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# Perspectives on HIV stigma in Asia and Middle East: Legal protections, ethical considerations, and public health solutions

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## Perspective

Statistics show high rates of HIV infections and AIDS-related deaths from the emergence of the epidemic in the 1980s to the present day. Women and girls accounted for 53% of people living with HIV (PLHIV) in 2023 and represented 44% of all new infections. Although the incidence of HIV among children has decreased, progress has stalled in recent years (1,2).

Stigma and discrimination against PLHIV are recognized as significant barriers to providing quality services and achieving universal access to healthcare. However, these barriers have not been adequately addressed in policies and laws (3). A Stigma Index Survey conducted in 25 countries revealed that approximately 25% of PLHIV experienced stigma when seeking non-HIV healthcare services in the past year (4). Furthermore, research continues to indicate stigmatization of PLHIV even by healthcare providers (HCPs). In a 2021 qualitative study conducted in Indonesia, some HCPs admitted to stigmatizing and discriminating against PLHIV due to low knowledge, fear of HIV transmission, and personal, cultural, and religious beliefs and values (5).

**These restrictions are typically justified on the grounds of protecting public health and reducing economic costs:**

Forty-eight countries and territories still enforce HIV-related travel restrictions, most of which are in the Middle East and North Africa. Several countries in Asia, the Pacific, Eastern Europe, and Central Asia also impose these restrictions (6). These restrictions are typically justified on the grounds of protecting public health and reducing economic costs. However, evidence does not support their effectiveness in reducing new HIV cases. Instead, it recommends reframing the issue in terms of human rights (7).

Approximately a quarter of new HIV infections occur annually in Asia and the Pacific region, predominantly among key populations. This region has the second-largest epidemic globally, following eastern and southern Africa (3). Given the cultural context of Asian countries, which often includes negative attitudes towards extramarital sexual relations and diverse sexual orientations, we conducted a rapid review of policies and laws in Asian and neighboring Muslim countries regarding the prohibition of HIV stigma and discrimination.

A study of policies and laws in selected countries highlights three key themes: legal protections for PLHIV, mandatory HIV testing, and the age of consent for HIV testing under constitutions, labor laws, and public health regulations. Legal protections against stigma and discrimination for PLHIV are provided in the constitutions or general laws, labor laws, or public health laws of countries such as Brunei, Indonesia, Malaysia, Myanmar, Singapore, Thailand, Timor-Leste, Bahrain, and the Islamic Republic of Iran. Some countries, including Cambodia, Laos, the Philippines, Indonesia, Vietnam, and Iran, have laws prohibiting stigma and discrimination against PLHIV (8). However, these laws and regulations are not always effectively implemented (9).

Cambodia, Indonesia, Laos, Vietnam, the Philippines, Timor-Leste, and Iran prohibit forced HIV testing. However, mandatory testing persists for specific purposes in several Asian countries. For example, immigrants must undergo testing in Brunei, Malaysia, and Singapore. In Malaysia, pre-marital HIV testing has been mandatory for Muslims since 2001 and is also required for prisoners. Cambodia mandates testing for applicants or employees in flight crews and defense and security roles. In the UAE and Qatar, HIV testing is required for work or residence permits.

The age of consent for HIV testing varies across countries: 14 years in Laos, 15 years in Iran, Cambodia, and Thailand, 16 years in Vietnam, and 17 years in Timor-Leste. These variations reflect cultural differences and judicial systems, resulting in ethical relativism in legal provisions for HIV prevention and control.

Top-down policies alone are insufficient to address these issues effectively. Multiple interventions across policy, institutional, community, and individual levels have been recommended by UNAIDS to combat HIV stigma (10). As HIV-related stigma often stems from associating PLHIV with unethical behaviors, achieving the 95-95-95 ethical targets by 2030 requires global solidarity. These targets focus on reducing disparities, which can only be achieved through community-based interventions to address the social barriers perpetuating stigma (11).

**Governments must reform policies to center on human rights and moral norms to promote a culture against HIV stigma and discrimination.**

Governments must reform policies to center on human rights and moral norms to promote a culture against HIV stigma and discrimination. Establishing national and transnational advocacy networks is crucial for changing societal attitudes and pressuring governments to act (7). Prevention and control of HIV rely on fostering responsible behavior and supporting the rights of PLHIV.

Interventions to reduce stigma in healthcare settings should address both individual and societal factors. At the individual level, these include increasing HCPs' knowledge and improving their attitudes towards caring for PLHIV. At the societal level, this involves ensuring the availability of necessary information and equipment to maintain good precautionary measures (12).

A cross-sectional study in China suggested that culturally appropriate education about HIV and promoting hospital policies to protect PLHIV could reduce stigma among nurses (13). A systematic review of interventions in healthcare settings found that combining information-based approaches with other interventions-such as training "popular opinion leaders"-was effective in reducing stigma and promoting adherence to universal precautions (14). A study in eastern China also demonstrated that continuous training for market workers and disseminating HIV/STD prevention messages significantly reduced community-level stigmatizing attitudes towards PLHIV after one year (15).

In conclusion, Professional ethics education and training for HCPs and other professionals should be a cornerstone of efforts to change societal attitudes and promote the prohibition of HIV stigma and discrimination. Nurses and midwives, as frontline HCPs, play a vital role in facilitating community-based interventions. Utilizing HCPs to train communities and facilitate interventions can pave the way for policy reform and ensure the effective implementation of protective laws.

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