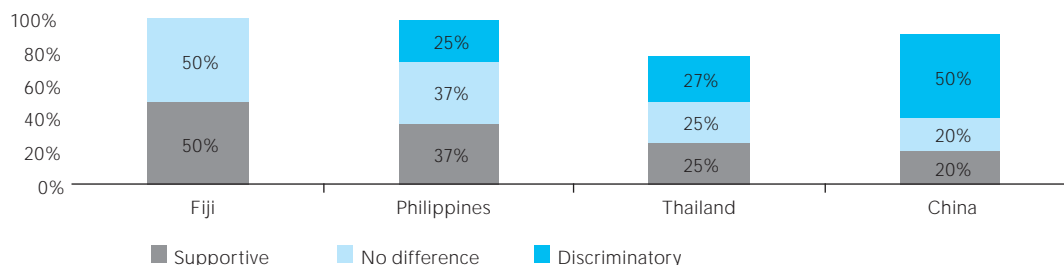
Figure 71: Employers’ and managers’ reactions to disclosure of respondent’s HIV status



Based on responses to Section 3B:5.

This chart reflects responses relating to respondents’ employers who were aware of the respondents’ HIV-positive status and does not show percentages of the whole respondent population.

Figure 72: Clients’ reactions to disclosure of respondent’s HIV status



Based on responses to Section 3B:5.

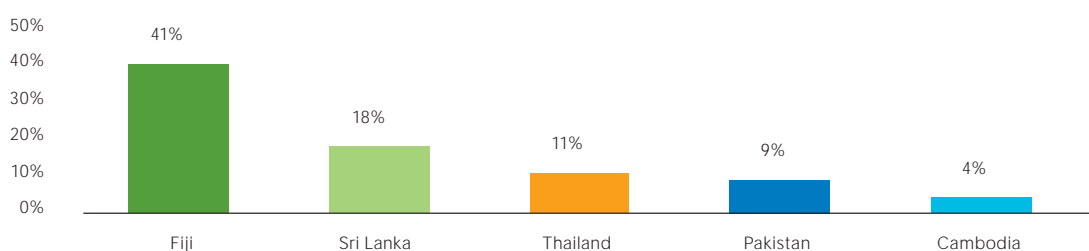
This chart reflects responses relating to respondents’ clients who were aware of the respondents’ HIV-positive status and does not show percentages of the whole respondent population.

The sample is based on very low numbers of responses: China (50), Fiji (2), Philippines (8), Thailand (55).

Reaction of health-care workers, social workers and counsellors

The PLHIV Stigma Index recorded instances of health-care workers being told of respondents' HIV-positive status without the consent of the respondent, ranging from 4% (Cambodia) to 41% (Fiji) (Figure 73).³⁵

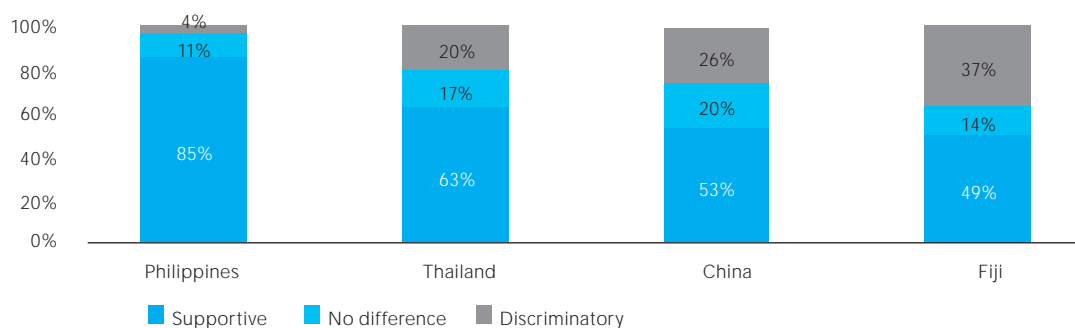
Figure 73: HIV status revealed to health-care workers without consent



Based on responses to Section 3B:1.

The PLHIV Stigma Index found that in most settings, health-care workers were supportive on discovering the respondent's HIV-positive status, but a significant portion were not supportive, ranging from 3% (Cambodia and the Philippines) to 29% (Fiji) (Figure 74).

Figure 74: Health-care workers' reactions to disclosure of respondent's HIV status



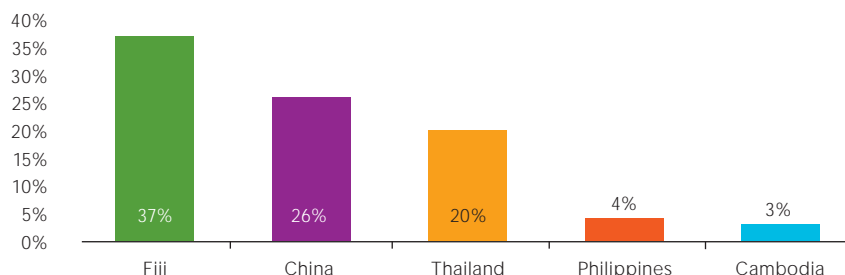
Based on responses to Section 3B:5.

This chart reflects responses relating to respondents' contact with health-care workers who were aware of the respondents' HIV-positive status and does not show percentages of the whole respondent population.

Figure 74 suggests a significant difference in rates of negative responses from health-care workers across the region, ranging from 4% (the Philippines) to 37% (Fiji) (Figure 75). Cambodia's low rate of discrimination by health-care workers is supported by Cambodia's recent Socio-Economic Impact Study, which reported that less than 1% of people living with HIV faced stigma and discrimination from health-care workers.

³⁵ AIDS Discrimination in Asia reported that 7% of respondents had experienced disclosure to health-care workers without the respondent's consent.

Figure 75: Discriminatory reactions of health-care professionals on discovering respondent’s HIV-positive status

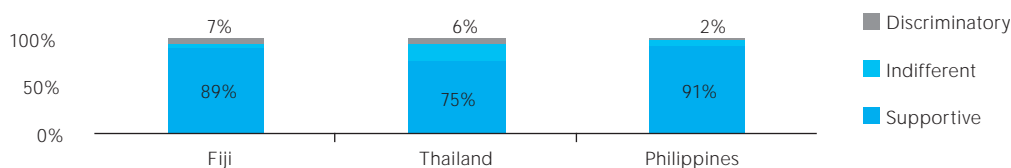


Based on responses to Section 3B:5.

The results from China relate specifically to “medical staff not involved with testing”.

The PLHIV Stigma Index survey asked respondents to rank the responses of social workers and counsellors on discovering the respondent’s HIV-positive status (Figure 76). The vast majority of social workers were supportive, and rates of discrimination were very low, ranging from 2% (Philippines), to 6% (Thailand) to 7% (Fiji).

Figure 76: Social workers’ and counsellors’ reactions to disclosure of HIV status

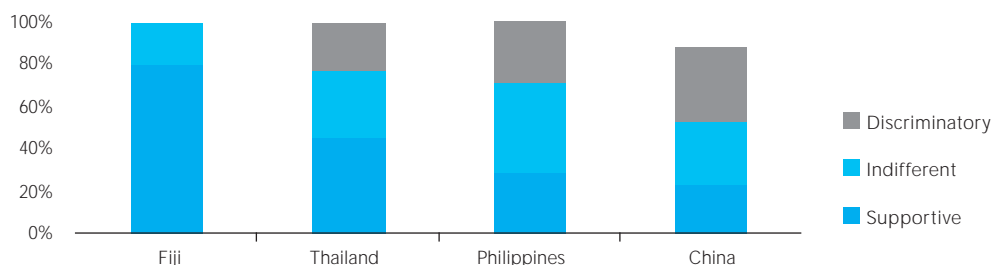


Based on responses to Section 3B:5.

This chart reflects responses relating to respondents’ contact with social workers and counsellors who were aware of the respondents’ HIV-positive status and does not show percentages of the whole respondent population.

Reaction of teachers

Figure 77: Teachers’ reactions to disclosure of HIV status



Based on responses to Section 3B:5.

This chart reflects responses relating to respondents’ contact with teachers who are aware of respondents’ HIV-positive status (not percentage of whole respondent population).

China’s data do not total 100%.

The PLHIV Stigma Index asked respondents to rank the responses of teachers on discovering the respondent's HIV-positive status (Figure 77). Relatively low levels of stigma were recorded in most settings, ranging from 4% (Cambodia) to 7% (Thailand), although China recorded a significant 36%. Care must be taken when interpreting these "trends", however, as in most instances few respondents were engaged in educational settings and fewer still had disclosed their HIV status to their teachers (Table 10).

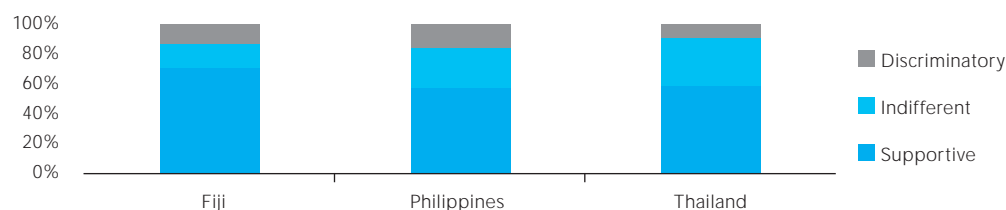
Table 10: Number of people who recorded discrimination in educational settings

Country	Number of responses that experienced discrimination	Number of responses where discrimination possible (i.e. teacher aware of HIV status)	Total number of respondents in survey
Fiji	0	5	45
Thailand	15	68	233
Philippines	2	7	80
Bangladesh	0	6 (willingly told)	238

Reaction of religious leaders

Five countries presented data on the reactions of religious leaders to HIV disclosure. Two things are apparent from Figures 78 and 79. First, in most settings, many or the majority of respondents had not encountered reaction from religious leaders because they had not disclosed their status, either because they had avoided such disclosure or because they had no interaction with a religious leader (such data are not available). Second, the data suggest that relatively low levels of stigma and discrimination have been exercised by religious leaders when dealing directly with individuals who have disclosed their HIV status (Table 11).

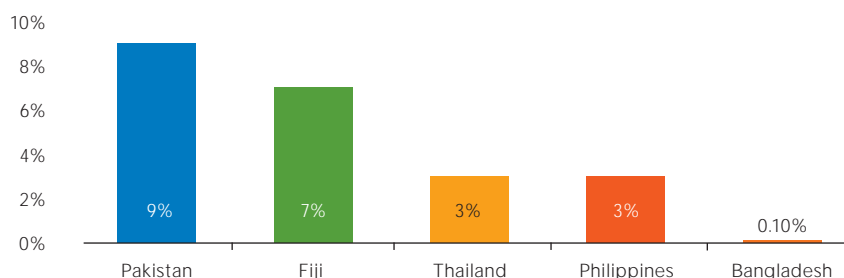
Figure 78: Religious leaders' reactions to disclosure of HIV status



Based on responses to Section 3B:5.

This chart reflects responses relating to respondents' contact with religious leaders who were aware of the respondents' HIV-positive status and does not show percentages of the whole respondent population.

Figure 79: Religious leaders' discriminatory reactions to disclosure of HIV status



Based on responses to Section 3B:5.

Table 11: Number of people who recorded discrimination by religious leaders

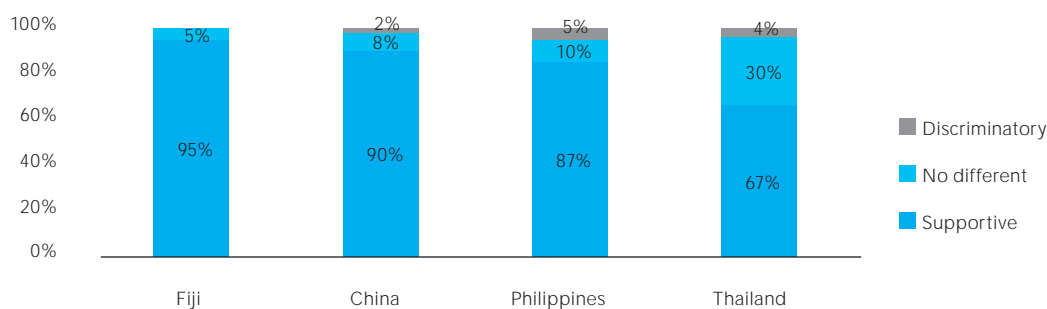
Country	Number of responses that experienced discrimination	Number of responses where discrimination possible (i.e. religious leader aware of HIV status)	Total number of respondents in survey
Fiji	3	24	45
Thailand	8	73	233
Philippines	2	15	80
Bangladesh	1	12	238

Care must be taken when referring to the above data as they are based on the experience of a very small number of people. Further research needs to be done in this area to gain an in-depth view of the reality. Rather than accurately representing discrimination by religious leaders against people living with HIV, the data show only that such discrimination is sometimes practised and that an individual's faith may not always be a source of comfort and support.

Reaction of people living with HIV

The PLHIV Stigma Index records very high levels of support from other people living with HIV, ranging from 67% (Thailand) to 95% (Fiji), suggesting the importance of peer-based support mechanisms throughout the region (Figure 80).

Figure 80: Peer reactions to people living with HIV

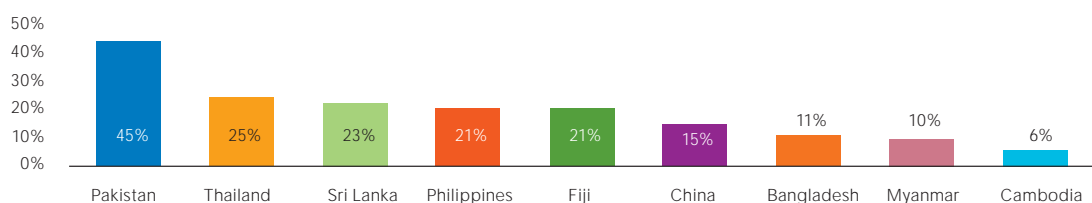


Based on responses to Section 3B:5.

Confidence in health and medical records

Respondents in all jurisdictions reported that their HIV-positive status had been disclosed without their consent, ranging from 45% (Pakistan) to 6% (Cambodia) (Figure 81).

Figure 81: Disclosure of HIV status by health-care worker without respondent's consent



Based on responses to Section 3B:1.

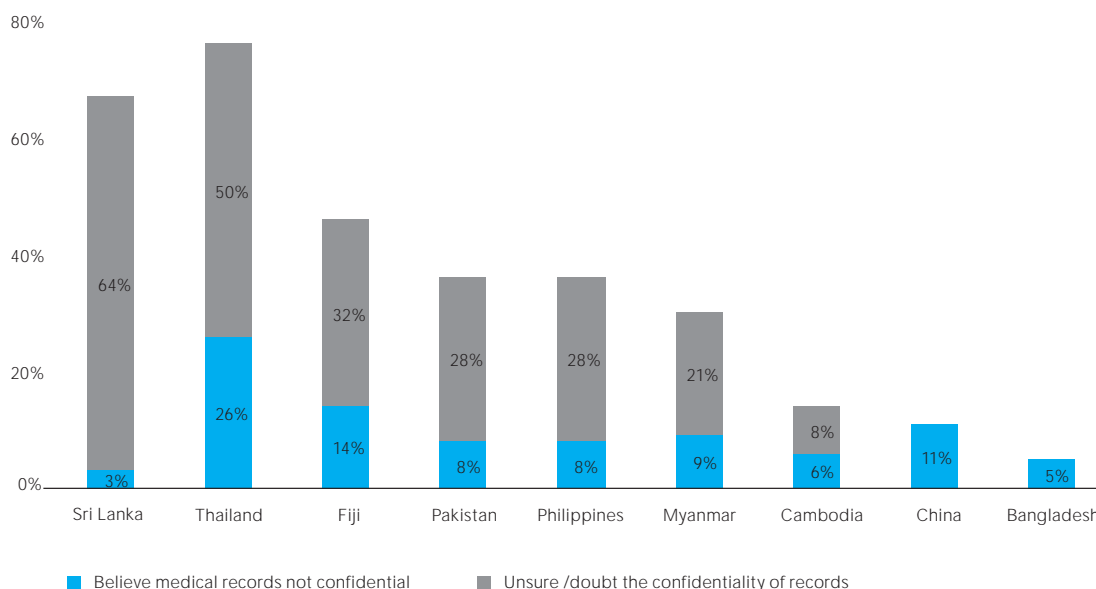
In all countries providing data, some respondents believed their medical and health records were not confidential, ranging from 3% (Sri Lanka) to 26% (Thailand) (Figure 82). In some cases, that belief was based on the respondent's experience of confidentiality breaches in a health-care setting, including in instances where such breaches are illegal (e.g. under the Philippines Republic Act RA8504). Far greater numbers of respondents were unsure of or doubted the confidentiality of their medical and health records, ranging from 64% (Sri Lanka) to 8% (Cambodia).

As noted in the China PLHIV Stigma Index Report:

There is an urgent need to ensure that both policies and practical guidelines are designed to protect the privacy of people living with HIV ... While ... numbers may seem low, the implications for the individuals involved are very significant. A lack of confidentiality alienates people and decreases people's confidence and willingness to present themselves to governmental and non-governmental institutions. Furthermore, knowing that medical records are not confidential may deter some from going to medical facilities when they are in need of treatment and care.

The need for strict rules of confidentiality in relation to HIV status derives from the intense atmosphere of fear, misunderstanding and prejudice that characterise many people's attitude to HIV. The consequences of a person's HIV status becoming known can often be disastrous for PLHIV and their families.

Figure 82: Confidentiality of medical and health records



Based on responses to Section 3B:3 and 4.

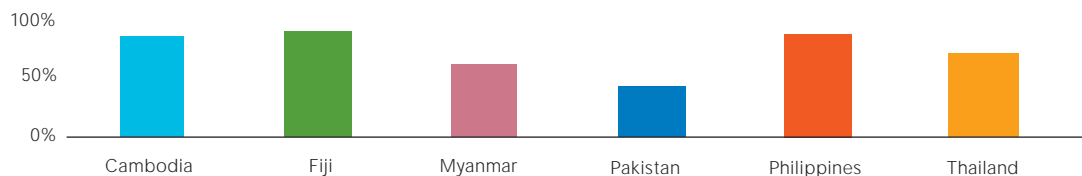
The Sri Lanka report notes that “anecdotal evidence on how PLHIV status was communicated by hospital workers to their village or community suggests ostracization, physical assault and damage to property resulted”.

Of note, the Bangladesh report found that only 20% of respondents had willingly disclosed their HIV status to their health-care providers. It also found that 11% of total respondents had experienced privacy breaches by health-care professionals. The Myanmar report also found health-care professionals had breached respondents’ confidentiality by disclosing their HIV-positive status without consent (10%), with others reporting they were “not sure” whether their confidentiality had been breached (9%).

Empowerment through disclosure of HIV status

The data related to disclosure, and especially disclosure without consent, suggest that stigma, discrimination and hence disempowerment are experienced by many people living with HIV when others learn of their HIV-positive status; however, disclosure of HIV-positive status is not disempowering per se. The PLHIV Stigma Index asked respondents to consider whether their disclosure of their HIV-positive status had been an empowering experience. Of the countries that provided data, all but Pakistan (at 40%) found that disclosure had been an empowering experience for the majority of people living with HIV, ranging from 61% (Myanmar) to 91% (Fiji) (Figure 83).

Figure 83: Experience of disclosure of HIV status as empowering



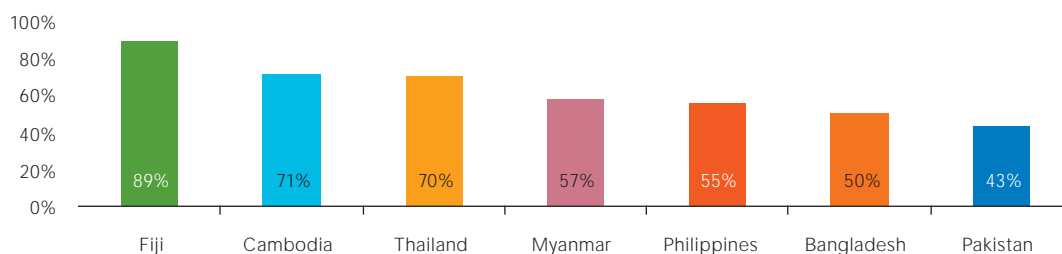
Based on responses to Section 3B:6.

Section 3C: Treatment

Self-assessment of current health

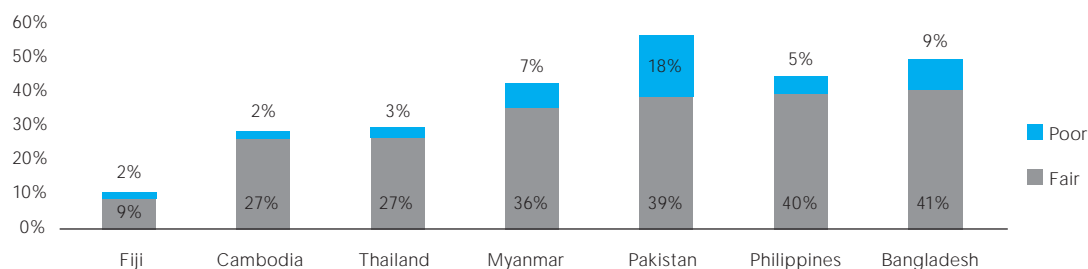
The PLHIV Stigma Index asked respondents to assess their current health based upon the following scale: excellent, very good, good, fair and poor. In all countries providing data, except Pakistan, at least 50% of respondents rated their health as “good” or better. Responses ranged from 43% (Pakistan) to 89% (Fiji) (Figure 84). Very few respondents rated their health as “poor”, ranging from 2% (Cambodia and Fiji) to 18% (Pakistan) (Figure 85).

Figure 84: Self-ranking of health as “good”, “very good” or “excellent”



Based on responses to Section 3C:1.

Figure 85: Self-ranking of health as “fair” or “poor”

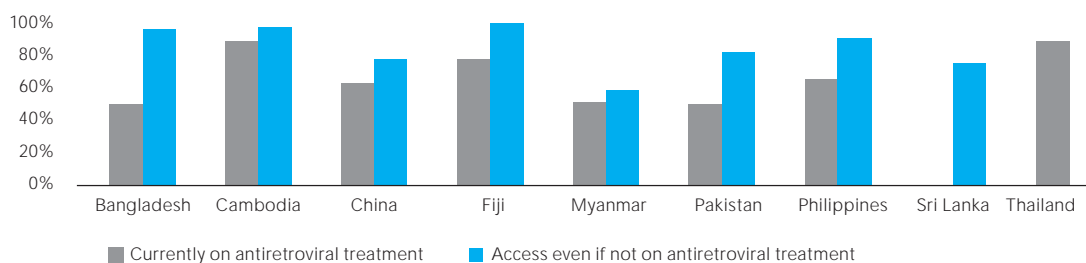


Based on responses to Section 3C:1.

Access to antiretroviral treatment

At least half of all PLHIV Stigma Index respondents were currently on antiretroviral treatment, ranging from 50% (Bangladesh) to 90% (Thailand) (Figures 86 and 87). Respondents were also asked whether they believed they could access antiretroviral treatment even if they were not currently receiving it; the PLHIV Stigma Index recorded high rates of response, ranging from 59% (Myanmar) to 100% (Fiji) (Figures 86 and 88). These percentages appear to represent the percentage of *all* respondents, including those currently on antiretroviral therapy.

Figure 86: Access to antiretroviral treatment



Based on responses to Section 3C:2a and 3a.

Some medicines are very costly ... I need to take money from my brothers but even in spite of having the money medicine is sometimes still not available.

Fiji

I have to do this treatment all my life but no organization can support me all this time.

Myanmar

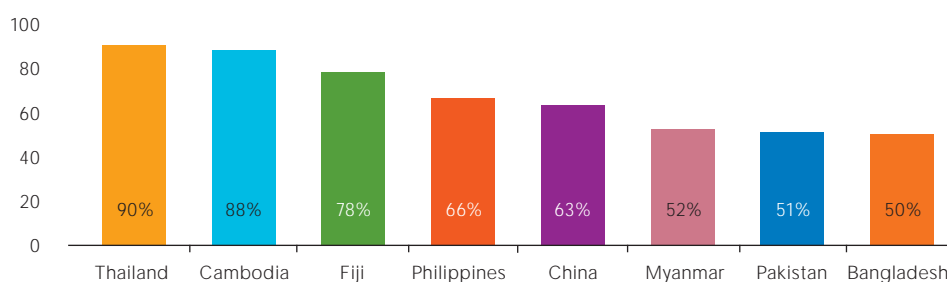
It is difficult for me to get the medicine. Because transportation costs are high, I have to pawn things first.

Myanmar

Hopefully ARV will be free forever.

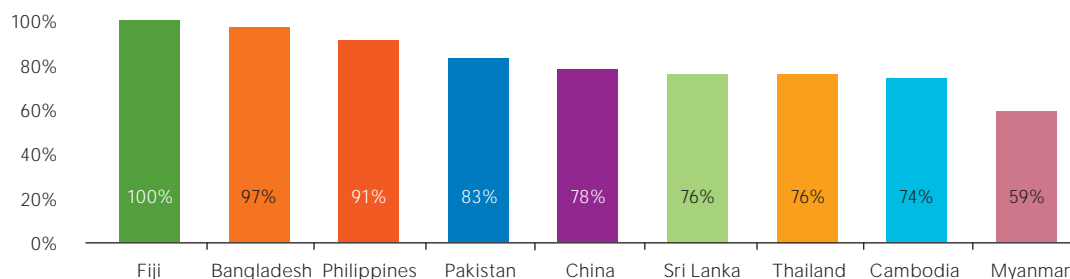
Philippines

Figure 87: Currently on antiretroviral treatment



Based on responses to Section 3C:2a.

Figure 88: Access to antiretroviral treatment (including people currently on antiretroviral treatment)

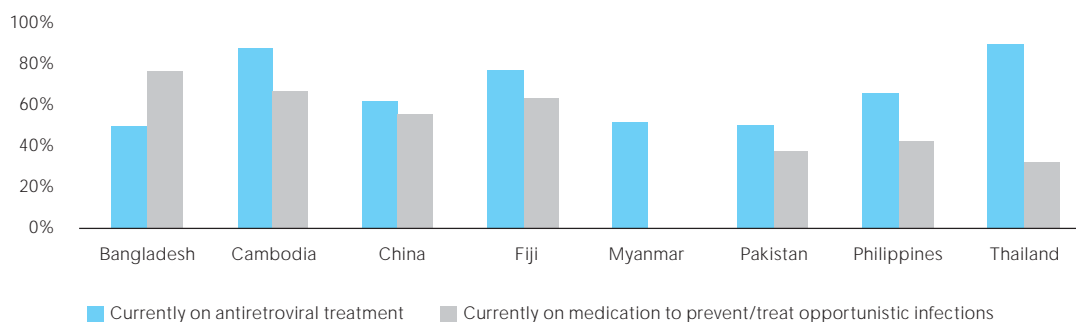


Based on responses to Section 3C:2b.

Access to treatment for opportunistic infections

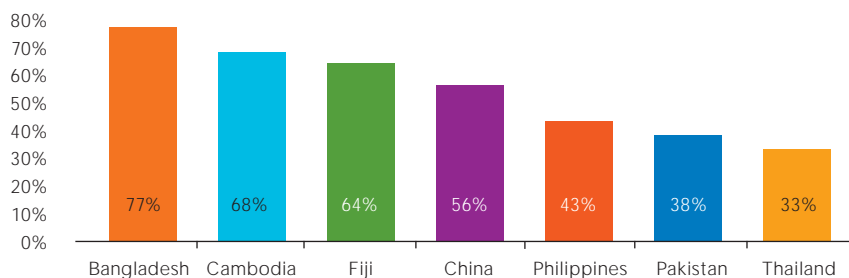
In most settings, respondents were taking medication for opportunistic infections, ranging from 38% (Pakistan) to 77% (Bangladesh) (Figures 89 and 90).

Figure 89: Currently on treatment



Based on responses to Section 3C:2a and 3a.

Figure 90: Currently on medication for opportunistic infections

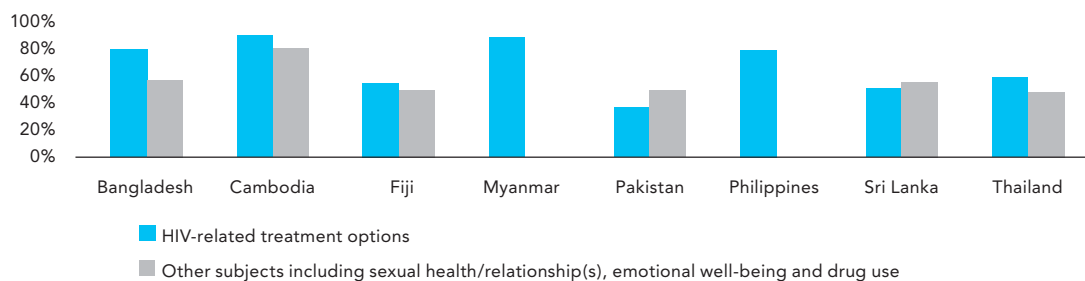


Based on responses to Section 3C:3a.

Constructive discussions with health-care professionals

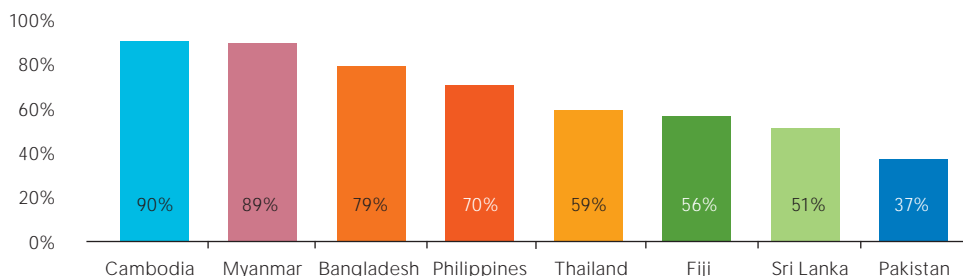
Respondents reported varied interactions with health-care professionals. The percentage of respondents who had had constructive discussions with health-care professionals about HIV-related treatment options varied significantly by country, ranging from 37% (Pakistan) to 90% (Cambodia) (Figures 91 and 92). Reporting of constructive discussions with health-care professionals about other subjects ranged from 49% (Pakistan) to 81% (Cambodia) (Figures 91 and 93).

Figure 91: Constructive discussion with health-care professional(s) in past 12 months



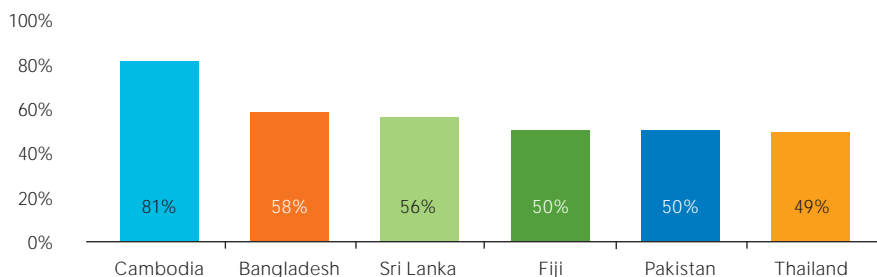
Based on responses to Section 3C:4 and 5.

Figure 92: Constructive discussion with health-care professional(s) about HIV-related treatment options in past 12 months



Based on responses to Section 3C:4.

Figure 93: Constructive discussion with health-care professional(s) about other subjects in past 12 months



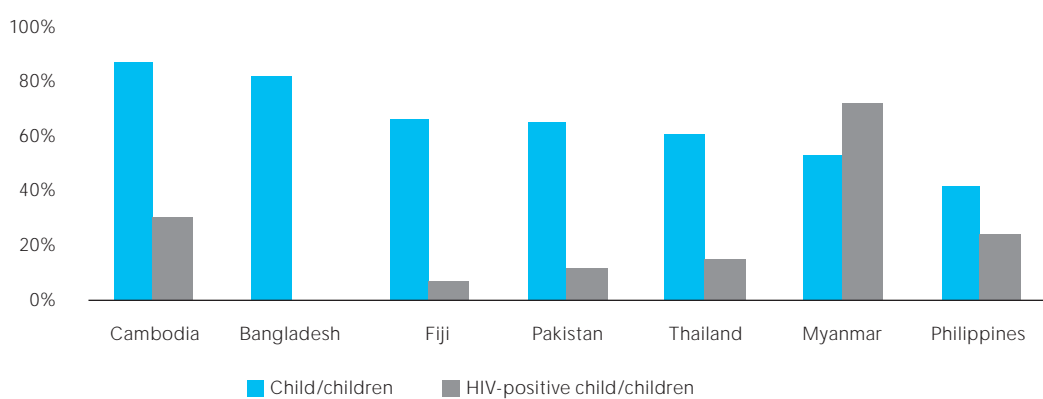
Based on responses to Section 3C:5.

Section 3D: Having children

Children of people living with HIV

Many of the people surveyed for the PLHIV Stigma Index had children, ranging from 42% (the Philippines) to 87% (Cambodia) (Figure 94). Of these people, some had children who were also living with HIV, ranging from 7% (Fiji) to 72% (Myanmar).

Figure 94: People living with HIV with a child or children

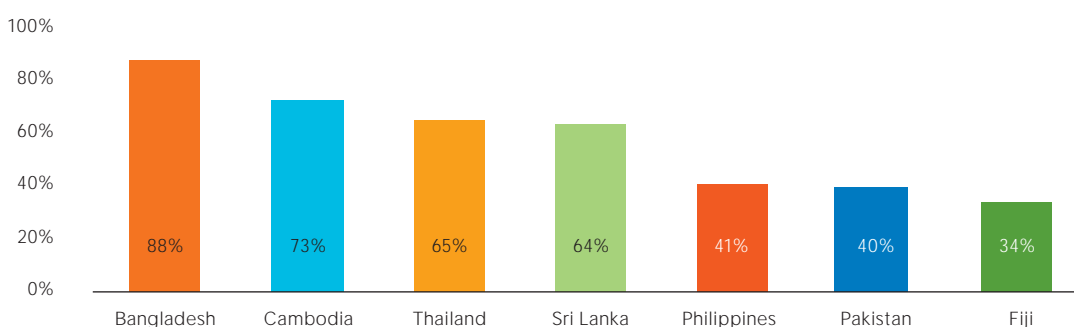


Based on responses to Section 3D:1a and 1b.

Reproduction options

The PLHIV Stigma Index asked respondents whether they had received counselling about their reproductive options. Responses varied greatly throughout the region, ranging from 34% (Fiji) to 88% (Bangladesh) (Figure 95).

Figure 95: Counselling regarding reproductive options

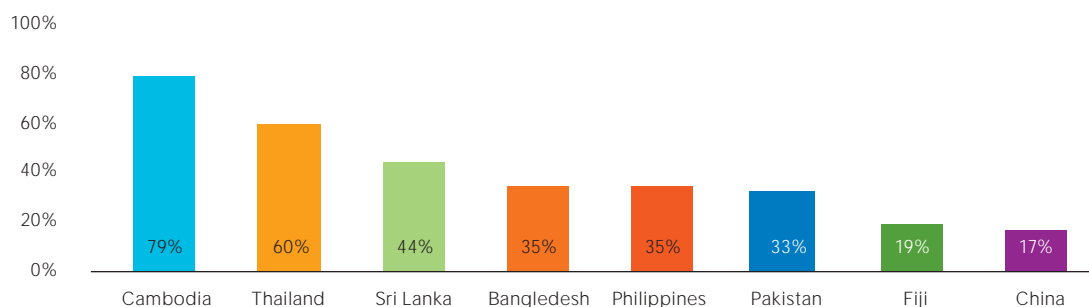


Based on responses to Section 3D:2.

Respondents were also asked whether they had been advised by a health professional not to have children since their HIV diagnosis. Many respondents had, ranging from 17% (China) to 79% (Cambodia) (Figure 96). This compares with a third of all respondents surveyed in the AIDS Discrimination in Asia report (45% of women, 18% of men) and 69% of women who tested positive for HIV during pregnancy.

The advice to not have children following a diagnosis of HIV is contrary to the human right to attain the highest standard of sexual and reproductive health, and the right to decide freely the number, spacing and timing of children, and to have the information and means to do so. It is also contrary to guidelines of the International Federation of Gynecology and Obstetrics, which state that people living with HIV should not be discouraged from becoming pregnant.

Figure 96: Advised by health-care professional not to have children following diagnosis of HIV



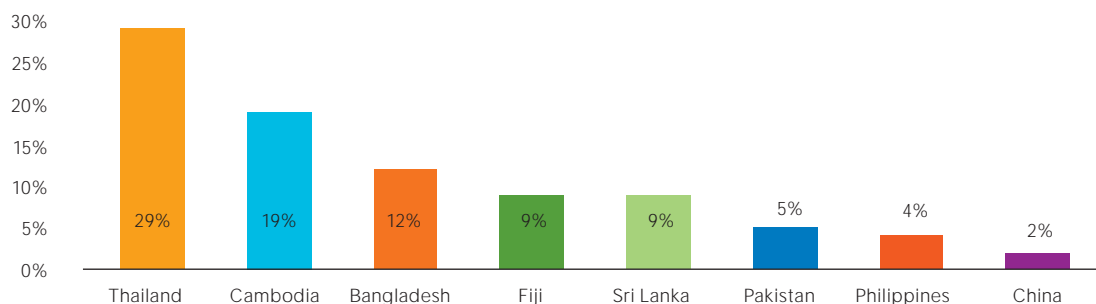
Based on responses to Section 3D:3.

It is not clear whether China's report of 17% does or does not relate to China's "one child" policy. Furthermore, the question was asked of only 996 of China's 2096 survey respondents. The figure for Bangladesh is based on the assertion that 65.1% reported that "no health-care professional had ever advised them not to have a child", which suggests 34.9% were so advised; however, it is not known whether or not this 65.1% also includes people to whom the question was not applicable.

Forced or coerced sterilization

The PLHIV Stigma Index asked respondents whether they had ever been coerced into being sterilized by a health-care professional. Many respondents had, ranging from 2% in China³⁶ to 29% in Thailand (Figure 97). These findings compare with 21% reported in the AIDS Discrimination in Asia report.

Figure 97: Coercion by health-care professional into sterilization



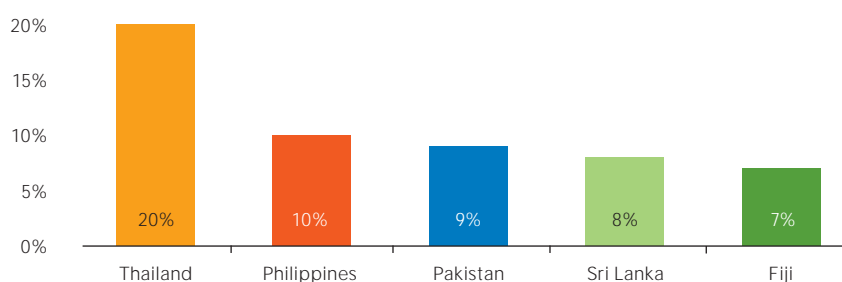
Based on responses to Section 3D:4.

³⁶ It is not clear whether China's report of 2% does or does not relate to China's "one child" policy, and the question was asked of only 996 of China's 2096 survey respondents.

Antiretroviral therapy conditional on use of contraception

The PLHIV Stigma Index includes a question regarding whether provision of antiretroviral treatment is conditional upon the use of contraception. Those countries that provided data suggested that such conditional provision of antiretroviral treatment does occur, ranging from 7% (Fiji) to 20% (Thailand) (Figure 98).

Figure 98: Antiretroviral treatment conditional on use of contraception



Based on responses to Section 3D:5.

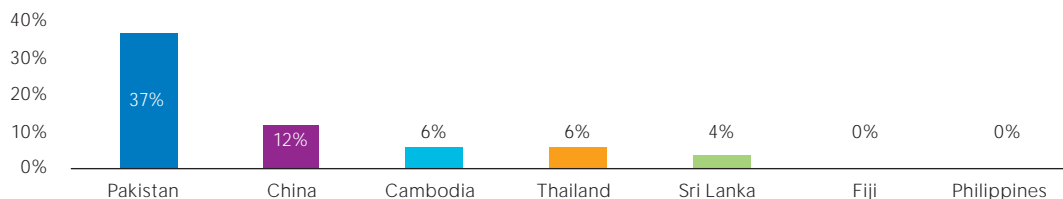
The Bangladesh report notes that more than half of respondents did not face any type of conditionality on the use of certain types of contraception in order to receive antiretroviral treatment, but this suggests that a proportion of respondents may have faced such conditionality.

Pregnancy, birth and postnatal coercion

Female respondents were asked whether they had been coerced or forced by health-care professionals into making key decisions regarding pregnancy, birth and postnatal issues, and some female respondents stated they had. Care must be taken when interpreting these data, however, as in some instances very small numbers of women were surveyed.

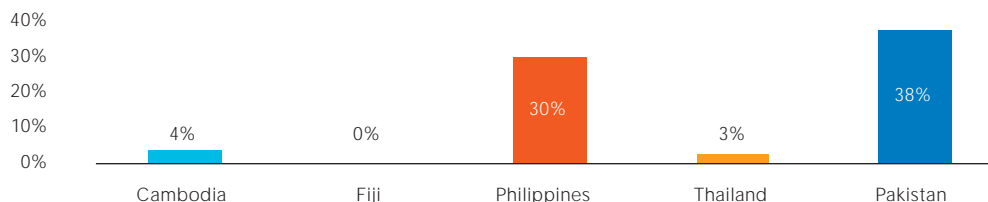
- ▶ **Termination of pregnancy:** Responses from seven countries ranged from 0% (Fiji and the Philippines) to 37% (Pakistan) (Figure 99).
- ▶ **Method of giving birth:** Responses ranged from 0% (Fiji) to 38% (Pakistan) (Figure 100).
- ▶ **Infant feeding practices:** Responses ranged from 10% (Thailand) to 37% (the Philippines) (Figure 101). In the Philippines 37% equates to 11 mothers, and in Fiji 25% equates to only 2 mothers. In other instances, larger numbers of women were surveyed; for example, in Pakistan 25% equates to 60 mothers.

Figure 99: Coerced into termination of pregnancy



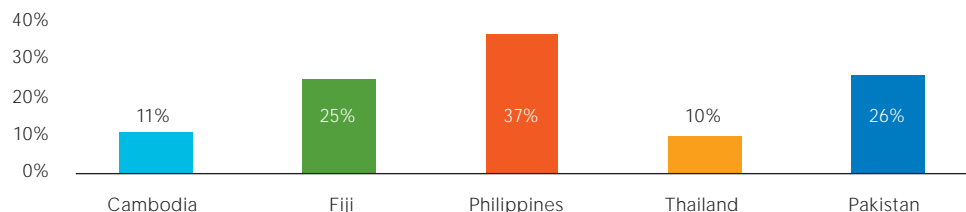
Based on responses to Section 3D:6.
 China's response relates to 44 of the 369 people who answered this question.

Figure 100: Coerced into method of giving birth



Based on responses to Section 3D:6.

Figure 101: Coerced into using certain infant feeding practices

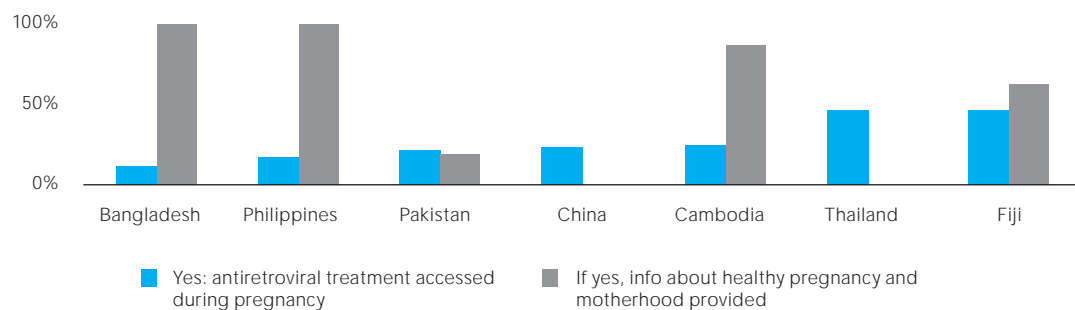


Based on responses to Section 3D:6.

Information about healthy pregnancy

Female respondents were asked whether they had been given information about healthy pregnancy and motherhood as part of the programme to prevent mother-to-child transmission of HIV. Many women reported that they had received such information, ranging from 100% (Bangladesh and the Philippines) to 19% (Pakistan) (Figure 102). Care must be taken when interpreting these figures, particularly those related to provision of information, as they refer to very low numbers of women (often less than 10).

Figure 102: Pregnancy, antiretroviral treatment and information



Based on responses to Section 3D:7b.

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ANNEX 1: SOUTH ASIA REGION DEVELOPMENT MARKETPLACE (2008–2010)

In its 2008 grants round, the South Asia Region Development Marketplace³⁷ prioritized projects to address HIV-related stigma and discrimination. Consultation with marginalized populations most affected by stigma (including representatives of community groups and networks of people who use drugs, sex workers and men who have sex with men) led to a targeted approach, including:

- ▶ disbursement of relatively small grant amounts (maximum US\$ 40 000 per project) to enable small community organizations to compete with larger groups;
- ▶ funding of organizations led by and for key populations at risk of HIV, who were frequently marginalized in their communities;
- ▶ support for grantees, including the provision of external technical guidance on programme design, effective messaging, and measurement and evaluation (provided by the International Center for Research on Women).

To maximize outreach, calls for proposals were disseminated through local media channels and in many local languages, and proposals could be submitted as hard copy or online in local languages, which were then translated by World Bank country office staff.

There was an enormous response to the initial call for proposals, with almost 1000 submissions received. Grants totalling US\$ 1.04 million supported 26 implementers from 7 countries (Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka) to pilot innovative interventions over a period of 12–18 months. Projects used a diverse range of approaches to address stigma, including training for radio journalists, food and catering services for people living with HIV, a restaurant run by sex workers and a beauty pageant.

37 The South Asia Region Development Marketplace partnership is sponsored by the World Bank Group, including the International Finance Corporation, UNAIDS, the Government of Norway, the Swedish International Development Cooperation Agency, the United Nations Children's Fund and the United Nations Development Programme.

A number of broad principles were drawn from the South Asia Region Development Marketplace process, including the following:

- ▶ Community organizations can achieve a great deal for relatively little investment: 26 implementers trained almost 5000 people and reached more than 97 000 people.
- ▶ Effectively designed grants can seed considerable innovation, new alliances and insights.
- ▶ The most effective projects require substantial up-front planning and effort, including engaging gatekeepers, research on different audiences, training and new partnerships.
- ▶ The most successful efforts to address stigma use multiple strategies and stakeholders.
- ▶ Effective efforts are led by or continuously engage marginalized communities, which strengthens capacity, ensures appropriate messaging and maximizes results.³⁸

38 For an overview and evaluation of the South Asia Region Development Marketplace, see Stangl et al. (2010).

ANNEX 2: SYNOPSIS OF PLHIV STIGMA INDEX DEMOGRAPHIC DATA

This annex is a synopsis of some of the demographic data contained in the PLHIV Stigma Index country reports and provides a basic overview of the respondents' demographic profiles. The data are provided in an abridged format primarily as a means to demonstrate agencies' efforts to survey a sample of people living with HIV that is diverse and large enough to capture both the main features of the population and divergence from those main features.

Many country reports indicate whether respondents identified as belonging to particular groups, including men who have sex with men, gay or lesbian people, transgender people, sex workers, people who inject drugs, indigenous people, and people whose partner is living with HIV. Most countries reported respondents from at least three (and up to six) categories. Please refer to the country reports for details.

Number of respondents

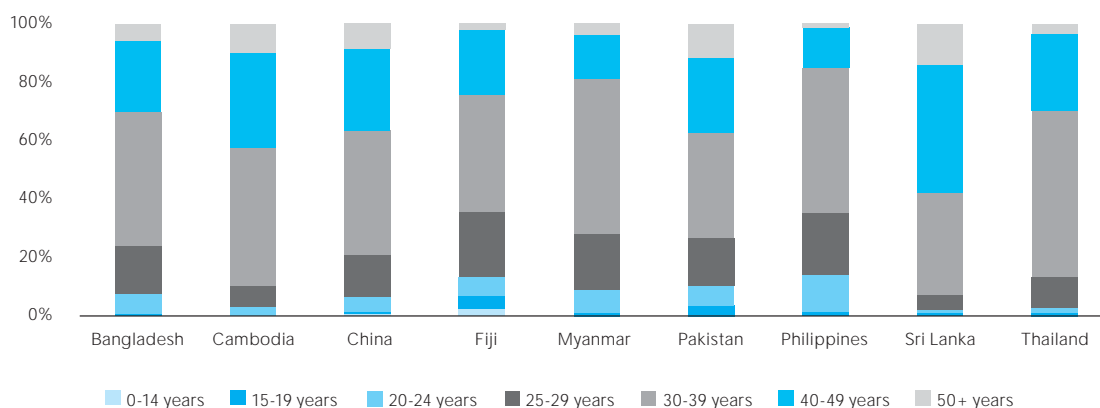
Table 12: Number of respondents

	Total respondents	Men	Women	Transgender people
Bangladesh	238	152	86	–
Cambodia	397	114	280	3
China	2096	1413	666	3
Fiji	45	19	25	–
Myanmar	324	158	166	–
Pakistan	883	649	228	6
Philippines	80	50	30	1 ^a
Sri Lanka	99			
Thailand	233	57	148	28

^aThe Philippines survey definition of transgender relied on the definition *operada*, which is a colloquial term for having undergone surgery.

Age distribution of respondents

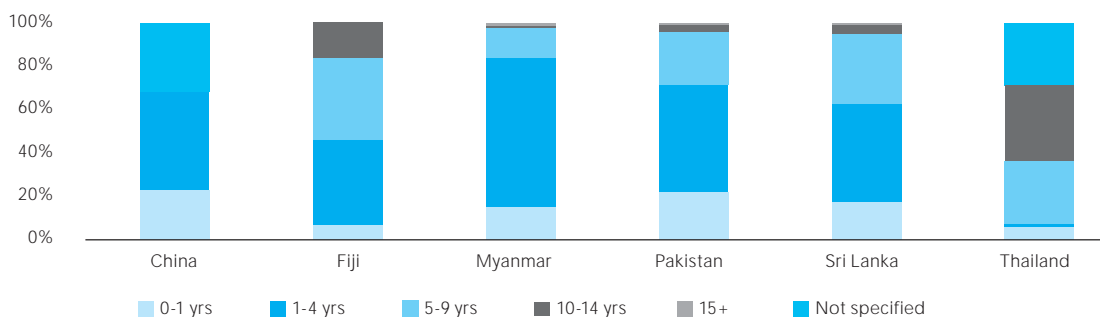
Figure 103: Age distribution of respondents



Cambodia's 20-24 years range includes a number of respondents aged under 20 years.

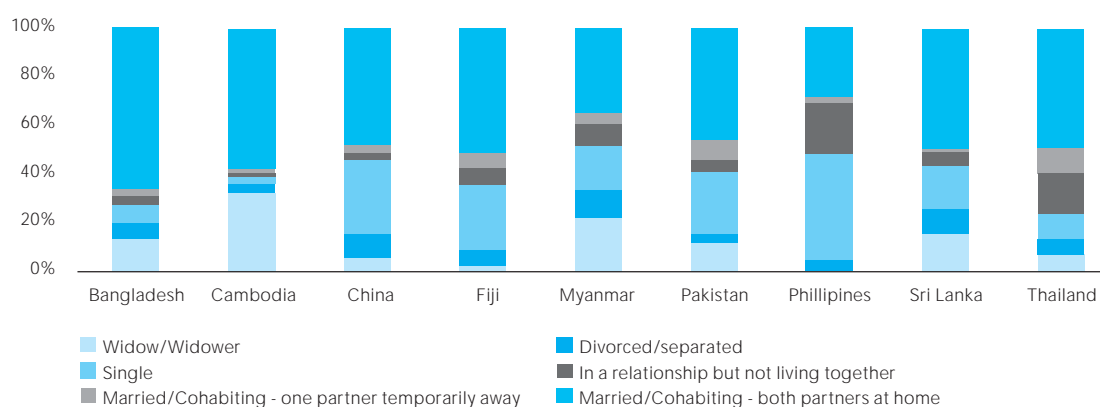
Length of time living with HIV

Figure 104: Length of time living with HIV



Current relationship

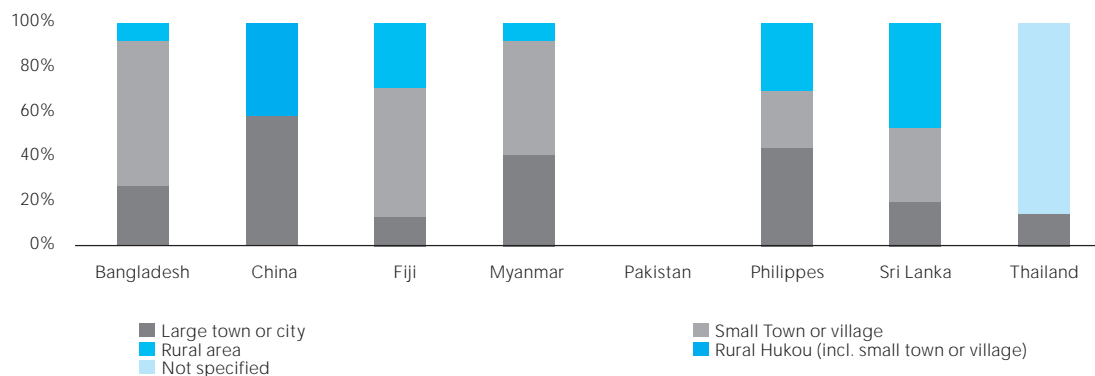
Figure 105: Current relationship



The Philippines "divorced" category includes people who have been widowed.

Residential location

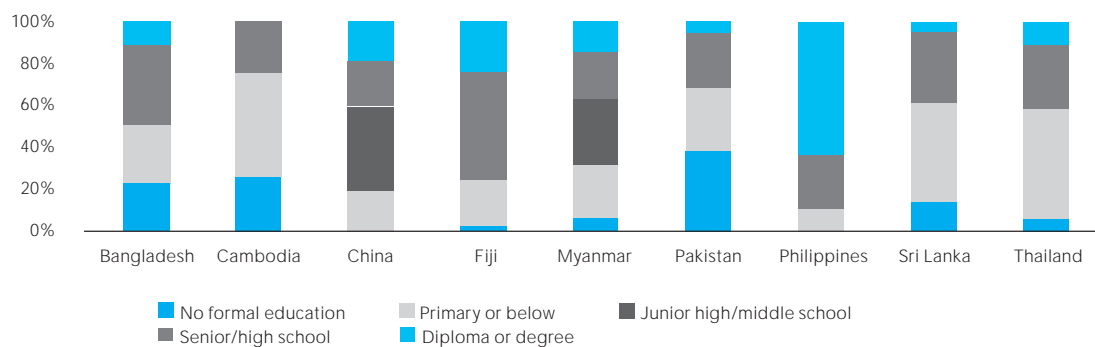
Figure 106: Residential location



In China, respondents came from 25 different Chinese provinces. More than half of respondents (59%) had urban *hukou* (household registration), and 41% had rural *hukou*. It should be noted that *hukou* status is not always an accurate guide to the actual place of residence, as many people with rural *hukou* migrate to urban areas to live and work.

Highest level of education

Figure 107: Highest level of education



Note that some countries that provided gender-disaggregated data reflected clear gender differences in educational attainment (Figures 108–110).

Figure 108: Highest level of education, by gender: Bangladesh

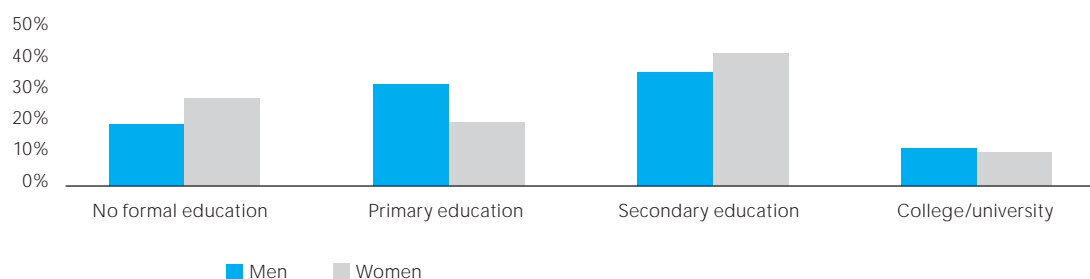


Figure 109: Highest level of education, by gender: Pakistan

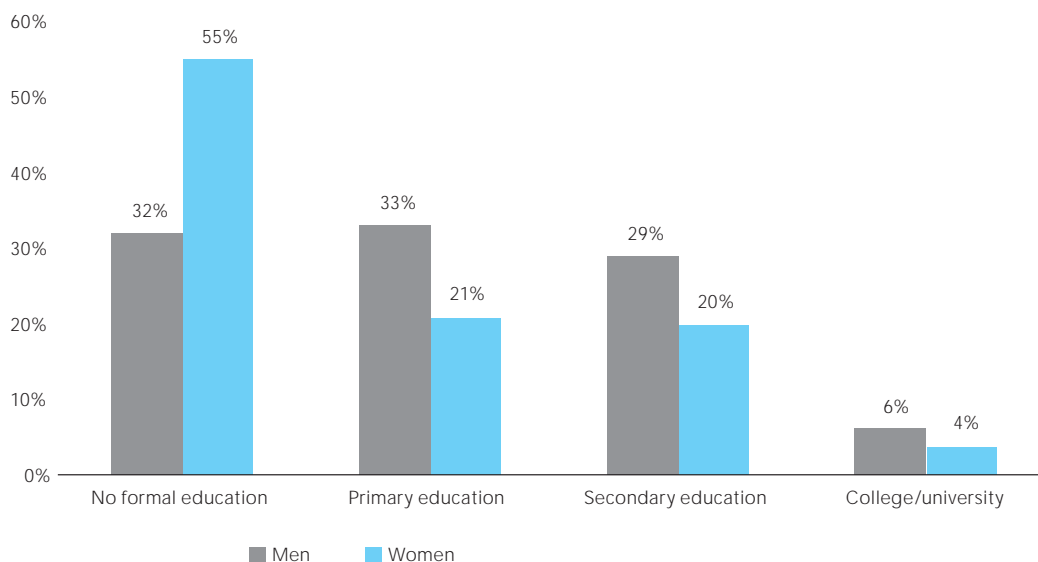
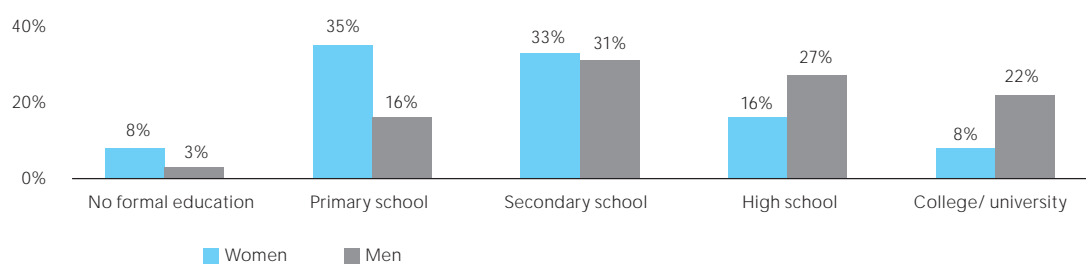
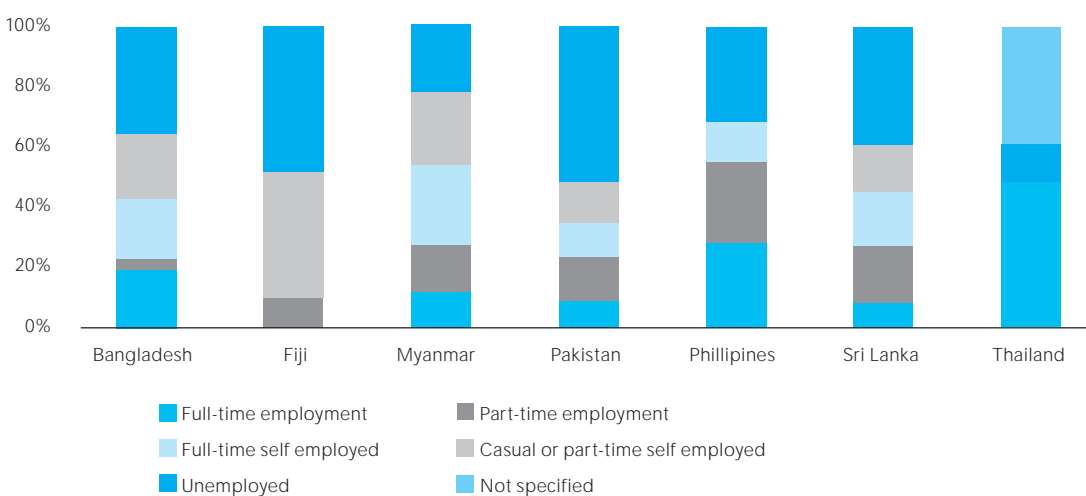


Figure 110: Highest level of education, by gender: Myanmar



Current employment status

Figure 111: Current employment status



The Bangladesh and Sri Lanka country reports provided gender-disaggregated data on occupational status, which reflected a highly gendered pattern of work and employment (Figures 112 and 113).

Figure 112: Current employment status, by gender: Bangladesh

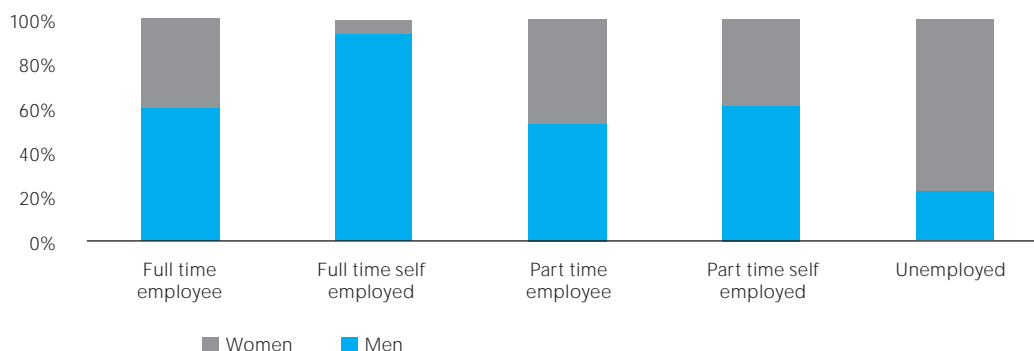
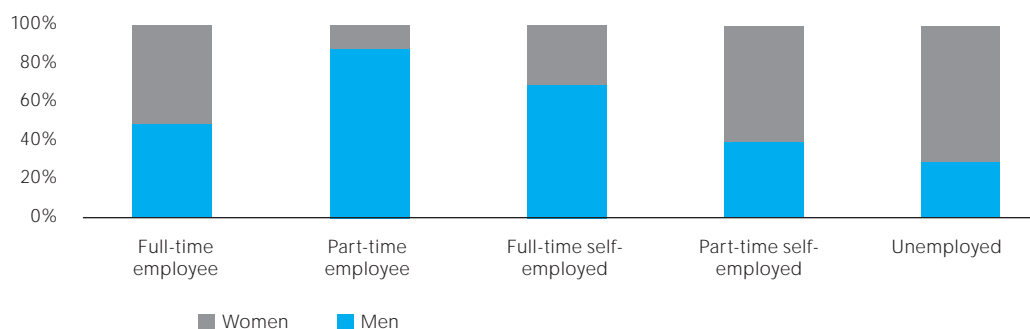


Figure 113: Current employment status, by gender: Sri Lanka



The impact of this gender difference is particularly pronounced when condensed and reflected as full-time, part-time and unemployed (which should also be understood in terms of employment status as an indicator of social status and also likely income generation) (Figures 114 and 115).

Figure 114: Condensed employment status, by gender: Bangladesh

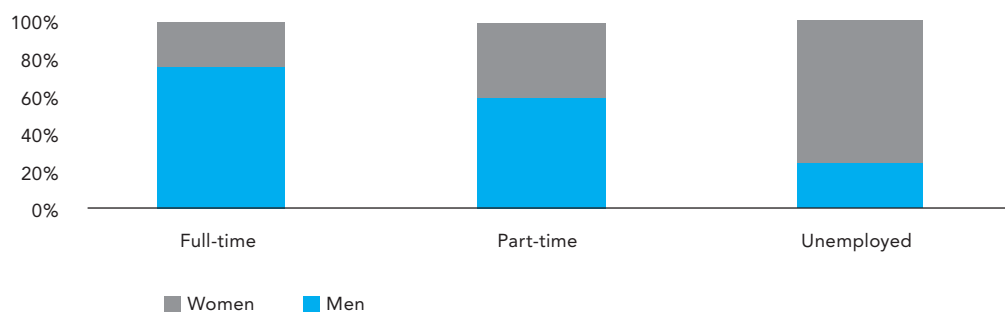
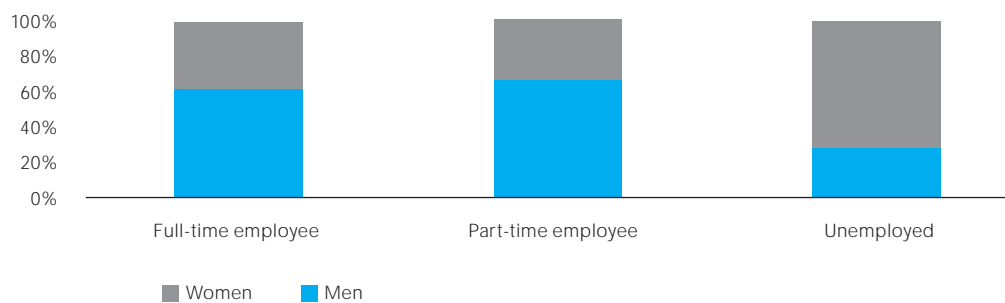


Figure 115: Condensed employment status, by gender: Sri Lanka



ANNEX 3: HIV-BASED TRAVEL RESTRICTIONS – ASIA PACIFIC REGION³⁹

According to the publication *Mapping of restrictions on the entry, stay and residence of people living with HIV* (UNAIDS, 2009) and latest developments as of February 2011:

- ▶ 15 countries, territories and areas in the region impose some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status (Table 13);
- ▶ 1 country (Brunei Darussalam) requires declaration of HIV status for entry or stay, and HIV-positive status results in either a bar to entry/stay or the need for discretionary approval (including through granting of waivers);
- ▶ 6 countries deport people living with HIV as soon as their HIV-positive status is discovered: Brunei Darussalam, Democratic People's Republic of Korea, Malaysia, Mongolia, Singapore, Taiwan.

Table 13: Restriction on entry, stay and residence based on HIV status

Asia	
Afghanistan	–
Bangladesh	No
Bhutan	–
Brunei Darussalam	Yes
Cambodia	No
China	No
China, Hong Kong Special Administrative Region	No
China, Macau Special Administrative Region	No
China, Province of Taiwan	Yes
Democratic People's Republic of Korea	Yes
India	No
Indonesia	No
Iran	No
Japan	No
Lao People's Democratic Republic	No
Malaysia	Yes
Maldives	No
Mongolia	Yes
Myanmar	No
Nepal	No
Pakistan	No
Philippines	No
Republic of Korea	Yes
Singapore	Yes
Sri Lanka	No
Thailand	No

39 From *HIV-related restrictions on entry, stay and residence*. Geneva, UNAIDS Human Rights and Law Team, 2011; and *Mapping progress towards universal access*. UNAIDS. Full details available at <http://www.unaids.org/globalreport/AIDSinfo.htm>.

Tibet	-
Timor Leste	-
Viet Nam	No
Pacific	
Australia	Yes
Cook Islands	-
Fiji	Yes
Kiribati	-
Marshall Islands	Yes
Micronesia, Federated States of	No
Nauru	-
New Zealand	Yes
Niue	-
Palau	-
Papua New Guinea	Yes
Samoa	Yes
Solomon Islands	Yes
Tonga	Yes
Tuvalu	-
Vanuatu	No

ANNEX 4: REGIONAL SUMMARY OF REDRESS MECHANISMS FOR HIV-RELATED STIGMA

Systematic documentation of stigma and discrimination at the country level is a high priority in line with the UNAIDS priority area “We can remove punitive law, policies, practices, stigma and discrimination that block effective responses to HIV”. Documentation of stigma and discrimination must be followed by efforts to establish or improve remedial instruments and to ensure the existence of agencies for seeking redress and the availability of legal services. Table 14 seeks to consolidate basic country specific information on:

- ▶ agencies that may assist people living with HIV to seek redress (e.g. courts, tribunals, human rights commissions, ombudsmen);
- ▶ availability of legal services, for example those providing legal services (e.g. government-run legal aid, national human rights institutions, NGO services) and advocacy for law reform responding to HIV-related stigma;
- ▶ projects to develop legal services or expand HIV-related legal capacity of existing agencies.

Table 14: Summary of projects, national instruments and agencies enabling legal redress for HIV-related stigma and discrimination (March 2011)

Bangladesh	<p>Partnership between the National Network of People Living with HIV in Bangladesh (NNB+) and the Bangladesh National Human Rights Commission being established to deal with human rights violations of people living with HIV</p> <p>UNAIDS partnering with rights-based organization Ain O Salish Kendro to ensure rights of people living with HIV</p> <p>NNB+ and other civil society organizations able to support people living with HIV seeking redress</p> <p>National Strategic Plan 2011–2015 specifically incorporates the human rights issues of most-at-risk populations and people living with HIV</p>
Cambodia	<p>Cambodian Human Rights and HIV/AIDS Network (CHRHAN) previously documented HIV-related human rights violations and advocated for appropriate policy programmatic responses; CHRHAN dissolved in 2008 due to complex governance issues</p>
China	<p>Yunnan University Legal Aid Centre (including legal officer and peer counsellor) supported by International Development Law Organization (IDLO) Health and Law Program and USAID's Health Policy Initiative (HPI) to deliver legal services for people living with HIV and vulnerable populations in China</p> <p>Korekata AIDS Law Center assisting with litigation</p> <p>University of Peking mapped HIV-related legal services in China (<i>Mapping initiatives to strengthen the legal environment for the response to HIV in China</i>. Rome, International Development Law Organization, 2010; available in English and Chinese)</p> <p>Translation of <i>Toolkit: Scaling up HIV-related legal services</i> (Rome, International Development Law Organization and Joint United Nations Programme on HIV/AIDS, 2009) into Chinese</p> <p>China Red Ribbon Forum on HIV and Rights brings together key figures from government, civil society, academia and the law to explore key issues and develop concrete recommendations in meetings held twice a year</p> <p>National conference on HIV and law under discussion with HPI, building on IDLO project in Yunnan</p> <p>Asia Catalyst working with AIDS Law Center Beijing to develop model curriculum on human rights documentation and activism and web site in Chinese on social rights, AIDS and the rule of law</p> <p>Regional AIDS law database</p>

Fiji	<p>HIV/AIDS Board (as stipulated in the HIV/AIDS Decree 2011)</p> <p>Fiji Human Rights Commission</p> <p>Fiji Legal AID Commission</p> <p>Pacific Islands AIDS Foundation Legal and Advocacy Initiative</p> <p>Secretariat of the Pacific Community Regional Rights Resource Team</p>
India	<p>NGOs, including Lawyers Collective and Human Rights Law Network, provide free legal aid services to people living with and affected by HIV and AIDS</p> <p>In several states, free legal aid services are provided by state AIDS control organizations under the National AIDS Control Organisation in collaboration with state legal authorities (e.g. Kerala State Legal Services Authority in Kerala, Tamil Nadu State AIDS Control Society)</p> <p>UNDP in partnership with National AIDS Control Organization (NACO) has supported legal aid services for people living with HIV in Tamil Nadu and Andhra Pradesh</p> <p>Solidarity and Action Against the HIV Infection in India has set up legal aid units in Orissa and West Bengal in partnership with the Bar Councils of these states to build capacities of people living with HIV and sexual minorities</p> <p>IDLO HIV and Health Law programme evaluated HIV-related legal services in Tamil Nadu (State AIDS Control Society) under a joint IDLO/UNAIDS research project to describe and cost different legal services models (<i>Scaling up HIV-related legal services: Report of case studies – Ukraine, Kenya and India</i>. Rome, International Development Law Organization and Joint United Nations Programme on HIV/AIDS, 2010)</p> <p>NACO includes detailed information about human rights of people living with HIV and a link to the Lawyers Collective HIV/AIDS Unit. NACO web site has public information on what to do when faced with stigma and discrimination and a format for registering complaints about stigma and discrimination. Follow-up under way re monitoring and follow-up of the registered cases. NACO's draft GIPA policy clearly outlines the grievance redress mechanism and systems in place to address stigma experienced by people living with HIV, but this information needs to permeate all state- and district-level networks of people living with HIV for efficient redress of grievances</p>
Indonesia	<p>LBHM Community Legal AID Institute (Jakarta) provides legal services to people living with HIV and vulnerable populations (IDLO provides technical and financial support)</p> <p>Stakeholder consultations conducted in 2008/2009, and rapid needs assessment report published in English and Bahasa Indonesia (2010)</p> <p>IDLO and LBHM implemented training workshop on HIV and the law for lawyers and community representatives engaged in rights-based work (2010). LBHM facilitated paralegal training workshop to build capacity of representatives from key communities to support delivery of HIV-related services and community legal empowerment (2010). LBHM published community information materials (http://www.idlo.int/hivhealthlaw).</p> <p>Potential role for National Human Rights Commission, but complaint procedure being revised so currently not available</p> <p>JOTHI (network of people living with HIV) registering and monitoring human rights abuses among people living with HIV, including stigma and discrimination cases. Referral to local legal services</p> <p>Law department of Atma Jaya University Jakarta is involved in advocating for people living with HIV and key population rights, e.g. drug treatment for people who use drugs as an alternative to prison (reference to 2009 Drug Law)</p> <p>Some individual legal aid and human rights projects in Jakarta and a few large towns may be accessed by people living with HIV, but these projects are not well known, are not always linked with people living with HIV or other HIV networks, and are on a very small scale</p> <p>Legal issue limits access of unmarried people to contraceptives (including condoms), making access by teenagers to government sexual and reproductive health services difficult; however, new Family Law facilitating has improved access to services</p>
Lao People's Democratic Republic	<p>None known</p>

Malaysia	<p>Ministry of Human Resource has established standards (e.g. Code of Practice on HIV/AIDS in the Workplace) to provide guidance for redress of HIV-based discrimination within the work environment</p> <p>Human Rights Commission of Malaysia able to consider HIV and AIDS issues for redress</p> <p>Bar Council Legal Aid facility able to consider HIV cases related to discrimination and denial of human rights</p> <p>Various civil society organizations and entities such as the Bar Council and Legal Aid Centre record and document cases, but few cases have been brought. People experiencing discrimination are reluctant to proceed due to risk of exposing their HIV-positive status</p>
Maldives	<p>National Human Rights Commission with some capacity on HIV issues</p>
Myanmar	<p>Some international NGOs have lawyers to provide legal advice to sex workers, men who have sex with men and people living with HIV, but scale of activity is very small</p>
Mongolia	<p>National Human Rights Commission has some experience handling documented cases and complaints from people living with HIV</p> <p>No legal services available. UNDP is considering the feasibility of establishing a legal service point for people living with HIV through training and advocacy</p> <p>Amendment of 2004 AIDS Law currently being undertaken, including review of discriminatory provisions violating rights of people living with HIV. Review process included technical input from UNAIDS human rights and law team</p>
Nepal	<p>Forum for Women, Law and Development (FWLD) supports people living with HIV and most-at-risk population groups to access legal support remedies (since 2003)</p> <p>Nepal Environmental Lawyers Association (NELA) provides legal aid, predominantly to communities of people who use drugs</p> <p>The Blue Diamond Society provides legal aid for sexual and gender minorities</p> <p>IDLO HIV and Health Law Program partnered with local IDLO Alumni Association, FWLD and NELA to conduct legal services scoping activities in Kathmandu, and host a stakeholder consultation in 2010. Needs assessment report published 2011. IDLO and IDLO Alumni Association hosted a second stakeholder consultation in 2011 to gather community input on curriculum for an HIV law training workshop. IDLO and IDLO Alumni Association partnered with FWLD, NELA and the national drug users network Recovering Nepal to implement an HIV law training workshop for lawyers (government and private practice)</p> <p>IDLO has an office with one legal officer (since October 2010)</p> <p>Legal audit was carried out in 2004 by the National Centre for AIDS and STD Control, the Policy Project/Nepal and FWLD. As a result, a Bill was drafted aiming to include protection for people living with HIV, and affected and most-at-risk populations. The Bill did not make it through the Cabinet, however</p> <p>In 2008, the content of the failed Bill was merged with new HIV-related content. That Bill has been submitted to the Government but has not yet been submitted to the Cabinet</p> <p>IDLO has launched an HIV legal services project with IDLO Alumni Association in Kathmandu</p> <p>In 2010, IDLO contracted an intellectual property consultant to undertake a needs assessment on intellectual property rights and access to medicines in Nepal. In line with the recommendations from the needs assessment, IDLO, IDLO Alumni Association and UNDP hosted a training seminar on intellectual property and access to medicines in April 2011 in Kathmandu. The seminar programme was designed with a view to exploring roll-out of the seminar across Asia</p>

Pakistan	<p>Few NGOs provide legal services to people living with HIV. The National Association of People Living with HIV is documenting HIV-related human rights issues, and the level of stigma and discrimination, and advocating for appropriate policy programmatic responses. There is a need, however, to compile evidence from the PLHIV Stigma Index Survey to create a "national index" so that country progress can be measured periodically and advocacy can be undertaken for law reform. This process has the potential to build a redress mechanism for people living with HIV in Pakistan</p> <p>The right to health is recognized in Article 38 of the Constitution</p> <p>The HIV Policy and HIV Law/Act was developed in 2007 but has not yet been approved by the Government or Parliament</p> <p>The Supreme Court's 2009 decision to grant inclusive rights to transgender people is a key achievement for the transgender community in Pakistan and will assist in reducing stigma and discrimination</p>
Papua New Guinea	<p>IDLO HIV and Health Law Program, with support of the University of Papua New Guinea School of Law, initiated research and scoping activities to support the delivery of legal services for people living with HIV and vulnerable populations in Port Moresby (2010). Needs assessment report published February 11</p> <p>IDLO and the national network for positive people, Igat Hope, co-hosted the Positive People's Workshop to explore HIV-related legal issues (2010). IDLO collaborated with the Save the Children Poro Sapot Project to host a broader consultation on HIV-related legal services, engaging stakeholders from community groups, NGOs, the health sector and the law and justice sector (2010)</p> <p>IDLO, Igat Hope and the Office of the Public Solicitor held a legal information stall on "HIV and your rights" at the National AIDS Council World AIDS Day Expo (2010)</p> <p>IDLO engaged a lawyer/legal officer and project officer to deliver legal services in Port Moresby from January 2011. Legal services are provided both outreach at community organizations and at the project office</p> <p>IDLO and the AIDS Project Management Group facilitated a training workshop on HIV, law and policy in Port Moresby in March 2011. Participants included representatives from law and justice sector agencies, the health sector, national AIDS commission and community organizations. For publications, see http://www.idlo.int/hivhealthlaw; contact Naomi Burke-Shyne, Legal Officer Asia-Pacific (nburkeshyne@idlo.int).</p>
Philippines	<p>Commission on Human Rights Labor and Employment – Arbitration national offices provide services to people seeking redress for human rights concerns, respond to specific cases, and provide guidelines and recommendations</p> <p>Department of Justice – Office for Alternative Disruptive Resolution advocates for use of mediation as a means to resolve disputes. The Public Attorney's Office serves as "triage", referring cases to appropriate institutions</p> <p>Supreme Court – Philippine Mediation Center can address legal cases that have been filed in court through a mediation process</p> <p>Department of Labor and Employment – Arbitration can address work-related grievances</p> <p>Barangay (Village) Justice System is the first line of resolution for disputes but is not yet fully sensitive to HIV-related issues</p> <p>Private legal services (mainly associated with cases of violence against women) are now being approached and linked</p> <p>HIV capacity development for alternative law groups is planned for 2011 (to be implemented by civil society organizations)</p> <p>Draft document describing redress mechanisms (agencies, legal services and processes) has been developed with engagement of people living with HIV. Phase 2 roll-out (i.e. popularize and use this reference document) planned for 2011, with support of UNAIDS</p>
Sri Lanka	<p>UNAIDS country office will soon bring together three or four people who have expressed interest in offering legal services to people living with HIV</p> <p>National AIDS Subcommittee on Policy, Law and Ethics is tackling a number of issues, including insurance discrimination</p>

Thailand	<p>No specific agency currently exists, but the UNAIDS country office has started to build capacity for development of an informal legal service</p> <p>A key country recommendation from the PLHIV Stigma Index was the need to establish mechanisms for documenting legal rights violations and to establish legal aid services. Consequently, a UN Joint Team offered three scholarships for lawyers interested in HIV to attend the IDLO e-learning course "Using the Law and Legal Policy for an effective response to HIV and AIDS". Two of those lawyers have expressed interest in offering their services to people living with HIV for legal advice</p> <p>National AIDS Committee has approved establishment of a national subcommittee on AIDS rights promotion and protection. The subcommittee will function as a national mechanism to monitor and respond to human rights violations related to HIV in Thailand</p> <p>The PAF(B)-funded project on stigma-discrimination prevention and AIDS rights protection has been approved. The project aims to:</p> <ul style="list-style-type: none"> • provide secretariat support to the national subcommittee on AIDS Rights Promotion and Protection and provincial working committees; • strengthen the AIDS rights team to implement stigma and discrimination prevention education in selected provinces and to ensure rights protection; • develop a reporting process, including a national data set and strategic information on stigma, discrimination and human rights and HIV to be included in the National Composite Policy Index. <p>The project will involve key government agencies, including the National Human Rights Commission and the Department of Rights and Liberty Protection, and law organizations such as the Lawyers Council of Thailand under Royal Patronage, and the Civil Rights and Liberty Association. Cosponsoring agencies (UNDP, UNICEF, UNESCO, ILO, WHO, UNFPA) will make technical and financial contributions</p>
Timor Leste	<p>The Constitution makes provisions in Part 2, Title 1, Section 16 on Universality and Equality, enabling general fundamental rights, duties, freedoms and guarantees, but it does not specifically name discrimination based on HIV</p> <p>Provedoria de Direitos Humanos e Justica is a national human rights institution with the function and obligation to promote and protect the rights of all citizens as guaranteed by the Constitution and international conventions ratified by Timor-Leste</p> <p>Citizens may address the Ombudsman for Human Rights and Justice</p> <p>Mechanisms for redress are in place, but as of early 2011 no person living with HIV has sought access</p>
Viet Nam	<p>Administrative sanctions are available against people who break State management laws (e.g. disclosing testing results without consent, publishing names in the media), although these acts do not constitute "crimes". Sanctions include fines and orders for employers to reinstate people living with HIV who have been fired. Relevant bodies include People's Committee Presidents, People's Police, People's Court and civil judgment executive bodies</p> <p>Judicial remedies: Article 161 of the Civil Procedure Code allows people living with HIV to bring a civil action asking the Civil Court to enforce their right. According to Decree 07/2007, people living with HIV are eligible for free legal aid, which may be provided in the form of legal advice, legal representation, mediation, etc. In every province there is a Provincial Legal Aid Center (PLAC) under the Provincial Department of Justice. PLACs provide legal aid to eligible groups through their legal aid officials and collaborators. PLACs can also establish branches at the district level. The budget from central and local government to fund PLACs is very limited, so the ability of people living with HIV to obtain legal aid through PLACs is also limited</p> <p>Lawyers' offices and law companies may register with the Provincial Department of Justice in the same province to provide legal aid. So far, very few lawyers have registered to provide legal aid to people on a pro bono basis</p> <p>Mass organizations (e.g. youth unions, women's unions) and other social organizations can open their own legal advice centres to provide legal advice</p> <p>Six legal aid clinics and one telephone hotline have been established to work exclusively on HIV (supported by USAID). These clinics are dealing with increasing numbers of consultations and cases. Their capacity remains fairly weak, and so sustainability is of concern</p> <p>The director of one of the legal aid clinics (Center for Consulting on Law, Policy, Health, and HIV/AIDS) also coordinates the HIV and Law Network, which actively promotes involvement of people living with HIV during the development of new policy or legal documents, and organizes quarterly consultation meetings with Government officials and people living with HIV self-help groups</p>

ANNEX 5: TOOLKITS, REPORTS AND NEEDS ASSESSMENTS ABOUT HIV-RELATED LEGAL ISSUES IN THE ASIA PACIFIC REGION⁴⁰

Toolkit: Scaling up HIV-related legal services. Rome, International Development Law Organization and Joint United Nations Programme on HIV/AIDS, 2009 (<http://www.idlo.int/Download.aspx?Id=144&LinkUrl=Publications/HIVtoolkit.pdf&FileName=HIVtoolkit.pdf>) (also available in Chinese).

Scaling up HIV-related legal services: Report of case studies – Ukraine, Kenya and India. Rome, International Development Law Organization and Joint United Nations Programme on HIV/AIDS, 2010 (<http://www.idlo.int/english/WhatWeDo/Programs/Health/Pages/Details.aspx?ItemsID=210>).

Mapping initiatives to strengthen the legal response to HIV in China. Rome, International Development Law Organization, 2010 (<http://www.idlo.int/english/WhatWeDo/Programs/Health/Pages/Details.aspx?ItemsID=231>) (also available in Chinese).

Legal Aid Center at Yunnan University: First annual report July 2009 to June 2010. Kunming, Yunnan University Legal Aid Center, 2010 (<http://www.idlo.int/english/WhatWeDo/Programs/Health/Pages/Details.aspx?ItemsID=232>) (also available in Chinese).

Rapid needs assessment of the legal needs of people living with HIV and key populations in Jakarta. Rome, International Development Law Organization, 2010 (<http://www.idlo.int/english/WhatWeDo/Programs/Health/Pages/Details.aspx?ItemsID=171>).

Report on the policy and legal environment and legal needs for HIV and AIDS prevention and control. Yunnan Righteous Law Firm, 2008 (<http://www.idlo.int/english/WhatWeDo/Programs/Health/Pages/Details.aspx?ItemsID=84>) (also available in Chinese).

HIV and Health Law Program 2009–2012: First annual report April 2009–March 2010. Rome, International Development Law Organization, 2010 (<http://www.idlo.int/english/WhatWeDo/Programs/Health/Pages/Details.aspx?ItemsID=194>) (includes information on legal services in China, Indonesia, Nepal and Papua New Guinea).

⁴⁰ This annex is pulled directly from the submission of the International Development Law Organization to the Global Commission on HIV and Law Asia Pacific Regional Dialogue 2011. See *Ten reasons why legal services must be central to a rights-based response to HIV*. Rome, International Development Law Organization, 2010 (<http://www.idlo.int/Publications/10reasonsWhyHIV.pdf>).

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