ASEAN
GOOD PRACTICES AND NEW INITIATIVES IN HIV AND AIDS

one vision
one identity
one community

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GOOD PRACTICES AND NEW INITIATIVES IN HIV AND AIDS

The ASEAN Secretariat
Jakarta

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FOREWORD

As we move towards an ASEAN Community 2015, we take into account the contribution of the ASEAN Health Sector in supporting this vision by ensuring that the ASEAN peoples are healthy and living in a community with accessible, affordable and quality health care and service. Thus, the current initiatives and partnerships in the ASEAN health cooperation are moving towards enhancing regional preparedness and capacity through integrated approaches to prevention, surveillance and timely response to communicable and emerging infectious diseases.

Included in this strategic objective are the initiatives in addressing HIV and AIDS concerns in ASEAN. According to the First ASEAN Regional Report on HIV and AIDS, launched at the 11th ASEAN Health Ministers Meeting in July 2012, there are more than 1.5 million ASEAN people estimated to be living with HIV and AIDS. As our 2015 ASEAN Community vision draws near, we re-evaluate the status of HIV epidemic in ASEAN and the progress of collective efforts in reversing this epidemic.

In 1993, after receiving mandate from the 4th ASEAN Summit in Singapore, the ASEAN Task Force on AIDS (ATFOA) was established. This is for the promotion of regional cooperation and partnership in combating HIV and AIDS by strengthening regional response capability as well as providing a platform for cooperation with other regional, international and civil society organizations. The current regional priority efforts on HIV and AIDS of ATFOA are reflected in the implementation of the 4th ASEAN Work Programme on AIDS for 2011-2015 and the localization of the ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths adopted by the 19th ASEAN Summit in November 2011.

The ATFOA has collectively agreed to document practices and evidence-based programmes and activities in HIV and AIDS in ASEAN in line with their Work Programme and the 2011 HIV and AIDS declaration. ASEAN Good Practices and New Initiatives in HIV and AIDS highlights the initiatives in ASEAN Members States in achieving Zero New HIV Infections, Zero Discrimination, and Zero AIDS-Related Deaths.

The critical need to sustain and scale up activities in addressing the multi-factorial concerns on HIV and AIDS necessitates documenting and sharing of good practices and new initiatives of ASEAN Member States to other stakeholders. Hopefully, this publication will inspire other health and non-health sector-stakeholders in continuing and enhancing the fight against HIV and AIDS.

Le Luong Minh
Secretary-General of ASEAN

INTRODUCTION

The Association of Southeast Asian Nations (ASEAN) response to HIV and AIDS initially emanated from the 4th ASEAN Summit Declaration held in Singapore in January 1992. Under the Singapore Declaration of 1992, ASEAN Leaders articulated that "ASEAN shall make a coordinated effort in curbing the spread of AIDS by exchanging information on AIDS, particularly in the formulation and implementation of policies and programmes against the deadly disease."

As a result of this initial recognition and commitment to curb the threat of HIV in the region by the ASEAN Leaders, the ASEAN Task Force on AIDS (ATFOA) was established the following year. ATFOA immediately began its task by developing and implementing the 1st ASEAN Work Programme on AIDS (AWP I) for 1995 to 2000. Included in this Work Programme were the initial regional activities that promoted regional cooperation in addressing HIV and AIDS and in strengthening the regional response in the ASEAN. The current initiatives of ATFOA are based on the 4th ASEAN Work Programme on AIDS (AWP IV) that is being implemented from 2011 to 2015. This current Work Programme complements the regional and global response in "Getting to Zeros".

Overview of the Situation

According to the First ASEAN Regional Report on HIV and AIDS in 2011, "Addressing AIDS in ASEAN Region", there are 1.5 million people estimated to be living with HIV distributed amongst the ASEAN Member States (AMS). The national HIV prevalence rates in the region range from 0.1 per cent to 0.7 per cent. Although prevalence rates are decreasing, current estimates indicate that there are some AMS that are showing an increasing trend.

The key risk behaviours that drive the HIV epidemic in the region are unprotected sex with multiple partners and needle sharing in injecting drug use. Seventy-five per cent of all HIV infections in ASEAN are reported among key populations (KPs) of sex workers, men who have sex with men, transgender, and people who inject drugs. Other vulnerable populations include the intimate partners of KPs, youths, and mobile populations.

Response to HIV and AIDS

The establishment of ATFOA in 1993 has provided the mechanism to operationalise the initial commitment made by the ASEAN Leaders during the 4th ASEAN Summit in 1992. ATFOA is one of the health subsidiary bodies of the ASEAN Health Cooperation, composed of the officially-designated focal points from each AMS. They are supervised for strategic direction by the official focal points to the Senior Officials Meeting on Health Development (SOMHD) and for further policy support by the highest sectoral body in the ASEAN Health Cooperation, the ASEAN Health Ministers Meeting (AHMM).

From AWP I to AWP IV, spanning the implementation period of 1995 to 2015, ATFOA has engaged various stakeholders at the national and regional levels in advocating for leadership

in intensifying country response, facilitating appropriate and timely multi-sectoral response, advocating for regional policies that are supported by political leaders, and enhancing regional cooperation for resource generation and for monitoring and evaluation. These four multi-year ASEAN Work Programmes have been implemented by ATFOA through cost-sharing mechanisms, support from development and dialogue partners, and the use of formal instruments of cooperation.

While AMS continue to address HIV and AIDS at the national and community levels, ASEAN, through ATFOA and other relevant sectoral bodies, are providing the necessary platforms for regional activities that can collectively address common gaps and needs under its Work Programme.

ASEAN Regional Priorities on HIV and AIDS

Based on the first regional report and other documents and position papers relevant to ATFOA, the following issues have been found to be priorities in ASEAN:

- Achieving Universal Access targets for prevention, care, and treatment focused on KPs and to address the underlying factors that limit effective response
- Cross-border migration concerns
- Early detection, antenatal screening, and the prevention of parent-to-child transmission of HIV
- Supporting and strengthening the role of civil society and to promote collaborative and synergistic partnerships with relevant partners across the region
- Funding and resource mobilisation
- Knowledge-sharing
- Improving leadership and governance towards creating an enabling environment
- Generating and utilising strategic information and addressing data gaps

ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, and Zero AIDS-Related Deaths

To further foster the political commitments on HIV and AIDS, ATFOA spearheaded the development of the ASEAN Declaration of Commitment. The development process started with the establishment of the ASEAN Core Group tasked with drafting the Declaration. It was followed by the ATFOA Expanded Consultation on the Draft ASEAN Declaration of Commitment. The consultation process included development partners and regional civil society organisations (CSOs). The document was endorsed during the 6th Senior Officials Meeting on Health Development in July 2011 and, subsequently, by the ASEAN Health Ministers through a referendum in October 2011. The ASEAN Leaders adopted the Declaration during the 19th ASEAN Summit in Bali, Indonesia in November 2011.

The Declaration stated the ASEAN commitments to be realised by 2015:

- Reducing sexual transmission of HIV by 50 percent

- Reducing transmission of HIV among people who inject drugs by 50 percent
- Scaling up antiretroviral therapy, care, and support to achieve 80 percent coverage
- Eliminating new HIV infections among children and substantially reducing AIDS-related maternal deaths
- Reducing by 50 percent tuberculosis deaths among people living with HIV and AIDS

To operationalise the Declaration, ATFOA proposed and got approval for a number of key initiatives that support the Declaration strategies, including the following:

- ASEAN Cities Getting to Zeros
- South-South collaboration, especially ASEAN-ASEAN sharing of expertise levels
- Sustained engagement with regional non-governmental organisations and CSOs, networks of KPs, and national/local partners
- Documentation of good practices, innovations, and other cross-cutting themes in HIV and AIDS

The last, documentation of good practices, innovations, and other cross-cutting themes in HIV and AIDS, became the basis of this publication.

LIST OF ACRONYMS

3MDG	Three Millennium Development Goal Fund
100% CUP	100 per cent Condom Use Programme
Albion	The Albion Centre
AusAID	The Australian Agency for International Development
ACG2Z RAS	ASEAN Cities Getting to Zero Rapid Assessment Survey
ADB	Asian Development Bank
AfA	Action for AIDS
AIDS	Acquired Immunodeficiency Syndrome
AMS	ASEAN Member States
ANC	Antenatal Care
APBD	Mean of allocated domestic funds
APLHIV	Lao PDR Association of People Living with HIV
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASEAN	Association of Southeast Asian Nations
ATFOA	ASEAN Task Force on AIDS
ATS	Anonymous Test Site
AWPI	First ASEAN Work Programme on AIDS
AWPIV	Fourth ASEAN Work Programme on AIDS
AZP	AIDS Zero Portal
AZT	Azidothymidine
BATS	Bureau of AIDS, TB and STIs
BCC	behaviour change communication
BDB	Breaking Down Barriers
CBO	Community-Based Organisation
CCDAC	Central Committee for Drug Abuse Control
CCM	Country Coordinating Mechanism
CD4	Cluster of differentiation 4
CDC	Centers for Disease Control and Prevention
CES4PHR	Community Engagement Support for the Philippine HIV Response
CHAS	Centre for HIV/AIDS and STI
CHO	City Health Officer
CHS	Commune Health Station
CM	Case Manager
CoC	Continuum of Care
CoPCT	Continuum of Prevention to Care and Treatment
CPS	Comprehensive Package of Services
CSO	Civil Society Organisation
CSS	Client Satisfaction Survey
CT	Consulting and testing site
DBF	Dreaming of a Brighter Future
DHO	District Health Office
DIC	Drop-In Centre
DILG	Department of Interior and Local Government
DMS	Department of Medical Services

DOH	Department of Health
DOH-CHD NCR	DOH-Center of Health Development for NCR
DSWD	Department of Social Welfare and Development
EE	Entertainment Establishment
EEO	Entertainment Establishment Owner
EID	Early Infant Diagnosis
EMPOWER	Education Means Protection of Women Engaged in Recreation
eMTCT	Elimination of MCTC
EW	Entertainment Worker
FDC	Fix-Dosed Combination
FGD	Focus Group Discussion
FP	Family Planning
FSW	Female Sex Worker
Globe	Globe Telecom
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	General Practitioner
GWL	gay, waria (transgender), laki-laki seks dengan laki-laki (MSM)
GWL INA	National Network of Gay, Transgender, and MSM Indonesia
HAARP	HIV/AIDS Asia Regional Programme
HAART	Highly-Active Antiretroviral Therapy
HCPI	HIV and AIDS Cooperation Programme for Indonesia
HIV	Human Immunodeficiency Virus Infection
HIV-NAT	HIV Netherlands Australia Thailand Research Collaboration
HIVQUAL-T	HIV Quality Programme in Thailand
HPB	Health Promotion Board
HPSP	Hospital Peer Support Programme
HRP	Harm Reduction Programme
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioural Surveillance
IDA	Infectious Diseases Act
IDHS	Indonesia Demographic and Health Survey
IDR	Indonesian Rupiah
IEC	Information, Education, and Communication
i-RAR	Information Risk self-assessment and referral
IVR	Interactive voice response
JAKIM	Jabatan Kemajuan Islam Malaysia
KHANA	Khmer HIV/AIDS NGO Alliance
KP	Key Population
KPAN	Indonesia National AIDS Commission
Lao-TACHIN	Lao-Thai-Australian Collaboration in HIV Nutrition
LCP	League of Cities of the Philippines
LGA	Local Government Academy
LGU	Local Government Unit
LPV/r	Lopinavir/Ritonavir
LSL	Laki-laki seks dengan laki-laki/MSM

LTTA	"Love Them. Talk About Sex."
M&E	Monitoring and Evaluation
MAC	Malaysian AIDS Council
MAIS	Selangor Islamic Religious Council
MCC	Maternal and Childcare
MCH	Maternal and Child health
MDG	Millennium Development Goal
MJHR	Ministry of Justice and Human Rights
MMM	Mondul Mith Chuoy Mith/Centre for Friend Helping Friends
mmm	MMM for Children
MMT	Methadone Maintenance Treatment
MNCH	Maternal, Newborn, and Child Health
MOE	Ministry of Education
MOH	Ministry of Health
MOPH	Ministry of Public Health
MPG	Myanmar Positive Group
MPWN	Myanmar Positive Women's Network
MPWT	Ministry of Public Works and Transport
MRP	Malaysian Royal Police
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
MW	Migrant worker
NAC	National AIDS Commission
NADA	National Anti-Drug Agency
NAP	National AIDS Programme
NAR	National AIDS Registry
NAR	National AIDS Response
NCCA	National Committee for the Control of AIDS
NCHADS	National Centre for HIV/AIDS, Dermatology and STD Control
NCR	National Capital Region
NDHS	National Demographic Health Survey
NEC	National Epidemiology Center
NGO	Non-governmental organisation
NHSO	National Health Security Office
NSAP	National Strategic Action Plan
NSEP	Needle and Syringe Exchange Programme
NSP	National Strategy Plan
NTFHR	National Task Force on Harm Reduction
OFW	Overseas Filipino Worker
OI	Opportunistic infection
OST	Opiate Substitution Therapy
PCCA	Provincial Committee for the Control of AIDS
PCR	Polymerase chain reaction
PE	Peer Educator
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHAMIT	Prevention Of HIV/AIDS among Migrant Workers In Thailand
PHANSUP	Philippine NGO Support Program
PITC	Provider-Initiated Testing and Counselling

PLHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PNAC	Philippine National AIDS Council
POC	Point of Care
PPTCT	Parent-to-child transmission
PSA	Public Service Announcement
PWID	People who inject Drugs
PWT	Project Working Team
PWUD	People who Use Drugs
QI	Quality improvement
QM	Quality management
RAATs	Regional AIDS Assistance Team
RAS	Rapid Assessment Survey
RRCSP	Red Ribbon Celebrity Support Programme
sd-NVP	Single dose of nevirapine
SHC	Social Hygiene Clinic
SHG	Self-help group
SHO	State Health Office
SMS	Short-Messaging Service
SNEF	Singapore National Employers Federation
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex worker
TACHIN	Thai-Australian Collaboration in HIV Nutrition
TB	Tuberculosis
TCSP	Treatment, Care, and Support Programme
TDF + 3TC + EFV	Tenofovir DF + Lamivudine + Efavirenz
TG	Transgender
TPMC	Township Project Management Committee
TRC-ARC	Thai Red Cross AIDS Research Centre
TUC	Thailand Ministry of Public Health-United States Centers for Disease Control and Prevention Collaboration
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
USAID	United States Agency for International Development
US CDC	United States Centers for Disease Control and Prevention
VCT	Voluntary Counselling and Testing
VND	Vietnamese Dong
WHO	World Health Organization
WIDE	Workplace Infectious Disease Education Programme
YKP	Young key population
ZDV	Zidovudine

COUNTRY BRIEFS

Brunei Darussalam Country Brief

Overview

- Population: 399,800[1]
- Capital City: Bandar Seri Begawan
- Official Language: Malay
- Religions: Islam (67 per cent), Buddhism (13 per cent), Christianity (10 per cent), Other (10 per cent)
- Location: Borders the South China Sea and Malaysia

Profile of the HIV and AIDS Epidemic

- Since the first local case of HIV was recorded in 1986, Brunei Darussalam has recorded a cumulative number of 81 local cases until the end of 2012. Of the 81 cases, 44 new cases were reported between 2008 and 2012.[2]
- Between 2008 to 2012, women accounted for 11 out of the total 44 new HIV cases, representing 25 per cent of new HIV cases within that period.
- Five out of nine newly reported cases of HIV in 2012 were reported as transgenders.

Modes of Transmission

- Heterosexual transmission accounts for the majority of HIV cases reported in Brunei Darussalam.[3]
- Transmission between men having sex with men was the second most common mode of transmission, accounting for a third of new cases between 2008 and 2012.[2]
- Of all cases recorded between 2010 and 2011, there was no known transmission through injecting drug use.[3]
- Brunei Darussalam conducts antenatal screening for HIV of all pregnant women presenting themselves for antenatal care (ANC). In 2011, Brunei Darussalam recorded its only case of mother-to-child transmission (MTCT) since 1995. The pregnant mother only presented herself for ANC during labour.[3]

Access to Information

- A policy on sex education has yet to be included in the curriculum, although the Ministry of Education is considering the introduction of life-skills based education.[3]
- The Brunei Darussalam AIDS Council, the sole non-governmental organisation looking at HIV issues in the country, in collaboration with the government, has made considerable efforts in increasing awareness on HIV, particularly among the youth, through its peer education programmes.[3]
- Standard Chartered Bank is also active in creating awareness on HIV in the corporate sector.[3]

Access to Services

- The government provides free and comprehensive health care to all citizens and permanent residents of Brunei Darussalam. This includes all aspects of prevention, care, treatment, and support for HIV although there is no separate budget allocated for HIV and AIDS specifically. Healthcare services for migrants and overseas workers are also provided by the government but on a chargeable basis. In addition to government hospitals and health centres, several private health clinics and a private hospital also cater to the health needs of the general population.
- First-line antiretrovirals are readily provided to citizens and permanent residents. Although available, second- and third-line have to be applied for on an individual basis.[3]
- Seventeen adults and children with advanced HIV infection received antiretroviral therapy in 2010.[4]
- Dried Blood Spot technology is available for prevention of MTCT and paediatric HIV care.[3]

Legal and Policy Environment

- Laws, regulations, and policies exist that present obstacles to effective HIV prevention, care, treatment, and support for female sex workers, female drug users, and female migrant workers.[3]
- HIV tests are not required for short-term visits, but persons who wish to work or study in Brunei Darussalam must undergo a health examination that may include a mandatory HIV test in their country of origin and again within two weeks after arrival. A positive HIV result may lead to the cancellation of a foreign worker's work permit. However, the government provides appropriate post-test counselling to foreign workers who test positive for HIV including instructions to access health services upon return to their home country. Workers who do not speak English or Malay are provided with a translator from their embassy.[2]
- Under the Infectious Disease Act (2010), it is compulsory for all clinicians to report any positive cases to the Department of Health Services. The Infectious Disease Act also specifically protects the confidentiality of all persons who are diagnosed with HIV.[4]
- The Infectious Disease Act (2010) allows for the prosecution of deliberate exposure and transmission of HIV by known HIV-positive persons.[5]
- Sex work is illegal in Brunei Darussalam.
- The law does not criminalise spousal rape; it explicitly states that sexual intercourse by a man with his wife is not rape, as long as she is not under age 13. The legal age of marriage is 14. Protections against sexual assault by a spouse are provided under the amended Islamic Family Law Order 2010 and Married Women Act Order 2010, and the penalty for breaching a protection order is a fine or imprisonment not exceeding six months. There is no specific domestic violence law, but arrests were made in domestic violence cases under the Women and Girls Protection Act 1972.[6]

Cambodia Country Brief

Overview

- Population: 14,952,000 (est.)[1]
- Capital City: Phnom Penh
- Government: Constitutional Monarchy
- Official Language: Khmer
- Religions: Buddhism (official) (96.4 per cent), Islam (2.1 per cent), Other (1.3 per cent), Unspecified (0.2 per cent)[2]
- Location: Shares borders with Lao PDR (north), Thailand (west) and Viet Nam (east); Gulf of Thailand is at west and south

Profile of the HIV and AIDS Epidemic

- Number of people living with HIV: 83,000[3]
- Number of adults aged 15 and up living with HIV: 75,000[3]
- HIV prevalence rate among adults aged 15 to 49: 0.7 per cent[3]
- Percentage of total adults living with HIV who are women: 54 per cent[3]
- Estimated number of women living with HIV (aged 15+): 41,000[4]

Key Populations

- **Men who have sex with men (MSM):** The MSM population in Cambodia is at an elevated risk of infection. A 2010 study showed the rate of infection among all MSM at 2.1 per cent among men who have sex only with other men and a slightly higher 2.2 per cent among men who have sex with both men and women.[5]
- **Entertainment workers (EWs):** Data from a 2010 study showed that venue-based EWs averaging more than seven clients per week had 13.9 per cent HIV prevalence rate, down from the 2006 rate of 14.7 per cent. EWs with seven clients or less per week had HIV prevalence of only 4.1 per cent.[5]
- **People who inject drugs (PWID):** Most recent data collected in 2007 showed that 24 per cent of PWID were living with HIV.[5]

Modes of Transmission

- Cambodia's epidemic has been attributed primarily to heterosexual transmission among high-risk groups, particularly female sex workers (FSWs), their clients, and the other sexual partners of clients. As the epidemic has matured, the proportion of women among people living with HIV and AIDS has increased.[6]
- In a 2010 survey of 2,623 respondents, 98 per cent of women who cited sexual transmission of HIV as their source of infection reported that they contracted the virus from their spouse or long-term partner.[7]

- Many MSM do not regard themselves as homosexuals and many also have sex with women. Data from a 2010 study indicated the rate of HIV infection among all MSM as 2.1 per cent among exclusive MSM and a slightly higher rate of 2.2 per cent among men who have sex with both men and women.[8]
- A 2007 study among 500 drug users in 4 provinces found that females accounted for 10.1 per cent of PWID. The majority of them were young women aged 18 to 25.[9]
- In 2010, just under half (49.5 per cent) of eligible women received antiretroviral therapy for prevention of mother-to-child transmission (PMTCT) and coverage increased to 63.5 per cent in 2011, the peak of a nine-year trend in increasing coverage.[10]

Access to Information

- HIV clinicians are mostly male so it is difficult for women to openly share their concerns. Counsellors are trained to provide information on care and treatment of HIV and AIDS, not on sexual and reproductive health, so there is a gap in the information provided to women, especially those who are living with HIV and AIDS.[11]
- In a survey conducted amongst most-at-risk young people aged between 10 to 24 years, almost 32 per cent of the sexually active females surveyed had never received a condom and 37 per cent had not received HIV and AIDS information in the preceding three months.[1]
- Among females surveyed, the age group most likely to report having taken an HIV test and who know the result were women aged between 20 to 24 years at 13.3 per cent, an increase from 5.4 per cent in 2005.[10]

Access to Services

- Strong linkages and integration of HIV into health systems are being promoted, especially through the "linked response" approach that seeks to integrate PMTCT with maternal and newborn health and with sexual, reproductive, and family planning services.[10]
- However, key affected young people report little knowledge of the services available and a reluctance to use public clinics. The main barriers to using health services were reported as shyness, concern for confidentiality, non-same sex health providers, long waiting times, and transport or service fees.[12]
- In practice, there are multiple social, practical, and economic barriers to girls and young women accessing HIV-related services, including:
  - Judgmental attitudes of family members, community members, and health workers
  - Stigma associated with sex and HIV and AIDS
  - Inadequate youth-friendly services especially for young key populations including those under 18 years
  - Legal and policy barriers
  - Distance to services
  - Unsuitable opening hours and long waiting times
  - Double costs for fees and transport
  - Traditional gender norms and roles

  Many of these barriers particularly affect girls and young women who are poor and/or live in rural areas.[13]

- While the "100% Condom Use Programme" in brothels has proven successful in the past, with the closure of brothels in 2008 as a result of the Law on Suppression of Human Trafficking and Sexual Exploitation, it has become more difficult to reach out to FSWs at risk of HIV infection because they are now conducting their work in various entertainment establishments and on the street.[6]
- Despite progressive national legislation against HIV-related discrimination, many Cambodian women still experience extreme levels of stigma, discrimination, and violations of their rights in relation to their reproductive and maternal health. Attitudes of health care workers result in some HIV-positive women avoiding health care during pregnancy because of the fear of discrimination, subsequently missing out on appropriate antenatal care and PMTCT services.[11]
- A study among 397 people living with HIV reported that 79 per cent of respondents had been advised by health staff not to have any children. Among those surveyed in the last 12 months, 14.3 per cent of pregnant respondents had been advised to terminate their pregnancy.[14]
- A 2011 study by the Cambodian Community of Women Living with HIV among 200 HIV-positive women reported that:
    - Because of their HIV status, 35 per cent of the women had been encouraged to consider sterilisation, usually by a gynecologist or HIV clinician, and in some instances, members of home-based care teams; 50 per cent of these women said they did not feel they were given an option to decline.
    - Due to their HIV-positive status, 55 per cent of the women had difficulty finding a gynecologist to care for them. Many women said they wanted advice about sexual and reproductive health but did not know where to find it.
    - Only 42 per cent of women reported that they could access HIV, reproductive, maternal, and childcare services at the same government facility. Several women complained that, for a single antenatal visit, they were required to travel to different locations with referral slips for ultrasound and laboratory testing, often consuming an entire day and adding to transport costs, making it too expensive for many poor and rural women.
    - The biggest challenges to health care access identified by respondents were the cost of doctors' fees and transport expenses every month. Most women said if health services were integrated they would utilise them more regularly. Many women also expressed frustration with the quality of paediatric care, including inconsistent information about antiretroviral prophylaxis among infants.[11]
- The same 2011 study also highlighted the importance of having HIV-positive women deliver peer support services and their pivotal role in raising awareness about women's sexual and reproductive health and rights and providing information about HIV and AIDS within healthcare and community settings.[11]

Legal and Policy Environment

- The revised Drug Control Law has enshrined harm reduction approaches but at the same time has increased periods of incarceration for minor drug offences. In addition, the inconsistent implementation of the Commune Safety Policy continues to interrupt access and use of HIV services among key affected women, including female PWID and FSWs.[10]

- The 2008 Law on the Suppression of Human Trafficking and Sexual Exploitation criminalised procurement of commercial sex, public soliciting for commercial sex, and many forms of financial transactions connected to sex work. The law has been criticised for conflating sex work and trafficking and for improper implementation leading to illegal detentions and physical abuses. Furthermore, the law has resulted in the closure of brothels and an increase in the number of women selling sex in entertainment establishments, such as beer gardens, karaoke bars, and massage parlours. These women are much more difficult to reach with HIV prevention interventions such as condoms, HIV and STI information, as well as health service referrals.[6, 15]

Indonesia Country Brief

Overview

- Population: 237,641,326[1]
- Capital City: Jakarta
- Government: Presidential System, Constitutional Republic
- Official Language: Indonesian
- Religions: Islam (87.1 per cent), Christianity (9.87 per cent), Hinduism (1.69 per cent), Buddhism (0.72 per cent)[1]
- Location: Southeast Asia, lying between the Indian Ocean and the Pacific Ocean. To the north are the Philippines and Malaysia, with which it shares a border in Borneo. To the east is Papua New Guinea. Down south is Australia. To the west is the Indian Ocean.

Profile of the HIV and AIDS Epidemic

- Estimated HIV prevalence among adults (aged 15+): 0.41 per cent[2]
- Percentage of total adults living with HIV who are women: 39 per cent[2]
- Estimated number of women living with HIV (aged 15+): 241,941[2]
- Estimated number of Key Populations:
  - People who inject drugs (PWID): 74,326[2]
  - Direct sex workers (SWs): 124,996[2]
  - Indirect SWs: 104,860[2]
  - Men who have sex with men (MSM): 1,095,970[2]

Key Populations

- **Female sex workers (FSWs)**: Between 3.6 per cent to 25 per cent of direct FSWs and 0.4 per cent to 8.8 per cent of indirect FSWs were infected with HIV, depending upon the province. (Direct FSWs are those whose primary occupation is selling sex. Indirect FSWs are those who have other occupations, but are also selling sex, such as masseuses, waitresses, etc.)[3]
- **PWID** are concentrated in the Greater Jakarta area, East Java, West Java, North Sumatra, and South Sulawesi. PWID were estimated in 2012 at 74,326, with about 40 per cent of them infected with HIV. The prevalence of HIV among PWID was 25 per cent to 56 per cent in cities in which biological data were collected.[3]
- **MSM and Transgenders (TGs)**: MSM population was estimated nationwide in 2012 at 1,095,970. The 2009 country-wide HIV prevalence estimate for MSM and TGs was 5.23 per cent, 23.7 times higher than the national prevalence of 0.27 per cent.[4]

Modes of Transmission

- Unprotected sex particularly among people with a high number of partners has become the dominant mode of transmission of HIV infection. Relatively high HIV prevalence has been reported in the 2011 Integrated Biological and Behavioural Surveillance Survey,

especially among transgender sex workers (SWs) (43 per cent), male SWs (34 per cent), and FSWs (10 per cent).[5]

- In the last 4 years, there has been a noticeable shift in the predominant mode of infection among reported AIDS cases (cumulative) from 2,873 (2007) to 29,879 (2011). Unsafe injecting is no longer the dominant mode of infection. While in 2007 49.8 per cent of new reported AIDS cases were drug-related and 41.8 per cent were the result of heterosexual transmission, by 2011 that situation had changed with only 18.7 per cent of the new total reported cases associated with drug injecting, and 71 per cent were the result of heterosexual infection.[5]
- The number of pregnant women in 2011 was estimated at more than 5,136,041, with 0.8 per cent (42,372) of them having been tested for HIV and received the results. Of these women, 3.1 per cent (1,339) were HIV-positive. Also in 2012, it was estimated that only 21.6 per cent of HIV-positive pregnant women received antiretroviral prophylaxis to reduce the risk of mother-to-child transmission.[5]

Access to Information

- Sexuality education within schools is influenced by social norms. Rather than giving attention to the promotion of understanding and practice of safe sex, the primary concern of sexuality education in Indonesia is to delay sexual debut and promote fidelity within marriage. Sexuality is approached as a science and moral subject while the social context and issues of gender equity related to sexual practices are either left out altogether or given very minor attention in some schools.[6]
- Data from the 2007 Indonesia Young Adult Reproductive Health Survey reported that only 14.3 per cent of young people aged 15 to 24 had comprehensive knowledge about HIV and AIDS.[6]
- The 2007 Indonesia Demographic and Health Survey (IDHS) reported that 9.5 per cent of ever married women and 14.7 per cent of currently married men aged 15 to 24 had comprehensive knowledge about HIV.[7]
- Data show FSWs having a lower understanding about HIV prevention than male SWs and the lack of gender-sensitive services might be one of the explanations. Among FSWs, 37 per cent reported knowing where to get an HIV test and 38 per cent received a condom in the preceding three months.[7]
- In general, female PWID are more knowledgeable about HIV and AIDS than FSWs. Moreover, PWID tend to have more networks and are better organised. There are more programmes for PWID compared to other vulnerable populations and they are more likely to be exposed to HIV education messages.[7]
- Women who are likely to visit antenatal care (ANC) clinics on their own have generally not thought about having an HIV test prior to being offered the opportunity as part of their ANC. Most of these women have not talked with their partners prior to having an HIV test.[7]

Access to Services

- A continuing challenge is the promotion of couples' counselling and community-based initiatives to assist women prior to, during, and post HIV disclosure in addressing negative outcomes should they occur. Without such initiatives, the antiretroviral therapy rate among (pregnant) women may remain low.[7]

- Support to key affected women and girls is still limited through community health insurance (Jamkesmas) and local health insurance (Jamkesda) and is not accessible to all key populations, including FSWs and female PWID.[6]
- Sharing contaminated injecting equipment and the possibility of being involved in risky sexual practices make female PWID vulnerable to HIV. Family, outreach workers, and counsellors need to understand their psychological situation to be able to encourage female PWID to seek the best treatment available.
- Although the percentage of female PWID who received sterile injecting equipment is higher than their male counterpart (94 per cent compared to 88 per cent), in reality the number of male PWID exposed to harm reduction programmes was much greater than female PWID.[8]
- While the priority of the national response remains focused on efforts to work for and with people of key populations, the steadily increasing number of reported HIV-positive women has made scaling up of prevention of mother-to-child transmission (PMTCT) of HIV services a priority concern. By 2011, it was estimated that 14,194 pregnant women were HIV-positive in Indonesia.[9]
- There were 128 PMTCT service centers available in 31 provinces up to June 2013. However, comprehensive services (including HIV testing and counselling for pregnant women and provision of formula for infants) were available in all 33 provinces.[10]
- The 2007 IDHS showed low involvement of fathers during their partner's pregnancy, with only 32 per cent of fathers talking to health care providers about the pregnancy care and health of their partners during their partners' last pregnancy.[7]
- A 2010 study conducted among prople living with HIV and AIDS identified twice as many women as men who reported difficult access to healthcare facilities (20.83 per cent vs. 10.31 per cent) as the major reason for not accessing treatment. A higher number of women (23.6 per cent women against 16.03 per cent men) also cited fear of disclosure to their healthcare provider as a reason for not accessing treatment.[11]

Legal and Policy Environment

- The priority of the national response remains focused on efforts to work for and with key populations, including female PWID and FSWs, in order to prevent HIV from spreading into the general population.[7]
- Policymakers recognise that prevention efforts also need to be broadened to reach other people such as HIV-positive pregnant women, women who are intimate partners of men with high-risk behaviour, migrant workers, and young people at risk.[6]
- A multi-pronged national strategy has been formulated to guide the response to a range of HIV and AIDS issues related to women. There are five main elements:
    - Improving availability and quality of services for prevention, care, treatment, support, and impact mitigation for vulnerable women
    - Protecting the rights of women
    - Creating an enabling and conducive environment within family and community to protect women from infection with sexually transmitted infections (STIs) including HIV, thus reducing women's risk of becoming AIDS patients

    - Conducting gender-informed operational research related to STI and HIV and AIDS to identify new approaches in responding to the epidemic that will increase acceptability and effectiveness in addressing the specific problems of women at risk or infected with STIs and HIV
    - Involving men in the response to HIV and AIDS and specifically in the search for more gender-appropriate approaches for women and men[6]
- In some areas of Indonesia, addressing the risk of HIV transmission is being done through legal approaches rather than enhancing health services. Repressive methods are more common than protecting the rights of key affected women and girls.[6]
- Sex work per se is not illegal but due to the complexity and ambiguity of the laws, FSWs are marginalised and prone to discrimination from different agencies and through the divergent interpretation of the laws. For instance, crimes "against decency or morality" are enforced against FSWs.[12]
- The punitive nature of the 2009 Law on Narcotics does not support harm reduction services and special arrangements and negotiations with the local police are needed to enable needle and syringe programmes to be provided. More advocacy and better dissemination are needed in order to minimise violations of human rights and to ensure the protection and promotion of women's human rights, including those of female PWID.[6,12]
- There is a lack of gender-sensitive policies and programmes for female PWID and the female partners of PWID.[13]
- In addition to a specific law to protect women (Law No. 7/1984 on the Elimination of Violence against Women), Indonesia has a series of laws and government regulations to protect vulnerable groups. Unfortunately, not many key affected women and girls are familiar with these regulations.[6]
- Regulations to ensure the implementation of these anti-discriminatory laws include:
    - Regulation No. 2/2007 on harm reduction among PWID, issued by the Coordinating Minister for People's Welfare.
    - Chief of National Police Regulation No. 8/2009 on human rights approach in carrying out National Police tasks. Article No. 20 in this regulation particularly emphasises the special approach to women.
    - Government Regulation No.9/1999 on gender mainstreaming.[6]
- The Population and Family Development Law (No. 52/2009) and the Health Law (No. 36/2009) stipulate that only married women have access to family planning and contraception. Both adolescents and unmarried women are excluded from reproductive health services, thereby placing them at greater risk of unwanted pregnancies and STIs, including HIV.[14]
- Legislative frameworks that constrain women's rights to own economic assets increase the vulnerability of women to the economic impacts of HIV.[11]
- Services that provide access to justice for women and girls living with HIV and most-at-risk female population, whose behaviors are criminalised, are limited. There are a few isolated examples of services that provide targeted legal aid and community legal education for these population groups, such as the Community Legal Aid Institute.[12]

Lao PDR Country Brief

Overview

- Population: 6.586 Million (est.)[1]
- Capital City: Vientiane
- Government: People's Democratic Republic
- Official Language: Lao
- Religions: Buddhism (67 per cent), Christianity (1.5 per cent), Other (31.5 per cent)[2]
- Location: Landlocked, its boundaries shared with Myanmar (northwest), China (north), Viet Nam (east), Cambodia (south), and Thailand (west).

Profile of the HIV and AIDS Epidemic

- Number of people living with HIV: 10,000[3]
- Number of adults aged 15 and up living with HIV: 9,700[3]
- HIV prevalence rate among adults aged 15 to 49: 0.29 per cent[3]
- Percentage of total adults living with HIV who are women: 48 per cent[4]
- Estimated number of women living with HIV (aged 15+): 4,700[4]

Key Populations

- **Migrant workers (MWs):** The first wave of the epidemic in the 1990s started with the return of Lao MWs from neighbouring countries whose respective HIV epidemics were already far advanced. Case reports from 2003 to 2009 showed that there were more or less HIV-positive younger (age lower than 25) female migrants than male migrants but older (age higher than 25) male migrants tended to be more predominantly HIV-positive compared with female migrants.
- **Female sex workers (FSWs):** No hard data on the number of FSWs in the country but surveillance data since 2001 showed a steady increase in both sexually transmitted infections (STIs) and HIV prevalence among FSWs. The Integrated Biological and Behavioural Surveillance (IBBS) conducted in six provinces in 2008 and 2011 indicated that HIV prevalence is 0.43 per cent and 1 per cent, respectively, among FSWs in Lao PDR.
- **Men who have sex with men (MSM):** In 2011, MSM were estimated to be around 17,000, according to the National Strategic Action Plan (NSAP). In 2007, the first IBBS among MSM in Vientiane Capital detected a prevalence of 5.6 per cent. The other surveys conducted later were IBBS in Luang Prabang in 2009; "Mapping of Sexual and Social Networks of Men Who Have Sex with Both Men and Women in Vientiane Capital"[5] and "First Round HIV/STI Prevalence and Behavioural Tracking Survey among Transgender in Vientiane Capital and Savannakhet"[6], both in 2010. These surveys found a complex pattern of sexual behaviours in this population. High prevalence of HIV was also found among MSM and transgender in Vientiane Capital, 4.4 per cent, and in Savannakhet, 3.8 per cent, in 2010, but 0 per cent among MSM in Luang Prabang in 2009.

- **People who inject drugs (PWID):** Northern Lao PDR is in the golden triangle known for high production and trafficking of drugs to other countries. Bordering with Lao PDR to the north is Yunnan, China and to the northeast is Dien Bien, Viet Nam. Both of these neighbouring provinces are known to have high prevalence of PWID, as well as high prevalence of HIV among PWID: 50 per cent in Yunnan, China (2007) and 55 per cent in Dien Bien, Viet Nam (2009).[7] This condition has triggered the World Health Organization, Australia Agency For International Development, United Nations Office on Drugs and Crime, Centre for HIV/AIDS and STI (CHAS), and the Lao National Commission for Drugs Control and Supervision to conduct a rapid assessment on drug use and HIV situation in the two provinces of Houaphanh and Phongsaly in 2011. The finding was 1.5 per cent of people who use drugs (PWUD) who took unlinked anonymous HIV tests were found to be HIV positive.

Modes of Transmission

- The major mode of transmission is through heterosexual intercourse, 87 per cent.[8]
- According to the 2009 IBBS survey, among FSWs, consistent condom use in the preceding 3 months was only 48 per cent with regular partners and 49 per cent with casual partners.[9]
- An estimated 47 per cent of MSM who have multiple partners, with 33 per cent having had sex casually with both men and women in the last 3 months.[8]
- The 2008 and 2009 IBBS surveys reported that 1 per cent of sex workers (SWs) reported injecting drug use in the preceding 12 months.[10]
- The number of HIV-positive cases among pregnant women was 10 (0.33 per cent) for 2010 and 15 (0.48 per cent) in 2011.[10]
- Fifteen per cent of infants born to HIV-positive mothers were also infected with HIV.[8]
- Women who received antiretroviral therapy (ART) during pregnancy to reduce the risk of mother-to-child transmission represented between 8.5 per cent (27) and 14 per cent (49) of the total estimated number of HIV-positive women who were pregnant in 2010 and 2011, respectively.[10]

Access to Information

- HIV and AIDS awareness among women is not widespread. Among the population as a whole, only 70 per cent of women have heard of HIV and 46 per cent of women living in hard-to-reach rural areas have never heard of HIV and AIDS.[11]
- Little is understood about the social (or other) structures through which women receive sensitive information, including information about sex.[12]
- Among women who have heard of HIV and AIDS, knowledge that HIV can be transmitted from mother to child is just 19 per cent.[11]
- Efforts have been made to deliver HIV and reproductive health information not only to pregnant women but also to their husbands. In 2008, 50 per cent (17,000) of all pregnant women attending antenatal care (ANC) clinics in the 6 priority provinces and 2,500 of their husbands were recipients of HIV outreach activities from ANC and maternal child health facilities.[8]
- Conservative views about sexuality make it difficult for young people to access sexual health information and services.[13]

- In the 2009 surveillance survey, 46 per cent of FSWs reported that they received their HIV and STI prevention information from peers.[8]
- In 2009, 74 per cent of schools provided life skills-based HIV education within the academic year.[8]

Access to Services

- Voluntary counselling and testing (VCT) services are available in all provincial hospitals, as well as in ART sites in district hospitals in Vientiane and Savannakhet. In total, there are 7 sites at central level, 40 sites at provincial level, 89 sites at district level, and 3 sites at health centres, with 10 drop-in centres providing VCT in 2011.[10]
- There are about 180,000 estimated pregnancies per year in the country but, although ANC coverage rates are increasing across the country, those most at risk of HIV are not accessing ANC services.[10]
- HIV counselling and testing of pregnant women appears low, reflecting low access to ANC services in general (28.5 per cent) and the low-risk profile of most ANC clients. Most pregnant women at higher risk of HIV infection are not accessing ANC services and this reinforces the need for stronger programmatic linkages between interventions for women at higher risks and ANC promotion.[14, 10]
- Monitoring of prevention of mother-to-child transmission of HIV pilots in five target provinces between 2007 and 2008 showed that, as VCT was not provided at the point of ANC service, there were high rates of loss to follow up. Identification by ANC staff of pregnant women at higher risk of HIV has shown to be problematic without sufficient training in counselling and addressing stigma and discrimination.[10]
- FSWs who received HIV tests and know their results increased from 14 per cent (2009) to 22.2 per cent (2011). Since 2007, HIV testing of FSWs has almost doubled and the 100% Condom-use Programme has expanded to cover 15 provinces with a total of 7 drop-in centres for FSWs.[10]
- Sex workers and their clients are frequently stigmatised by health service providers and society in general causing them to fail to seek care, to practice self-treatment, or to seek care from less-skilled providers.[12]

Legal and Policy Environment

The National AIDS Response (NAR) in Lao PDR is led by National Committee for the Control of AIDS Bureau (NCCA). It is a multi-sectoral body chaired by the Minister of Health. NCCA brings together the expertise and commitment of senior representatives of twelve line ministries and mass organisations, plus recently proposed representatives of the National Assembly, the Lao Network of People Living with HIV, the Lao Chamber of Commerce and Industry, the Lao National Commission for Drug Control and Supervision, and the Buddhist Association.

- The Secretariat of NCCA, CHAS, is responsible for the implementation of the NAR and the coordination of the national and international partners within the framework of NSAP 2011 to 2015. NSAP is aligned with the 7th Health Sector Plan and the 7th National Socio-Economic Development Plan 2011 to 2015.[15]

- The NSAP on HIV/AIDS/STI Control and Prevention (2011 to 2015) states that "a gender analysis framework must be applied to all planning, service delivery, and research processes" and recognises that a more intensified gender-sensitive and gender-responsive strategy is required to guide the national response to HIV and AIDS in Lao PDR.[14, 8]
- Current policies and legislation could be strengthened to take into account gender-specific vulnerabilities and to protect the rights of key affected women and girls.[8]
- In Lao PDR, sex work is illegal and thus defining, identifying, and reaching out to women who sell sex for money poses a challenge.[8]
- Sex work, same-sex relations, and drug use remain criminalised and/or stigmatised, which makes it harder for people who are involved in them to access health services and health information.[14]
- The female partners of male clients of sex workers and female injecting drug users remain overlooked in the current HIV response.[12]
- In 2009, the National Framework of Maternal, Newborn and Child Heath (MNCH) Services 2009 to 2015 was launched. The National Framework of MNCH introduces a comprehensive package of MNCH services, including STI and HIV risk assessment, counselling, referral, and syphilis testing for all pregnant women attending ANC, among other elements.[10]
- In 2011, the Law on HIV/AIDS Control and Prevention was approved by the National Assembly and then promulgated by the President. The Law is progressive in terms of addressing stigma and discrimination, and promoting equity. The section of the Decree relating to the enforcement of the law and which will stipulate how the law should be implemented is still under consideration.[10]
- The Law on Protection of Women directs ministries and mass organisations to ensure that the position of women in Lao society is protected and enhanced.[8]

Malaysia Country Brief

Overview

- Population: 29.3 Million[1]
- Capital City: Kuala Lumpur
- Government: Constitutional Monarchy, Parliamentary System
- Official Language: Malaysian
- Religions: Islam (61.3 per cent), Buddhism (19.8 per cent), Christianity (9.2 per cent), Hinduism (6.3 per cent)[2]
- Location: Southeastern Asian peninsula bordering Thailand and one-third of the island of Borneo, bordering Indonesia, Brunei, and the South China Sea, south of Viet Nam

Profile of the HIV and AIDS Epidemic

- Estimated adult HIV prevalence: 0.43 per cent[3]
- Number of people living with HIV: 82,591[4]
- Estimated number of people living with HIV and AIDS (PLHA): 81,990[3]
- New HIV cases: 3,438 (6,978 in 2002)[4]
- Cumulative number of reported HIV infections since 1986: 98,279[4]
- Cumulative number of reported AIDS cases since 1986: 19,047[4]
- Cumulative number of reported deaths related to HIV and AIDS since 1986: 15,688[4]
- Number of PLHA on antiretroviral therapy: 15,084[4]

Key Populations

- **People who inject drugs (PWID)**: Accounted for 29.5 per cent of reported new HIV infections in 2012; HIV prevalence decreased from 22.1 per cent in 2009 to 18.9 per cent according to the Integrated Biological and Behavioural Surveillance (2012).[5]
- **Female sex workers (FSWs)**: Estimated 40,000, HIV prevalence decreased from 10.5 per cent in 2009 to 4.2 per cent in 2012.[5]
- **Men who have sex with men**: Representing about 3.1 per cent out of the total cumulative number of reported HIV infections since 1986, HIV prevalence rose from 3.9 per cent in 2009 to 12.6 per cent in 2012.[5]
- **Transgenders (TGs)**: HIV prevalence decreased from 9.3 per cent in 2009 to 5.7 per cent in 2012.[5]

Modes of Transmissions

- Sexual transmission has replaced injecting drug use as the main cause of HIV infection, from a ratio of one sexual transmission for every nine injecting drug use in 1990 to seven sexual transmission for every three injecting drug use in 2012. This is the result of rigorous harm reduction programmes for PWID incepted nationwide in 2006. However, the total number of new infections has declined.[6]
- The very few cases of vertical transmission are the result of vigorous implementation of prevention of mother-to-child transmission (PMTCT) programmes incepted nationwide in 1998.[6]

Access to Information

- The 2009 IBBS that focused on FSW, PWID, and TGs reported low levels of HIV-related knowledge among all three groups. Among those surveyed, only 38.6 per cent of sex workers, 37 per cent of TGs, and half of PWID (50 per cent) could correctly identify ways to prevent transmission of HIV.[6]
- Among young women and men aged 15 to 24 years, only 28.5 per cent could correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission.[6]

Access to Services

- The government is committed to providing affordable and accessible antiretroviral therapy to all those who need it.[6]
- The national PMTCT programme is available in government health facilities serving approximately 75 per cent of total antenatal mothers nationwide, as well as private sector referrals.[6]
- Since 2001, premarital HIV screening for Muslim couples has been made available in all government health centres, and to any couple who wants it irrespective of religious background. In 2012, 0.06 per cent of screened couples were confirmed as HIV-positive.[6]
- The number of HIV prevention programmes working with sex workers (SWs/MSM/TGs) has increased from 7 in 2010 to 17 in 2012, resulting in a 64 per cent increase in the number of SWs reached (from 2,889 in 2010 to 4,740 in 2012) through 159 outreach points.[6]
- There have been 605 Needle and Syringe Exchange Programmes (NSEP) sites and 715 Methadone Maintenance Therapy outlets established in government, private health, non-governmental organisation (NGO) health facilities or sites, National Anti-Drug Agency service outlets, and in prisons.[6]
- There is a small number of enrolment of harm reduction initiatives among women and girls who use drugs.[6]
- Less than 30 per cent of permanent partners of PWID with HIV go for HIV screening.[5]
- The Ministry of Health is the main funder for HIV activities by NGOs.
- Community-based organisations are also working in partnership with the Ministry of Women, Family and Community Development to provide essential support services (shelters, financial assistance for income-generating activities) for people, including women and girls living with HIV.[6]

Legal and Policy Environment

- The National Strategic Plan on HIV and AIDS 2011 to 2015 clearly indicates that people, including women and girls living with HIV, have the same right to health care, community support, and to participate, without prejudice or discrimination, in any socio-economic activity as other members of society.[6]
- The cornerstone of the government's HIV prevention strategy is still the Harm Reduction Programme, made up of the NSEP and the Opiate Substitution Therapy.[6]
- The government has moved from a repressive approach to one that integrates health imperatives. As a result, key agencies are shifting their programme objectives from compulsory abstinence to voluntary treatment options.
- The Ministry of Women, Family and Community Development has established and chairs the Taskforce on Women, Girls, and HIV and AIDS, which has designed awareness-raising programmes to empower women and girls.[6]

Myanmar Country Brief

Overview

- Population: 54.58 Million (est.)[1]
- Capital City: Nay Pyi Taw
- Government: Parliamentary System
- Official Language: Burmese
- Religions: Buddhism (89.4 per cent), Christianity (5.0 per cent), Islam (3.8 per cent)[2]
- Location: Bordered on the north and northeast by China, on the east and southeast by Laos and Thailand, on the south by the Andaman Sea and the Bay of Bengal, and on the west by Bangladesh and India

Profile of the HIV and AIDS Epidemic

- HIV prevalence among adults aged 14 to 49: 0.61 per cent[3]
- HIV prevalence in 2009: 34.6 per cent among people who inject drugs (PWID); 22.3 per cent among men who have sex with men (MSM); and 11.2 per cent among female sex workers (FSWs)[4]
- Percentage of total adults living with HIV who are women: 37 per cent[5]
- Estimated number of women living with HIV aged 15+: 77,000[5]

Key Populations

- **PWID:** estimated at 75,000, most of them male[6]
- **MSM and Transgender:** estimated at 224,000[6]
- **FSWs:** estimated at 60,000[6]
- **Clients of FSWs:** estimated at 880,000[6]

Modes of Transmission

- HIV prevalence among FSWs was estimated at 9.4 per cent, from 2011 surveillance data, showing a decline from 18.4 per cent in 2008.[7]
- HIV prevalence among PWID was estimated at 21.9 per cent, from 2011 surveillance data, showing a decline from 34 per cent in 2009.[7]
- HIV Sentinel Sero Surveillance data in 2011 showed that 13 per cent of infants born to HIV-positive mothers were infected with HIV.[7]

Access to Information

- Programmes for FSWs have greatly expanded in recent years. These prevention programmes operate through drop-in centres as well as outreach programmes and they provide access to information and services, including condoms, sexually transmitted infection screening, and HIV testing and counselling.[7]
- Other programmes target clients of sex workers through social marketing and some work in hotspots where behaviour change messages are provided.[7]

- MSM have started organising networks, based on the informal groups that already existed. This provides an opportunity to involve MSM in designing and implementing their own programmes.[7]

Access to Services

- By the end of 2011, antiretroviral therapy (ART) coverage was 43.8 per cent for all adults and children. Women and girls constituted 44 per cent of those receiving ART.[7]
- Voluntary and confidential testing for HIV continues to be low. Only a handful of non-governmental organisations can provide the full range of testing services. This is considered an important impediment to accessing testing services since many providers cannot give same day or same session results.[7]
- Despite increases in service availability and uptake in recent years, overall coverage is still low in terms of the proportion of the key populations reached by services.[7]
- Accessibility to and availability of condoms is not considered a major constraint by sex workers. The major barriers for consistent condom use are related to emotional bonds between sex worker and client, monetary incentives, and the perception of the client by the sex worker.[7]
- Harm reduction programmes have continued to extend their reach in 2010 but the expansion of harm reduction programmes is constrained by a number of factors, such as sites with known populations of PWID are not accessible and the methadone maintenance therapy only has a few distribution points.[7]
- Prevention of mother-to-child transmission services have reached a relatively large part of the country while the number of women choosing to access the services has risen continually. The services are constrained by a relatively low attendance to antenatal care services in rural areas and a considerable loss to follow-up before and after birth. However, enrolment of clinically eligible pregnant women in ART programmes has increased substantially.[7]
- The shortage of staff at all levels poses serious challenges to the scale-up of service delivery in the public health sector, including service delivery to women and girls. There is no policy that addresses this and the tradition of shifting non-specialised medical tasks to other health workers or to specifically trained lay persons (such as people living with HIV and AIDS) as of the present.[7]

Legal and Policy Environment

- Laws that criminalise behaviour of groups who are most at risk (sex workers, MSM, and PWID) remain in place. This may lead to incidents of harassment of key populations and may discourage effective and open interventions with these populations.[7]
- Sex work is illegal in Myanmar.
- Under the Narcotic Drugs and Psychotropic Substances Law (1993), while the possession of narcotic drugs is illegal, there is no specific offence stated for consumption. Drug users are mandated to register with a government-identified facility for treatment. Non-compliance with medical treatment can result in penal consequences, namely imprisonment from three to five years.
- The government recognised the role of injecting drug use in the spread of the HIV epidemic early on and has expressed explicit policy support for harm reduction in national policy documents. Reducing HIV-related risk, vulnerability, and impact among drug users was one of the main priorities within the National Strategic Plan on HIV/AIDS (2006 to 2010).

Philippines Country Brief

Overview

- Population: 92.34 Million[1]
- Capital City: Manila
- Government: Republic
- Official Languages: Filipino and English
- Religions: Catholic (82.9 per cent), Islam (5 per cent), Evangelical (2.8 per cent), Iglesia ni Kristo (2.3 per cent), Other Christian Religions (4.5 per cent)[2]
- Location: Southeastern Asia, archipelago between the Philippine Sea to the east and the South China Sea to the west, Viet Nam to the west, Malaysia and Indonesia to the south, and Taiwan to the north

Profile of the HIV and AIDS Epidemic

- National HIV prevalence remains under 0.1 per cent, although prevalence ranging from 4 to 7 per cent has been recorded in some areas of the country. The trend is steadily increasing exponentially.[3, 4, 5]
- HIV prevalence among all key populations is 1.97 per cent, broken down as follows: female sex workers (FSW) who are registered is 0.12 per cent while FSWs who are free lancers is 0.43 per cent, men who have sex with men (MSM) is 1.68 per cent, and people who inject drugs (PWID) is 13.57 per cent.[3, 4, 5]
- The total number of HIV cases from 1984 to 2013 September is 15,283, with 13,880 asymptomatic cases and 1,403 AIDS cases.[3, 4, 5]
- The number of women aged 15 and up living with HIV is 3,500.[6]
- New HIV infections during the first quarter of 2013 is 370 cases (96 per cent male).[7]
- One of the 9 countries that has shown an increase of more than 25 per cent in HIV infection among adults 15 to 49 years old, from 2001 to 2011.[8]

Key Populations

- **Men who have sex with men (MSM):** They are the predominant drivers of the HIV epidemic in recent years.[7] This was not the case when the epidemic started in 1984 but beginning in 2007, the heterosexual transmission began to be replaced by MSM transmission. This group also showed a dramatic spike in terms of HIV prevalence: from 0.30 per cent in 2007 to 1.68 per cent in 2011 or more than a five-fold increase.[4]
- **People who inject drugs (PWID):** For years, PWID have been confined primarily in Cebu City and HIV prevalence among them has been less than 1 per cent (0.40 per cent in 2007 and 0.59 per cent in 2009). In 2011, however, the prevalence of PWID in Cebu City dramatically increased to 53.16 per cent. Furthermore, other sites started to report HIV prevalence among PWID as well: Mandaue City (3.59 per cent) and Zamboanga City (0.33 per cent).[9]

- **Female sex workers (FSWs):** The population size of venue-based FSWs was estimated in 2009 at 70,167 and freelance FSWs at 89, 175. Of the 5,322 venue-based FSWs, 0.13 per cent (7) were found to be HIV-positive while of the 4,154 freelance FSWs, 0.39 per cent (16) were HIV-positive.[9]
- **Overseas Filipino workers (OFWs):** Since 1984, there have been 2,258 HIV-positive OFWs, comprising 18 per cent of all reported cases, 79 per cent of them being males. Sexual contact (97 per cent) was the predominant mode of transmission.[7]

Modes of Transmission

- Since 1984 when HIV started to be monitored, 93 per cent of the infections came from unprotected sexual contact. In the first quarter of 2013, 99 per cent of the cases were due to sexual transmission.[7]
- Of the 15,283 HIV-positive cases reported from 1984 to 2013, 93 per cent were infected through sexual contact and 4 per cent through needle sharing among PWID. There was transmission of less than 1 per cent through mother-to-child transmission and through blood transfusion and needle prick injury. No data is available for 2 per cent of the remaining cases. [3,4,5]

Access to Information

- Only 20 per cent of women aged 15 to 24 surveyed in the 2008 National Demographic and Health Survey (NDHS) were able to both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. Other studies indicate that women and girls living with HIV have no comprehensive awareness of their sexual and reproductive rights.[4]
- The Philippine AIDS Prevention and Control Act commits to the integration of HIV prevention into education at the intermediate, secondary, and tertiary levels, but also states that such teaching requires parental approval and must not be used to promote contraception. Some non-governmental organisations (NGOs) have generic programmes that provide youth-focused but broad strategies for HIV prevention like peer education. Life skills are emphasised but not the causes of vulnerability, such as gender inequality.[10]
- Due to lack of knowledge about the potential for cross infection, HIV-positive women whose partners were also positive avoid condom use.[11]
- The 2011 Integrated HIV and Behaviour Serologic Surveillance (IHBSS) reported that only 16 per cent of FSWs surveyed received an HIV test in the previous 12 months and knew their results, compared to 37 per cent of male sex workers.[4]
- Sixty-five per cent of sex workers used condoms, with male sex workers at 84 per cent and FSWs at 64 per cent. Thirty-six per cent of MSM used condoms as well as 15 per cent of PWID (male: 14 per cent, female 24 per cent).[3, 4, 5]
- HIV prevention programmes reached 63 per cent of sex workers, 79 per cent of which were male while 63 per cent were female. HIV prevention programmes also reached 23 per cent of MSM. There was no established programme specific to PWID.[3, 4, 5]
- The rate of sex workers who have been tested and know their results was 17 per cent, with males at 37 percent and females at 16 per cent. Five per cent of MSM and PWID, respectively, had been tested and know their results.[3, 4, 5]

Access to Services

- Young women and girls encounter barriers in accessing sexual and reproductive health and HIV prevention services: conservative religious or cultural norms that create social stigma for people living with HIV and AIDS (PLHA), dislike of females who are perceived as sexually aggressive in accessing condoms, young women and girls' activeness in sexual relations, and the high cost of condoms, HIV testing, etc.[12]
- Antiretroviral therapy (ART) is available and free of charge, but economically-deprived women living with HIV have reported difficulties in accessing ART and other HIV-related testing and treatment due to economic hardship. Commuting time and distance impose significant costs and these have prevented some women from being able to begin ART.[11]
- Social hygiene clinics (SHCs) serve as the principal means of the Philippine government to reach registered sex workers to monitor their health status, provide treatment for those infected with sexually transmitted infections (STIs), and deliver STI/HIV prevention programmes for them.[14]
- Findings from the 2009 IHBSS show that freelance FSWs generally suffer from poorer outcomes because of their exclusion from SHC services: they have lower condom use rates, lower attendance in any HIV information seminar, and lower awareness of HIV testing in the SHC.[14]
- The rate of registered FSWs 15 to 18 years who used a condom with their last client was 64.7 per cent, compared to 73.2 per cent for those over 24 years.[13]
- Despite official commitment to providing respectful and gender-sensitive services, there are reports of discriminatory treatment in hospitals. Women living with HIV report that the confidentiality of test results is not always followed and that there is no systematic provision for post-test counselling.[11]

Legal and Policy Environment

- The Philippine AIDS Prevention and Control Act of 1998, the national anchor for policies and programmes on HIV and AIDS, contains provisions on confidentiality, non-discrimination of persons living with HIV, prohibition of compulsory testing and partner disclosure, the full protection of the human rights and civil liberties of PLHA, including women and girls, and the need to address socio-economic conditions that increase the risk of HIV.[15]
- There is a lack of political response for HIV and AIDS at national and local levels. The national approach to sexual and reproductive health services is not clearly integrated with the response to HIV and AIDS.[15]
- Drug-use is often treated as a criminal act rather than a social or health issue. There is no legislation supporting harm reduction strategies for injecting drug users.[15]
- Sex work is illegal yet common in many areas.[15]

Singapore Country Brief

Overview

- Population: 5.40 Million (3.313 Million Singapore citizens)[1]
- Government: Parliamentary Republic
- Official Languages: English, Malay, Mandarin, and Tamil
- Religions: Buddhism (33.3 per cent), Islam (14.7 per cent), Taoism (10.9 per cent), Hinduism (5.1 per cent), Catholicism (7.05 per cent), Other Christian Religions (11.3 per cent), None (17.0 per cent)[2]
- Location: Island city state at the southern tip of the Malay Peninsula

Profile of the HIV and AIDS Epidemic

- Number of residents living with HIV: 4,193[3]
- HIV prevalence rate among adults aged 15 and up: 0.1 per cent[3]
- Adults aged 15 and up living with HIV: 4,178[3]
- Women aged 15 and up living with HIV: 414[3]

Key Populations

- **Men who have sex with men (MSM)[4]**
- **Men who buy sex from illegal sex workers (SWs)[4]**
- **Illegal SWs[4]** (street- and entertainment-based)
- **People who inject drugs**

Modes of Transmission

- The epidemic in Singapore is driven mainly by sexual transmission. Of the 469 cases reported in 2012, 457 cases acquired the infection through the sexual route, with heterosexual transmission accounting for 47 per cent of infections, homosexual transmission, 45 per cent, and bisexual transmission, 6 per cent. Intravenous drug use (two cases) accounted for 0.4 per cent of infections. Newly-diagnosed infections among heterosexuals declined in 2010 and 2011 compared to 2009, in contrast to increasing number of infections among MSM.
- Some 97 per cent of persons living with HIV in 2012 acquired HIV through sexual transmission.[5]
- About 41 per cent of the female cases of HIV diagnosed in 2012 were married.[5]
- About 99 per cent of female brothel-based SWs reported the use of a condom with their most recent client.[6]
- HIV prevalence among brothel-based SWs between 2010 and June 2011 was 0.0 per cent.[4]
- Vertical transmission is not a very significant factor in the spread of HIV in Singapore. Since the implementation of opt-out antenatal HIV screening, the uptake of antenatal HIV testing is almost 100 per cent in Singapore. Only two HIV-positive babies were born to HIV-positive mothers in Singapore between 2005 and 2012, out of a total of 90 HIV-

positive mothers detected through antenatal screening in that period. Both mothers of the two HIV-positive babies had sought pregnancy care late, and therefore were only diagnosed to be HIV-positive at a later stage of their pregnancy.

Access to Information

- HIV and AIDS prevention programmes for youths are largely focused on empowerment and education. A sexually transmitted infection (STI) and HIV education programme entitled "Eteens" (an updated version of the previous "Breaking Down Barriers" programme) has been implemented in all secondary schools. Based on a consistent prevention message of Abstinence, Be faithful and Condom-use, it aims to increase students' awareness of STIs and HIV, including the correct way to use condoms, as well as to inculcate life skills such as sexual negotiation and decision-making skills.[7]
- According to surveys conducted by the Health Promotion Board (HPB), knowledge of HIV prevention improved dramatically in recent years, from 36.6 per cent in 2007 to 66.6 per cent in 2010.[8]
- For vulnerable youths aged 15 to 24 who are at risk of engaging in unprotected sex or have had an unintended pregnancy, a targeted and gender-segregated programme, "Youth Matters!", was conceptualised and introduced in 2008. The programme sought to equip youths with life skills to make informed choices; increase the awareness of STI and HIV and unplanned pregnancy prevention; influence youths to adopt less permissive attitude towards casual sex; and encourage youths to practice abstinence/secondary virginity. Evaluation data collected in 2012 revealed that more youths had the confidence to say "no" to premarital sex and more had indicated the intention to put on condoms when having sex.
- Peer-led education is also a constant feature in HPB's education efforts. STOMPAIDS and Project Prodigy are just two initiatives that managed to draw in the interest of youths aged 17 to 23 to conceptualise and implement STI and HIV prevention programmes for their peers. For both initiatives, youths are expected to conceptualise and implement an STI and HIV education package for their peers.
- Research has revealed that parent-child communication on sexuality helps to mitigate negative effects of peer pressure to have pre-marital sex. With this in mind, "Love Them. Talk About Sex" (LTTAS) is a programme that aims to encourage and impart skills to parents with children aged 7 to 17 so that they are confident when speaking to their children about sexuality issues. The website www.parentstalksex.sg is dedicated to parents who wish to get more information on sexuality. Public campaigns such as television series and seminars are also carried out to augment LTTAS.

Access to Services

- Rapid testing: Rapid HIV testing is available in Singapore. Both finger prick and oral fluid-based kits are used. To date, staff from almost 400 primary care clinics have been trained to offer rapid testing for HIV.
- Anonymous testing: Anonymous testing is available for persons who are at risk of HIV infection but are reluctant to identify themselves to medical personnel. Currently there are seven anonymous test sites in Singapore and a van with testing equipment on board, which serves as a Mobile Test Site for anonymous HIV testing.

- Antenatal screening: Antenatal HIV screening has been a standard of care since December 2004. More than 99 per cent of pregnant women are screened for HIV in Singapore. The Ministry of Health (MOH) implemented voluntary opt-out HIV screening for all inpatients aged 21 years and above in 2008, as part of routine medical care. The programme has detected about 40 cases each year since its inception.
- Like all other patients, HIV and AIDS patients have access to subsidised inpatient and outpatient care. The cost of HIV medication in Singapore has decreased significantly in recent years, and people living with HIV and AIDS (PLHA) can use their Medisave[i] to pay for their HIV medications.
- Financial assistance is available to needy citizens who require HIV treatment (including HIV medications) through Medifund[ii] as well.

Legal and Policy Environment

- The National AIDS Control Programme comes under the central control of the MOH, with active involvement from other relevant government agencies and ministries as well as community groups. The Programme focuses on HIV education and prevention for the general population as well as key populations at higher risk, to reduce the pool of undiagnosed HIV-positive individuals and to provide care and support to PLHA. In September 2008, the MOH established the National Public Health Unit, responsible for maintaining and enhancing the National HIV Registry, carrying out contact tracing and partner notification for newly-diagnosed HIV patients, and conducting HIV-related public health research.[7]
- Article XII of Singapore's Constitution guarantees the equal protection of all people under the law, and therefore prevents discrimination based on gender, marital status, age, disability, or other such grounds including HIV status.[9]
- Under the Infectious Diseases Act (IDA), a person who knows that he has HIV and AIDS must refrain from engaging in sexual activity with another person unless he informs his partner of the risk of contracting HIV and AIDS and his partner voluntarily accepts the risk. The IDA was amended in 2008 to shift greater responsibility to individuals whose sexual behaviour places their spouses or partners at risk of contracting HIV and AIDS. A person who does not know that he has HIV and AIDS but who has reason to believe that he has been exposed to a significant risk of contracting HIV and AIDS must either a) inform his partner of the risk of contracting HIV and AIDS and his partner agrees to accept the risk, b) go for HIV testing to ascertain his status, or c) take reasonable precautions during sexual activity to ensure that he does not expose the other person to the risk of contracting HIV and AIDS.

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[i] *Medisave is a national medical savings scheme that helps individuals put aside part of their income to meet their future personal or immediate family's hospitalisation, day surgery and selected outpatient expenses. Under the scheme, every employee contributes 7 to 9.5 per cent of his monthly salary to his personal Medisave account. Savings can be withdrawn to pay the hospital bills of the account holder and his immediate family members.*

[ii] *Medifund is an endowment fund from the government to help needy Singaporeans who are unable to pay for their medical expenses despite Medisave and Medishield coverage.*

- No HIV test is required for short-term visitors. Those above the age of 15 years who seek long-term stay (six months or more) by applying for social visit passes, employment passes, long-term immigration passes and permanent residence, must have a medical examination, including HIV tests. Singapore's immigration law lists people living with HIV as "prohibited immigrants".[10]
- Commercial sex work is not an offence in Singapore. Public solicitation, living on the earnings of a sex worker, and maintaining a brothel are illegal. Commercial sex with a minor under the age of 18 (within or outside Singapore) are offences under Sections 376B and 376C of the Penal Code respectively.[11]
- Singapore has strict drug laws that incorporate treatment and rehabilitation options for people who use drugs.[10]

Thailand Country Brief

Overview

- Population: 67 Million (est.)[1]
- Capital City: Bangkok
- Government: Constitutional Monarchy
- Official Language: Thai
- Religions: Buddhism (94.6 per cent), Islam (4.6 per cent)[2]
- Location: Southeast Asia, bordering with Myanmar (west and northwest), Lao PDR (east and northeast), Cambodia (south), Andaman Sea (west) and Gulf of Thailand (south east)

Profile of the HIV and AIDS Epidemic

- HIV prevalence among adults: 1.2 per cent (est.)[3]
- Number of people of all ages living with HIV: 490,000 (est.)[3]
- HIV prevalence among women aged 15 to 24: 0.02 per cent (est.)[3]
- Estimated number of women living with HIV aged 15+: 200,000 (est.)[3]
- Recent estimates reveal around one-third of new infections occur in women infected by husbands or intimate sexual partners[4]

Key Populations

- **People who inject drugs (PWID)**: 22 per cent HIV prevalence and estimated to be around 40,300 in the country[5]
- **Men who have sex with men (MSM)**: The AIDS Epidemic Model forecast on new infections during 2012 to 2016 found that four per cent of HIV infection in Thailand were transmitted via MSM. In 2010, HIV prevalence of 31.3 per cent, a far higher rate of HIV infection compared to the general population.[6]
- **Female sex workers (FSWs)**: HIV prevalence of 1.8 per cent among venue-based FSWs while HIV prevalence among non-venue based sex workers is very difficult to monitor; According to a 2007 study, freelance FSWs in Bangkok had a prevalence of 19 per cent whereas venue-based FSWs, had 4.3 per cent prevalence.[7]

Modes of Transmission

- Heterosexual transmission accounts for the majority of new HIV infections. A decade ago, around 80 per cent of HIV infections occurred among FSWs and their clients. Based on recent estimates, around one-third of new infections occur in women infected by husbands or intimate sexual partners.[8]
- Only 46 per cent of PWID reported using condom at last sex.[9]
- More than 90 per cent of antenatal care (ANC) clients who are HIV-positive and of HIV-exposed infants continue to receive anti-retroviral treatment (ART) prophylaxis.[10]

Access to Information

- Significantly, more venue-based FSWs are reached by formal HIV prevention programmes and receive more information about prevention of HIV and sexually transmitted infections (STIs) than non-venue-based FSWs.
- HIV knowledge and understanding among the young have declined even as their risk behaviour (e.g., more than one sex partner at a time, low condom use) has increased.[10]
- Migrant population has a low level of HIV knowledge due to Thai illiteracy, which represents a barrier to migrant women accessing information and services for prevention of HIV and STIs.[10]
- The success of the 100 per cent condom use campaign during the 1990s has had backlash in the acceptance of condom use among the general population, who associate condom use with sex work, thus the perception that it is socially unacceptable to use condoms with a regular partner.[11]

Access to Services

- More than 90 per cent of people living with HIV and AIDS get their ART financed by health insurance. Some patients are unable to avail of these benefits, including female migrant workers.[10]
- About 94 per cent of HIV-positive pregnant women receive ART to reduce the risk of mother-to-child transmission.[10]
- Though services for pregnant women, their respective partners, and family members have been introduced, there is a need to increase the number of women coming to ANC clinics with their partners as part of wider efforts to increase the participation of male partners in HIV testing and counselling in ANC settings.[10]
- The prevention of mother-to-child-transmission (PMTCT) policy is in place and being implemented nationwide. However, the PMTCT programme overly emphasises the health of the infant, with limited focus on the women's body and her decision options: pregnancy planning, carrying the pregnancy, or choosing abortion. These decisions need to be based on comprehensive information for the pregnant woman and her partner.[7]
- Many HIV-positive pregnant women have experienced discrimination in clinics while seeking ANC services, thus discouraging them to return during subsequent pregnancies.[7]
- Human rights violations against women living with HIV have been recorded. These include violations of their right to informed consent, confidentiality, and instances of forced sterilisation.[7]
- Three major problems have been identified when it comes to sex education: 1) less than the recommended global standard of 30 hours of sex education per academic year is being provided in most schools; 2) not all schools in different geographic locations are providing sex education; and 3) there has been no evaluation of the effectiveness of the programme of instruction in altering behaviours.[10]
- Most youth-friendly service delivery centres are still not meeting felt needs of young key populations and not all geographic locations are providing these services. Youths under age 18 who desire HIV counselling and testing still require parental consent.[10]
- The referral system for FSWs from outreach services provided by non-governmental

organisations (NGOs) to voluntary counselling and testing and STI services in hospitals is in place but needs to be improved. Local participation and involvement need strengthening.[10]

- Non-Thai lack access to free services and essential information. Thus, laws and regulations are still an obstacle to access prevention and health care.[10]
- Sex work is illegal in Thailand. The police reportedly target the carrying or distribution of condoms as evidence of sex work, thus discouraging the availability and use of condoms.[8]
- Many PWID, including female PWID, are afraid to access harm reduction and other health services because injecting drug use is illegal and widely discriminated against.[8]
- Stigma and discrimination against transgender people act as a deterrent to demand for services and needs to be addressed.[10]

Legal and Policy Environment

- The National Strategy on HIV and AIDS 2012 to 2016, entitled "AIDS Zero", launched in June 2012, has two main strategic directions: Innovation and Change, and Optimisation and Consolidation. The first focuses on promoting strategies to better prevent new HIV infections particularly among key populations (including key affected women and girls); to better localise responses at the sub-national level; and to better address the social and cultural factors that hinder access to HIV prevention and care services, and fuel stigma and discrimination. Under the second, effective programmes already in place will be strengthened.[10]
- A national policy and associated strategy for reproductive health was developed during 2010 to 2011 and includes expansion of youth-friendly services, delivery of sex education in the community, and strengthening of life skills through school-based education.[10]
- Though the Constitution forbids discrimination against persons based on ethnicity, place of origin, gender, language, age or religion, the enforcement of the laws is at times unevenly applied.[10]
- A sub-committee for the Support and Protection of AIDS Rights, established in 2010 to 2011 under the National AIDS Committee, monitors HIV and human rights related situations and programmes at various levels and oversees the policy direction on HIV and AIDS and human rights in Thailand.[10]
- Some existing laws impede implementation of AIDS policies and programmes on prevention, care, and treatment especially discrimination against some groups of the population. One such law is the drug law of 1979 that considers drug users as criminals.[10] Another is the Prostitution Prevention and Suppression Act (1996), which decriminalised sex work, but created offences for soliciting, pimping, advertising, procuring sex workers, and managing sex work establishments.[12]
- Abortion is generally prohibited under the Thai Penal Code of 1956, with the woman (but not the man) subject to imprisonment or payment of a fine. Under certain circumstances, abortion may be allowed on grounds decided entirely by professional staff, with little opportunity for women to input into the decision. With the introduction of the national PMTCT programme, abortion for women living with HIV is still considered a criminal offense. As a result HIV-positive women with unwanted pregnancies seek illegal and unsafe abortions.[11]

- A memorandum of understanding for cooperation on harm reduction of injecting drug use was signed in 2009 by the Ministry of Health with the Office of the Permanent Secretary for Health, the Department of Medical Services, the Department of Disease Control, the National Health Security Office, and the Office of the Narcotics Control Board.[8]
- The NGO Education Means Protection of Women Engaged in Recreation (EMPOWER), which provides support to women in the sex industry, advocates for sex work to be recognised as legitimate employment under the Thai labor law, social security legislation, and occupational health and safety codes. EMPOWER has worked with government agencies to address HIV and improve working conditions.[12]
- National efforts, which started in 2010 to 2011, to address intimate partner violence have their basis in the Protection of Domestic Violence Victims Act BE 2550 or the "DV Act", which came into force in 2007. Article 276 of the Penal Code was amended in the same year to extend the penalty for rape to, among others, cases of marital rape, recognising that sexual violence within intimate partnerships, including marriage, is a matter of concern.[11]

Viet Nam Country Brief

Overview

- Population: 91.519 Million (est.)[1]
- Capital City: Ha Noi
- Government: Socialist Republic
- Official Language: Vietnamese
- Religions: Buddhism (9.3 per cent), Catholic (6.7 per cent), None (80.8 per cent)[2]
- Location: Borders Laos and Cambodia to the west, China to the north, the South China Sea and the Gulf of Tonkin to the east.

Profile of the HIV and AIDS Epidemic

- Number of people living with HIV: 250,000[3]
- Adults aged 15 to 49 prevalence rate: 0.45 per cent[3]
- Adults aged 15 and up living with HIV: 240,000[3]
- Women aged 15 and up living with HIV: 48,000[3]

Key Populations

- **Men who inject drugs:** They are the predominant group of HIV-positive people in Viet Nam. According to the sentinel surveillance data, HIV prevalence among men who inject drugs decreased steadily from 2004 through 2011, falling below 15 per cent in 2011 for the first time since 1997. The heterogeneity of the epidemic among men who inject drugs is highlighted by the range of prevalence among the provinces: the highest prevalence was registered in Dien Bien (45.7 per cent) in the north west and the lowest in Hoa Binh (1.1 per cent) in the north central region.[3]
- **Men who have sex with men (MSM):** Eight provinces that collected HIV sentinel survey data on MSM in 2011 found a mean HIV prevalence among them of 4.0 per cent. The data were strongly influenced by a single province, Ho Chi Min City, where prevalence was estimated at 16.1 per cent in 2010 and 16.3 per cent in 2011.[3]
- **Female sex workers (FSWs):** HIV prevalence among FSWs began declining in 2002. In 2011, at 3.0 per cent, it reached a level not seen since 1998. Brief behavioural surveys integrated into sentinel surveillance indicate that this estimate is somewhat influenced by injecting drug use among sex workers (SWs). In 2010, 7.2 per cent of FSWs interviewed reported a history of injecting drug use. HIV prevalence among these women was 25.4 per cent.[3]

Modes of Transmission

- The major source of HIV infection among women is transmission by a high-risk intimate partner: men who inject drugs, MSM, and men who are clients of SWs. Consistent condom use among men who inject drugs with regular partners in the previous 12 months varied, ranging from a low of 15 per cent to a high of 56 per cent. MSM reported sex with a female regular partner in the previous 12 months but consistent condom use with the regular sexual partners by the MSM is well below 30 per cent. Among FSWs, condom

use with their most recent client was as high as 87 per cent but consistent condom use with stable or regular partners was very low at 21 per cent in the last three months.[3]

- Needle and syringe sharing is another mode of transmission. According to the IBBS Round II data, needle and syringe sharing in the last 6 months was relatively high (15 per cent to 37 per cent) in all provinces surveyed except Hai Phong (7 per cent). Reported sharing in the last 6 months was highest in Da Nang (37.2 per cent) and Lao Cai (35.3 per cent). According to IBBS 2009, consistent condom use in the past 12 months among MWID with regular partners (wives and girlfriends) varied, from 15 per cent in Da Nang to 56 per cent in Quang Ninh. While consistent condom use with sex workers was higher than with regular partners, from 38 per cent in Ho Chi Minh City to 74 per cent in Hai Phong, it was still low in the provinces surveyed.[3]
- Viet Nam's strong basic health infrastructure and capacity, demonstrated by the provision of at least one antenatal care visit to 95 per cent of pregnant women, and its remarkable success in reducing infant and maternal mortality, provide a solid basis for eliminating mother-to-child transmission (MTCT). According to the Ministry of Health, the coverage of both "pregnant women tested for HIV and who know their results", and "HIV-positive pregnant women who received antiretroviral for prevention of mother-to-child transmission (PMTCT)" increased, from 480,814 (21 per cent of all pregnant women) and 1,372 (32.3 per cent of estimated HIV-positive pregnant women) in 2009 to 690,108 (36.0 per cent) and 1,838 (49.1 per cent) in 2010, respectively, and 846,521 (36.7 per cent) and 1,707 (44.0 per cent) in 2011, respectively. However, more efficient, integrated, and sustainable PMTCT services need to be established to ensure that declining donor funds do not threaten the sustainability of achievements so far.[3]

Legal and Policy Environment

- The Law on HIV/AIDS Prevention and Control No. 64/2006/QH11 (hereafter, the Law on HIV), passed in 2006, provides the legal foundation for a strong, multi-sectoral response to HIV, and for the protection of the rights of people living with HIV and AIDS (PLHA).[4]
- The Viet Nam Authority for HIV/AIDS Prevention and Control coordinated the development of a new National Strategy on HIV/AIDS Prevention and Control by 2020, with a vision for implementation by 2030. The new Strategy was written in consultation with government ministries, civil society, the United Nations and international partners, and contained ambitious targets that resonated with the Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS that was agreed upon at a special session of the United Nations General Assembly in June 2011. The National Assembly passed a National Targeted Programme on HIV 2011 to 2015 that secured more state budget for HIV activities.[3]
- The Communist Party reviewed Directive 54 on HIV, leading to Party Notice 27-TB/TW renewing the Party's commitment to continued leadership on HIV prevention and control at both the central and local levels.[3]
- Decree No. 69/2011/ND-CP, dated 08 August 2011, is about handling administrative violations in health prevention, the medical environment, and HIV and AIDS prevention and control. The decree provides crucial support to the enforcement of the Law on HIV. While administrative violations and their sanctions are contained in various pieces of legislation,

Decree 69 describes the overall framework, provides more details about administrative violations affecting PLHA, and increases the number and types of sanctions for such administrative violations.[3]

- Following the success of the pilot project to deliver methadone maintenance therapy (MMT) to people addicted to heroin, Viet Nam's leaders increasingly recognise the value of the approach. The programme has already been expanded and is due to be extended to additional provinces. As a result, new legislation has been enacted/drafted, including:
  - The Protocol on Manufacturing and Using Methadone in Viet Nam (2010 to 2015) that will support the expanding MMT programme with nationally-produced methadone products, up to 80 per cent of need, by 2015.[3]
  - Decision 5146/QD-BYT, dated 27 December 2010, of the Ministry of Health to approve the above Protocol.[3]
  - A draft Decree on Substitution Treatment for Opioid Addiction that elaborates the conditions for the recipients and delivery of MMT.[3]
  - Decision 3140/QD-BYT, dated 30 August 2010, of the Ministry of Health to issue Guidelines on Substitution Treatment by Methadone and Implementation Instructions.[3]
  - Decree 94/2010/ND-CP, dated 09 September 2010, of the government on home-based and community-based detoxification.[3]
- Additional workplace-related protection has been established to complement those under Article 14 of the Law on HIV, according to which employers are responsible for HIV prevention and control in the work place:
  - Under Decree No. 69/2011/ND-CP, employers who violate the right to work of PLHA can be fined or obliged to re-hire PLHA and arrange appropriate jobs for them.[3]
  - Notice 316/TB-VPCP aims to reduce HIV-related stigma and discrimination in the work place, including through legal recourse for employees fired based on their HIV status.[3]
  - Under Decree 122/2011/ND-CP, expenditure on workplace-based HIV prevention and control (including relevant training for staff, communication activities on HIV prevention and control for employees, counselling fees, HIV tests, and financial support for HIV-positive employees) is excluded when calculating income for corporate income tax. Businesses of 20 employees or more (and not working in the areas of finance and real estate) with at least 30 per cent HIV-positive and/or disabled staff, and/or staff recovering from drug addiction, can apply for corporate income tax exemptions, while income earned from vocational training for PLHA or recovering drug users is exempt.
  - Circular No. 42/2011/TT-BYT adds HIV infection to the list of occupational hazards covered by insurance schemes under the provisions of the Labour Law and its guiding documents.[3]
  - Viet Nam was among the States of the International Labour Organization to adopt the Recommendation Concerning HIV and AIDS and the World of Work (R200) that calls for the delivery of workplace safety and health and HIV prevention, care, and treatment to all workers and their families/dependents and in all labour forms or arrangements, including formal and informal sector workers, sex workers, migrant workers, and people in the uniformed services.[3]

Despite these new legal and policy environment, there are still inconsistencies between policy and regulatory documents. In particular, public security measures to control drug use and sex work conflict with public health messages.

- Although the Law on Drugs was amended to decriminalise drug use under the Ordinance on Administrative Violations, which improved its overall consistency with the Law on HIV, drug use still remains an administrative violation, with users subject to administrative detention for up to two years. This presents a barrier to the provision of effective HIV services.[3]
- In addition, a number of new legal obstacles may affect the ability of HIV programmes to reach key populations at higher risk of HIV infection. Decree 94/2009/ND-CP, which guides the implementation of the Law on Drugs following the 2009/21 Directive, threatens to create a more punitive legal environment for PWID. Under this new legislation, repeat drug offenders are subject to an additional period of "'post-detoxification management"' for between one and two years. As detainees have limited access to HIV services, this measure may further impede HIV prevention efforts with people who inject drugs as well as the provision of HIV care and treatment to PLHA within these facilities.[3]

GETTING TO THE THREE ZEROS THROUGH GOOD PRACTICES

GETTING TO ZERO NEW INFECTIONS

A PMTCT Success Story, Thailand

Introduction to the Practice

During the 90s, Thailand was ranked by the World Bank as a low-middle income country. In spite of that, the country had health care financial schemes that covered almost all health-related needs of Thais: the social security scheme for employees, the civil servants medical benefit scheme for government employees, and the universal health coverage scheme for the rest of the citizens.

It was during this period that the country suffered from a high prevalence of HIV. Cost notwithstanding, Thailand went ahead and piloted the National Antiretroviral Therapy (ART) programme, which was later on expanded for Thai patients desiring universal access to ART. It was also during this time that the National Prevention of Mother-to-Child Transmission Programme was launched. It later won commendations from international agencies for its advanced programming and success in implementation.

Today, Thailand is an upper-middle income country, with enviable ART and prevention of mother-to-child transmission (PMTCT) programmes. Yet, its many successes in its fight to reduce or eliminate mother-to-child transmission (MCTC) came at a time when the country had limited resources and a large number of pregnant women who were at risk.

How It Works

The Evolution of PMTCT Interventions in Thailand

In 1996, the Thai Red Cross AIDS Research Centre, supported by public donations under the patronage of Her Royal Highness Princess Soamsawali, initiated the first PMTCT effort in Thailand. It successfully demonstrated that PMTCT was effective and feasible for implementation.

From 1996 to 1999, the Ministry of Public Health (MOPH) successfully implemented the PMTCT programme in all public hospitals in the north and north eastern regions of Thailand (Region 10 and Region 7) using a short-course azidothymidine, better known as zidovudine (AZT), from 34 weeks gestation for pregnant women living with HIV and 1 to 4 weeks AZT syrup and free infant formula for their babies. The programme had a high uptake and was well accepted by health care providers that led to the decreased MTCT rate to less than 10 per cent in the two regions. This success led to PMTCT programme's expansion nationwide in the following year.

By 2000, MOPH rolled out a national PMTCT programme that consisted of an opt-out HIV voluntary counselling and testing for all pregnant women, the provision of short-course AZT for HIV-positive pregnant women (from 34 weeks of gestation) and their babies (1 to 4 weeks), and the provision of free infant formula for babies.

In 2004, MOPH changed the PMTCT regimen to AZT at 28 weeks gestation plus the use of single dose of nevirapine (sd-NVP) for pregnant women during labour and newborn babies.

In 2006, following the expansion of ART access to all people living with HIV and AIDS, MOPH changed its PMTCT regimen again to the highly active antiretroviral therapy (HAART), with its three drug regimen of AZT + 3TC + lopinavir/ritonavir (LPV/r), but only for pregnant women with cluster of differentiation 4 (CD4) count <200 cells/mm3.

By 2009, there was a strong collaboration among expert clinicians, researchers, and leaders of non-governmental organisations to advocate for strategies that would drastically reduce if not eliminate PMTCT in the country. Directly or indirectly, it led to the Department of Health, with two other organisations, to do a cost-benefit study to evaluate HAART for all pregnant women. The findings showed that HAART and its three-drug regimen generated cost-savings better than the two-drug regimen of AZT + ad-NVP under the Thai health care setting. The positive results prompted the conduct of a feasibility study involving 46 public hospitals in 4 provinces to assess technical and practical barriers to introducing the three-drug regimen for PMTCT. The study provided evidence-based recommendations to the Advisory Committee on AIDS in Maternal and Child Health at MOPH, which then developed the National PMTCT Guidelines, and the Sub-Committee of HIV and AIDS System Development at the National Health Security Office, which provided financial support to the National PMTCT Programme.

In 2010, after six years of widespread use of AZT + ad-NVP in PMTCT in the country, MOPH instituted a nationwide change to the three-drug regimen of AZT + 3TC + lopinavir/ritonavir for all pregnant women. This landmark decision came at the same time as the World Health Organization (WHO) PMTCT recommendation for resource-constrained countries to move from recommending the two-drug regimen as the only option for PMTCT for women who were not yet eligible for ART to recommending a choice of either the three-drug regimen or the two-drug one.

Some major reasons behind the National PMTCT recommendation to use the three-drug regimen, with specific reference to LPV/r, were:

- A regimen containing LPV/r could be initiated without the need to wait for CD4 count result, where women with CD4 count higher than 250 to 350 could be at increased fatal risk of developing NVP-related hepatotoxicity.
- The three-drug regimen also would help in preventing resistance.
- A single preferred regimen would ease implementation at all levels.

In 2013, the new National PMTCT Guidelines were revised. It has forward-looking provisions for:

- Providing free antenatal care (ANC) for all pregnant women at all health centre facilities, thus eliminating barriers to ANC access while promoting increased quality of ANC and PMTCT services
- Promoting couple HIV counselling and testing
- Changing CD4 count criteria from <350 to <500 cells/mm3 for continuing ART after delivery and to serodiscordant couples
- If born to HIV-positive mothers, provide polymerase chain reaction at 1,2, and 4 months to children and ART to infants as soon as possible

Monitoring and Evaluation (M&E) of the Thailand National PMTCT Programme

M&E has always been an essential component of Thailand's National PMTCT Programme. Starting from the pilot implementation of the AZT short course for PMTCT in 1998 in one region, the simple aggregated monthly report on key PMTCT programme performance was found to be very effective in identifying gaps and designing quality improvement. It was a useful tool for the regular review of data among programme implementers and managers. In 2002, the same simple concept of M&E system was integrated into the scaled-up PMTCT.

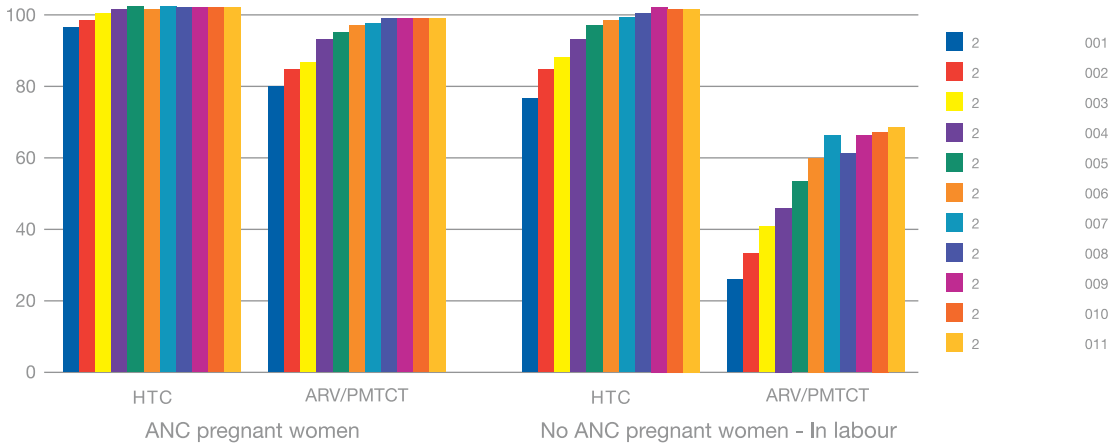
- The simple aggregate monthly data to summarise HIV testing in pregnant women, ART uptake in HIV-infected pregnant women and their infants, and infant formula intake was launched in all public hospitals of Thailand. It continues to be in use.
- It provides process and output monitoring of key PMTCT services.
- The monitoring is also implemented in 14 surveillance sites to provide outcome/impact on MTCT rates and new HIV infection in children.
- This is an individual case reporting system with a two-step report. The first report is at birth, to collect intervention data received by mothers and babies, and the second, when HIV infection outcome was determined in infants.

Since this system is more resource intensive, it is designed to be used only in surveillance sites that are geographically distributed throughout the country. Programme managers at provincial, regional, and central levels can generate their own reports and use these for monitoring and supervision of hospitals.

Outcomes

Data from the national monitoring systems showed high uptake of HIV testing in all pregnant women and antiretroviral prophylaxis in HIV-positive pregnant women, even as it showed a lower uptake in HIV-positive pregnant women without ANC (Chart 1).

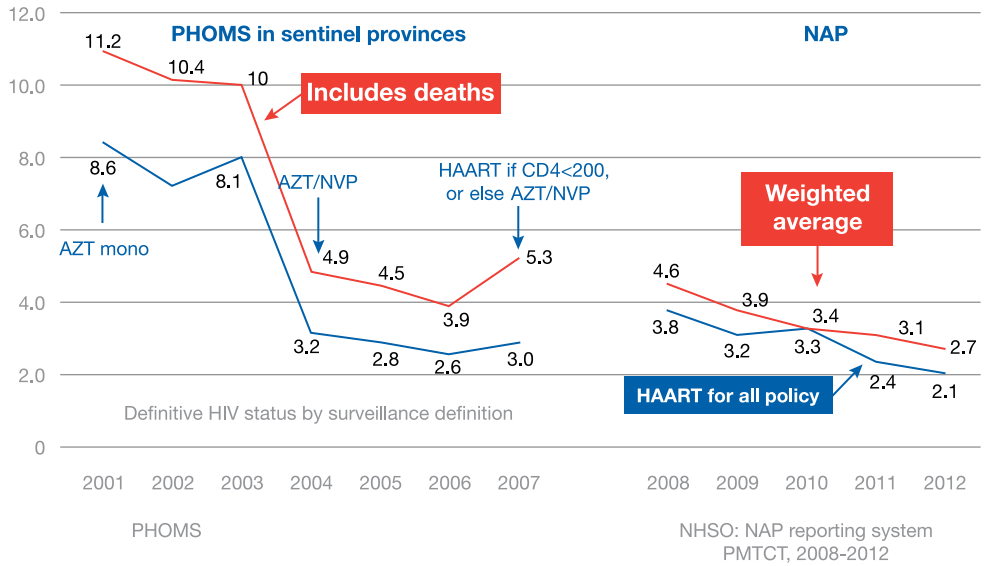
Chart 1. PMTCT Data 2001 to 2011



HTC: HIV Testing and Counselling

Source: PHIMS, Bureau of Health Promotion, Department of Health

Chart 2. Mother-to-Child Transmission Rate 2001 to 2012



NAP: National AIDS Programme
NHSO: National Health Security Office
PHOMS: Perinatal HIV Outcome Monitoring Case Reporting Surveillance

The MTCT rates continued to decline from approximately 8 to 10 per cent in 2001 to 2 to 3 per cent in 2012 (Chart 2).

Challenge

The new 2013 Guidelines carry very progressive provisions. The biggest challenge that is being faced by the MOPH is how to effectively make the stakeholders, who are mostly in the medical field-obstetricians, neonatologists, paediatricians, internists, and other health care workers-and who are spread all over the country, understand and follow the guidelines correctly and consistently.

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Addressing HIV Risks in the Context of Infrastructure Development: Pre-Construction, During Construction, and After Completion, Lao PDR

Introduction to the Practice

Major development of road infrastructure could exacerbate the spread of HIV among people living in areas along and near to the road construction sites and migrant and mobile populations involved in or attracted to the road construction. More so, if the road construction passes through adjacent provinces of two countries, as in the case of the improvement of Road 6 in Houaphanh Province, Lao PDR, and the connecting Road QL217 in Viet Nam's Thanh Hoa Province. This is the background of the ensuing narrative of how Lao PDR successfully prepared residents, local governments, and migrant and mobile populations for the distinct possibility of the spread and impact of HIV during and after road construction.

Lao PDR and Viet Nam participated in this Asian Development Bank (ADB)-initiated project, HIV Prevention and Infrastructure: Mitigating Risks in the Greater Mekong Subregion. The project ran from 2011 until 2013.

For Lao PDR, the main focus of the project was Houaphanh Province, close to the border with Viet Nam. The project beneficiaries were the local people, mostly rural villagers, including different ethnic groups, migrant, and mobile populations. The project undertook to help the beneficiaries to have a better understanding of HIV, consider their own potential risks, and prepare for further HIV risks as more people visit the province during and after road construction. The underlying principle behind the project was early warning and rapid response.

The goal of the project was to reduce HIV transmission and sexually transmitted infections (STIs) prevalence among migrant and mobile populations and communities along the road construction route. Its specific objectives were:

1. To build capacity of local authorities in dealing with HIV, including improved service delivery and preparation for the upcoming construction period
2. Prepare communities located along the road construction sites and migrant and mobile populations to prevent HIV transmission during and after the road development
3. Address HIV risks already present in the communities and among migrant and mobile populations
4. Build capacity of local health services in voluntary counselling and testing (VCT), sexual and reproductive health (SRH), and STI management

The overall project was managed by Burnet Institute in partnership with the Research Communication Group. In Lao PDR, activities were conducted in close collaboration with the Centre for HIV/AIDS and STI (CHAS), the national authorities in Health and Transport, as well as the Provincial Committee for the Control of AIDS. There was direct involvement of the Lao Ministry of Public Works and Transport (MPWT). There was also cross-border collaboration with the Health and Transport authorities in Viet Nam.

The project was funded by ADB, with support from the former Australian Agency for International Development. Funds were utilised for Burnet Lao technical and management staff, international advisers from Burnet Australia, travel, training and workshop costs, and travel costs to support the involvement of the technical staff from CHAS and the MPWT.

With the ongoing road construction, and a few months after the project completion, Lao PDR is planning to conduct a series of training for local communities and to develop information, education, and communication (IEC) materials for different types of vulnerable groups of people, including ethnic groups, most-at-risk youth and women, people who inject drugs, and migrant and mobile populations. This new initiative is in collaboration with Viet Nam, with new funding support from ADB. Preparatory to this, Lao PDR just completed a mapping of vulnerable groups in and around the construction sites.

How It Works

From its inception, the project focused on building long term sustainability of responses to HIV by organising district Project Working Teams (PWTs). They led the implementation of activities in HIV prevention, HIV and STI testing and treatment, and in SRH. Although multi-sectoral, many of the members of a district PWT were also residents of the district, thus, the project was assured of their long term engagement in responding to HIV. The district PWTs reported to the provincial PWT, whose composition was similar to that of the district PWT but at a higher level. Aside from supervision, the provincial PWT monitored and provided continuous technical support to the district PWTs.

To ensure the fullest preparation of the PWTs, their training took two years, covering an initial basic training, followed by other courses on topics necessary for a successful HIV and STI prevention programme. Their basic training, with succeeding refresher courses, covered the following:

- Support for community discussion
- Behaviour change

- Upgrading capacity for VCT and STI testing, counselling and treatment
- Linking the districts with the national monitoring and evaluation (M&E) system

Additionally, PWTs were taught how to analyse local situations, identify future challenges, and engage the residents in planning for long term responses.

The district PWTs included staff from the provincial Health and Transport authorities and the Provincial Committee for Control of AIDS. Other members were from the Lao Women's Union, the Lao Youth Union, the Lao Trade Union, and the provincial staff of the Ministry of Information, Culture and Tourism, who were responsible for all radio and television services for the province. Also included were the provincial staffs of the Ministry of the Interior, the Police, and the Military. These local organisations allocated staff time to the HIV response under the project. All were also expected to continue to do so in the long term. Because many of the members of the district PWTs were from the district themselves, their understanding of their own communities was much better than any outsiders.

During project implementation, the district PWTs helped their communities to prepare for changes in HIV transmission that were likely to occur once the road construction commenced and after the road was completed. They built community capacity in HIV awareness, situation analysis, mapping of services, peer education, communication skills, referrals to HIV and STI services, and some enhancements to those services. It is worthwhile to note that the project used existing materials being used in the country: IEC materials and curricula and manuals for behaviour change communication workshops, STI training, and M&E training. A project officer from Burnet lived in Houaphanh Province for the duration of the project to provide continuous technical support. In its later stages, an expert in STI was appointed as the project officer, seconded from CHAS. This ensured closer collaboration between national and provincial partners.

One of the critical processes of the project involved a three-step progression leading to an analysis of the future impact of road development on HIV transmission:

Step 1: District PWTs learned of the varied HIV needs of people in the districts: the local villagers and ethnic groups, key populations, such as female sex workers, men who have sex with men (MSM), and young people deemed most-at-risk of being exposed to HIV.

Step 2: District PWTs conducted an analysis on how the road construction could lead to an increase in HIV transmission; how road construction could impact the current low HIV prevalence in Houaphanh; how increased contact with outsiders who may be practicing risky behaviours contribute to changing the current prevalence rate; and what possible scenarios could contribute to an increase in HIV transmission. The following were some of the scenarios identified:

- If the local village women had sex with male road construction workers for money, for exchange of goods or services, or in hope of future marriage
- If more men and women started using drugs because the road made transporting drugs easier and if the high rate of injecting drug use in the nearby provinces of Viet Nam spilled over to the area

- If the number of MSM increased without them practicing safe sex
- If all of the above happened as the provincial capital of Xam Neua grew from a small town to a small city

Step 3: The province and district PWTs worked to further analyse the current situation, the likely changes that may occur, and what needed to be done in the future to deflect an increase in HIV transmission.

In the final six months of project implementation, the province and district PWTs prepared their own proposals for sustainable responses to HIV during road construction and post-construction phases. They submitted their proposals to the provincial authorities for Health and Transport for action.

Outcomes

- The most sustainable outcome of the project was the relationships that were developed between the national, provincial, and district project partners and between the district PWTs and their own communities. Through the project, partners learned to address HIV and appreciate the varied needs of different people.
- The sustainability proposals produced by the project has become a template that can be used to inform future projects, regardless of whether they are related to road construction or not.
- This project proved that certain existing materials could be successfully used as long as they were for projects with similar purposes. These included IEC materials, behaviour change communication workshops, STI training, and M&E training.

Challenges

The biggest challenges that the project faced during implementation were:
- Building capacity of local communities to understand what changes could occur in the future, even though they had little experience of HIV
- Planning for sustainability when it was not known how much external funding would be available
- The long waiting time of one year before the actual road construction started that necessitated refresher courses to be conducted for the PWTs and the communities

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Anonymous HIV Testing, Singapore

Introduction to the Practice

In Singapore, during 2012, 48 per cent of the new HIV cases already had late-stage HIV infection when they were diagnosed. Studies have shown that individuals who are aware of their HIV-positive status will take steps to protect their partners. Therefore, early testing will help to control the spread of HIV. Early detection and treatment of HIV infection can also help to significantly delay the onset of AIDS, reduce the risk of death, and improve the quality of life.

Anonymous HIV testing was first implemented in 1991 at the Action for AIDS (AfA) Anonymous Test Site (ATS). In a move to further encourage individuals at risk of HIV infection to go for testing and to do so early, anonymous testing was extended in June 2006 to two general practitioner (GP) clinics. In November 2008, the number of ATSs increased by another four GP clinics making a total of seven ATSs. In December 2011, a Mobile Anonymous Testing Service was launched as an extension of one of the ATSs to make anonymous testing even more accessible to the public.

The aim of anonymous HIV testing is to increase testing among at-risk populations. Anonymous HIV testing provides an alternative option to those who would like to be tested for HIV but would prefer not to be identified to healthcare personnel. It is a supplement to conventional name-based HIV testing where the confidentiality of an HIV-infected person is protected under the Infectious Diseases Act (IDA).

Patients pay a fee that ranges from S$30 to S$60 for the services and includes the price of the test as well as consultation charges.

The Ministry of Health (MOH), together with AfA and six GP clinics, implement the programme.

How It Works

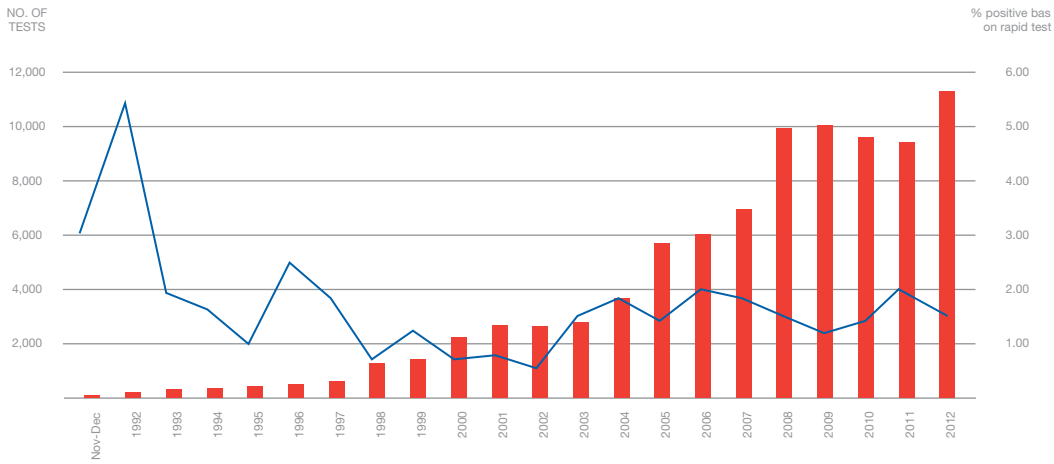
Anonymous HIV testing is carried out with oral fluid or blood from finger prick using rapid HIV test kits. All doctors who wish to provide rapid HIV testing in their clinics are required to undergo training that includes:

- An explanation of the types of HIV rapid tests that may be used (only test kits registered with the Health Sciences Authority are permitted)
- Instructions on how to perform the test and interpret test results
- Instructions on how to follow-up on positive rapid test results
- Guidelines on pre- and post-test counselling
- Quality assurance standards that clinics are expected to maintain

The use of rapid HIV tests allows results to be ready in about 20 minutes, within the same clinic visit. Pre- and post-test counselling is provided to all individuals who undergo anonymous HIV testing. Individuals with reactive rapid HIV test results undergo confirmatory HIV testing by clinical laboratories.

Chart 1. Anonymous HIV Testing Programme

Nov 1991 - Dec 2012



Although HIV is a legally notifiable disease under the IDA, ATSs are exempted from the legal requirement to notify MOH of any HIV positive cases detected via this programme. ATSs are, however, required to provide epidemiological information to MOH for surveillance purposes. This enables MOH to perform further epidemiological analyses by age, gender, ethnicity, nationality, sexual orientation, marital status, etc.

Outcomes

The total number of HIV tests done each year in ATS has been on an increasing trend. In 2012, 11,243 tests were performed. The percentage of positive HIV tests by rapid testing in ATSs has held stable at between 1 per cent and 2 per cent in the last 15 years (Chart 1).

Anonymous testing is an important alternative to confidential name-based testing. Individuals who know their HIV status are better able to take care of their health and take steps to prevent further transmission. Even though individual identifiers are not reported to the Ministry, the programme allows for crucial epidemiological information to be gathered for surveillance purposes.

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Breaking Down Barriers: A School-Based STI and HIV Prevention Programme, Singapore

Introduction to the Practice

Sexually transmitted infections (STIs) among youths aged 15 to 19 years had been increasing steeply since 2003. In view of this, an inter-ministry workgroup comprised of the Ministry of Health (MOH), Ministry of Education (MOE) and the Health Promotion Board (HPB) in Singapore was formed to enhance STI and HIV prevention efforts among youths aged 15 to 19 years. It was decided that a new STI and HIV prevention programme would be developed to complement the sexuality education programme already being conducted in schools.

In 2006, the workgroup developed "Breaking Down Barriers" (BDB), a programme targeted at 15 to 17 year-old students in schools.

The objectives of the programme are to:

- Increase students' knowledge about the correct modes of transmission of STI and HIV
- Increase their knowledge about the effective methods of protection against infection
- Empower students with life skills to say "no" to peer pressure to have premarital sex

The HPB implements the programme with support from MOE and MOH. The programme is fully funded by HPB, which makes it free of charge to the schools and students.

How It Works

The BDB programme comprises a one hour mass education component, followed by classroom sessions (120 minutes). The former utilises multi-media and real-life testimonies to impart information on modes of transmission and protection against STI and HIV while the latter focuses on life skills, namely decision making, assertiveness, and negotiation, to enable students to resist pressure to have sex.

A key component of BDB was the consistent prevention message of "Abstinence, Be faithful and Condom use". Abstinence was the priority message and emphasised as the only foolproof method for prevention. The condom use message emphasised consistent and correct use of condoms.

The content and format for BDB was developed utilising an evidence-informed approach, by scouring available scientific literature and data on school-based STI and HIV prevention programmes globally. Development of the multimedia aspects (videos, presentations) and class-based activities employed experts from the creative industry (film production) and social workers with casework and counselling experience. In addition, focus group discussions were conducted with different stakeholders (school management, teachers, and students) to gather feedback during content development and production.

BDB was conducted by trained and experienced social workers, counsellors, and teachers. The social workers and counsellors conducted the mass education component of the programme while the teachers conducted the class-based component. The BDB programme was evaluated by getting students to complete feedback forms before and after the programme was conducted.

HPB took charge of programme implementation, monitoring, and evaluation, while MOE supported the programme by strongly encouraging schools to take it up. Parents were informed ahead about the programme via letters with a form they need to fill out and return to the school, wherein they could choose to allow or not to allow their children to join it, if they so wished.

In 2012, MOE lent further support to the programme by classifying it as a staple programme under the school sexuality education co-curriculum, i.e. all schools henceforth had to take up BDB.

Outcomes

From 2007 to present, BDB reaches out to almost 100 per cent of schools for both 15 to 17 year old students each year.

An evaluation of the project in 2008 to 2010 concluded positive results. The evaluation involved more than 4,000 students from 23 randomly selected schools that best represented the different types of schools in the Singapore education system. The respondent-students were given self-administered pre- and post-programme questionnaires to assess their knowledge levels as well as their perceived susceptibility to STI and HIV infection.

After attending the programme, more students were aware of the main modes of HIV transmission and the modes of protection against infection (Charts 1 and 2). For example, significant differences were observed for "casual sex" as a mode of transmission of HIV (Chart 1: Pre 85 per cent; Post 92 per cent) and for "abstinence" as a mode of protection against infection (Chart 2: Pre 44 per cent; Post 57 per cent).

Chart 1. Correct Modes of HIV Transmission

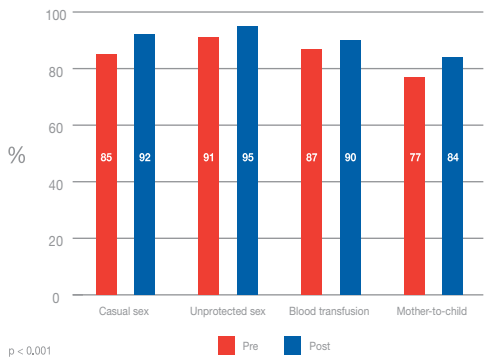
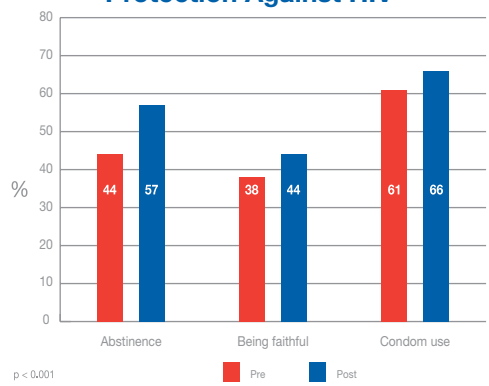
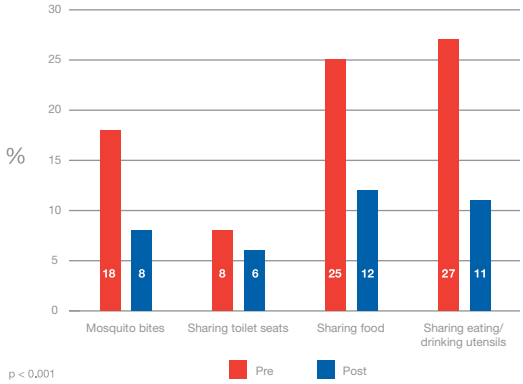


Chart 2. Effective Modes of Protection Against HIV



Students were also more aware of the misconceptions associated with HIV and AIDS transmission, e.g. fewer students chose “mosquito bites” as a mode of transmission (Chart 3: Pre 18 per cent; Post 8 per cent) after attending the programme.

Chart 3. Misconceptions about HIV Transmission



In addition, students were more likely to perceive themselves as being vulnerable to STI and HIV after the programme
(Table 1).

Table 1. Self-Perceived Susceptibility to STI and HIV Infection

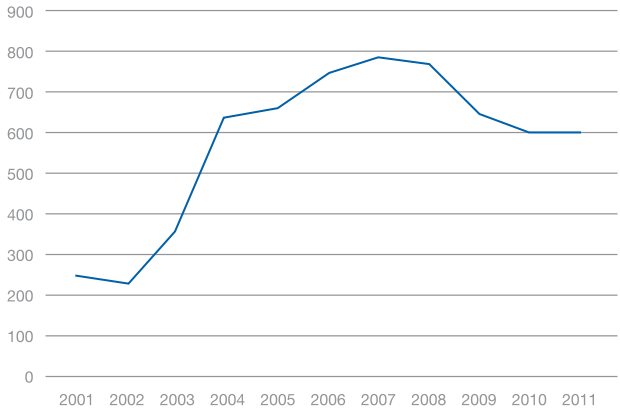
	Pre	Post
Mean score (perceived likelihood of contracting STIs) + Std Error Mean	1.87 + 0.018	1.99 + 0.02
Mean score (perceived likelihood of contracting HIV and AIDS) + STD Error Mean	1.85 + 0.018	1.97 + 0.02

$p < 0.001$

Students were asked to rate, on a 5-point scale (‘1’ being ‘Very unlikely’ to ‘5’ being ‘Very likely’), their perceived likelihood of contracting STIs and HIV and AIDS.

Being the only national programme implemented on a wide scale and reaching almost 100 per cent of the target population since 2007, BDB has contributed to declining STI rates among youths 15 to 19 years (Chart 4).

Chart 4. Number of STIs among Youths Aged 15 to 19 Years



Source: Ministry of Health Singapore

Challenges

As BDB is implemented on a wide scale for 15 to 17 year olds in general, it will not be able to address the needs of specific groups of students in schools, e.g., those at-risk of or are already engaging in risky sexual behaviour. To this end, HPB had already developed programmes for at-risk youths.

Looking at the HIV and AIDS figures for the 15 to 19 years age group, there may be a need to reach young males with more targeted efforts and messages (Table 2).

Table 2. HIV and AIDS Cases among Youths Aged 15 to 19 Years, by Gender

Year	2008	2009	2010	2011	2012
Total No.	7	3	6	4	11
Male	7	3	5	4	10
Female	0	0	1	0	1

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Building Blocks Towards Eliminating New HIV Infections by 2020, Cambodia

Introduction to the Practice

In the mid-1990s, Cambodia had one of the fastest growing HIV epidemics in Asia. It reversed the trend within five years of the following decade. This achievement won for the country a United Nations Millennium Development Goal Award in 2010 in recognition of its commitment and progress towards halting and reversing the spread of HIV and achieving universal access to HIV treatment.

How did Cambodia achieve this success and how will it progress into the future?

Cambodia's response to the HIV epidemic happened in three distinct phases:

Phase I, which began in 1991, is remembered for the "100 per cent Condom Use Programme" (100% CUP). HIV prevention efforts targeted brothel-based sex workers, resulting in high rates of safer sex behaviour and declining HIV and Sexually Transmitted Infections (STIs) incidence levels.

Phase II, started in 2001, would be a decade focusing on the rapid expansion of HIV interventions such as the availability of antiretroviral Therapy (ART), Prevention of Mother-To-Child Transmission (PMTCT), integrated Tuberculosis (TB) and HIV services, and HIV prevention among Key Populations (KPs). Collaborative actions were established across key health and social services organisations.

Phase III, which started in 2012, is quite ambitious. Within this decade, Cambodia envisions reaching zero new infections by 2020 through an initiative known as Cambodia 3.0 that strongly links the health services. It combines prevention and treatment services to KPs and seeks to eliminate mother-to-child transmission in new paediatric cases. This constitutes consolidated care and treatment strongly linking the health services.

International donors, the national government as well as local authorities funded Phases I and II, while Phase III is being funded by several donor agencies with increasing resources provided by the national and local governments. Non-governmental organisations (NGOs) contributed to Phases I and II, and largely to Phase III, through their international grants and fund-raising efforts.

How It Works

Phase I. Intensive Response to the Epidemic (1991 to 2000)

The setting for Phase I was during the time when Cambodia was categorised as having a generalised epidemic. Unprotected sex work proved to be the fuel that caused the rapid spread of HIV and other STIs. The government, therefore, saw the need for a close collaboration

among brothel owners, local authorities, and health workers from both government and NGOs, particularly, those involved in STI services and in implementing 100% CUP. Their efforts were complemented by mass media and social marketing programmes, as well as peer education and community outreach that helped raise the level of awareness of the public about the HIV epidemic.

The collaborative approach resulted in increased practice of safe sex behaviour among sex workers and their clients, resulting in a rapid decline in infection rates. From less than 40 per cent in 1996, condom use in the sex trade rose to over 90 per cent in 2001. HIV prevalence among brothel-based sex workers showed a big drop from 42 per cent in 1996 to 14 per cent in 2006, with STIs declining by more than half, from 1996 to 2001, among both sex workers and high-risk males.

Envisioning an environment in which people living with HIV and AIDS (PLHA) could seek health and social support, the government established testing and counselling services and a network of home-based care providers in the mid-1990s. By 1995, it introduced the first set of Voluntary Counselling and Testing (VCT) sites. These standalone sites were purposely located beside other health facilities, enabling them to support the linking model that would follow. Health centre staff and volunteers, many of whom were PLHA, formed what had become a growing community network that provided home-based care activities. Many peer support groups of PLHA emerged and their networks were expanded. The three structures of VCT, home-based care, and PLHA peer support groups in tandem with awareness-raising efforts, served as the building blocks for the successful implementation of Phase II.

Phase II. Rapid Expansion of HIV Health Services (2001 to 2011)

Great enthusiasm to expand services characterised Phase II. This phase saw the rapid scale up of HIV counselling, testing, care, and treatment: the four major building blocks marking the second decade of Cambodia's aggressive response to the HIV epidemic.

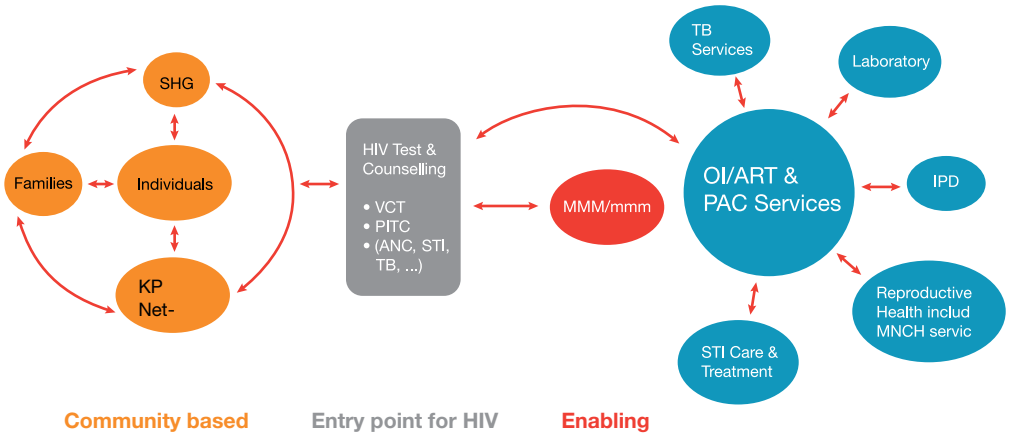
1. *Expanded VCT and ART Service Facilities as Backbones*

   VCT sites, which were located only in Phnom Penh and some provincial towns and totalled less than 20, were expanded to cover all 77 operational districts, with 1 site for every 5 health centres. ART was decentralised in 2011 by the National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS) to 55 operational districts where 92 per cent of HIV positive cases were found. The widened coverage in Cambodia of VCT and ART services served as the backbones of various linkages between the community and health facilities, across different levels of health services, and across different programmes as well.

2. *Continuum of Care (CoC) for ART Expansion and Retention*

   During the strategy conceptualisation in 2002 for the expansion of ART, several service delivery models that could provide comprehensive care within the existing health system were considered. To guide this process and lay the foundation for the systematic expansion of a standard service package, the CoC Framework was developed in 2003 and revised in 2011 (Figure 1).

Figure 1. Continuum of Care for PLHA, 2011 Framework



ANC: antenatal care
IPD: in-patient department

MNCH: maternal, newborn, and child health
OI: opportunistic infection

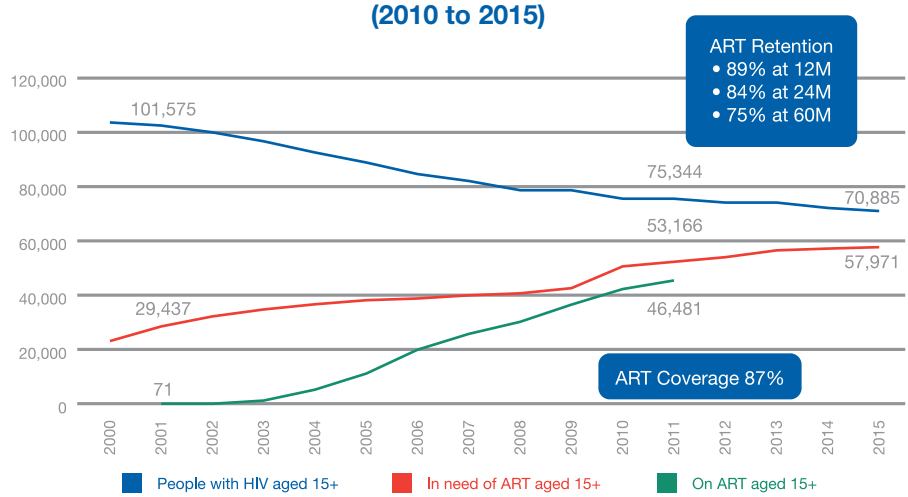
PAC: Provincial AIDS Committee

The CoC Framework was applied at the operational district level, where the Vice Governor and the Referral Hospital Director and/or the pre-ART/ART Team Leader co-chaired the CoC Coordination Committee. The involvement of high-level authorities ensured better coordination among the stakeholders and facilitated communication among them. Representatives from health facilities, NGOs, PLHA, and the local community regularly attended the meetings.

At the community level, home-based care teams and PLHA self-help groups (SHGs) encouraged those who were at high risk of HIV infection, such as partners of PLHA, to access VCT and then linked them to pre-ART/ART services at district-level hospitals. PLHA volunteers at the hospitals helped patients enrol in pre-ART care. They were then referred back for care and support in their own communities. Since SHGs now played a major role in supporting home-based care, government centre staff were no longer burdened with visiting homes.

Also during this period, Centres for Friends Helping Friends (Mondul Mith Chuoy Mith, or MMM) were organised and attached to pre-ART/ART service centres. MMM members acted as facilitators for social support and community education. In paediatric wards, the AIDS care services for children, referred to as mmm, were extended. With all HIV-related facilities located within the compound of the hospital, MMM/mmm helped build connections between PLHA, families, NGOs, health workers, religious leaders, and local authorities, thus, significantly improving the health and well-being of PLHA. In the course of Phase II, the standard model laid out in the Framework, which by then was expanded across the nation, assured faster and wider coverage of PLHA, which grew to over 85 per cent by

Chart 1. PLHA in Need of/on ART 15 Years Old + (2010 to 2015)



Source: Conceptual Framework for Elimination of New HIV Infections in Cambodia by 2020 (National Centre for HIV/AIDS, Dermatology and STD Control, 2012)

2011. ART Retention at 12, 24, and 60 months reached 89 per cent, 84 per cent, and 75 per cent respectively (Chart 1).

3. *HIV-Maternal and Child Health (MCH) and HIV-TB Service Linkages Involving Health Centres for Provider-Initiated Testing and Counselling (PITC)*

In the late 1990s, several attempts were made to introduce PMTCT and TB/HIV collaborative activities. At that time, HIV services, including VCT, were available only at referral hospitals and very few health centres. MCH and TB services were available at the health centre level. A trial of coordinating HIV, MCH and TB services, however, did not lead to substantial service coverage.

By 2006, it was clear that the collaboration of HIV, MCH, and TB progammes could only succeed if a service delivery model explicitly prescribed their linkages. Concerted efforts identified the roles and responsibilities of respective programmes and established systematic linkages between the related services.

The use of PITC within health centres, where pregnant women and TB cases were checked, became a strategic intervention. PITC for PMTCT and TB cases was expanded for pregnant women, supported by blood sample referrals from health centres.

By 2011, HIV testing coverage among pregnant women and TB cases progressively increased to over 80 per cent. Coverage of ARV among estimated HIV positive pregnant women reached 65 per cent, while 89 per cent of all newly-diagnosed TB cases with HIV infections received ART in 2012.

4. *Network for Reaching and Serving Key Populations (KPs)*

Even as strategically forged links between the community and various services were making impressive achievements, the 1998 crackdown on brothels, required new, more creative approaches in reaching sex workers who shifted from brothels to entertainment houses, giving rise to the term Entertainment Workers (EWs). The 2007 law on human trafficking intensified political, legal, and social policies and regulations making it doubly hard to reach SWs and to refer them to health services.

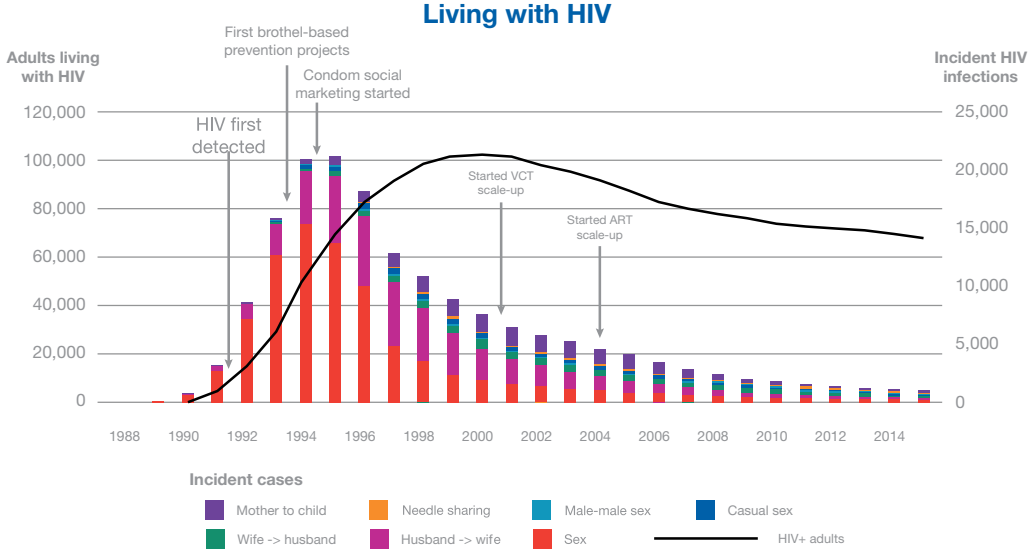
NGOs worked closely with NCHADS to intensify prevention and referral efforts for KPs among whom HIV transmission was escalating. The need for HIV prevention was highlighted not only due to the growing number of EWs (indirectly offering sex), but also the recognition of men who have sex with men, transgender, people who use drugs, and people who inject drugs. This new trend engaged civil society and peer networks to reach and educate these KPs and to help them to access HIV testing, STI services, HIV treatment, and other health services.

Phase III. Towards the Elimination of New HIV Infections (2012 to 2020)

The achievements of Phases I and II led to the decline of HIV infections, as shown in Chart 2. At the United Nations General Assembly High Level Meeting on AIDS in New York in June 2011, Cambodia expressed its support of the global goals and targets to intensify efforts to eliminate. As such, it has set an ambitious goal of eliminating new HIV infections by 2020 via Cambodia 3.0. The main components of this strategy are:

- Elimination of MTCT
- HIV prevention targeting KPs and linking them to health services
- Optimisation of the cascade of interventions: HIV testing, linkages to care and treatment, and eventual prevention

Chart 2. Estimated Number of Adults Newly Infected with HIV and Those Living with HIV



The series of building blocks from Phases I and II will be maximised to implement Cambodia 3.0.

Outcomes

Efforts during the first two phases of Cambodia's response to HIV have significantly reduced HIV infection in the country. By 2011:

- HIV prevalence rate among adults aged 15 to 49 had gone down to 0.60 per cent.
- Coverage of PLHA grew to over 85 per cent, with ART retention at 12, 24, and 60 months, reaching 89 per cent, 84 per cent, and 75 per cent, respectively.
- HIV testing coverage among pregnant women and TB cases increased to over 80 per cent.
- Coverage of ART among HIV positive pregnant women reached 65 per cent.
- Of all newly diagnosed TB cases with HIV infections, 89 per cent received ART.

Challenges

With Cambodia 3.0, the country is facing many challenges, such as:

- Reaching and serving KPs at highest risk
- Partner notification and involvement
- Overload of health workers receiving very low salary
- Still fragmented health and community systems (Primary Health Care, TB, malaria, etc.)
- Limited leadership and management capacity at sub-national level
- Real time data generation and use (surveillance, programme, financial) and limited data for modelling, impact monitoring, and verifying elimination
- Programme efficiency, cost effectiveness, and financial sustainability

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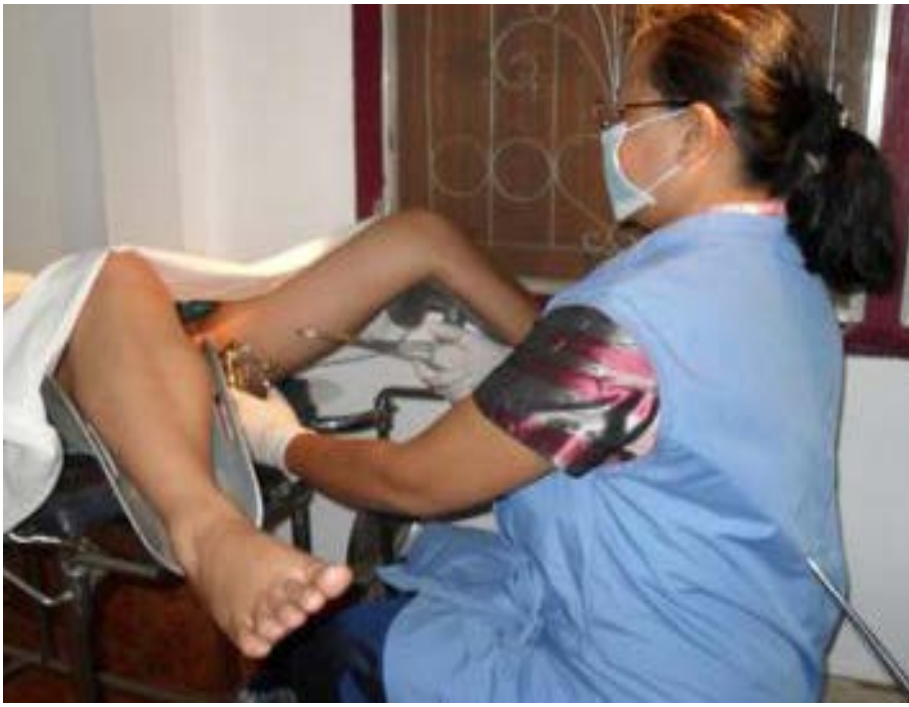
Drop-In Centres for Female Sex Workers: The Lao PDR Model

Introduction to the Practice

Lao PDR has a comprehensive prevention programme targeting female sex workers (FSWs) and men who have sex with men (MSM). The prevention programme consists of peer-led interventions, Drop-in Centres (DICs), testing and counselling for HIV and sexually transmitted infections (STIs) as well as referral for antiretroviral therapy. In 2012, about 84.5 per cent of FSWs and 26.9 per cent of MSM had been reached by peer-led interventions. By the end of 2012, there were 28 FSW outreach workers, 632 peer educators working with FSWs, 25 MSM outreach workers, and 494 peer educators working with MSM. The Integrated Biological and Behavioural Surveillance (IBBS) in 2011 estimated HIV prevalence among FSWs to be 1 per cent to 1.5 per cent using the Asian Epidemic Model.

This was not always the case. In 1999, the prevalence rate among FSWs was high. Sex work was fast evolving, with FSWs increasingly using mobile phones to contact clients and engaging more and more in opportunistic work, making them harder to reach through traditional drop-in centres and outreach HIV prevention programmes.



An FSW having a clinical service at the DIC

In spite of HIV surveillance among FSWs, which was started in 2001, there was still not enough knowledge to adequately understand contextual factors, especially among FSWs operating outside the bars or karaoke restaurants.

As a response to the changing practices in sex work by FSWs and the lack of knowledge about FSWs within this context, the government and some of its partners initiated an HIV prevention project referred to as the Drop-in Centre Initiative. It was a new approach because the DICs were peer-led.

The DIC Initiative was supported by The Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States Agency for International Development, and FHI 360, in close collaboration with the Lao PDR Centre for HIV/AIDS and STI, the Ministry of Health, and other partners.

Although the basic design remained through the years, the mechanics of the project and the DICs themselves changed as FSWs continued to evolve. Because it adapted, the DIC Initiative remains an active and successful project. Currently, there are nine DICs: one each in Xieng Khouang, Bokeo, Luang Prabang, Savannakhet, and Champasak, and four in the capital, Vientiane.

The objective of the DIC Initiative, which has remained the same until today, was to deliver a comprehensive package of services (CPS) that includes:

- Intensive inter-personal communication activities to promote behaviour change
- Free voluntary counselling and testing (VCT) using rapid test kits
- Diagnosis and treatment of STIs
- Referral to HIV care and treatment
- Provision of male and female condoms and lubricant

How It Works

- The DIC was a place where FSWs and their clients visited to access VCT, STI services, and referral information. Being able to bring clients to the DIC for services was one of the project's unique innovations.
- It was set up like a home because it offered a comfortable and safe environment for FSWs to rest, relax, and discuss common and intimate issues freely. They could also take part in outreach activities.
- It was a learning centre where FSWs acquired skills such as condom use and condom negotiation, safe sex practices, and life skills.
- It was a centre for health where FSWs received:
    - Free consultation and treatment from a doctor
    - On-site VCT with same day result and STI screening and treatment, including symptomatic treatment and monthly periodic asymptomatic presumptive treatment
    - Male and female condoms and lubricants
    - Referral services

Each DIC had a peer outreach programme where FSWs trained as outreach workers linked FSWs based in bars and in other entertainment establishments to the DIC.

- Intensive outreach was the key to the success of the DIC. Participatory development of interactive behaviour change communication (BCC) themes for outreach activities helped in upholding the morale of the outreach workers. The changing monthly BCC themes were based on FSWs needs. It also helped retain the interest of FSWs by preventing "message fatigue" during outreach activities.
- Trained FSWs, who were either recruited from the bars or selected by the Provincial Committee for the Control of AIDS (PCCA), worked as outreach workers and conducted the outreach activities.

- In order to have good access to FSWs, the outreach workers established a strong relationship with bar owners (mamasans) and obtained permission from them to talk to the FSWs.
- Each DIC had four outreach workers who worked five days a week and visited at least two bars a day. Some DICs covered as few as 11 bars while others covered as many as 56.
- The outreach workers used their own motorcycles for outreach while the DIC provided the fuel. Each visit lasted 30 to 45 minutes during which outreach workers presented themed education sessions on STIs, HIV and AIDS, condom use, sexual and reproductive health, basic life skills, men's desires, and other intimate topics.
- Outreach workers used the outreach manual and information, education, and communication materials, produced with FHI 360 assistance, for the education sessions that usually included a demonstration on the proper use of both male and female condoms and ended with condom distribution. The bar managers or owners sometimes attended the outreach sessions and participated in the discussions.

The PCCAs coordinated the activities of the DICs, in consultation with the FSWs, who served as outreach workers. They also supervised and monitored the outreach workers and provided feedback for further improvements. Usually, a nurse managed the DIC while a doctor coordinated all the DICs in a province.

Outcomes

The project showed how an effective HIV and STI intervention could be built through close collaboration between government, key populations, civil society, and private sector partners, with a strong element of peer leadership in the delivery of products and services to a target group. The 2011 IBBS showed the following results:

- The provision of quality CPS to FSWs through the DICs reached 80 per cent of FSWs in target provinces.
- Due to the high coverage of FSWs through DICs, there was a significant increase in condom use among FSWs across the five provinces and in Vientiane.
- Access to prevention and STI interventions among FSWs, mainly in DICs, reached 84.5 per cent.
- Condom use rate among FSWs was 92 per cent.

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Harm Reduction-A Way Towards Achieving A Goal, Malaysia

Introduction to the Practice

Malaysia reported its first case of HIV in 1986. By 31 December 2005, a cumulative total of 70,559 HIV cases was reported to the Ministry of Health (MOH). Of this, 52,407 or 74.2 per cent were people who inject drugs (PWID). In 2002, when the country experienced its highest number of HIV cases ever reported, which was 6,978, the percentage of infection among PWID was at 5,176 or 74.2 per cent.

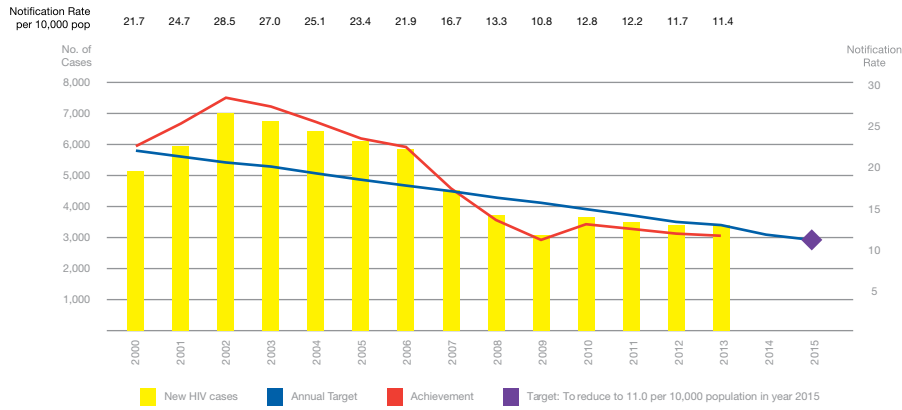
The rapid spread of the HIV epidemic among PWID in Malaysia was mainly caused by sharing needles and syringes. With PWID being the major affected population, the government instituted a Harm Reduction Programme (HRP) that included Opiate Substitution Therapy (OST) and Needle and Syringe Exchange Programme (NSEP). At that time, HRP operated side-by-side with a repressive programme that called for compulsory detention and treatment of drug users to ensure abstinence from drugs.

It is worthy to note at this point that since 2007, the Malaysian government has discontinued compulsory detention and treatment and instead has promoted and offered voluntary treatment options for clients. This major policy change is widely seen as a landmark change in the government's former repressive attitude towards PWID and people who use drugs in Malaysia. It has become a prototypical model for other countries.

HRP started as a pilot project in October 2005. On 12 April 2006, it was implemented nationwide to reduce, if not altogether halt, HIV infection among PWID in the country. This was in line with Malaysia's commitment to the Millennium Development Goals (MDG) to reduce new HIV cases from 21.7 per 100,000 population in 2000 to 11.0 per 100,000 population in 2015 (Chart 1).

HRP was entirely funded by the Malaysian government. Aside from OST and NSEP, HRP also provided other harm reduction services such as voluntary counselling and testing, the provision of antiretroviral

Chart 1. Targets and Achievements 2000 to 2015



drugs, treatment for sexually transmitted infections (STIs), counselling, health education, social welfare, job placement, and rehabilitation.

Today, HRP remains at the heart of Malaysia's response to HIV and AIDS. It is jointly implemented by the MOH, the National Anti-Drug Agencies (NADA), the Prison Department, and the Ministry of Education (MOE), as well as non-governmental organisations (NGOs), and at the latest count, 387 general practitioners (GPs), all zealously working together to make the programme a major contributor to the HIV and AIDS response of the country.

How It Works

Globally, harm reduction has been proven to contribute to the decline of HIV infection among PWID. In the case of Malaysia, the decrease of HIV infection among PWID is considered an important achievement, considering the overall social and political environments when HRP was started.

To ensure that HRP was implemented successfully, from the beginning, the interplay between and among 3 Ps-Political Will, Policy, and Participation-was addressed and managed.

Political Will. Commitment and support from the country's highest leaders played a major role in ensuring the success of the HRP. Besides Malaysia's commitments to international communities, such as the United Nations Declaration of Commitment on HIV and AIDS and to the MDGs, the national leadership endorsed the National Strategic Plan on HIV and AIDS 2006 to 2010 in April 2006. This plan emphasised HRP as the way to reduce HIV vulnerability among PWID, and between them and their sex partners. The programme was further strengthened under the National Strategic Plan on HIV and AIDS 2011 to 2015, as well as the government's commitment to provide a specific budget allocation for HRP implementation.

The National Task Force on Harm Reduction Committee was established at the national level to ensure the proper monitoring and consultation regarding the progress of HRP. The committee members consisted of selected government personnel, NGO representatives, and private practitioners. Quarterly meetings were held during the initial stages of programme implementation and, currently, at least once a year. The committee members were later assigned to the implementation level for the same purpose (monitoring and consultation).

Policies. Using a public health approach created a remarkable paradigm shift in the policy. Under this approach, harm reduction interventions and voluntary treatment options replaced the repressive focus on punishment and law enforcement. The public health approach that the government took considered the numerous drug-related harms among PWID that had health impacts on individuals and communities, such as transmission of HIV and STIs.

HRP changed the perception of government and the public towards PWID, from criminals to patients in need of services and voluntary treatment options. It was the platform that enabled PWID to come forward and access HRP services, and to participate in health promotion that contributed to positive behavioural change.

The shift enabled law enforcement officers and health professionals to cooperate and work together when dealing with drug related issues. The Malaysian Royal Police (MRP) and health professionals were communicating regularly before judicial actions were taken in situations related to the arrest of HRP patients/clients. Because of the public health approach, the MRP has included HRP as one of the subjects in the curriculum of police training. This consistently raised awareness about HRP among law enforcers. The police also conducted regular meetings with NGOs involved in HRP to ensure that HRP activities, in particular NSEP at outreach sites, ran smoothly.

Following the new policy, key government leaders from various involved agencies shifted their own programmes. NADA, for example, has transformed its programme from punishment to harm reduction and voluntary treatment options for drug users. It now offers OST services in 59 of its facilities. This process has been documented and is recognised as a major success for the country and the Southeast Asian region as a whole.

Participation in service delivery. Guided by the new policy, HRP was implemented by the government, NGOs, and private sector health professionals. The participation of private sector health professionals was deemed important to provide choices of service settings to PWID. Prior to the implementation of the HRP at each site (NGO, government, and private), proper training was carried out, covering programme implementation and addressing issues of stigma and discrimination.

Client receiving OST

The delivery of harm reduction services, especially OST and NSEP, was integrated with existing services provided at the government's primary health care settings. Government's secondary health care settings and private sector health providers concentrated on OST while NGO sites provided NSEP. The variety of service providers enabled PWID to have choices on where to go for harm reduction services. Continuous awareness and promotion of HRP at all health care settings has contributed to the reduction of stigma and discrimination toward PWID, thus ensuring HRP services could be provided smoothly. In cases where other health or social services were required, PWID were referred to other clinics or offices, including those operated by NGOs. This service delivery strategy optimised manpower, finances, as well as infrastructure, especially when the project ran in the same facility.

Outcomes

Based on HIV surveillance and various surveys under the Integrated Biological and Behavioural Surveillance, the following were the results attained by the HRP:

Harm reduction staff preparing for an outreach

- Successful decline in new HIV cases reported
  - From 6,120 cases in 2005 to 3,393 cases in 2013
  - From 23.4 per 100,000 population in 2005 to 11.4 per 100,000 population or a reduction of 44.6 per cent of new HIV cases since 2005
- Reduction in the percentage of notified HIV infection due to PWID, from 4,038 cases in 2005 to 728 cases in 2013 (66 per cent to 21.5 per cent)
- Decrease in the prevalence of HIV among PWID, from 22.1 per cent in 2009 to 18.9 per cent in 2012

Additionally, as of December 2013, HRP achieved the following:

- A cumulative number of 137,935 (81 per cent) of an estimated 170,000 PWID were enrolled in the HRP.
- Patients totalling 62,249 were registered for OST at 811 facilities that included 424 public facilities under MOH, NADA, the Prison Department, MOE, as well as 387 GPs.
- For NSEP, 72,686 clients were enrolled at 728 sites, with 576 sites managed by NGOs, specifically the Malaysian AIDS Council and its affiliates, while public health clinics managed 152 sites.

Challenges

The integrative action of the various government departments and agencies together with their partners, NGOs, private agencies, and health professionals, has made HRP truly beneficial to the country. However, in order to reverse the HIV epidemic, it is crucial to continue to strengthen and expand it. To ensure continuity and accessibility of services, constant monitoring and evaluation, as well as the review of guidelines and policies, would also need to be done.

The following are specific challenges that the programme faces by the end of 2015:

1. To further improve accessibility to HRP. Since all the government health clinics are within reach, there is a need for all government health clinics to be able to provide harm reduction services throughout the country. Continuous HRP awareness and training for health professionals at health clinics must be carried out to ensure that they are well prepared to provide HRP services to PWID.
2. To review specific policies, guidelines, and standard operating procedures on OST and NSEP, for example, policies on take home dose and dose for special circumstances, e.g. for seafarers who are away for more than two weeks with no other access to harm reduction interventions.
3. To further develop, expand, and strengthen the response to drugs and HIV and AIDS in order to materialise the dream of an AIDS-free Malaysia.

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HIV and STI Prevention and Care for Gay, Transgender and MSM, Indonesia

Introduction to the Practice

In July 2009, the Australian Agency for International Development (AusAID) Indonesia, through the Australia-Indonesia Partnership for HIV and the Indonesia Partnership Fund, provided AUD$170,000 to the National AIDS Commission (KPAN) for a project to develop a comprehensive National Action Plan for the prevention of HIV and AIDS among gays, warias, (transgender and transvestites), and men having sex with men (MSM), known in Indonesia as Laki-laki seks dengan laki-laki (LSL). They are collectively referred to as GWL. The project also supported some initiatives to start up the National Action Plan's implementation.

This Plan later on became part of the National HIV and AIDS Strategy and Action Plan 2010 to 2014, launched in March 2010, signalling KPAN's commitment to address HIV among GWL as a national priority. Under this Plan, a programme was developed with the goal of reducing HIV transmission amongst GWL in Indonesia and to improve their quality of life. This will be achieved by improving the coverage and quality of the comprehensive HIV prevention and care for GWL. The initiatives funded by AusAID in 2009 are still on-going under another AusAID, now known as Department of Foreign Affairs and Trade, project.

The Programme is being implemented through multi-sectoral collaboration among KPAN, the Ministry of Health (MOH), National Network of Gay, Warias, and LSL Indonesia (GWL INA), and other local partners, including local non-governmental organisations (NGOs).

How It Works

The national programme for GWL has five components, categorised as technical, structural, and monitoring and evaluation.

Technical

1. GWL involvement and ownership of the programme, ensuring that they take part in planning and programme development
2. Interventions to create a social environment that supports the GWL programme through peer approach whether using outreach programmes or the social media to increase access to services by GWL
3. Prevention of new HIV and sexually transmitted infections (STI) among GWL through GWL-friendly clinics

Structural

4. Increased availability of high quality, accessible, and friendly sexual health services for GWL

Monitoring and Evaluation

5. Increased HIV treatment access associated with a strong positive prevention programme for GWL

In line with the above components, KPAN identified five GWL priorities under the project:

1. Development of a collaborative GWL HIV programme model at national and local levels
2. Development of an enhanced communication strategy for the prevention of new HIV infections
3. Improvement of the quality and accessibility of sexual health, including STIs and HIV treatment services
4. Addressing stigma and discrimination against GWL
5. Research and data analysis to better understand the epidemic among GWL and ensure an evidence-based effective approach In December 2010, KPAN identified the project area, made up of 36 districts and cities in 10 provinces, based on prevalence (Table 1).

The project used a decentralised and inclusive community-based model, carried out by employing a member of the GWL community as Programme Officer, who then sat at the Local AIDS Commission office. The programme officer developed and nurtured relationships with the local community.

Table 1. KPAN Project Areas

No.	Province	City/District	No.
1	North Sumatera	Kota Medan Kota Pematangsiantar Deli Serdang	1 2 3
2	Riau	KotaPekanbaru Indragiri Hilir Rokan Hilir	4 5 6
3	Riau Islands	Kota Batam Kota Tanjungpinang Karimun	7 8 9
4	DKI Jakarta	Jakarta Barat Jakarta Timur Jakarta Pusat Jakarta Utara Jakarta Selatan	10 11 12 13 14
5	West Java	Kota Bandung Kota Bekasi Kota Bogor Kota Cirebon Indramayu	15 16 17 18 19
6	East Java	Kota Surabaya Sidoarjo Malang Kediri Gresik	20 21 22 23 24
7	Bali	Kota Denpasar Badung Buleleng	25 26 27
8	South Sulawesi	Kota Makassar Kota Pare-pare Jeneponto	28 29 30
9	East Kalimantan	Kota Samarinda Kota Tarakan	31 32
10	West Kalimantan	Kota Pontianak Kota Singkawang Sambas Ketapang	33 34 35 36

Outreach for Hidden GWL

To increase contact with hidden GWL, outreach was carried out using two diverse methods, namely:

- *Outreach through GWL Peer Educators*. This involved developing and accrediting a curriculum and its training modules; conducting a training of trainers of representatives from MOH, NGOs, peer outreach, and GWL community representatives; and holding a post-training evaluation through site visits to see the impact of the training on the GWL.
- *Outreach through Social Media*. A web site, www.proyekcinta.com, was created and managed by GWL INA. It contained information regarding lifestyle using popular GWL lingo. With this format, it aimed to casually inform and educate the GWL community, including young GWL, about HIV and STI prevention and other sexual health issues.

Access GWL-Friendly Services

The project conducted two STI Sustainable Management Training courses focusing on the health of GWL. Trainees were composed of doctors, paramedics, laboratory personnel, and administrative officers. By December 2012, key personnel of 12 public and 4 private clinics in 15 districts and cities were trained to provide GWL-friendly services (Table 2).

Outcomes

- In September 2011, the community-based GWL model that began in 10 cities was successfully expanded. It now covers all of the project areas, consisting of 36 districts and cities in 10 provinces. In each district and city, GWL Programme Management Teams have been trained and are integrated as part of the Local AIDS Commission.
- GWL-friendly services in Bali and Jakarta are but two of the districts and cities seeing increasing access by GWL in clinics involved in the project.

Challenges

Projections indicate that the GWL population will continue to be one of the main drivers of the HIV epidemic through sexual transmission. Modelling results of the MOH in October 2012 shows an increase in the number of new HIV infections in the GWL population. With these anticipated challenges, GWL studies aimed at the following are being undertaken:

- Reviewing the implementation of the models of existing GWL projects
- Developing strategy recommendations to improve the quality of GWL programming, including effective communication strategies to further extend the reach towards hidden GWL

Table 2. Clinics Providing GWL-Friendly Services

No.	Clinics (public, private)	Location (city, province)
1	Klinik IMS Bestari (private)	Medan, North Sumatera
2	Puskesmas Lubuk Baja (public)	Batam, Islands of Riau
3	Ruang Carlo, RS. St. Carolous (private)	Central Jakarta, DKI Jakarta
4	Puskesmas Tambora (public)	West Jakarta, DKI Jakarta
5	Puskesmas Ciracas (public)	East Jakarta, DKI Jakarta
6	Klinik Mawar PKBI (private)	Bandung, West Jawa
7	Puskesmas Makkasau public)	Makassar, South Sulawesi
8	Puskesmas Alianyang (public)	Pontianak, East Kalimantan
9	Puskesmas Kaliabang Tengah (public)	Bekasi, West Jawa
10	Puskesmas Jagir (public)	Surabaya, East Jawa
11	Puskesmas II Denpasar Utara (public)	Denpasar, Bali
12	Puskesmas Kuta II (public)	Kuta, Bali
13	Klinik Balimedika (private)	Kuta, Bali
14	Puskesmas Buleleng I (public)	Buleleng, Bali
15	Puskesmas Kampung Baru Tengah (public)	Balikpapan, East Kalimantan
16	Puskesmas Simpang Tiga (public)	Pekanbaru, Riau

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HIV Prevention, Care, Treatment, and Support Programme in a Prison Setting, Indonesia

Introduction to the Practice

Currently, there are 232 prisons, 201 remand centres, and 72 probation units throughout Indonesia. Sixteen of these units are classified as narcotics prisons.

Prisons were designated as narcotics prisons starting in 2003, with the aim of addressing the needs of inmates sentenced for drug-related crimes. As of September 2012, there were 148,352 inmates in prisons and remand centres, of which 35 per cent were incarcerated for drug-related offences.

In the national prison study, Report on HIV and Syphilis Prevalence and Risk Behaviour among Prisoners in Prisons and Detention Centres in Indonesia 2010 (HIV and AIDS Cooperation Programme for Indonesia (HCPI) and the United Nations Office on Drugs and Crime (UNODC) (2010), 8 per cent of male inmates in general prisons and remand centres and 13 per cent of male inmates in narcotics prisons reported a history of injecting drug use. The Directorate General of Correctional, Ministry of Justice and Human Rights (MJHR), in recognition of the findings, called for and led the development of a multi-year strategy known as the Control of HIV and AIDS and Drug Abuse in Prisons 2005 to 2009. Under the strategy, 95 prisons and remand centres were designated as national priority correctional units. Technical training and management programmes were conducted for the prison officers. In 2009, an extensive scale up of the comprehensive HIV programme in correctional facilities was planned and implemented.

In January 2010, the National Action Plan for the Control of HIV and AIDS and Drug Abuse in Correctional Units in Indonesia 2010 to 2014 was released.

In 2012, as Indonesia took the lead in the regional initiative ASEAN Cities Getting to Zero, MJHR launched the Getting to Zero HIV and Drugs in a Prison Setting programme, a platform for HIV prevention, care, treatment, and support in prisons. The programme aimed to increase the coverage and services related to HIV and drug use among inmates.

Prison officials saying prayers before a training on HIV and AIDS

The objectives of the programme are:

- To reduce HIV and sexually transmitted infections (STIs) among prisoners
- To improve the life-quality of prisoners and to provide them the necessary skills to prevent HIV and STIs post-release
- To ensure that HIV prevention and care services are accessible to prisoners in Indonesia

This effort is a collaboration by many sectors, including the National AIDS Commission (NAC), the Ministry of Health (MOH), MJHR, in particular the Directorate General of Correctional (Prison), and local non-governmental organisations working inside prisons across Indonesia.

Originally supported in 2004 by the former Australian Agency for International Development through the Indonesia HIV/AIDS Prevention and Care Project, it is currently funded by Australia's Department of Foreign Affairs and Trade, channelled through HCPI, The Global Fund to Fight AIDS, Tuberculosis and Malaria, and domestic funds.

How It Works

The National Action Plan for the Control of HIV and AIDS and Drug Abuse in Correctional Units in Indonesia 2010 to 2014 outlines the direction and policies, strategies, values, programme scope, and its measures of success. The plan consists of three main programmes:

1. Sustainable provision of guidance and law enforcement, social services, and therapy and rehabilitation
2. Prevention, care, and treatment of HIV, AIDS, and other opportunistic infections (OIs)
3. Evaluation, research, and development

The following sub-programmes and activities have been implemented since 2009 to this day:

- **Education programme.** Activities include prevention education for new inmates, followed by a more in-depth one as the inmates continue to spend time inside the prison; peer support and drug rehabilitation groups; condom distribution in the prison clinics; bleach for cleaning equipment for injecting, tattooing and piercing; inmate training as peer and health educators; and improved occupational safety and environmental health. As part of this sub-programme, an HIV curriculum is officially taught at the corrections' pre-service training institution for prison staff to ensure that inmates and the prison staff themselves are knowledgeable about HIV.
- **Clinical programme.** Activities include strengthening the provision of voluntary counselling and testing (VCT) and provider-initiated testing and counselling for HIV, TB diagnosis and treatment, case management, methadone dispensing, drug rehabilitation, referral to treatment for Ois, antiretroviral therapy (ART), and treatment for sexually transmitted infections.
- **Mentoring.** A variety of training courses are provided for the prison clinical staff. Learning tools that are being used are mentorship, site visits, internships, and case study discussions.
- **Model Prisons.** There are 11 correctional facilities providing comprehensive HIV programmes that have been designated by MJHR as models and learning centres for other prisons. The 11 model prisons, located in 11 provinces, have the role of training, mentoring, and supporting other prions located in their respective provinces.
- **Partnership and mobilising resources.** Partnerships have been strengthened between MOH, NAC, and other key stakeholders at the national, provincial, and at the district levels.

- **HIV monitoring and evaluation.** An integrated HIV recording and reporting network in the correctional system has been developed and established. The system assists the correctional institutions and staff to monitor and evaluate their programme and services promptly.

A prisoner taking his methadone maintenance treatment dosage in front of the health officer, Kerobokan Prison, Bali

Outcomes

The main achievements of the HIV Prevention, Care, Treatment, and Support Programme in a Prison Setting include:

- One hundred sixty-five correctional units (prisons) in 25 of Indonesia's 33 provinces have an HIV programme.
- HIV information is being provided routinely to new prisoners in 142 prisons and remand centres and to inmates who are about to be released from 23 probation units.
- A comprehensive HIV programme consisting of the provision of HIV information and education, VCT, ART, and support groups are provided in 122 prisons and remand centres. In some prisons, inmates are referred to nearby clinics, while in others the prison clinics provide ART.
- Methadone maintenance treatment (MMT) is available in nine prisons and detention centres.
- Integrated HIV recording and reporting, as part of the comprehensive monitoring and evaluation of the prisons programme, is being implemented in 165 corrections units.

The Education programme also showed positive results:

- The 2010 national prison study showed over a third of the respondents reported prison officers as a source of HIV information, higher than any other source.
- Prisoners' knowledge of HIV was high, with a third having a comprehensive knowledge and with most understanding the risks of sharing injecting equipment and unsafe sex.
- HIV programming has helped with the upgrading of systems and human resources within the correctional system and has demonstrated that much can be done even with limited resources.

Female prisoners meeting with local NGOs in Pontianak to talk about HIV and AIDS

Challenges

Despite significant developments in the response to HIV in the correctional system in Indonesia, there remain many areas for programme improvement.

- In the context of a comprehensive programme, the major gaps are in the limited or non-availability of condoms, bleach, and sterile needles.
- While availability of condoms in correctional facilities is part of the National Action Plan, they are not currently available in many facilities as the policy is yet to be universally accepted.
- The correctional system's monthly reports showed only 2 per cent to 3.5 per cent of inmates were identified as people who inject drugs but the prison study in 2010 and 2012 showed the distribution of inmates with history of injecting drug use was between 8 per cent to 13 per cent.
- The high prevalence of HIV among female inmates compared to male inmates in general prisons is a concern.
- Improving health programmes for female prisoners need to be intensified.
- There is a need to enhance pre- and post-release programmes to ensure continuity of care, including improvement of the knowledge and skills of parole officers as case managers.

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HIV Serosurveillance, Brunei Darussalam

Introduction to the Practice

Brunei Darussalam has always been considered a country with an estimated low HIV prevalence of only 0.01 per cent in the general population. This figure is approximated from the number of positive HIV cases reported through the serosurveillance system that the country has been using since the 1990s, a strategy initiated and implemented by the Ministry of Health as part of its routine services and fully funded by the government.

Brunei Darussalam recorded only 81 cases of HIV infections among its local population, from 1986 to 2012, with 44 (54 per cent) of these cases recorded in a period of 5 years (2008 to 2012). By the end of 2012, a total of 56 persons were known to be living with HIV, with 2 AIDS-related deaths recorded.

Since 1995, Brunei Darussalam only had one case of mother-to-child transmission (MTCT) which was recorded in 2011 when the mother was screened during labour. In the past five years, a total of eight other children were born to four HIV-positive mothers.

Other than the above-reported cases of MTCT, nearly all of the cases recorded from 2008 to 2012 were reportedly transmitted through sexual contact. Of these cases, 30 per cent were from men having sex with men (MSM). Some 75 per cent of new cases reported were male and 36 per cent of new cases were married during the given period. There is no known transmission through people who inject drugs (PWID), for in general, in Brunei Darussalam, drug use is reportedly done through oral or inhalational means.

Key populations (KPs) such as sex workers (SWs), MSM, and PWID are either hidden or seeming to be virtually non-existent. With difficulty in reaching these KPs and taking into consideration the available resources and services, Brunei Darussalam's strategy for HIV surveillance is based largely on serosurveillance of certain identified groups in the general population. Screening of these groups enables the early detection of new cases of HIV infection which would allow for their early treatment. Also, this would enable necessary measures to be taken in order to limit further transmission.

How It Works

Other than what is reported in the serosurveillance system itself, there have been no studies to quantify the prevalence of HIV within the general population. HIV serosurveillance has been ongoing for the past two decades, with the following groups screened routinely for HIV (Table 1):

- **Pregnant women.** They are generally considered a good proxy for HIV prevalence for the general population. This is according to the Guidelines for Conducting HIV Sentinel Serosurveys among Pregnant Women and Other Groups by the Joint United Nations Programme on HIV/AIDS, World Health Organization Working Group on Global HIV and AIDS and Sexually Transmitted Infections (STIs) Surveillance, 2003. All expectant

mothers residing in Brunei Darussalam are provided free antenatal care. During antenatal assessment, HIV, syphilis, and hepatitis B are screened. A positive HIV test would result in an urgent referral to a specialist at the hospital to access treatment for the prevention of mother-to-child transmission.

Table 1. Number of HIV Tests Done by the Main Laboratories in Brunei Darusalam 2010 to 2012

	2010		2011		2012	
	No. of Tests	Positive Tests	No. of Tests	Positive Tests	No. of Tests	Positive Tests
Blood donors*	N/A	0	13,042	0	13,545	1
Antenatal**	6419	0	8098	1	7468	1
Routine**	11310	5	12992	8	13525	8
Foreign workers***	63784	8	64485	23	65945	12
Total	-	13	98,617	32	100,483	22

* Data from Blood donors is number of total blood samples screened provided by National Blood Bank, RIPAS Hospital
** Data from Antenatal and Routine tests provided by Department of Laboratory Services
*** Data from Foreign workers provided by Department of Scientific Services

- **Blood donors.** All blood donors are screened for HIV and other diseases for every donation.
- **Frequent recipients of blood and blood products.**
- **Tuberculosis (TB) patients.** Brunei Darussalam's policy is to routinely screen all persons diagnosed with TB for HIV. It is a well-established fact that TB is one of the most common opportunistic infections in HIV patients. In a low-level HIV epidemic state, the main objective of HIV surveillance in TB patients is to alert TB and HIV programmes about a potential HIV problem in order that appropriate changes can be made to their programmes.
- **Potential employees during medical check-ups.**
  - Under the Employment Order 2009, every employee entering into a contract of service is required to be examined by a medical practitioner. HIV testing is included in the comprehensive medical examination but is not a pre-requisite for the purpose of employment.
  - Workers who are deemed to be high-risk are also routinely screened every few years. This group includes healthcare workers and other first responders such as police, security, fire, and rescue personnel.
  - Foreign workers applying for a permit to work in Brunei Darussalam are required to undergo pre-departure medical examination that includes an HIV test in their country of origin. The worker is tested again for HIV within a few weeks of arrival in Brunei Darussalam to endorse the work permit. The worker is required to undergo another HIV test every two years for renewal of the work permit. A positive HIV test would result in denial or cancellation of a foreign worker's permit.

- **High risk contacts of known HIV cases.**
- **Patients presenting symptoms of STIs.** Individuals who are infected with an STI are at least two to five times more likely than uninfected ones to acquire HIV infection if they are exposed to the virus through sexual contact. In addition, an HIV-infected individual infected with another STI is more likely to transmit HIV through sexual contact than other HIV-infected persons.
- **Detainees**, e.g., prisoners and persons in drug rehabilitation. In many prisons around the world, there are high rates of HIV infection. Detainees such as prisoners and drug rehabilitees are routinely screened for HIV at the start of detention. Although there is no data on prevalence of PWID in Brunei Darussalam, the Narcotics Control Bureau reports minimal injecting drug use with the preference for drug use tending towards oral and inhalational use. HIV serosurveillance in prisoners and drug rehabilitees in Brunei Darussalam also acts as the nearest possible proxy for HIV in PWID.
- **Muslim couples for pre-marital screening.** Prior to marriage, Muslim couples are required to undergo a set of talks which involve issues ranging from religious to health to finance. Part of the health talk is a section on HIV and testing. Couples are encouraged during the talks to go to their nearest health centre for testing before marriage. Testing is not mandatory for marriage.

Outcomes

Despite the constraints on surveillance of KPs, such as SWs, MSM, and PWID, and the absence of HIV prevalence surveys in the general population, with relatively high screening numbers, the country is able to estimate that the prevalence of HIV is at a very low level. The serosurveillance programme also ensures that the national blood supply is safeguarded (there have been no cases of transmission through blood transfusion since the late 1980s) and MTCT has been virtually eliminated.

Challenges

Although persons newly diagnosed with HIV are always counselled, pre-test counselling is not always done and post-test counselling may not necessarily be given if the test is negative. It has also been reported that those with a negative result may be unaware of their HIV test result and some persons are even unaware that they have been tested for HIV.

The mindset of many healthcare workers in Brunei Darussalam is that the consent of a person to have blood taken automatically allows the healthcare worker to perform any blood test, including for HIV, and this seems to be generally accepted by the population. This has considerable ethical implications and Brunei Darussalam intends to address this issue through the implementation of voluntary counselling and testing in the future.

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How Townships are Reducing HIV Transmission among PWID, Myanmar

Introduction to the Practice

People who inject or use drugs are among the highest risk groups in a large part of Asia. In Myanmar, they were identified as a most-at-risk population in the 2011 to 2015 National Strategic Plan. Thus, when the HIV/AIDS Asia Regional Programme (HAARP), funded by Australia and addressed to people who inject drugs (PWID), was implemented in the region, it included Myanmar, aside from Lao PDR, Viet Nam, Cambodia, and China. In 2012, HAARP funding for the project in Myanmar was integrated into the Three Millennium Development Goal (3MDG) Fund, a fund contributed to by a consortium of donors including Australia, where it remains today.

The project aims to reduce HIV transmission associated with injecting drug use between an estimated 35,000 PWID and their sex partners through comprehensive risk reduction and sexual and reproductive health (SRH) services in at least 9 sites. The project's activities are directed to a) improving the legal and policy environment in the country with respect to reducing HIV transmission, b) increasing access to harm reduction and SRH services, and c) involving PWID and their family members by building their capacity to participate in project planning and implementation at the community level.

Geographically, the project covers the injecting drug use hot spots in the country, namely Yangon, Mandalay, Pyinoolwin, Mogoke, Lashio, Tachileik, Taunggyi, Myitkyina, and Hpakant cities. To reach remote PWID, the project also covers five satellite sites located in the townships of Kachin State, Lonekhin and Shaduzup in Hpakant, Nansayan in Myikyina, Monghsu in Shan State, and Mogoke, close to Thabeikkyin. A joint annual progress report of the National AIDS Programme (NAP) and the Joint United Nations Programme on HIV and AIDS indicate that in 2009, the project covered 30 per cent of the hot spots, and in 2010, it increased the coverage to 40 per cent.

From its inception until December 2012, the project was funded by the Australian Government. It is currently supported by the 3MDG fund.

How It Works

The United Nations Office on Drugs and Crime in Myanmar manages the project and collaborates with government implementing partners: NAP for overall guidance and coordination, the Central Committee for Drug Abuse Control (CCDAC) for clean needles and syringes, and drug treatment centres for methadone. All three provide technical support to each Township Project Management Committee (TPMC), who in turn supervises the actual implementation of activities at the field level.

The TPMC is composed of local community leaders and elders, authorities from township hospitals, local branches of the NAP, and the Anti-Narcotic Task Force, and recovering PWID or relatives of current PWID.

The harm reduction activities are done in fixed sites like "drop-in centres", manned by trained staff, where services such as needles and syringe exchange, provision of methadone, condom distribution, primary health care, voluntary counselling and testing, referral to other services, and behaviour change communication sessions are provided. There are also outreach activities for condom distribution, distribution of clean needles and syringes and collection of used ones, follow up of clients, identification of new contacts, and provision of necessary referrals. These are done by trained outreach workers, including PWID, who underwent training in dealing with clients, health education discussions on risk behaviours, linking services and referrals, as well as distribution and collection of needles and syringes.

In view of improving the enabling environment in the project sites and at the national level, and considering the varying situations and needs of key populations, the project facilitates the ongoing review of existing laws related to people who use drugs (PWUD) and PWID. This is led by NAP, working with CCDAC and other relevant government departments.

Outcomes

As of 2012, the project has demonstrated tangible achievements (Table 1).

Other achievements:

- A total of 2,695 law enforcement personnel enrolled at the Central Police Training Institute were given awareness training on HIV and drugs. Similar trainings were conducted for the police forces in Lashio, Tachileik, and Taunggyi. Together with other United Nations agencies and harm reduction organisations, the project facilitated the strengthening of self-help groups of drug users. It also contributed in the procurement of methadone to support 1,500 clients under the national drug treatment programme.
- A legal review workshop attended by relevant government departments and national and international non-governmental organisations working in areas of drugs and HIV has put forth a set of recommendations towards revising or amending the existing law (1993 Narcotic Drugs and Psychotropic Substances Law) related to PWUD/PWIDs:

Table 1. Project Achievements

Services	Reach
HIV prevention services	15,676 drug users of which 10,478 are PWID
Distribution of clean needles and syringes	7.3 million
Distribution of condoms	1.14 million
Enrolment in the methadone programme	776
Referral to social and health services	8,052
Distribution of information, education and communication materials in local languages (Shan, Kachin, Burmease)	171,859

- Decriminalising drug use
- Removing compulsory registration of drug use
- Compulsory treatment
- Reducing punitive areas of the law

- The TPMC-managed implementation in each township has resulted in positive developments:
  - Key stakeholders, such as the Township Medical Officer, Sexually Transmitted Diseases team leader, Anti-Narcotic Task Force, Social Welfare Department, and other local authorities, together with community representatives, are seeing to it that the project is being implemented as intended.
  - In some townships, members of the community are more involved. For example, they contribute foodstuff during gatherings with clients, many times cooking the food side-by-side with PWID and project staff. These actions augur well for future sustainability.
  - Local authorities monitor project implementation. They speak for the accomplishments of the service staff and advocate for the project. They also provide insights on how the activities could better be adapted to local needs.
  - During security threats, the TPMCs provide guidance to project teams on personal safety and security of activities.

Challenges

Security is a major challenge. The hot spots are located in the mountainous parts of the country, where armed conflicts between the Myanmar military forces and armed local ethnic groups happen frequently. The smooth running of activities in places like the states of Kachin and Shan are usually met with security threats.

To prevent service interruption and to help ensure security for the field teams, the project developed a security strategy that calls for maintaining close collaboration with local authorities. The project management team in Yangon has a focal person to contact field teams, as well as authorities in relevant project areas.

The security strategy also includes:
- Regular scheduling and mechanisms of communication that have been set up in line with the changing field situation
- A well-formulated evacuation plan
- Working with PWID peers and their family members to prevent service disruption when the field teams are constrained to limit their movements

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Opt-Out Antenatal HIV Screening, Singapore

Introduction to the Practice

The majority of HIV infections in children are acquired through mother-to-child transmission (MTCT) that can occur during pregnancy, labour and delivery or during breastfeeding. In the absence of any intervention, the risk of such transmission is 15 to 30 per cent in non-breastfeeding populations and 20 to 45 per cent if breastfed by an HIV-positive mother. The risk of perinatal transmission can be reduced to less than 2 per cent by measures such as voluntary HIV counselling and testing of pregnant women, prophylactic administration of antiretroviral drugs to women and to the infant, elective caesarean delivery, and avoidance of breastfeeding.

In January 1998, the Ministry of Health (MOH) wrote to all medical practitioners encouraging them to offer HIV screening to their antenatal patients on an opt-in basis.

In October 2004, the United States Centers for Disease Control and Prevention (US CDC) recommended that an opt-out approach be implemented for antenatal HIV screening. Studies had shown that the opt-out approach could:

- Increase testing rates among pregnant women
- Increase the number of HIV-infected women who are offered treatment
- Reduce HIV transmission to their babies during birth

With the increasing trend of HIV infection in Singapore, MOH recognised that the risk of MTCT would also increase. In view of the effectiveness of the opt-out system in improving HIV detection among pregnant women and hence, allowing preventive measures to be taken, MOH decided to adopt the US CDC's opt-out recommendation for antenatal HIV screening as a standard of care for antenatal women in Singapore.

The aim of the antenatal opt-out HIV testing programme in Singapore is to detect HIV infection in pregnant women early so that appropriate interventions can be implemented to prevent MTCT. The target population of the project are all antenatal patients in Singapore.

Antenatal patients pay for the screening test as part of their antenatal care package. Government subsidies are available for antenatal patients seen at public hospitals.

The programme is implemented by both public and private hospitals and clinics and practitioners where antenatal care is offered.

How It Works

In a circular issued in December 2004, the MOH advised that all medical practitioners should implement HIV screening using the opt-out approach as a standard of care for all antenatal patients.

Under this approach, medical practitioners were asked to obtain written consent for the complete antenatal screening panel, which included the HIV test, and not for HIV testing alone. Otherwise, the HIV test would become a stand alone opt-in test. Antenatal women who objected to HIV screening could opt out of the test. However, it was important that this be an informed decision after counselling regarding the risks and implications of not undergoing antenatal HIV screening. Doctors were asked to make appropriate notation of the counselling process,

Table 1. Proportion of Antenatal Women Screened and Tested Positive for HIV in Singapore, 2005 to 2012

Year	2005	2006	2007	2008	2009	2010	2011	2012
% screened	98.3	99.1	99.6	99.7	99.9	99.4	99.6	99.6
% HIV positive	0.09	0.08	0.08	0.07	0.07	0.06	0.08	0.05

as well as the patient's decision not to undergo testing. Antenatal patients who had already undergone HIV testing elsewhere earlier in the course of their pregnancy were exempted from repeat testing but doctors were to document the date and place of testing as well as the test results.

All antenatal women undergoing HIV testing should be adequately counselled on the test results, as well as its implications, and reassured of patient confidentiality. Pregnant women who tested positive for HIV would be referred to a public tertiary hospital specialising in communicable diseases for further medical evaluation and treatment. In the circular, doctors were reminded about the medico-legal implications that may arise if HIV screening was not offered to antenatal patients, given that it was now adopted as standard of care. As part of the HIV surveillance programme, quarterly reports on antenatal HIV screening were required from all medical practitioners providing care to antenatal women for compilation and analysis.

Outcomes

The uptake of HIV antenatal screening in Singapore has increased dramatically. From less than 40 per cent uptake using an opt-in approach prior to December 2004, the use of the opt-out approach has pushed the uptake to almost 100 per cent. Today, more than 99 per cent of pregnant women are screened for HIV.

In 2012, the prevalence of HIV among screened antenatal women was 0.05 per cent. This was the lowest prevalence observed in the last eight years (Table 1).

Since the implementation of opt-out antenatal HIV screening, only two HIV-positive babies were born to HIV-positive mothers in Singapore between 2005 and 2012, out of a total of 90 HIV-positive mothers detected through antenatal screening in that period. Both mothers of the two HIV-positive babies had sought pregnancy care late and therefore were only diagnosed to be HIV-positive at a later stage of their pregnancy. In contrast, 14 HIV-positive children were born between 1998 and 2004.

Shifting from an opt-in to an opt-out strategy has resulted in an increase in the coverage of the programme to almost 100 per cent of pregnant women in Singapore. It is crucial for the prevention of MTCT. With this initiative, hospitals and clinics have been able to detect HIV-positive mothers early and offer them preventive treatment to minimise vertical transmission of HIV to their children.

Challenge

The antenatal screening programme continues to be useful for HIV surveillance in the general population. Maintaining the high screening coverage for the target population may become a challenge in the years ahead.

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Preventing Mother-To-Child Transmission in Can Tho City, Viet Nam

Introduction to the Practice

Can Tho City is the centre of Viet Nam's Mekong River Delta. It has a population of approximately 1,200,000 spread throughout 9 districts and 85 communes/wards. In 2008, it was considered to be one of the country's "hot spots" for HIV.

One of the major concerns of the Can Tho leadership at that time was addressing mother-to-child transmission. The city's leadership wanted to reduce it to a minimum, thus, a prevention of mother-to-child transmission (PMTCT) programme came about.

The main objective of the PMTCT programme was the reduction of mother-to-child transmission to below three per cent by the end of 2015. Implemented by the Can Tho City Centre of HIV/AIDS Control, the programme has three major components:

1. HIV consulting and testing for pregnant women
2. PMTCT treatment for HIV-positive pregnant women
3. Reference and post-natal care

One barrier to the programme was the lack of facility for PMTCT. In 2008, there was only one treatment clinic for PMTCT, at the Obstetric Clinic of the Cai Rang Ward, Cai Rang Hospital, and seven consulting and testing (CT) sites for pregnant women, all located in the Cai Rang ward clinics. To overcome this barrier, the city developed an expansion plan:

- 2009. Two treatment clinics were opened, one at the City General Hospital and the other, at the O Mon District Hospital. To better serve more pregnant women, seven CT sites were started in O Mon.
- 2010. Three additional treatment clinics in City General Hospital were opened plus 14 new CT sites in the commune/wards of Cai Rang and O Mon.
- 2011. One treatment clinic at the Thot Not District Hospital opened and 57 additional CT sites located in the rest of the city's commune/ward clinics.

By the end of 2011, Can Tho City had 7 treatment clinics and 85 CT sites, 1 per commune/ward.

The PMTCT programme is supported by Can Tho City through its facilities and its hospital and clinic staff. The following partners provided additional resources:

- Funding from the National HIV/AIDS Control Target Program
- Funding and technical support from the United States President's Emergency Plan for AIDS Relief, The Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Health Organization
- Technical support from the Viet Nam Agency of HIV/AIDS Control, the Joint United Nations Programme on HIV/AIDS, and FHI 360.

How It Works

Setting up the treatment clinics and CT sites did not happen overnight. The preparation stage took several steps. The first was the city's decision to integrate the treatment facilities and CT sites within existing hospitals and clinics. The second was to embark on a capacity-building effort in phases, corresponding to the PMTCT programme expansion.

The main purpose of capacity-building was to ensure the provision of quality consultation, testing, and treatment to clients. To achieve this, all involved officers and staff from hospitals and commune/ward clinics were enjoined to participate. The comprehensive capacity-building comprised of the following:

- Training on consulting, testing, care and treatment, and programme management. Refresher courses were undertaken at planned intervals.
- Regular provision of on-site technical support and supervision.
- Issuance of follow-up notebooks, flyers, posters and media disks, as needed.
- Development and implementation of referral and transition networks to ensure better access to the programme by the mother and the child.

Implementation of this complex programme involves several agencies operating at several levels:

- At the city level: The Department of Health is in charge of general management; the Provincial AIDS Committee Can Tho is responsible for programme monitoring and evaluation, in providing guidelines and support for activities, and monitoring the quality of services delivered by all PMTCT clinics; and the Centre of Reproductive Health refers HIV-positive pregnant women to PMTCT services.
- At the district level: Each District's Centre for Disease Control is in charge of the management, implementation, and monitoring of the treatment clinics at the hospitals and CT sites at the commune/ward level.
- At the hospitals' treatment clinics: Staffs are focused on treatment for women who are at the labour stage.
- At the commune/ward clinics:
    - Conduct PMTCT consultation for pregnant women, collect blood samples, and transport them to the district laboratory.
        - For the clinics which deploy the 2.0 treatment protocol, conduct CT and blood test. From 2012, all results will be provided to clients in privacy and in confidence.
    - Conduct follow-up monitoring for HIV-positive pregnant women and refer HIV-positive mother and child to out-patient clinics.

Outcomes

Because the programme was planned from the very beginning to be based in existing health facilities (hospitals and commune/ward clinics), PMTCT, as part of the HIV and AIDS prevention programme, was quickly integrated into the reproductive health programme. This has resulted in the integration of services and better coordination, resulting in better support for the mother and the child. This decision also guarantees the programme's long-term sustainability.

The expansion in number and location of CT sites and treatment clinics contributed to high levels of consultation, testing, and treatment.

- The percentage of pregnant women who consulted and where tested increased from 38.5 per cent in 2009 to 97.4 per cent in 2012. The increase in numbers reflected the increase in the number of PMTCT facilities (Table 1).

Table 1. Expansion of CT and Result of Consultation, Testing, and Treatment

	2009	2010	2011	2012
PMTCT facilities	CT sites in 3 districts covering 14 wards	CT sites in 3 districts covering 14 wards	CT sites in all communes/ wards	CT sites in all communes/ wards
Number of pregnant women who consulted and were tested	7,283 (38.5%)	10,280 (56.5%)	16,435 (97.6%)	19,182 (97.4%)
PMTCT programme	40 (0.55%)	65 (0.63%)	69 (0.42%)	51 (0.27%)
Sentinel Surveillance	0.25%	0.25%	0.25%	0.5%

- The percentage of pregnant women tested during pregnancy increased from 42.4 per cent (2009) to 75.5 per cent in 2012. PMTCT treatment rate for HIV-positive pregnant women was over 92 per cent (Table 2).
- HIV infection rate among children of HIV-positive mothers was 6.7 per cent in 2009 and 3 per cent in 2011. There was no case of child infection in Can Tho city since 2012. This was mostly the result of the increase in testing among children, from 65.2 per cent in 2009 to 85 per cent in 2012, with 100 per cent of children from HIV-positive mothers getting PMTCT treatment and milk replacement (Table 3).

Table 2. Pregnant Women Who Consulted, Tested, and Got Treatment

	2009	2010	2011	2012
Number of pregnant women who consulted and tested	7,283	10,280	16,435	19,182
During the pregnancy stage	3,090 (42.4%	3,370 (32.8%)	10,045 (61.1%)	14,482 (75.5%)
During the labour stage	4,193 (57.8%)	6,910 (67.2%)	6,390 (38.9%)	4,70 (24.5%)
Percentage of HIV-positive pregnant women who got PMTCT treatment	100%	87.9%	86.8%	92.9%

Table 3. Pregnant Women Who Consulted, Tested, and Got Treatment

Content	2009	2010	2011	2012
Number of live births from HIV-positive mothers	23	36	45	40
Number of children who got PMTCT treatment	23	36	45	40
Number of children who got milk replacement	23	36	45	40
Number of children tested (Polymerase Chain Reaction and serum)	15	28	33	34
Number of HIV-positive children	1	1	1	0

Lastly, the number of mothers and children who did not return for postnatal and well-baby care follow-up decreased from 25 per cent of mothers and 34.8 per cent of children in 2009 to only 11 per cent and 15 percent, respectively, in 2012.

Challenges

- Detection rate of HIV during labour is still high. One possible solution being considered by the city is the inclusion of HIV testing for pregnant women under the government's health insurance scheme.
- Postnatal care and treatment is still limited.
- Funding does not meet the demand.

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Prevention of HIV and AIDS among Migrant Workers, Thailand

Introduction to the Practice

Migration alone is not a risk factor for HIV. It is the conditions associated with migration that increase vulnerability to HIV. In Thailand, language barriers, issues of documentation, and working in remote areas limit migrants' access to information and health services, including voluntary counselling and testing (VCT). Behaviours that increase migrants' risk of HIV, sexually transmitted infections (STIs), and unplanned pregnancies arise mainly due to inaccurate knowledge and sub-culture norms. While increased awareness is leading to more migrants with HIV coming forward for assistance, stigma and discrimination, and policies on antiretroviral drugs still act as barriers to increasing the number of migrants receiving care, treatment, and support. To meet these challenges, the Prevention of HIV/AIDS Among Migrant Workers In Thailand (PHAMIT) project has been leading the HIV response for migrants.

PHAMIT received its funding from The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), with Raks Thai Foundation as the principal recipient. The sub-recipients included World Vision Foundation Thailand, Stella Maris Seafarers Centre, Foundation for AIDS Rights, MAP Foundation, Pattanarak Foundation, AIDS Network Development Foundation, the Social Development Association, and selected provincial health offices.

PHAMIT's first phase was implemented from 2003 until 2009, covering migrants in 22 provinces. It was then extended until 2014 and expanded to reach 36 provinces. PHAMIT will complete its second phase in 2014.

PHAMIT's Phase I goals were to reduce new infections among migrants and increase migrants' access to services. Towards this end, PHAMIT aimed to achieve the following:

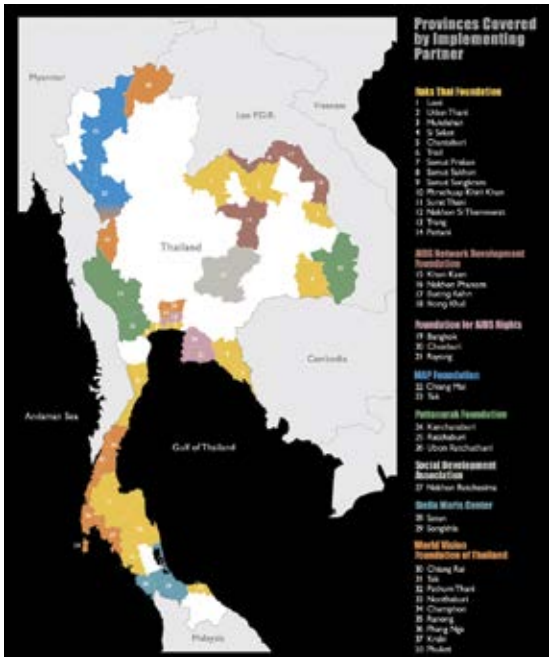
- Scale-up comprehensive HIV prevention activities for documented and undocumented migrants from the three countries of Myanmar, Cambodia, and Lao PDR through increased outreach and capacity-building.
- Improve the enabling environment through promotion of positive policies, such as "Migrant Friendly" health services, and by increasing awareness among stakeholders and the public in order to decrease stigma and discrimination while supporting migrants' rights.
- Strengthen strategic information systems and undertake operational research to improve health management information and related monitoring systems that support policies and programming for migrants.

PHAMIT, through its non-government partners, used a combination of strategies to raise migrants' awareness and knowledge of HIV, increase condom use, and support the uptake of VCT as well as proper sexual and reproductive health services.

How It Works

PHAMIT activities were implemented by Thai and Migrant Field Officers as well as networks of Migrant Health Volunteers who received regular trainings. Migrant staff and volunteers would go to where migrants lived and worked to provide information in their language, raising knowledge and awareness about HIV and AIDS, safe sex and condom use, reproductive health, and health rights. Condom distribution was done through a variety of channels, including, as a part of outreach activities, volunteers, drop-in centres, and condom boxes. Outreach staff and volunteers also assisted in providing referral for STI diagnosis and treatment, and VCT at government hospitals and health centres.

Increasing migrant workers' access to government health care services through the development of "Migrant Friendly" health services was primarily done through the development of Migrant Health Assistants. Being migrants themselves, these people could communicate in migrants' languages and in Thai. They were recruited and trained to help translate for Thai medical personnel, including in the provision of HIV counselling. Migrant Health Assistants were then placed in participating hospitals in 10 provinces to assist with communicating with migrants in the uptake of services, counselling, and to follow up in the surrounding migrant communities.



Map of provinces covered by PHAMIT's implementing partners

A number of other supplementary activities were also implemented as part of the HIV prevention strategy. Drop-in centres were opened in certain areas to provide a variety of services. Mobile health clinics, which were set up in partnership with health offices and went to work in communities, helped increase access to screening and referral for HIV and STIs. Cultural activities, child-learning centres, a range of different types of support groups, as well as sensitisation activities with stakeholders were actions that helped affect the enabling environment and support the migrant community. There were also a number of operational researches completed, ranging from Knowledge, Attitude, and Practice Surveys, including the Integrated Biological and Behavioural Integrated Surveillance and the Baseline and Impact Survey, to research on Migrant Health Insurance System financing and Gender-Based Violence against women migrant workers.

Under the project, PHAMIT produced various information, education, and communication materials in Burmese, Cambodian, and Laotian languages to provide information and support positive messages about HIV prevention and living with HIV. The types of media included video dramas, posters and brochures, cartoon booklets, as well as shirts and other campaign items with slogans.

The materials were mostly distributed to migrants directly while some were placed in strategic locations or were available for viewing in drop-in centres.

Outcomes

By the end of 2013, the project reported the following achievements (as summarised from Raks Thai reports to the GFATM):

- Over the period of 2003 to 2013, more than 800,000 migrants received a basic package of HIV prevention through direct outreach activities in 36 provinces.
- Between 2009 to 2013, more than 8,000 migrants were tested for HIV and knew their results.
- 2,223 migrants were on antiretroviral therapy (ART) through support under a separate grant by the GFATM through the Ministry of Health, Bureau of AIDS, TB, and STD, with possibly another thousand migrants on waiting lists, and unknown numbers purchasing ART on their own.

A poster in Cambodian language that encourages condom use: "No matter what type of job you work in or which country you are from, you could get HIV. So, prevent HIV by using a condom every time you have sex."

PHAMIT partners at a Lessons Learned workshop

Challenges

- Although the National AIDS Strategy has recognised migrants as a key population, migrants are not included in the HIV strategies and therefore not included under the National HIV budget.
- There are still many obstacles migrants must overcome to access health services, including being undocumented or lacking health insurance, language barriers, distant hospitals, and long waits to obtain services.
- In 2013, the Migrant Health Insurance policy was amended to include ART for migrants, though the policy has yet to be implemented consistently.
- Although 10 provinces currently have Migrant Health Assistants in hospitals and there is a Migrant Health Strategy that endorses the use of these people, the strategy has not yet been approved by the Cabinet or made an official policy.
- A database-type of information system is needed to allow migrants to utilise their health insurance to receive services in different provinces that would eventually contribute to the development of a cross-border referral system to assist those who may wish to cross borders to continue taking ART without interruption.

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The 4-Pronged Approach to PMTCT, Myanmar

Introduction to the Practice

In 2001, the National AIDS Programme (NAP), under the Department of Health (DOH) and the Ministry of Health (MOH), initiated the project on prevention of mother-to-child transmission (PMTCT) of HIV by using a 4-pronged approach. This project involves:

1. Reducing new HIV infections among women of reproductive age
2. Reducing unwanted pregnancies among HIV positive couples
3. Preventing mother-to-child transmission of HIV during antenatal, delivery, and breastfeeding periods
4. Providing care and treatment for mothers, children, and families in need

The nationwide project covers 258 township health centres and 38 hospitals. It is implemented by the various units of the DOH in partnership with United Nations agencies, non-governmental organisations (NGOs), and networks of people living with HIV and AIDS (PLHA).

Directed towards the goal of eliminating mother-to-child transmission (MTCT) of HIV by 2015 and to keep mothers alive to take care of their children, the key objective of the project is to ensure that more than 80 per cent of women living with HIV are receiving antiretroviral therapy (ART) to reduce the risk of MTCT.

The project is jointly funded by the government and international agencies. MOH provides support in the form of health infrastructure, human resources, logistics management of supplies, and in 2014, procurement of test kits. Funds for commodities, training, reporting, and transport of blood samples are being provided by The Global Fund to Fight AIDS, Tuberculosis and Malaria, the United Nations Children's Fund (UNICEF), and the United Nations Population Fund.

How It Works

The 4-Pronged Approach to PMTCT involves providing family planning (FP) counselling and services to HIV-positive women, and maternal and childcare services and ART to positive pregnant women and HIV-infected children. Each approach delivers a distinct package of related services. The packages are delivered not only by the DOH but also by other partners of NAP: the Ministry of Education, UNICEF, United Nations Educational, Scientific and Cultural Organization, and NGOs like Population Services International, Marie Stopes International Myanmar, Medecins Du Monde, and Asia Harm Reduction Network Myanmar. The following are the package of services corresponding to each target group:

- **Reducing new HIV infections among women of reproductive age belonging to key populations.** Being a country with a concentrated epidemic, Myanmar's first approach in PMTCT of HIV is to focus on women of reproductive age among sex workers, people who inject drugs, and, when applicable, female partners of men who have sex with men. The package consists of voluntary counselling and testing, condom distribution, sexually transmitted infection screening and treatment, and needles and syringe exchange

programme, all coupled with a strong behaviour change component. Additionally, for young women of reproductive age, there is life skills education provided for those who are in-school and out-of-school.

- **Reducing unwanted pregnancies among HIV-positive couples.** The second approach establishes the linkage between providers of HIV care, treatment, and support services with FP and reproductive health care providers, including PMTCT, to respond to the needs of HIV-positive women. Under this approach, the package of services includes: PMTCT information and services, and access to FP counselling, contraceptives, and reproductive health services.
- **Preventing mother-to-child transmission of HIV during antenatal, delivery, and breastfeeding periods.** The third approach is implemented through the service delivery component that provides maternal and child care (MCC) through midwives, auxiliary nursing midwives, obstetricians, and paediatricians. The package of services include: PMTCT information, provider-initiated counselling and testing during pregnancy, ART throughout the pregnancy period and for 6 months while breastfeeding, testing children whose mothers are positive for early infant diagnosis, and linking children and parents to care, treatment, and support.
- **Providing care and treatment for children and families in need.** The fourth approach ensures that HIV-positive children and their families get ART based on their needs. This is done by linking the children to the DOH's MCC services and the nearest ART centre. The package of services includes: cluster of differentiation 4 (CD4) testing, management of opportunistic infections, ART and adherence, and breastfeeding counselling services.

Complementing the 4-Pronged Approach to PMTCT are innovations, such as the decentralisation of VCT and CD4 count to point-of-care, i.e. rural health centres, the piloting of a community outreach intervention for the first approach, and increasing access in hard-to-reach areas as part of the scaling up process at the DOH. In the planning stage are greater integration between HIV and maternal and child health services as well as the use of web-based and mobile-based technologies to increase access and reduce loss to follow up.

To soundly implement the programme, there is a strong partnership among involved agencies and institutions in coordinating and monitoring, reporting, procurement, and building the capacity of the project implementation staff.

- Coordinating and monitoring the overall implementation of the project is the responsibility of the NAP, which is under the DOH. Strong partnerships and coordination between and among the MOH, international funding and development agencies, national and international NGOs, PLHA networks, and the media have been established. Monitoring through review of reports and other documentations are done periodically at the township, state, regional, and national levels. Field visits and observations are conducted by the staff from NAP, the concerned State Health Department, and partner agencies. Referral systems have been coordinated among service providers from government, NGOs, and the PLHA networks. A system of pooled supply and logistics management has been organised to ensure greater efficiency.
- Reporting is done on a monthly basis by the health centres to the townships. The reports are then collected and analysed at the state and national levels.

- The procurement of supplies and materials, mainly test kits, reagents, drugs, job aids, and communication materials, is done by individual partner agencies and are then channelled into a pooled supply and logistics management system. This pooled system is managed by NAP.
- The capacity-building of staff involved in the project is continuously attended to through a cascade or echo system of training. It involves a national level training of master trainers who pass on the learning to national experts, who in turn, develop a pool of state level trainers. The state level trainers train staff at the service delivery level.

Outcomes

Over the last 12 years since the introduction of the PMTCT project in Myanmar, there has been a progressive improvement in coverage. In 2012, based on PMTCT programme data:

- Fifty per cent of pregnant women who accessed antenatal care services were tested for HIV.
- Ten per cent of HIV-exposed children were tested for HIV within the first three months after birth compared to 3 per cent of HIV-exposed children tested for HIV only by their 18th month.

Another important progress is that the first HIV testing can now be performed by all types of health care workers up to midwife level. This will have a positive impact on current PMTCT efforts.

Challenges

In spite of the nationwide coverage, less than 35 per cent of the estimated pregnant women in Myanmar have been tested for HIV. To achieve the optimum number of the project's key objective, the following challenges and proposed solutions must be addressed:

- A high proportion of loss to follow-up. Only 10 per cent of the HIV-exposed children have been tested for HIV at 3 months and 3 per cent at 18 months. This has resulted in a low number of HIV-positive children being linked for treatment, indicating loss to follow-up. A possible solution is to deploy new laboratory equipment and utilise privately-owned laboratories paid through a reimbursement scheme.
- Lack of access to PMTCT is experienced in some hard-to-reach areas due to geographic constraints and the presence of armed conflict in some areas. One solution currently being piloted in conflict townships in Kachin state is the PMTCT project managed and implemented by the Kachin people themselves. This is being done through UNICEF.
- Continuing procurement issues faced by some procuring agencies have resulted in sporadic shortages of test kits. The proposed solution is to increase technical assistance from development partners.

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The Colours of Prevention: Watching Out for FSWs, MSM, and Young KPs at Entertainment Establishments, Myanmar

Introduction to the Practice

Female sex workers (FSWs), men who have sex with men (MSM), their clients and/or partners, as well as young key populations (YKPs), are the focal target key populations (KPs) of this National AIDS Programme (NAP) initiative. It integrates HIV and sexual and reproductive health (SRH) and uses innovative colour-coded dots for monitoring. Started in 2010, this on-going project has the following features:

- Awareness raising and provision of HIV prevention and SRH services to the focal target KPs
- Collaboration among township stakeholders, such as local authorities and entertainment establishment owners (EEO), on strategies to reduce stigma attached to condom use
- Training of SRH service providers on HIV counselling and integration of HIV and SRH services
- Building capacity of focal target KPs on educating their peers on HIV prevention, SRH, sexually transmitted infection (STIs), and legal issues
- Conduct of outreach activities by trained KP peer educators and health staff in entertainment establishment (EE) areas

This project uses a life-cycle approach, where SRH needs are determined by the various stages in life: adolescence (aged 13 to 17), youth (18 to 24), mature adulthood (25 to 44), mid-life (45 to 60), and senior years, and are used as a guide in planning the provision and access to various SRH services. The goal of the project was to improve the SRH status and to reduce the sexual transmission of HIV among FSWs, MSM, their clients and/or partners, as well as YKPs. Specifically, it aimed to:

- Improve existing health systems, both government and private, to ensure that the focal target KPs living in urban and in remote locations would have access to high quality services for the prevention and treatment of HIV
- Increase the collaboration among the different stakeholders at the Township level in order to create a more enabling environment for the effective delivery of integrated HIV and SRH information and services

The NAP currently implements the project in 34 townships and in Yangon, Mandalay, Ayarwaddy, Rachine, Shan, Bogo, and Magway. The project's Phase I was funded by the United Nations Population Fund (UNFPA). UNFPA is also funding its second phase (2012 to 2015) for USD 4 Million.

How It Works

Phase I consisted of the following:

- **Package of services.** The integrated HIV and SRH package consisted of behaviour change communication materials, voluntary counselling and testing, distribution of male

and female condoms and lubricants, referral for antiretroviral therapy, family planning, and diagnosis and treatment of STIs.

- **Involving the people who matter.** Rather than close EEs, such as beauty salons, massage parlours, karaoke lounges, bars, and pubs where sexual connections were happening, as a way to prevent HIV, thereby making FSWs, MSM, their clients/partners, and YKPs harder to reach, township authorities sought the EEOs' cooperation. They and their managers collaborated with government authorities in implementing condom distribution and in referring the focal target KPs to health facilities for HIV and SRH services.
- **Geographical mapping of EE areas.**Geographical mapping at field level was done to identify the location of EEs throughout the participating townships and to facilitate monitoring of the programme's progress. Mapping was done by the township service providers, assisted by EEOs and managers. During the course of mapping, confidentiality of collected information was observed.
- **Colour-coded dots to assess the level of support from EEs.** To monitor the degree of participation by EEs, colour-coded dots were used on the maps. Each township had its own colour-dotted map.
    - Purple signified that an EE was distributing condoms and was actively referring FSWs, MSMs, their clients/partners, and YKPs to health facilities for integrated HIV and SRH services.
    - Blue or Green meant that the EE was willing to collaborate but was not yet fully on-board in condom distribution and referral.
    - Red indicated that the EE did not welcome outreach workers or did not participate at all.

Colour-dotted Map

The colour-dotted map was a visual way of determining whether or not a certain area needed more support. At one glance, the field teams could also easily see indications of referrals that could then be compared to the actual report of services provided in the health facilities. It helped project workers see the degree of progress happening in an area. For example, by the use of the colour-dotted map, the monitoring team found out that Chanayetharzan Township in Mandalay Division made substantial progress, from many red dots in 2010 to many more purple ones in 2012 and onwards. Upon investigation, it was uncovered that:

- The advocacy messages were effectively reaching all the EEs.
- The township medical officer showed strong leadership in following up and negotiating with EEOs and managers.
- The township medical officer was receiving technical support from the Regional Officer of the Mandalay STI team.

Updating the colour-dotted maps was the shared responsibility of the township's health service providers and the condom distribution programme focal person.

Peer Education

From the ranks of male and female sex workers and MSMs were selected peer education (PE) trainees. Their training covered not only HIV prevention and SRH but also trafficking, gender equality, violence, and human rights. The training team was composed of health staff,

selected members of the sex workers' networks, the police, and lawyers. The involvement of members of the sex workers' networks as PE trainers helped build the capacity of the network members. The participation of the police and lawyers enabled them to have a better understanding of the plight of sex workers and MSM.

Table 1. Targets and Achievements for HIV Prevention among FSWs and MSM

Year	Key Population	Target	Achievement
2011	FSW	55,000	62,420
	MSM	65,000	64,740
2012	FSW	60,000	60,191
	MSM	70,000	68,067

Outcomes

National Programme data shows that the prevention interventions were able to meet the targets set for 2011 and 2012, as seen in Table 1.

Challenges

- Because sex work is still considered to be a criminal activity and punishable by law, stigma is high against male and female sex workers, even more so against sex workers who are also living with HIV.
- Quality of services remains an issue. As important is the need to focus on providing non-discriminatory and user-friendly services from both government and private providers.
- Shortage of manpower, turn-over of trained staff, mobility of KPs, and the dropping out of trained peer educators are some of the challenges in human resources.

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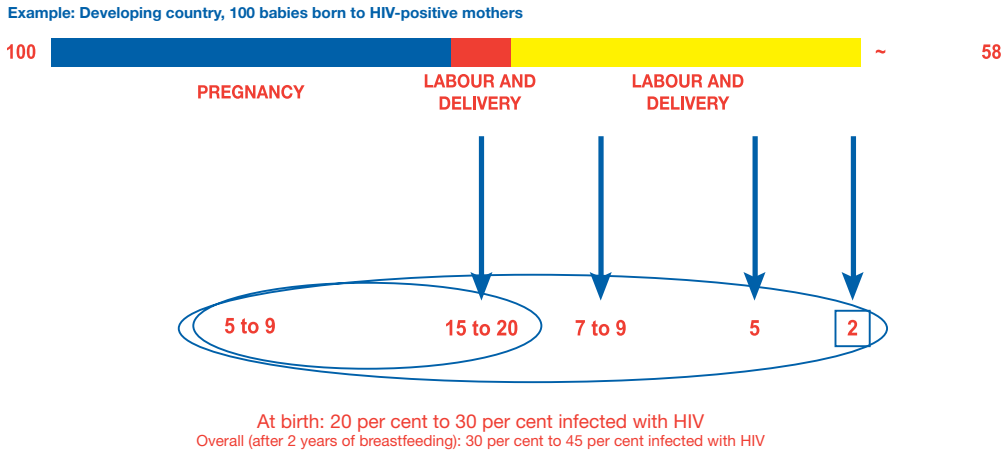
Towards HIV-Free Children through PMTCT, Malaysia

Introduction to the Practice

Mother-to-child transmission (MTCT) is the most common source of HIV infection among children in developing countries. In the absence of any intervention, between 30 per cent to 45 per cent of children born to HIV-positive mothers will themselves become infected with HIV during their mothers' pregnancy, labour or delivery, or through breastfeeding (Figure 1).

Figure 1. What are the Risks of MTCT? (no intervention)



The risk of MTCT can be reduced by standard interventions that include:

- Antiretroviral (ARV) prophylaxis for the mother during pregnancy and labour, and also for the infant during the neonatal period
- Obstetric interventions to avoid infant exposure to infected maternal secretions (including elective caesarean section prior to the onset of labour and rupture of membranes)
- The mother's complete avoidance of breastfeeding

Since 1998, Malaysia has taken noteworthy initiatives to counter the rise of HIV and AIDS. One such initiative is the Prevention of Maternal-to-Child Transmission (PMTCT) Programme. Under this Programme, more than 75 per cent of all antenatal mothers in Malaysia have been screened yearly.

The goal of this Programme is to prevent vertical HIV and AIDS transmission to children to realise the vision of an HIV-free generation in Malaysia. Specifically, the programme aims to fill up a shortfall in the HIV and AIDS prevention and care programme in Malaysia through an appropriate remedial action, i.e. by eliminating MTCT by 2015.

How It Works

In 1998, as part of its primary care services, Malaysia's Ministry of Health (MOH) initiated a national programme on PMTCT that is integrated in the perinatal and infant feeding intervention offered in government hospitals and health facilities. Within the context of the Programme, HIV screening is routinely offered on an opt-out basis to antenatal mothers, who are given pre-test counselling on a group basis. This Programme is integrated into primary care services. It is available at all government primary care clinics and hospitals. The screening is given free of charge. Should a screening test be reactive, individual "intra-test" counselling is provided prior to collection of a second specimen for confirmation.

Early detection of HIV infection among babies born to HIV-positive mothers

PMTCT Programme Care Strategies

The PMTCT Programme involves early detection of HIV infection of mother and baby, counselling, and provisional ARV. Specifically, the services involve:

- Early detection of HIV infection using a rapid screening test, with confirmatory testing if indicated
- Provision of counselling for HIV-infected mothers and their partners
- Provision of oral ARV to infected mothers as early as possible in the second trimester of pregnancy until the onset of labour, switching to intravenous zidovudine (ZDV) during labour, and oral ZDV for the baby for the first six weeks of life
- Early detection of HIV infection among babies born to HIV-positive mothers

The strategy also gives emphasis to the contact-tracing of partners of HIV-positive women, as well as the training of clinical staff.

Provisions exist for the immediate screening (using the HIV Rapid Test Kits) for women in labour with no record of antenatal care or HIV testing. Infants of said women found to be reactive to the rapid test are managed according to Clinical Practice Guidelines and Protocol.

These strategies are supplemented by safer modes of delivery (generally caesarean section) and MOH support for replacement feeding of infants born to HIV-positive mothers until the infant is two years of age.

Care for the HIV-Positive Mother and Her Infant

During her antenatal period, to ensure that she is safe and healthy, the HIV-positive antenatal mother will be put on highly active antiretroviral therapy (ART) and will be closely followed up with regular clinic appointments and home visits. During her third trimester, she will be given appointment dates for follow up by an obstetrician at the nearest hospital or at any hospital of her choice. Her appointment for caesarean section delivery will be made at this time.

A baby born to an HIV-positive mother will be given prophylaxis. The infant's HIV status will be monitored using polymerase chain reaction antigen-based tests at birth, 3 months, 6 months, 12 months, and 18 months of life. If the initial test is negative, antigen-based screening continues every 3 months until HIV infection is either confirmed or excluded by antibody-based testing, by enzyme-linked immunosorbent assay, particle agglutination, and Western Blot done when the infant is 18 months old.

Meanwhile, follow-up care for the postnatal HIV-positive mother continues as her cluster of differentiation 4 count continues to be monitored. If eligible for it, she will be given ARV.

Outcomes

Since the PMTCT Programme was implemented in Malaysia, HIV antenatal screening coverage among mothers in government facilities has been impressive.

- The annual zero-prevalence target to counter HIV and AIDS among women places Malaysian mothers detected as HIV-positive at 0.02 per cent to 0.07 per cent.
- With the intervention, vertical transmission has been reduced to 1.3 per cent in 2012.

For any infant born with HIV, thorough investigation is being carried out using the Quality Assurance Approach.

Challenges

The MOH is currently facing two main challenges with the implementation of the PMTCT programme. One issue involves the building of partnership with private hospitals, where agreements are currently being reached, so that implementation can occur in the very near future. The other issue involves ART for pregnant migrants that is still undergoing discussions.

Since the implementation of PMTCT in Malaysia, many loopholes in its antenatal HIV programme have been plugged, so to speak. Improvements have been done especially on HIV screening, care, and treatment among both antenatal mothers and their future babies. Although challenges will continue to be faced, management of systems will be improved and made better in view of future needs, as this impressive programme is helping hasten Malaysia's progress towards achieving zero HIV vertical transmission by 2015.

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WIDE-Workplace Infectious Disease Education Programme, Singapore

Introduction to the Practice

There are around 4,000 people known to be living with HIV in Singapore today, 4 out of 5 (79 per cent) of them between 30 to 59 years old, the most economically productive age group. As such, the workplace plays an important role in HIV prevention and control.

Since 2006, HIV and AIDS education programmes have been in place to encourage workplaces to inform their employees about HIV and AIDS. The uptake of such programmes, however, has been low due to the social stigma associated with the disease. The Health Promotion Board (HPB) then consulted with the AIDS Business Alliance on ways to promote workplace education of HIV and AIDS. A key recommendation from the Alliance was to integrate other infectious diseases of concern in Singapore (influenza and tuberculosis) with HIV and AIDS.

In August 2011, HPB, in partnership with the Singapore National Employers Federation (SNEF), launched the Workplace Infectious Disease Education (WIDE) programme, an integrated infectious disease education programme for the workplace.

The WIDE programme aims to increase the working population's understanding of HIV and AIDS, influenza and tuberculosis. Increasing knowledge on symptoms, transmission, and prevention of these diseases can dispel myths and reduce stigma. This will in turn encourage accurate risk perception as well as create a supportive environment for employees living with HIV.

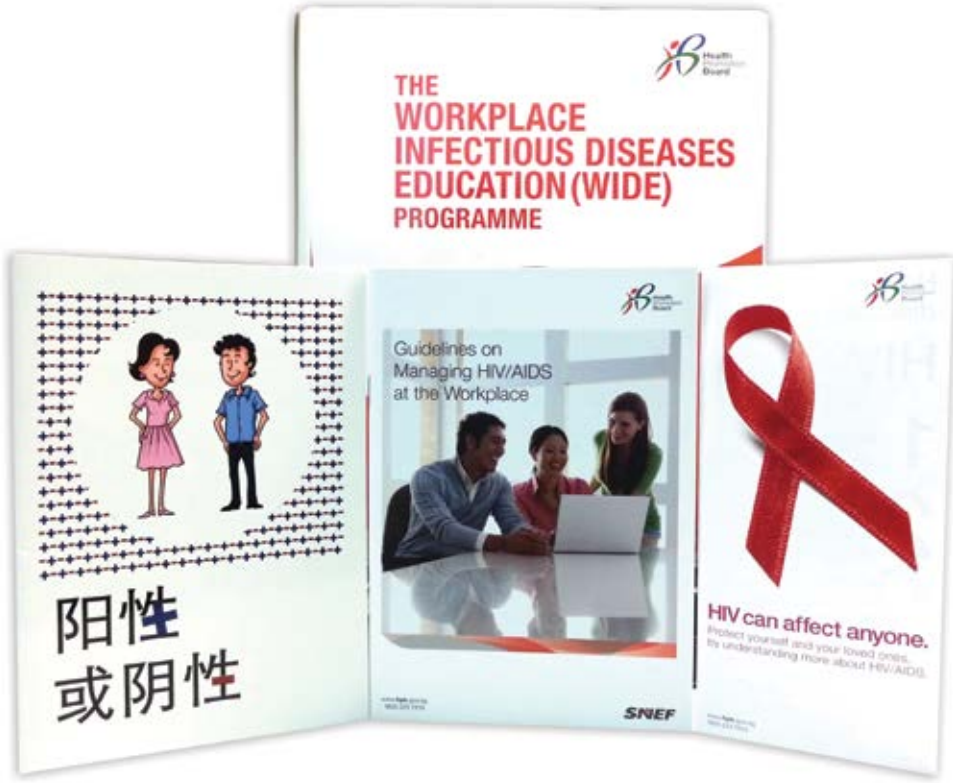
All materials and manpower costs for WIDE are funded by HPB and implemented in partnership with SNEF.

How It Works

The programme was developed by HPB and promoted to the workplaces through SNEF's extensive industrial networks. Companies were encouraged to take up the programme which was offered to them at no cost for a week. HPB and SNEF continued to work closely together to improve the programme.

The WIDE programme consists of three educational components:

1. **Workplace talks.** Employees are introduced to the symptoms, transmission, and prevention methods of HIV and AIDS, influenza, and tuberculosis during a one-hour lunchtime talk.
2. **Interactive Roving Exhibitions.** Three touch-screen exhibits are deployed to the workplace for a week. The exhibits complement the workplace talks and provide educational information and messages on HIV and AIDS, influenza, and tuberculosis.
3. **Print materials.** HPB and SNEF jointly produced an employer's handbook, *Guidelines on Managing HIV and AIDS at the Workplace*. This is housed along with other print materials in the WIDE resource folder that is actively distributed to managerial staff. Additional print materials are available to companies upon request.



Printed materials used in WIDE

Outcomes

The WIDE programme was launched in August 2011. In the next 18 months, 72 companies took up the WIDE programme, including blue collar and white collar companies. In contrast, only an average of 25 companies took up the stand alone HIV programme on an annual basis.

Challenges

In promoting HIV and AIDS education to the workplaces, companies were initially hesitant to take up the stand alone HIV and AIDS workplace education programme, launched by HPB in 2006. To overcome this, HIV and AIDS was repackaged into the WIDE programme, combining other infectious diseases of importance such as influenza and tuberculosis. This was more palatable to the general population and provided greater access to workplaces.

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GETTING TO ZERO AIDS-RELATED DEATHS

Lao-Thai-Australian Collaboration in HIV Nutrition, Lao PDR

Introduction to the Practice

The Lao-Thai-Australian Collaboration in HIV Nutrition (Lao-TACHIN) project came about as a response to a need for improved HIV nutrition in Lao PDR. It was implemented from July 2008 to June 2011, with a one-year extension from June 2011 to July 2012. It was a partnership between three countries: Thailand, with the Thai Red Cross AIDS Research Centre (TRC-ARC); Australia, with The Albion Centre (Albion); and Lao PDR, with the Ministry of Health's (MOH) Centre for HIV/AIDS and STI (CHAS); with funding from the Australian Agency for International Development (AusAID). The project was an extension of the Thai-Australian Collaboration in HIV Nutrition (TACHIN) project executed by TRC-ARC. TACHIN developed and implemented a successful model of nutrition assessment, education, and counselling services for people living with HIV and AIDS (PLHA) attending the TRC-ARC HIV clinic.

The project goal was to improve the health and quality of life of PLHA in Champasak Province, Lao PDR.

Its project objectives were to:

- Improve the quality of HIV care in Champasak province
- Improve the capacity of the PLHA group, Dreaming of a Brighter Future (DBF), to scale up and manage community and peer-based HIV services, including nutrition care in Champasak province
- Establish and maintain sustainable capacity-building partnerships with counterpart organisations

To integrate nutrition education into service provision, the Lao-TACHIN project was designed using a health systems strengthening approach.

The project piloted nutrition services for PLHA in Champasak province in its provincial hospital and in four district hospitals from July 2008 to June 2012. In the last year of the project, AusAID provided additional funding for a one year extension that enabled the addition of prevention of parent-to-child transmission (PPTCT) in the Champasak facilities and the expansion of the project, covering both nutrition and PPTCT, to Savannakhet province for its provincial hospital and its PLHA peer support group. The expansion also included the training of peer educators of peer support groups by the Lao PDR Association of PLHIV (APLHIV) on HIV nutrition education, as well as capacity strengthening in voluntary counselling and testing (VCT) and provider-initiated testing and counselling (PITC) in both Champasak and Savannakhet.

Consequently, the project goals and objectives were modified to reflect these additional activities.

The revised project goal became: To improve the health and quality of life of PLHA and to ensure project sustainability by supporting changes to the Lao PDR national HIV and nutrition strategy.
The revised project objectives were:

1. To strengthen the capacity of staff and peer support groups in HIV care, treatment, and support services in the provinces of Champasak and Savannakhet to ensure the sustainability of effective HIV service delivery
2. To demonstrate the efficiency and effectiveness of HIV and nutrition services for comprehensive care for PLHA
3. To establish and maintain sustainable partnerships with counterpart organisations

Aside from funding from AusAID, the project also received support from the World Food Programme.

How It Works

The Lao-TACHIN project was a North-South-South capacity development project. Albion developed the capacity of TRC-ARC to implement HIV-specific projects in Lao PDR. TRC-ARC built the capacity of CHAS and the two provincial hospitals to implement the project.

The project had four main components:

1. Clinical nutrition services
2. Community nutrition interventions
3. HIV management
4. Partnership development

The major project activities were in capacity-building, service delivery, clinical service management, nutrition education at the community level, referral and communication, and advocacy. Under the guidance of MOH, CHAS and the provincial hospitals implemented the project activities, with technical assistance and mentoring from TRC-ARC.

1. Capacity-building: TRC-ARC trained and mentored CHAS, on nutrition modelling and project management, and the provincial hospitals' nurse-nutritionists, on nutrition assessment, education, counselling.
2. Service delivery: CHAS, with technical support from TRC-ARC, facilitated the establishment of the HIV Nutrition clinics at the two provincial hospitals. To strengthen the HIV clinical services in Champasak Health Services and Savannakhet Health Services, TRC-ARC, with CHAS, trained and mentored the two hospital staffs in VCT and rapid test kit training, PITC, and PPTCT management. They also developed and localised the standards of practice and streamlined the client flow and referral processes.
3. Clinical service management: TRC-ARC, with CHAS, developed skills in clinical data management, accountability, financial management, project coordination, and communication through on-the-job mentoring and training.
4. Nutrition education at the community level: TRC-ARC, with CHAS, organised the nutrition education group within DBF and integrated HIV nutrition education into peer support groups and peer educators, under DBF and APLHIV, by providing training in HIV nutrition, health promotion, communication, and group facilitation.

5. Referral and communication: TRC-ARC, with CHAS, developed the referral system and the communication pathways between DBF and the HIV Nutrition clinic.
6. Advocacy: TRC-ARC, in collaboration with CHAS, advocated for government leadership of HIV nutrition activities by engaging the World Health Organization-Lao PDR and MOH in monitoring and evaluation visits and by sharing lessons learnt in HIV Nutrition, such as during the Stakeholders Workshop in March 2011.

Outcomes

The United Nation Development Programme awarded the Lao-TACHIN project the Best Practice Model in HIV Nutrition in the South-South Cooperation Award for Partnership at the Global South-South Development Expo 2011. The award recognised the project's achievements in respecting national sovereignty, ownership, and mutual accountability.

This global level recognition reflected documented feedback at both the national and project levels, reported during the Project Conclusion Meeting, and shared by implementing and collaborating partners, including AusAID.

The most significant outcomes of the project are:

- The provincial hospitals are continuing HIV nutrition and PPTCT by themselves, with monitoring from TRC-ARC and CHAS. This was a result of consciously integrating the project within the national and local health systems.
- APLHIV has integrated HIV nutrition education into the work of their 12 peer support groups located nationwide.
- There has been increased HIV testing among pregnant women attending antenatal clinics and delivery rooms, from 19 per cent in 2010 to 30 per cent in 2011.
- There has been improved nutrition status of participating PLHA as demonstrated by their increased body weight.

Challenges

- Improvements in weight and body mass index suggested benefits from nutrition assessment, education and counselling. However, the influence of antiretroviral drugs (ARV) on weight changes was not determined, therefore, more research on this is required.
- There is a need to address over nutrition and metabolic complications that tend to be common among PLHA, particularly after receiving ARV.
- There has to be continuing government support to integrate nutrition care into HIV care.
- There is a need to integrally link HIV nutrition within the health care system.
- It is important to make PLHA central in this multi-pronged approach to avoid loss to follow-up and promote coverage and impact.
- There is a need to provide ongoing mentoring to the involved hospital staff as training is unsustainable.

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Treatment 2.0, Viet Nam

Introduction to the Practice

In July 2011, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) jointly initiated Treatment 2.0. Viet Nam was one of five countries that committed to this initiative. It recognised that Treatment 2.0 could help the country to radically simplify HIV treatment in order to deliver the benefits to as many people living with HIV and AIDS (PLHA) as possible while reducing its costs.

Dien Bien in the north and Can Tho in the south were the provinces selected to pilot Treatment 2.0. The pilot, which took place from September 2011 to June 2013, with actual service delivery starting in September 2012, aimed to increase the number of PLHA accessing early care and treatment services through the provision of care and treatment services at commune level and the promotion of linkages between the commune healthcare staff and PLHA networks in diagnosis, prevention, care and treatment. The pilot adhered to the five pillars of Treatment 2.0:

Pillar 1: Optimise Drug Regimens

To promote the use of less toxic and efficacious antiretroviral therapy (ART) and to improve the adherence and programme operation, Tenofovir + Lamivudine + Efavirenz (TDF + 3TC + EFV) as a once-daily fixed-dose combination (FDC) pill was provided to most patients in the pilot districts.

Pillar 2: Provide Point of Care (POC) and Other Simplified Diagnostic and Monitoring Tools

Viral load, cluster of differentiation 4 (CD4) testing, and other diagnostic and monitoring tools were made readily available and easier to use.

Pillar 3: Reduce Costs

Costs of HIV care and treatment service delivery are expected to be reduced as a result of implementing the other four pillars in the pilot, not only for the health system but to the clients as well. It will also enable the implementation of national policy measures, such as the use of Trade-Related Aspects of Intellectual Property Rights flexibilities. Through implementation of the Treatment 2.0 approach, the following cost reduction is expected:

- Earlier access to treatment could potentially reduce hospitalisation and other costs, such as diagnosis and management of opportunistic infections.
- Use of an FDC regimen can potentially reduce the costs of supply management. Mathematical models developed in Viet Nam show that focusing interventions, such as HIV testing and counselling (HTC), to key populations provide greater cost-effectiveness than general population implementation.
- Early initiation of antiretroviral (ARV) drugs shows a significant decline in the number of new infections, as well as decreased morbidity and mortality, resulting in cost benefits for individuals, communities, and health systems in general.

- By providing HIV care and treatment at commune health stations (CHS) rather than at district and provincial levels, patients will benefit from reduced travel costs and fewer additional costs, such as loss of income due to workdays missed.

The actual cost of the pilot implementation is currently being analysed in a detailed study on cost-reduction and cost-effectiveness.

Pillar 4: Adapt Service Delivery

HTC was decentralised to communes for the first time in Viet Nam. Key populations, sexual partners of PLHA, and pregnant women received HTC at the CHS. Upon diagnosis, they were referred to outpatient clinics at district health centres, where they received clinical examination and were assessed for ART eligibility. ART was initiated if eligible and if the patient chose to accept it. Once the patient had stabilised, he/she was transferred to the relevant CHS for follow up. CHS in the pilot areas dispensed ARV drugs to patients they follow up. In addition, opportunistic infection (OI) prophylaxes and other basic care continue to be available at the CHS. Every six months, patients visit the outpatient clinic at the district health facility for a check-up, including CD4 count and creatinine levels.

Pillar 5: Community Mobilisation

Community mobilisation is a key pillar to the success of the Treatment 2.0 initiative. Community-based approaches were implemented to improve the ability of populations at high risk of HIV (people who use drugs, men who have sex with men, sex workers) to access HIV services and to benefit from ART and prevent new infections.

The pilot was funded by the National Target Programme on HIV/AIDS Prevention and Control, WHO, and UNAIDS. In the pilot period, the budget from WHO covered basic assessments, holding agreement conferences, training for commune health workers, and testing for high risk groups and pregnant women. The funds from UNAIDS was used for training peer educators and self-help groups (SHGs).

How It Works

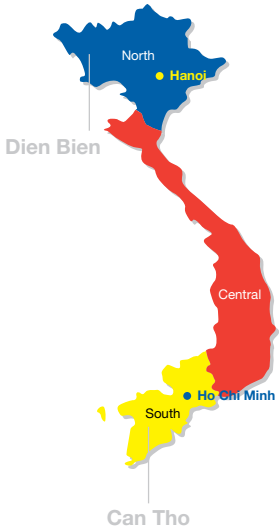
Implementation Scope

The pilot involved the provinces of Can Tho and Dien Bien. These provinces have marked differences in profile: Can Tho is flat and urban while Dien Bien is mountainous and rural and is home to many ethnic groups. In general, Dien Bien is less developed than Can Tho in terms of their socio-economic situation. In terms of the HIV epidemic, the provinces have many similarities: both Dien Bien and Can Tho provinces have high HIV prevalence, have a large number of PLHA with low educational attainment, and PLHA with low CD4 at the beginning of their ART. The pilot was implemented in 21 communes within the provinces (Figure 1).

Major Activities

- Providing care and treatment at the commune/ward level
- Screening HIV test at the commune/ward level for high-risk groups and pregnant women
- Checking CD4 cell at the district level out-patient clinic
- Using the combined formula of ARV in one tablet: TDF + 3TC + EFV
- Linking ART and Methadone Maintenance Treatment at the healthcare clinics and district hospitals

Figure 1. Treatment 2.0 Pilot in 21 Communes in 2 Provinces



Province	City/District	Communes
Can Tho	Ninh Kieu	An Hoa An Lac Cai Khe
	O Mon	Chau Van Liem Phuroi Thoi Thoi Long
	Vinh Tahnh	Thanh Tien Thanh Quoi Vinh Trinh
Dien Bien	Dien Bien City	Murong Thanh Tan Thanh Nam Thanh
	Dien Bien District	Thanh Luong Thanh Hung Thanh Xuong
	Muong Ang	Ang Cang Ang Nura Murong Dang
	Tuan Giao	Quai Cang Quai To Quai Nura

Services at the Commune/Ward Level

- Counselling and testing for high-risk groups and pregnant women
- Prevention and treatment of some OIs
- ARV care and treatment
- Psycho-social support
- Home-based care
- Harm reduction services: needle and syringe, condom distribution

Services at the District Level

- Prevention and treatment of some OIs
- ARV care and treatment
- Prevention and treatment of mother-to-child transmission
- Psycho-social support
- Provision of general health check up every six months including CD4 status
- Technical monitoring of care and treatment for HIV and AIDS at CHS

Table 1. Comparison Between Baseline and Results of Treatment 2.0

		Baseline	T2.0
Pillar 1	Proportion of PLHA starting ART with TDF + 3TC + EFV FDC	2%	44%
Pillar 2	Number of people who received HTC at CHS	Not available before T2.0	3,825
	Number of POC CD4 tests at pilot district		911
Pillar 4	Number of people receiving ART who were followed at CHS	Not available before T2.0	17
Pillar 5	Number of successful HTC referrals by community staff (e.g. PEs, community-health workers, home-based care workers, members of SHGs)	159	929

Outcomes

In June 2013, the Ministry of Health conducted an evaluation of the Treatment 2.0 pilot programme. Table 1 shows some of the significant findings.
Since implementing the Treatment 2.0 pilot, the proportion of PLHA who have begun their ART treatment with FDC drugs has increased from 2 per cent to 44 per cent. The number of successful HTC referrals by community staff has also increased, from 159 during the baseline period of 2011 to 929 during Treatment 2.0 pilot implementation.

Expanding Access to HIV Testing through Primary Healthcare Services

- Commune-level HIV testing and counselling commenced in September 2012 in Dien Bien and in October 2012 in Can Tho. Over the relatively short time frame (8 months for Dien Bien and 7 for Can Tho), an average of 20 people per month accessed HTC per commune in Dien Bien. In Can Tho, this number rose to an average of around 30 per month per commune (Table 2).
- A greater proportion of individuals from key populations were tested in Dien Bien than in Can Tho (11.7 per cent and 10.5 per cent respectively), while a greater proportion of pregnant women received testing in Can Tho compared with Dien Bien (75.9 per cent and 61.4 per cent, respectively). The median age of those tested was 26 years in Dien Bien (30 years among those who were HIV-positive) and 28 years in Can Tho (33 among those who were HIV-positive) (Table 2).
- Prevalence among those tested at commune level is particularly high among key populations in Dien Bien, at 13 per cent, reaching 31 per cent among key populations in Muong Anh district of Dien Bien province (Table 2).
- In both Dien Bien and Can Tho, the number of people who actually received their results was quite low at only 60 per cent and 75 per cent, respectively, among those who had HIV-positive results.

- During the pilot in Dien Bien, 222 people diagnosed at district and 21 people diagnosed at communes initiated ART. People diagnosed at communes during the pilot in Dien Bien started ART at a higher CD4 count (294 cells/mm3) than those who started ART at districts before and during the pilot (CD4 count at 256 and 101 cells/mm3 respectively). In Can Tho, there were only two patients who started ART during the pilot, therefore, it was difficult to draw any meaningful conclusion for that cohort.

Table 2. Access to HIV Testing in Dien Bien and Can Tho

	Dien Bien			Can Tho		
	Tested & Received Results	HIV+	%HIV+	Tested & Received Results	HIV+	%HIV+
Pregnant women	1,186	4	<1%	1,433	1	<1%
KPs	227	30	13%	198	13	7%
Partners	520	8	2%	256	2	1%
Males	412	31	8%	167	10	6%
Females	1,521	11	1%	1,720	6	<1%
Total	1933	42	2%	1,887	16	<1%

Diagnosis to Enrolment

- At the 2 study provinces, the median number of days between diagnosis and linkage to care was 6 for those diagnosed at commune level and 11 for those diagnosed at district level. In Can Tho, the difference was even more pronounced, with those diagnosed at the commune level who were linked to care in a median of 6 days, with a median of 15 days for those diagnosed at district level.

Enrolment to Receive CD4 Count Results

- Under Treatment 2.0, remarkable improvements have been made in reducing the time between enrolment to care and receiving CD4 count results, both generally and most notably in those districts with a POC CD4 count machine, the PIMA CD4 Assay. In Dien Bien, the median number of days between enrolling in care and receiving CD4 count was two days. In Can Tho, it was one.
- PIMA CD4 Assay was introduced to Tuan Giao district in Dien Bien and Thot Not district in Can Tho. In Tuan Giao, waiting times fell from a median of 109 days to a median of same day notification between July 2012 and May 2013. In Can Tho, the median waiting times also fell to same day notification. These results were achieved despite a two-month window in which the PIMA in Tuan Giao was broken.

Challenges

- Because of the continuing stigma and discrimination against PLHA in the communities where they live, some of them do not want to receive HIV care and treatment services at their CHS.
- Some patients consider the services being provided at the commune healthcare facility to be of poor quality.
- Health workers experience difficulties in communicating with and providing counselling services to ethnic groups due to language barrier.
- Most HIV patients are poor. Many do not have jobs or relatives who can take care of them, thus, they meet difficulties in adhering to their ARV.

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GETTING TO ZERO DISCRIMINATION

Islam Moves to Curb HIV and AIDS, Malaysia

Introduction to the Practice

The HIV and AIDS epidemic poses new challenges to people all over the world whatever their race, creed, or culture. This is true for Malaysia, with the majority of its relatively young multi-ethnic population belonging to the Islam faith. Thus, religious leaders who are respected and trusted have recognised their role in taking necessary action to help curb the health problems and social stigma in the country caused by HIV and AIDS. Their spiritual leadership, credibility, and closeness to the communities enable them to make a meaningful difference when helping stop the spread of this disease. Islam religious leaders imparting messages and acting on certain initiatives against HIV and AIDS have significant impact in helping their country and countrymen deal with the epidemic.

HIV Situation in Malaysia

From 1986 to 2012, or over the last 26 years, there have been 98,279 cases of HIV and 15,688 AIDS-related deaths reported in Malaysia. The total cases of people living with HIV and AIDS (PLHA) among the Muslim community was 71 per cent, with people who inject drugs (PWID) being initially the main driver of the epidemic in the country. In 2012, the Integrated Biological and Behavioural Surveillance (IBBS) showed a decrease in the prevalence of HIV among PWID, female sex workers (FSWs), and transgenders (TGs), but the prevalence rate had noticeably risen among men who have sex with men (MSM).

The Need for Islamic Participation in the AIDS Response

Traditionally, religious groups have been perceived as backward. But in truth, they are a force to make things happen or move forward. Religious bodies have shown a longstanding commitment and dedication in attending to local needs, as they have a deep, strong, loyal, trusted, and trusting relationship with fellow Muslims in their communities. Religious leaders not only give moral and spiritual sustenance to their fellow Muslims, they also extend financial aid to the needy.

It is a scientifically proven fact that diseases such as HIV and AIDS affect all physiological and socio-psychological conditions of the affected person's life, including his or her family's, as well as the larger community's. The responsibility of solving the problems caused by this epidemic, however, cannot and should not be the responsibility of government or health-related institutions only. It is quite significant that religious bodies such as Islam have recognised their responsibility and capacity to help deal with the challenges caused by HIV and AIDS.

To provide greater support to the country's Muslim population who have been hardest hit by the country's HIV epidemic, the Ministry of Health (MOH) has therefore been building partnerships since 2006 with the government's policy-making bodies, i.e. the Department of Islamic Development Jabatan Kemajuan Islam Malaysia (JAKIM), the Religious Division, Prime Minister's Department, and State Religious Departments.

Today, the participation and involvement of ethnic and religious bodies at various levels and working in committees in the HIV Prevention and Control Programme is a much welcome development. Partnerships established between JAKIM, MOH, and non-governmental organisations (NGOs) have successfully engaged religious leaders to actively, creatively, and efficiently develop and advocate approaches that would respond to the HIV and AIDS problem in the country. Thus, their projects and initiatives, whether it be in developing a training manual on HIV and AIDS for the training of religious leaders; setting aside a day to give sermons about AIDS; putting up shelters for AIDS victims; piloting an employment training programme for TGs to make them accepted especially within the highly conservative Muslim community, definitely produce a productive synergy towards countering HIV and AIDS.

How It Works

The MOH and JAKIM collaborated to hold the first HIV and Islam Conference in 2006, with the aim of making the religious influentials understand HIV and AIDS as a disease and its social and cultural implications. Additionally, the collaboration also needed to involve the influentials in the planning and implementation of intervention strategies to fight HIV and AIDS. Various officers and leaders from Islamic agencies and NGOs attended and participated in the conference.

Islam HIV and AIDS Programme and Initiatives

Plans were developed in order to run the HIV and AIDS programmes and activities among the Islamic bodies. The Family Social and Community Division of JAKIM was made to handle the HIV-related issues. A committee was set up and chaired by personnel from JAKIM with the participation of selected State Religious Departments, which included the Enforcement Division, MOH personnel, Muslim NGOs, and the Malaysian AIDS Council (MAC). The main activities planned then were:

- The development and production of a training manual on HIV and AIDS for Muslim religious leaders
- The working together of NGOs and religious leaders to reach out to key populations (KPs)
- Providing KPs with moral as well as financial care and support

Specific initiatives that grew from these plans are discussed as follows:

- *HIV and AIDS in Islam Manual.* This manual is intended to be used as the standard institutional material in the formal training of religious leaders. It was officially launched on 5 August 2010 at the Islamic Centre, Kuala Lumpur. JAKIM and MOH jointly developed the manual, with MAC assuming an advisory role. The Manual covers issues such as the role of religious leaders in spreading messages of HIV and AIDS awareness; Islamic principles of HIV prevention; healthcare and welfare services available for the Muslim

community; management of HIV in Islamic rituals; and most notably, Islam's intolerance for stigma and discrimination, which is considered a huge barrier to HIV prevention, care, and treatment in the Muslim community. The Manual is also being used in the HIV and AIDS education of new Muslim leaders during their institutional leadership training.

- *HIV and AIDS Prevention through Friday Sermons and TV Talk Shows.* One of the most effective ways to communicate HIV awareness and prevention to the Muslim public is through Friday sermons. JAKIM has now made it a policy that the Friday sermon closest to World AIDS Day should be about HIV. Consequently, since the HIV and Islam programme started in 2009, several one-hour talk show episodes with messages focusing on HIV and AIDS have been broadcasted on the highly popular television programme, Forum Perdana.
- *Shelter Care for Muslims Living with HIV.* The need for more and better provisions for support services for Muslim people living with HIV and AIDS has made the Selangor Islamic Religious Council (MAIS) take the lead in improving the availability and delivery of home-based HIV care and treatment services. This was through the building and operation of Istana Budi, the first shelter home for Muslims living with HIV. Istana Budi opened in Kuang, Selangor in 2010, with its construction and operations entirely funded by MAIS. The 10,000 square feet facility can accommodate up to 50 residents at one time. It is run by professional caregivers and offers rehabilitation services and basic nursing care, besides basic Islamic teaching. As of today there are several shelter homes in operation, with financial support from JAKIM and State Religious Departments.
- *Activities with Other KPs.* One of the most highly-stigmatised groups in Malaysian society is the TG community, who find themselves shunned by society and therefore struggle to find employment. As a result, they often resort to sex work, which increases their risk of being infected with HIV and being vulnerable to violence. An unprecedented move to improve the livelihood of Muslim TGs came with the joint venture between Dagang Halal, a food products and services company, JAKIM, and another NGO. They piloted an employment training programme for TGs, aiming to increase their social acceptance within the highly-conservative Muslim community. The pilot project provided TG participants with HIV and AIDS education and religious and spiritual lessons, as well as professional skills and development training. At the end of the project, participants were given the opportunity to apply for jobs. The success of the pilot project has been replicated in other parts of the country and expanded to include former prisoners, PWID, people who use drugs (PWUD), and single mothers who are infected with or affected by the disease.
- *Mosques as Sites for Methadone Maintenance Treatment (MMT) Programmes and Activities.* A mosque in one of the country's most prominent universities in Kuala Lumpur is currently being used as a place to administer MMT to PWID. This is all part of the wider outreach work being done by the state religious authorities and JAKIM to provide HIV education and spiritual support to KPs, giving them basic Islamic knowledge and moral values and access to discussions on other related social issues. Several camping activities known as "Mukhayyam" are conducted by JAKIM in collaboration with NGOs to help erase stigma and discrimination against and among the KPs.

The MOH and JAKIM collaborated to hold the first HIV and Islam Conference in 2006, with the aim of making the religious influentials understand HIV and AIDS.

- *Screening of Pre-Marital Couples Programme.* This is another noteworthy initiative started by MOH in collaboration with the Islamic Religious Authority, which agreed to start the programme. The programme already screens more than 200,000 pre-marriage couples yearly. Recently, the programme was extended to include non-Muslim couples, with about 20,000 already voluntarily availing of the service. This screening complements the HIV antenatal screening of MOH.

Outcomes

The HIV and AIDS Islam programme has achieved so much. The decrease in Malaysia's annual number of reported HIV cases, from 5,000 20 years ago to 3,000 in the last 4 years, can be traced to the expanding participation of various agencies and sectors, like major religions, such as Islam.

The ongoing partnership and commitment of the religious institutions with MOH and NGOs has continued to create an enabling environment for Muslims, specifically KPs, not only to facilitate their access to HIV prevention, care, treatment, and support but also to reduce stigma and discrimination suffered by these groups in the community.

Challenges

There is always room for truly-concerned and dedicated programmes, projects or strategies. Whether government or NGO, whether directly a health service or a community endeavour, the active and committed participation and involvement of all, particularly the religious sector, such as Islam, to see a Malaysia that is free of HIV and AIDS is a tremendous goal that has to be pursued and sustained.

The enabling environments for the infected and affected Muslim community in Malaysia started with the committed efforts of its planners and leaders, as well as the constant and steady partnership and cooperation between and among the programme initiators, MOH, JAKIM and other religious authorities, and NGOs. That this steadfastness be a lasting virtue among them is the true challenge.

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GETTING TO THE THREE ZEROS THROUGH COMBINED GOOD PRACTICES

Adopting the ACG2Z RAS in the National Response to HIV and AIDS, Philippines

Introduction to the Practice

The Philippines adopted the ASEAN Cities Getting to Zero Rapid Assessment Survey (ACG2Z RAS) as a major step towards localising HIV and AIDS responses to local government units (LGUs) comprising cities and rural and urban municipalities. The ACG2Z RAS is a tool used to establish the current HIV and AIDS situation in an LGU through the assessment of baseline epidemiological data, social network influence, behaviour change interventions, and current levels of responses, including their strengths, opportunities, constraints, and gaps. The findings are used to gauge the effectiveness of the LGU response and to direct local leaders to areas of their HIV programme that need strengthening, scaling up, and sustainability.

Implementation of the ACG2Z RAS was planned to be in phases, corresponding to the priority areas for HIV intervention: Category A, cities and municipalities that are the major contributors to the epidemic; Category B, cities and municipalities that are medium contributors; and Category C, cities and municipalities with emerging epidemics. The ACG2Z RAS is to be repeated every three years.

Phase I of the project involved 15 cities and 1 urban municipality under the National Capital Region (NCR). The period of implementation was from February to September 2013. Succeeding phases will follow for other regions.

The project was spearheaded by the Department of Health (DOH) through the Philippine National AIDS Council (PNAC), working closely with the Department of the Interior and Local Government (DILG), and the League of Cities of the Philippines (LCP).

It was funded by DOH with additional support from the United Nations Development Programme.

How It Works

Implementing ACG2Z RAS involved several major activities: advocacy and partnership building, modification and enhancement of the rapid assessment survey (RAS) tools, capacity development of partners, data gathering, data analysis and report writing, and report presentation to stakeholders that included evidence-informed participatory planning.

Advocacy and Partnership Building for a Meaningful Engagement

DILG and LCP issued a Memorandum Circular and endorsement letter to local government executives, enjoining their support for the initiative. The City Health Office (CHO) was designated as the lead at the LGU level. The DOH-Center of Health Development for NCR (DOH-CHD NCR) was the lead at the regional level.

Modification and Enhancement of RAS Tools

After a series of consultative meetings among the stakeholders, it was decided that RAS tools needed to be enhanced through an automated facility solution using Microsoft Access. DOH-CHD NCR led its development. The automation resulted in faster and more efficient data management at DOH and LGUs.

Capacity Development of Partners

Capacity development was a three-step process.

1. Orientation of CHOs and staff of DOH-CHD NCR
2. Training of 17 personnel from the DOH-CHD NCR, who were designated as the lead enumerators
3. Training of three staff members from each LGU, who were expected to work with the lead enumerators and, eventually, to be the lead enumerators themselves in the succeeding RAS, thus assuring the sustainability of ACG2Z RAS

The capacity development programme consisted of the use of the following RAS tools: document review forms, key informant interviews, focus group discussions (FGDs), and client satisfaction surveys (CSS). The programme also included skills building for becoming an enumerator.

Data Gathering

Data gathering took place in June and July. It included policy mapping and review; key informant interviews of those who had direct roles in the implementation of the local response; and CSS and FGDs of clients at the social hygiene clinics, Tuberculosis Directly Observed Therapy Short Course centres, and at antenatal clinics. During data gathering, privacy and confidentiality were observed.

Data Analysis and Report Writing

The PNAC Secretariat organised a four-day workshop on data management (encoding, analysis, and write-up) for the LGU teams made up of the

Workshop on data analysis and report writing for the LGU teams

social hygiene physician, the sexually transmitted infections and HIV programme coordinator, the city epidemiology/surveillance officer, and an information technologist. PNAC also provided mentoring until the report was completed.

Presentation to Local Chief Executives, Policy, and Programme Authorities

In August 2013, PNAC organised a forum to share the results of the ACG2Z RAS with the LGU executives. There were presentations on the local HIV situation and existing initiatives, good practices, challenges, and areas of response for possible scaling up. During the forum, PNAC also discussed the Accelerated Response and Coordinated Action Plan as a contribution to the country's Fifth AIDS Medium-Term Plan. The forum paved the way for the formulation of new city and district-wide strategies for HIV and AIDS.

Outcomes

The implementation of ACG2Z RAS in 15 cities and 1 urban municipality resulted in specific outcomes:

- Sixteen LGUs with evidence-based plans for an HIV response that can be incorporated into their own City Investment Plan on Health
- LGU plans that can be presented to external stakeholders for support
- Shortened implementation period for the ACG2Z RAS Phase II, from Phase I's nine months to the projected Phase II's four months

Challenges

- Due to competing priorities at both national and local governments, the budget for the expanded implementation of ACG2Z RAS was not included in the budget plans of PNAC and DOH-CHD NCR.
- The change of LGU leaderships after the May 2013 elections resulted in the re-organisation of LGU offices that led to tentative decisions about participating in the ACG2Z RAS project.
- Because the LGUs sent one-year contractual nurses to the RAS training, the sustainability of the project has been put in jeopardy.
- The ACG2Z RAS software and its manual of procedures need to be further modified.

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Building Sustainable HIV and AIDS Programmes, Indonesia

Introduction to the Practice

In 2010, the President of Indonesia signed Presidential Instruction No.3/2010 concerning the Acceleration of Millennium Development Goals (MDGs) 2015 programmes. This prompted the National Planning Agency and the Ministry of Home Affairs to instruct all local (sub-national: provincial/district/city) governments to prepare their own action plans for the acceleration of MDGs, which included HIV and AIDS indicators. In 2012, Indonesia took the lead for the ASEAN Cities Getting to Zero initiative. This action further pushed the HIV and AIDS agenda into the planning system. Under this initiative and upon the invitation by the National AIDS Secretary, three cities submitted proposals: Badung and Denpasar in Bali Province and West Jakarta. In addition, the Corrective Institution Directorate launched its Getting to Zero HIV and Drugs in Prisons.

Resulting from these initiatives, a project emanated aimed at producing sub-national Action Plans for the Accelerated Attainment of MDGs on HIV and AIDS targets. These Action Plans became the guide for local governments to design and appropriately allocate domestic funds to HIV and AIDS programmes on a yearly basis. The project was implemented in the country's 33 provinces.

The project was a collaborative effort by many sectors, including the National AIDS Commission or KPAN, National Agency for Development Planning or BAPPENAS, the local (Provincial/ District/City) AIDS Commissions, the Australian Agency for International Development (AusAID) HIV and AIDS Cooperation Programme for Indonesia (HCPI), and State Funds or APBN.

Initial funding for the project came from the Australian Government through HCPI. In the course of implementation, more domestic funds were being allocated for meetings and trainings. This was a reflection of the increasing ownership of local governments towards HIV and AIDS programmes.

How It Works

Since 2010, sub-national AIDS Commissions have been taking part in the local HIV and AIDS response across 141 districts and cities in 33 provinces, mostly using international aid from bilateral donors AusAID and the United States Agency for International Development (USAID) and the multilateral donor, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). At the same time, efforts to increase local funding began through allocation in national or sub-national budgets. In 2013, the Minister of Home Affairs enacted Ministerial Decree No. 27, concerning development planning, and Ministerial Instruction No. 444.24/2229/SJ, concerning the institutional strengthening and community empowerment in the sub-national HIV and AIDS response. These policies emphasised the role of the heads of districts, mayors, and governors to allocate funds for HIV and AIDS programmes in their respective areas. Three activities were implemented to carry out these regulations:

- Development and strengthening of facilitators through a series of training courses at national and sub-national levels. These trainings put emphasis on increasing knowledge and skills of facilitators on how to develop a local-based action plan based on MDGs targets (Presidential Instruction No. 3/2010), Mid-Term National Development Planning, and the HIV and AIDS programme, as well as facilitation and communication skills.
- Organising coordinating meetings by facilitators involving stakeholders at the provincial, district, and city levels, starting with 12 priority provinces and continuing on until all 33 provinces were facilitated. These meetings focused on consultation with local leaders, non-governmental organisations, government officials in the field of HIV and AIDS, and the Office of Development Planning officials. The output of these meetings was the operationalisation of the National Plan into implementable local-level programmes, of which at the end, MDGs targets may be reached.
- Conducting field visits by facilitators to provide technical assistance to sub-national stakeholders, in particular, when requested by local governments and/or other stakeholders. These visits were also aimed at finding practical solutions when problems occurred.

The National AIDS Commission, in collaboration with HCPI, developed the Guidelines for Planning and Budgeting of AIDS Responses to facilitate the integration of foreign-funded AIDS programmes into the national planning system. As of this date, concerned officials and staff from all 33 provinces across the country have been trained using the guidelines.

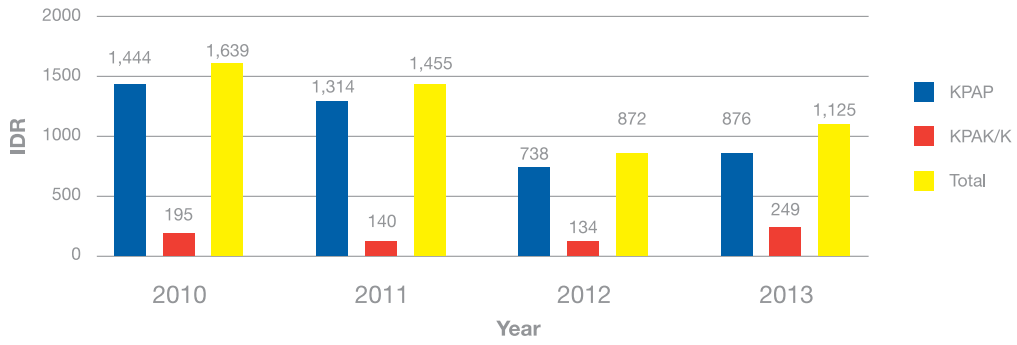
Outcomes

The rising support to the HIV and AIDS response using domestic funds has been a gradual process. It shows the increasing commitment and attention from heads of local governments towards issues related to HIV and AIDS. In 2013, the following achievements were noted:

- To push for increased local level fund allocation, policies were enacted, such as the 58 Local Regulations or PERDA, focusing on the management of the HIV and AIDS response in 39 districts and cities in 19 provinces. With this regulation in place, financial support using domestic funding saw an increase, either allocated by Provincial/District/City Secretariat Offices of the sub-national AIDS Commission or through public offices including health agencies, authorities for education, planning, and others.
- Some provinces have integrated HIV and AIDS programming, previously receiving international funding, into their sub-national development planning systems.
- Funding allocation for care, treatment, and support has seen tremendous improvements at all levels.
- Secretariats of sub-national AIDS Commissions at the provincial, district, and city levels have become the managers of local responses (Chart 1).
- At least 126 districts and cities have started to allocate funds for their sub-national AIDS Commission Secretariats. A total of Indonesian Rupiah (IDR) 249 million has been allocated in 2013, a considerable increase from that of 2012, which was IDR 134 million (Chart 1). Additionally, there has been an increase in financial support by various ministries, including the Ministry of Health and its agencies at all levels, though they are seen to fluctuate.
- The year 2012 saw the highest allocation of domestic funds for HIV and AIDS programmes at IDR 1,933 billion, an increase from IDR 1,314 billion in 2011.

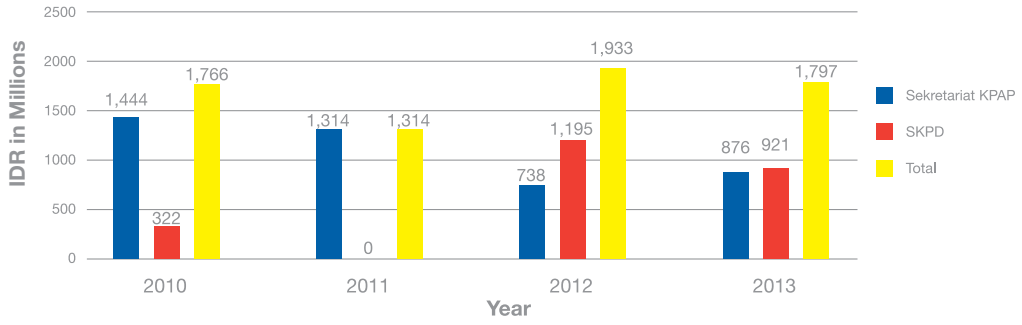
- For the years 2012 and 2013, the average allocated domestic fund to government agencies involved in HIV and AIDS has been greater than to the AIDS Commission Secretariat. This reflects an increasingly integrated and mainstreamed approach to HIV and AIDS among government agencies. In all these, the role of the AIDS Commission Secretariat remains the same, as the coordinator and manager of the response. Chart 2, which depicts allocated domestic funds by a government agency at provincial levels, further demonstrates the increasing commitment by the governments at all levels to budget funds for an issue previously not seen as a development priority. Fluctuations in size of funding are mostly affected by the political situation in each province. For example, when an election is held, local funds are absorbed during this period.

Chart 1. Mean of Allocated Domestic Funds (APBD) for AIDS Commission Secretariat, Year 2010 to 2013



KPAK/K: City AIDS Commission
KPAP: Provincial AIDS Commission

Chart 2. Mean of APDB by Provincial Government, Year 2010 to 2013



Sekretariat KPAP: Provincial AIDS Commission Secretariat
SKPD: MOH employees assigned to the National or Local AIDS Commission Secretariat

The role of international aid and funds, such as GFATM, AusAID, USAID, and from various United Nation agencies, remain crucial in stimulating the increasing role of local governments in the HIV and AIDS response at all levels (national, provincial, district/city). Domestic funds, however, are essential for the sustainability of the response to ensure that key populations are receiving the services, whether prevention, care, treatment, or support, they are entitled to.

Challenges

Despite increasing domestic support, the amounts allocated at all levels are still relatively small compared to the total need, hence the continuing dependence on international funding. As it stands, domestic funds are mostly spent on care, treatment, and support, while the prevention efforts such as needle and syringe programmes and the condom programme are still very much dependent on foreign funds.

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Decentralising the AIDS Response to Local Governments, Philippines

Introduction to the Practice

The fight to prevent and control HIV and AIDS in the Philippines is governed by Republic Act 8504, The Philippine AIDS Prevention and Control Act of 1998. However, due to the decentralised system of government in the country, operational responsibility for HIV prevention and control efforts fall on local government units (LGUs) and local AIDS councils, wherever they exist. The difficulty in establishing a national response is that LGUs are largely autonomous; national policy is guidance for local governments and is not binding.

This was the situation in 2008:

- While HIV policies were present at LGUs, interventions to prevent and provide services for people most-at-risk, indirectly affected by, or living with HIV were underfunded and uncoordinated.
- Technical, human, and financial resources at LGUs did not meet the needs for effective HIV prevention and so did the low level of awareness of HIV issues among LGU officials.
- Since HIV was traditionally viewed as a health issue and not a development issue, it was difficult to bring together other government departments and to coordinate policies more effectively.

As a response, in 2008, the United Nations Development Programme (UNDP), working with the Philippine National AIDS Council and the United Nations Joint Team on HIV/AIDS, formulated the programme, "Leadership for Effective and Sustained Responses to HIV and AIDS", to increase institutional leadership and improve local commitment to HIV and AIDS. The goals were to bridge the gap between national institutions and local ones and to encourage LGUs to implement local responses with the necessary technical support to be successful at it.

To achieve its goals, the programme:

- Reinvigorated the network of Regional AIDS Assistance Teams (RAATs), first established by PNAC in 2007
- Brought together the Department of Interior and Local Government (DILG), the Department of Social Welfare and Development (DSWD), and the Department of Health (DOH) to translate national policies and facilitate regional coordination
- Identified a group of local HIV and AIDS champions within the LGUs that RAATs could turn to for technical advice and support
- Partnered with the Local Government Academy (LGA), an institution that provides capacity-building services to local government officials, to integrate HIV awareness into the orientation curriculum for all incoming local government officials

Together, these major activities laid the foundation for sustainable local HIV and AIDS responses.

How It Works

In two major workshops in 2009, DILG, DSWD, and DOH came together to decide on the following:

- Structure and roles of RAATs and how they would complement existing local initiatives
- Scope of each department's responsibilities

- A common understanding of the underlying factors contributing to the HIV epidemic
- Baseline of knowledge necessary for better cooperation on interventions

Based on the results of the workshops, the three departments signed a Joint Memorandum of Agreement to operationalise RAATs. It was the first agreement on coordinating local HIV responses in the Philippines.

Simultaneous with the holding of the workshops, UNDP and LGA began integrating an HIV awareness course into the orientation curriculum that all newly-elected local officials undergo. It eventually resulted in having nearly 900 local government officials trained.

By 2010, there were RAATs in all the regions in the country. They served as focal points for gathering information on the local responses and on existing local AIDS councils and their functionality. RAATs led the way for the following major activities under the programme:

- Identification of vulnerable LGUs in target regions
- Identification of potential local AIDS champions, who were influential people within the government
- Provision of in-depth training as a follow-up to the orientation from LGA
- Development of a website for RAAT members that was also a central repository of research, policies, and other resources for their use and to share with LGUs

Through 2010 to 2011, the programme also embarked on a series of initiatives to better understand the needs of LGUs and encourage and recognise local responses.

- In partnership with the non-governmental organisation Action for Health Initiatives, the programme supported a policy review of local HIV ordinances in two cities, Quezon City and Pasay City.
- Working with the University of the Philippines Center for Local and Regional Governance, it sponsored a study that resulted in a step-by-step guide for LGUs in developing local HIV and AIDS responses.
- It facilitated the establishment of a national Technical Working Group made up of civil society, the health sector, and other government representatives.
- At the end of 2010, it sponsored the first annual Catalytic HIV and AIDS Mitigation Programme Awards or CHAMP, which recognised the best local HIV and AIDS responses in the country. Winners received cash grants for local programming.

Outcomes

By the first quarter of 2011, the programme achieved the following:

- Ninety-nine new local AIDS councils had been established.
- Two hundred fifty local AIDS champions and advocates were recruited.
- RAATs were operationalised in all 17 regions in the country.
- Forty-four local AIDS policies had been developed.
- Provincial governments in Regions VI, VII, XI, and the Autonomous Region in Muslim Mindanao have issued executive orders mandating the establishment of local AIDS councils.
- DILG and DSWD have both issued internal guidelines on implementing prevention programmes regarding sexually transmitted infections and HIV and AIDS in their workplaces, representing the first department-wide HIV-focused workplace policies. DILG is integrating the policy into its employee health programme.

Challenges

There remain challenges to be addressed to ensure the long-term sustainability of RAATs, the local AIDS councils, and the local AIDS champions.

- RAATs are currently composed of representatives from DILG, DOH, and DSWD. These government departments are not the only government stakeholders involved in the HIV and AIDS response but expanding its membership will require revisiting RAATs' composition, areas of responsibility, and issues of ownership and national reporting structures.
- RAATs will require a well-defined funding mechanism that includes cost sharing among participating organisations.
- As more local AIDS councils are established and more HIV responses are undertaken, there will be a greater need and demand for the systematic collection and dissemination of knowledge and experiences gained, as well as the implementation of a monitoring mechanism based on the national monitoring and evaluation framework, which may not be adequately met.

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Enhancing the Capacity of PLHA Networks, Myanmar

Introduction to the Practice

The Myanmar National Strategic and Operational Plan on HIV and AIDS (2011 to 2015) recognises the need to strengthen community systems as one of the essential cross-cutting interventions to carry out its three strategic priorities, namely prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use, comprehensive continuum of care for people living with HIV and AIDS (PLHA), and mitigation of the impact of HIV on PLHA and their families.

Civil society, faith-based and community-based organisations (CBOs), including those involving PLHA, all play a crucial role in the prevention of HIV. In the interest of key populations (KPs), these organisations advocate support for HIV interventions and assist in the mobilisation of human, financial, and material resources. They provide services to KPs and other vulnerable population groups through outreach activities and the facilitation of PLHA networks' community leadership and guidance.

There are seven national networks operating in the country. These are the Myanmar Positive Group (MPG), Myanmar Positive Women's Network (MPWN), Myanmar Men Who Have Sex with Men Network, Drug Users' Network, Sex Workers Network in Myanmar, National NGO Network, and the Myanmar Interfaith Network Association. The networks are made up of CBOs, self-help groups (SHGs), and individual members coming from various regions and states of the country. They support the national HIV prevention programme. One major activity that they undertake is providing PLHA care and support in cooperation with the National AIDS Programme (NAP).

Under the National Strategic Plan is the Project to Enhance Capacity of PLHA Networks. It is aimed at strengthening the participation of PLHA, CBOs, and SHGs in the response to the HIV problem. Its specific objectives are:

- To strengthen the capacity of CBOs and SHGs, particularly those of women living with HIV
- To enhance social protection in countering HIV and AIDS, and mitigate its impact on positive women and their families
- To promote partnership building and networking among PLHA, CBOs, and SHGs to create a coordinated HIV response

From the beginning, the PLHA networks faced inadequacies in programme management, budgeting, translating their knowledge and ideas into useful strategic information, in communicating, and other challenges. These challenges became barriers to their greater involvement and empowerment. To address the situation, the project has been providing financial and technical support to build the capacity of the PLHA networks through organisational development using rights-based programming. The project also supports, in a limited capacity, men who have sex with men (MSM) and female sex workers (FSWs)

networks in Myanmar, where the gaps in these areas have also been noted. Under the project, capacity-building is focused on the areas of training, research, and income generation.
Implementing the project are the PLHA networks themselves, with support from NAP, under the Ministry of Health's Department of Health. This on-going effort is in collaboration with the United Nations Development Programme (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), Burnet Institute, and Alliance Myanmar. Funding support comes from the Core and Global Thematic Trust Funds of UNDP and the UNAIDS Programme Acceleration Fund.

How It Works

The project is implemented in selected regions and states by the PLHA networks, through its member CBOs and SHGs. The implementation involves the following major activities:

Training. Two PLHA networks are engaged in training.

MPWN. It supports the conduct of capacity and needs assessment of its member CBOs and SHGs. It utilises the Network Capacity Analysis Toolkit that covers six areas of capacity:

1. Involvement and accountability
2. Leadership
3. Knowledge and skills
4. Internal communication
5. Advocacy
6. External communication

The toolkit also includes, inter alia, governance and strategy, project design and management, and technical capacity. Follow-up trainings are provided, as identified by the assessment process to SHG members, positive women core group leaders, and SHG leaders.

MPG. It provides the following training programmes for its CBOs and SHGs:

- Skills-building training on organisational development, under the Capacity-building Initiative, to potential trainers of MPG coming from Yangon as well as other regions and states
- Training of trainers for its teams on HIV and its related issues, such as human rights, positive health dignity, improved literacy counselling, prevention of mother-to-child transmission, nutrition, antiretroviral therapy (ART), and comprehensive continuum of care
- Training on organisational development, financial management, communication, and team building among members of SHGs
- Training on rights-based programming, monitoring and documentation for HIV and human rights, strategic planning and team building, also for MSM and FSW networks

Training is continuing under the project.

Research. HIV is not just a health concern but a socioeconomic one as well. The project, therefore, also addresses the need to help mitigate the impact of HIV on KPs, their families, and society in general. To substantiate the socio-economic aspects of HIV, evidence-based indicators were needed. Thus, a preliminary research study on the socio-economic impact of

HIV at the household level was conducted. The first phase of the socio-economic impact study focused on PLHA households in six regions and states: Yangon, Mandalay, Sagaing, Thinintari, Mon, and Shan. Its later phases covered the whole country.

The research study and its processes became a tool for learning for both MPG and MPWN. The study's use of the participatory enhancement approach enabled PLHA to be involved, from the design stage to the analysis of data. This approach is contributing to an ongoing cycle of participation and reflection.

The study, which has been completed, was implemented nationwide. Its preliminary findings and recommendations have been disseminated to all stakeholders for evidence-based advocacy, planning, and scaling up of the programmes to mitigate the HIV impact.

Income generation grants. The project provided small grants for income generation to 59 SHGs in 23 townships in the covered regions and states. It also provided small grants for income generation to members of MPWN and MPG who formed themselves into SHGs at the grassroots level. This move allowed MPWN and MPG to respond to the health and socio-economic needs of their individual members.

Although income generation grants have been completed, it is ongoing for SHGs under a project funded by UNDP.

Outcomes

MPWN. At the beginning of 2008, MPWN had only 30 individual members. Today, its membership is estimated at 4,000 across the country. In 2012, MPWN was able to:

- Establish its own office.
- Forge a formal communication channel with the Asia Pacific Women Plus Network.
- Mobilise funding from UNAIDS for a capacity-building project, and from the Asia Pacific Resource and Research for Women, a Malaysia based NGO, for a project on sexual and reproductive health and rights for women and young people.
- Carry out an advocacy meeting for key stakeholders that included government, international and national agencies, and NGOs, where information was shared about the situation and issues facing women living with HIV. As a result, MPWN is now recognised as a key national stakeholder, invited to national level meetings (e.g. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) meetings, annual review meetings of National AIDS programme), giving them opportunities to raise their issues.

MPG. It is the largest national network of PLHA. In 2012, its current membership totalled 214 SHGs, covering more than 10,000 PLHA, and with the following major achievements:

- Two representatives stand as members of the Country Coordinating Mechanism (CCM), chaired by the Minister of Health.
- Two representatives are members of the Technical Strategy Group, formed under the CCM, where they can contribute their views and opinions to inform decision making and implementation of the national AIDS response.
- Two PLHA SHGs were upgraded to CBOs and are now involved in the ART programme, with funding support from the GFATM.

Challenges

- CBOs that are not yet officially registered cannot receive funding support.
- Many CBOs do not have full governance structures.
- Professional management and accountability remain the major challenges for SHGs.
- The stigma and discrimination against PLHA, though reduced, still remain.
- The informal nature of SHGs makes quality assessment of their services and the scaling up of their activities difficult.

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HIVQUAL-T, HIV Quality Programme, Thailand

Introduction to the Practice

HIVQUAL is a development model for hospitals to enhance their capacity and capability to manage a quality-focused HIV and AIDS care. It was originally developed in the United States by the New York State Department of Health AIDS Institute in 1992.

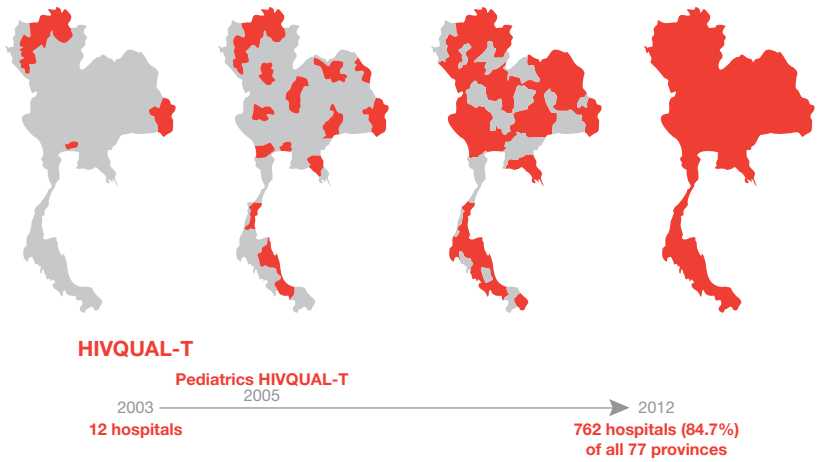
In 2003, Thailand's Bureau of AIDS, TB and STIs (BATS), in technical collaboration with the United States Centers for Disease Control and Prevention (CDC), adapted the model to fit Thailand's HIV and AIDS Programme. It was named HIVQUAL-T and was implemented for adults in 2003 and for infants in 2005. BATS and CDC initiated the HIVQUAL-T model starting with only 12 government hospitals. With HIVQUAL-T able to improve the quality of HIV care in the initial hospitals, participation grew nationwide, with antiretroviral therapy (ART) services offered in more than 700 hospitals in Thailand. By 2008, the implementation of HIVQUAL-T had expanded nationwide (Figure 1).

The HIVQUAL-T model, with its goal of creating sustainable, self-sufficient, local quality management programmes, focuses on strengthening and improving health systems. Quality improvement (QI) activities for both clinic staff and clients have been developed to solve any problems or gaps found in the service delivery process at the hospital.

The programme specifically aims to evaluate the accessibility and use of HIV and AIDS care and treatment services, address the barriers to services, and develop care networks among hospitals and health centres to improve the HIV and AIDS services in Thailand.

BATS, the Department of Disease Control (DDC), and the Ministry of Public Health (MOPH) implement the HIVQUAL-T programme. Funds for monitoring and measuring the programme's hospital performance and QI activities come from the Thailand National Health Security Office (NHSO).

Figure 1. Development of HIVQUAL-T

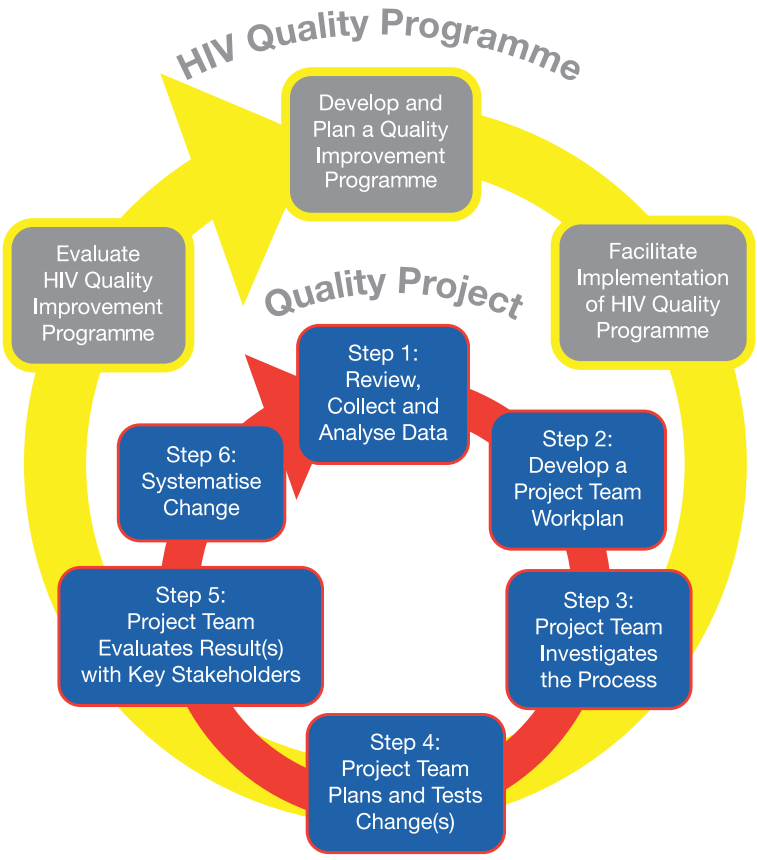


How It Works

HIVQUAL-T was based on the Yin and Yang Chinese philosophy. It is a continuous process, with three main factors: performance measurement, quality improvement, and systems development. Supporting these factors are group learning meetings that lead to the quality improvement of activities.

The HIVQUAL-T model consists of two interdependent cycles: the Programme Cycle (outer circle) and Project Cycle (inner circle'. The Programme Cycle shows the sequence of activities for developing a facility's HIV quality improvement programme, while the Project Cycle shows the steps for conducting specific quality improvement projects (Figure 2).

Figure 2. HIVQUAL-T Model



HIVQUAL-T Programme Cycle

To build and sustain an HIV-specific quality system, three steps in the HIV Quality Programme Cycle need to be completed. These are:

Step 1: Develop, plan, establish and maintain a Quality Improvement Programme throughout the organisation.

Step 2: Facilitate the implementation of the HIV Quality Programme through an HIV Quality Committee that would help implement the quality plan.

Step 3: Evaluate the HIV quality management programme.

The Programme Cycle falls under the cross-sectoral committee, the core team in the hospital responsible for overall quality improvement in the hospital.

HIVQUAL-T Project Cycle

The focal point of the HIV Quality Committee in a hospital for the HIVQUAL-T Project Cycle is usually the antiretroviral therapy (ART) clinic. It prepares and proposes a list of quality improvement activities to the hospital director for approval. When a project is approved, six steps have to be observed to ensure the quality of the project during its cycle. Steps 1 and 2 are carried out by the HIV Quality Committee, which is also responsible for guiding project implementation and monitoring its progress based on an agreed plan. Steps 3, 4, 5, and 6 are done by the project team.

Step 1: Review, collect and analyse project data in the hospital.

Step 2: Organise a project team, composed of a representative each from doctors, nurses, laboratory technicians, and other related health care staff, that then develop a team work plan. Although ad hoc in nature, the project team may continue to exist even after the work plan has been completed to tackle other problems or gaps needing QI.

Step 3: Investigate the process of HIV and AIDS service delivery at the hospital. This is to seek an opportunity for QI in areas found to be problematic or identified as experiencing gaps in service delivery concerning care and treatment.

Step 4: Plan, do, study, and act on the changes.

Step 5: Evaluate results with key stakeholders of the project.

Step 6: Systematise changes.

HIVQUAL-T Approaches

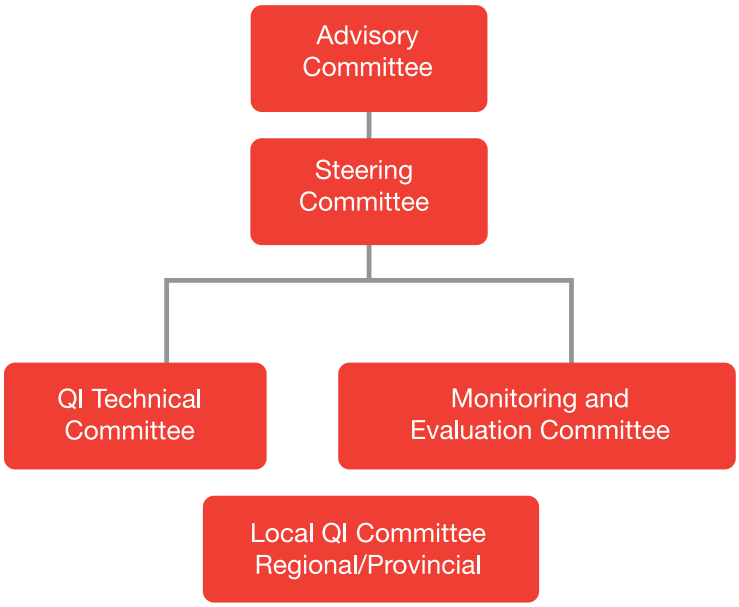
The factors that make HIVQUAL-T successful are the following:

- It is facility-based and voluntary.
- It uses sampling to measure data based on indicators developed, resulting in less workload.
- QI intervention, its formulation and implementation, is based on local analysis and context and exchange of stories among hospitals.
- It is a continuous process in measurement and quality improvement, including human capacity development.

HIVQUAL-T Quality Management (QM)

HIVQUAL-T administration teams have been created at the national, regional, and provincial levels to develop the QI plan, enhance understanding, and share learning to facilitate the adoption and implementation of QM, QI, and performance measurement initiatives (Figure 3).

Figure 3. HIVQUAL-T Administration



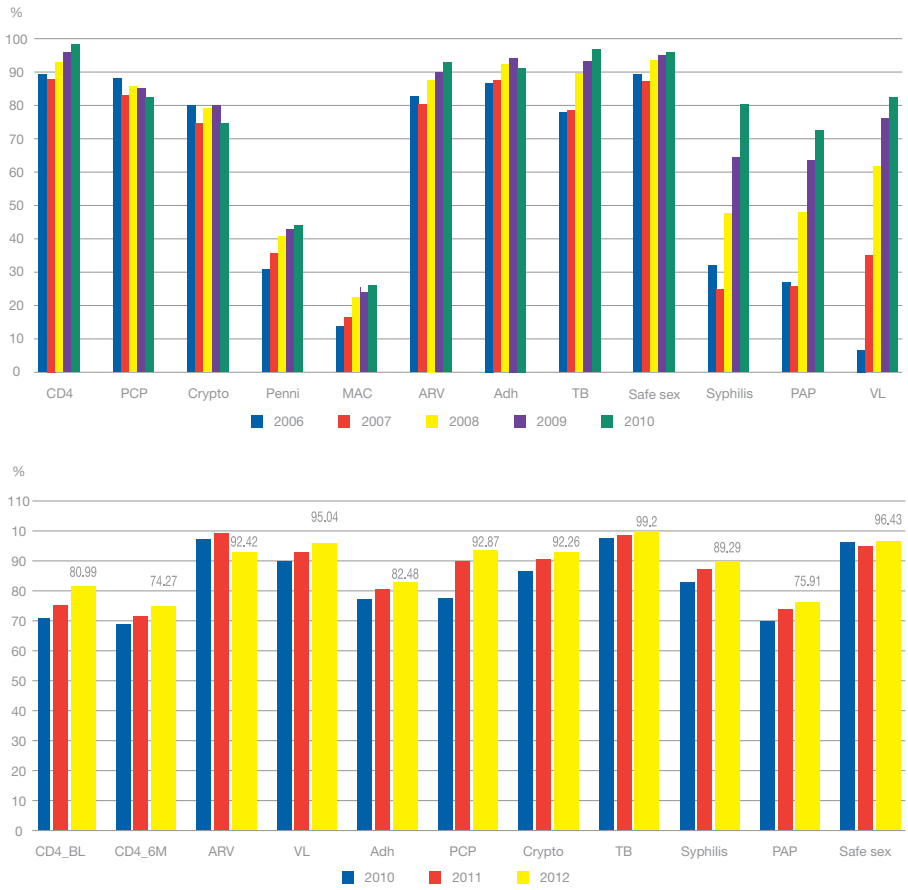
Regional QI Committee: Regional Offices of Health Security, Provincial Health, Disease Control, NGO, PHA hospitals

Provincial QI Committee: Provincial Health Office, NGO, PHA, hospitals

Outcomes

The HIVQUAL-T programme model has proven to be a powerful tool for monitoring and improving the quality of HIV care. In the charts below, HIVQUAL-T participating hospitals showed improved indicators in HIV care and treatment, such as coverage of cluster of differentiation 4, better known as CD4, and viral load testing, cervical cancer screening, syphilis screening, and cotrimoxazole prophylaxis. Chart 1 reflects progress indicators of the programme.

Chart 1. Adult HIVQUAL-T Indicators (2006 to 2010; 2010 to 2012)



Using the same measurement tool in monitoring and evaluating the HIVQUAL-T programme, hospitals not participating in the programme were found to have a lower performance level in several indicators, such as in the coverage of CD4 and viral load testing, adherence assessment, and follow up process
(Table 1).

Table 1. Results of Adult HIVQUAL-T Programme 2006 to 2012

Year	No. of participating hospitals	Current cases	Sample of current cases	New cases	Sample of new cases
2006	233	48,879	10,916	NA	NA
2007	651	93,639	35,448	NA	NA
2008	650	118,775	41,673	NA	NA
2009	701	138,844	48,624	NA	NA
2010	770	136,325	51,184	14,818	7,762
2011	760	142,669	53,379	19,044	9,601
2012	699	143,924	50,439	18,230	9,774

**In 2010, some criteria for indicators were changed; new cases indicators were added.*

Challenges

The development of more advanced ART has transformed HIV into a less chronic disease, allowing infected individuals to live longer and healthier lives—but only if they receive adequate treatment as early as possible. PLHA must be given hope that through successful care and treatment, they can live healthy lives again. This can happen only if the challenges of HIVQUAL-T programme can be met and overcome on such issues as:

- Sustainability
  - Linkage of the HIVQUAL-T programme to the hospital accreditation system
  - Advocacy for a humanised approach, such as holistic care; empowerment of patients to be partners in service delivery; and engaging more stakeholders or counterparts
  - Provision of other tools to strengthen the QI process, like clinical tracer in HIV care, composite indicators, and others
- Moving on to other QI programmes, such as STIQUAL and VCTQUAL, or if possible, HEALTHQUAL

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Linking HIV-MCH-TB Services, Cambodia

Introduction to the Practice

Cambodia received a Millennium Development Goal award in 2010 from the United Nations as recognition of the country's commitment and progress towards halting and reversing the spread of HIV and achieving universal access to HIV treatment. A critical element to the country's success in its HIV response was the innovative linkages between HIV, maternal and child health (MCH), and tuberculosis (TB) services. These resulted in the progressive coverage of HIV and TB testing of pregnant women to over 80 per cent; coverage of antiretroviral therapy (ART) among HIV-positive pregnant women reaching 65 per cent; and coverage of ART among all newly diagnosed TB cases with HIV infections achieving 89 per cent by 2012.

These achievements would not have been possible without persistent efforts to expand and strengthen HIV testing and counselling (HTC) services for nearly two decades.

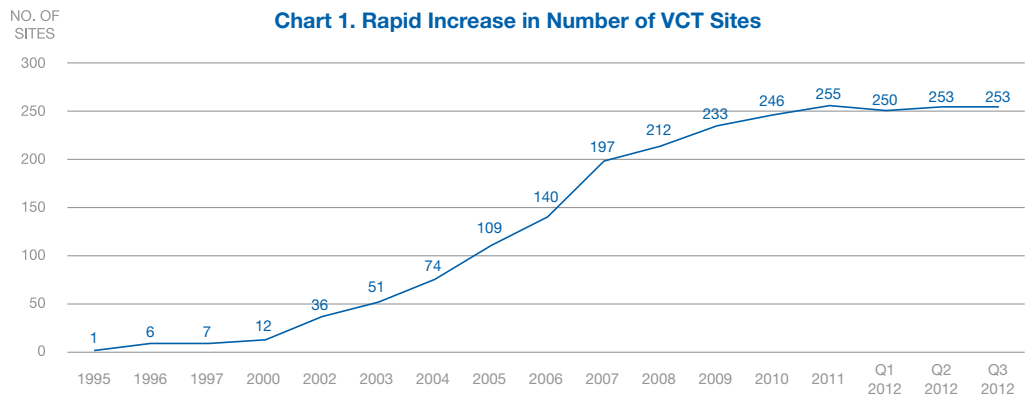
How It Works

HTC Model from 1995 to 2007

The country's first voluntary counselling and testing (VCT) site was established in 1995. Immediately after, an expansion effort put VCT services in all referral hospitals at the operational district level throughout the country. Right after, additional VCT sites were placed in selected health centres (Chart 1). Together with the ART sites, which were also expanded at the operational district level, VCT sites served as backbones of the HIV health services in the country.

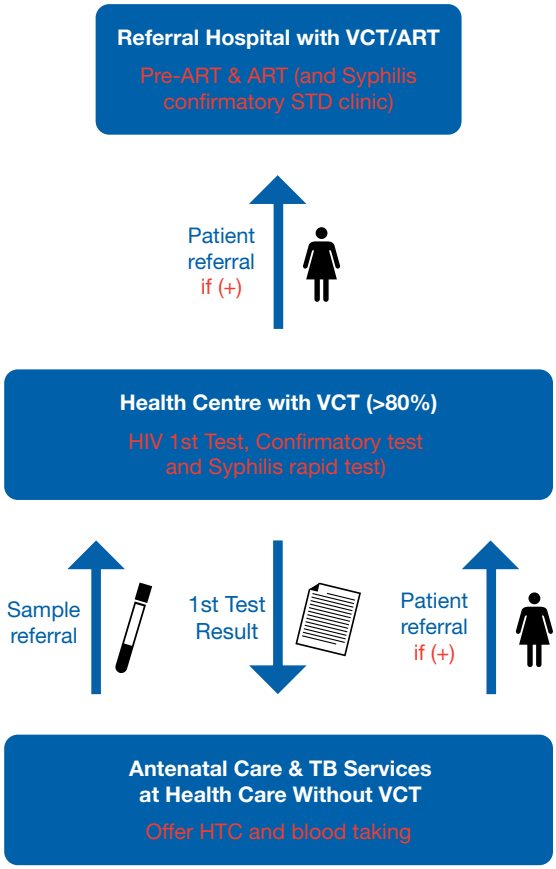
Although VCT sites were located inside referral hospitals and selected health centres, its model during this period had limited functional linkages with community leaders and with other health services. Since antenatal care (ANC) services for pregnant women and diagnosis and treatment of TB cases took place at the health centre, pregnant women and TB cases residing in the catchment areas of health centres without VCT had to travel to health centres with VCT or to referral hospitals to have HIV testing and counselling services.

Chart 1. Rapid Increase in Number of VCT Sites



In spite of measures taken to strengthen the collaboration between HIV and MCH services and between HIV and TB services, such as getting ANC and TB staff to send blood samples taken from pregnant women and TB cases to VCT sites, the coverage of HIV testing among pregnant women and TB cases did not increase substantially. In 2007, the percentage of estimated number of pregnant women who were tested for HIV remained at 28.2 per cent, and the percentage of TB cases tested for HIV was only 4.7 per cent.

Figure 1. HTC Model from 2008 to 2012



HTC Model from 2008 to 2012

By 2006, it was clear that connecting HIV, MCH, and TB programmes could only succeed if a service delivery model explicitly prescribed the linkage of these programmes. Concerted efforts were made to identify the roles and responsibilities of respective programmes, and to establish systematic linkages between the concerned services. In particular, it was considered more strategic to locate provider-initiated testing and counselling (PITC) within health centres since this was where pregnant women and TB cases were being seen. The model that emanated was that of PITC for pregnant women supported by blood sample referral from health centres without VCT. This became known as the HIV Testing and Counselling (HTC) model.

This new model was first implemented in one operational district. In a short time, it showed rapid increase in HIV testing uptake among pregnant women. To maximise the model, syphilis testing was added the following year (Figure 1). Almost immediately, the HTC model was introduced in five other operational districts showing equivalent results.

A similar approach was then introduced to HTC for TB cases in 2009 and TB-HIV collaboration was revitalised and accelerated. These two initiatives reinforced each other at the local level and created synergies: increased coverage for ANC and increased case finding for TB. These resulted in the rapid expansion of the prevention of mother-to-child transmission (PMTCT) and PITC for pregnant women and for those with TB at the health centre level. As a result, a huge increase of coverage was achieved for HIV testing among pregnant women (Chart 2) and TB cases (Chart 3).

Chart 2. Rapid Increase in Coverage of PMTCT

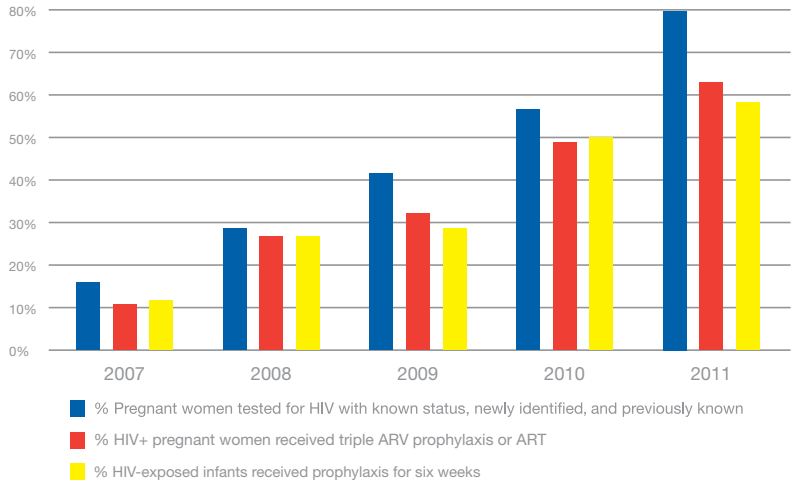
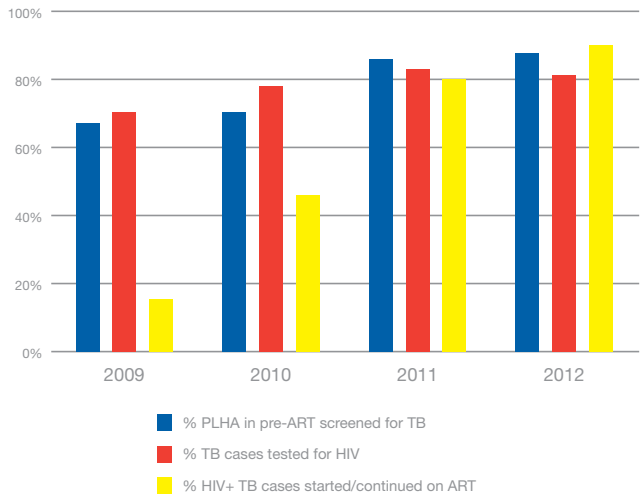


Chart 3. Rapid Increase in Coverage of TB-HIV Services



By 2011, HIV testing coverage among pregnant women and TB cases grew to over 80 per cent. Coverage of ART among HIV positive pregnant women reached 65 per cent. Of all newly diagnosed TB cases with HIV infections in 2012, 89 per cent received ART.

HTC Model from 2013

While the HTC model resulted in the rapid increase in coverage of HIV testing among pregnant women and those with TB, it did not, however, capture possible cases of loss to follow-up that could have been occurring during the process of patient referral: from a health centre without VCT to a health centre with VCT and then to enrolment in pre-ART care.

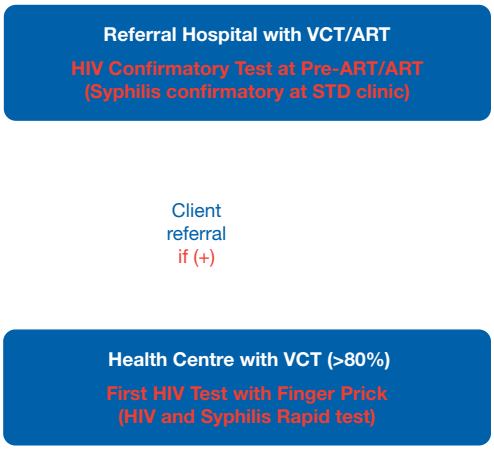
In order to minimise cases of loss to follow-up, the HTC procedures were significantly simplified and streamlined (Figure 2).

The streamlined HTC model features the following:

- By introducing finger prick testing in health centres (and referral hospitals), a client can now receive a negative test result or a reactive first test result within the same day.
- In case the first test result is reactive, the client is referred directly to a VCT site co-located with the ART site.
- If the client is confirmed as HIV positive at the VCT, he or she can be immediately enrolled in pre-ART care.

This new approach was introduced in Battambang Province on 19 April 2013 and then expanded to other provinces. By October 2013, around 400 health centres among the total of 1,024 health centres started to implement the streamlined HTC model.

Figure 2. Streamlined HTC Model from 2013



Outcomes

By systematically linking HIV, MCH, and TB services, introducing PITC at health centres with blood sample referral system, and with the introduction of finger prick testing and streamlining of other procedures, the uptake of HIV testing and counselling among pregnant women and those with TB, including ART, dramatically increased.

- By 2011, HIV testing coverage among pregnant women and those with TB grew to over 80 per cent. Coverage of ART among HIV-positive pregnant women reached 65 per cent.
- By 2012, of all newly-diagnosed TB cases with HIV infections in 2012, 89 per cent received ART.

Challenges

Under the streamlined HTC, the programme faces several challenges. These are:

- Quality assurance of HIV testing and counselling at health centre level
- Client tracking throughout the referral process
- Monitoring and evaluation of the streamlined HTC

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MAC Fights HIV And AIDS, Malaysia

Introduction to the Practice

RRCSP celebrity at a Red Ribbon event

For more than 20 years, Malaysian AIDS Council (MAC), which is a non-governmental organisation, has been working with policymakers, service providers, and government institutions to implement enabling measures for the prevention, care, treatment, and support of those living with and affected by the HIV and AIDS epidemic. MAC works closely with political leaders to establish and maintain public policies and structural environments that recognise human dignity and respect gender preferences, while ultimately seeking to help reduce the stigma and discrimination against people living with HIV and AIDS (PLHA) and key populations (KPs). This is the story of MAC and its drive for innovation, making it an important partner of government in the fight against HIV and AIDS.

Government support to MAC through the years, especially by the Ministry of Health, has been vital. It is a manifestation of the intent of the National Strategic Plan for HIV and AIDS 2011 to 2015: the need for synergy between the public sector and the grassroots communities in the national effort to mitigate the HIV and AIDS infection among its KPs (people who inject drugs (PWID), sex workers, transgender, and men who have sex with men).

To pursue its fight against HIV and AIDS, MAC implements innovative, strategic, and relevant initiatives. Some of them are:

- Involvement of celebrities
- Provision of shelter homes for PLHA
- Peer support in hospitals
- Support for marginalised groups
- Social reintegration of former prisoners

How it Works

MAC employs innovative approaches to bring prevention, care, treatment, and support to PLHA and KPs. Below are some examples.

The Red Ribbon Celebrity Support Programme (RRCSP). It is a signature programme initiated by MAC. RRCSP advocates for the creation of supportive environments to address the issue on stigma and discrimination against PLHA. The RRCSP celebrities are considered leaders by their peers in the field of music, film, and television and other alternative media. They come from diverse ethnic backgrounds that reflect the spirit of Malaysian unity. Although their involvement is purely voluntary, the celebrities have pledged to give their full commitment to the cause during their free time.

Red Ribbon celebrities are very popular among the rural fan base

Celebrities are selected based on their popularity especially among the rural fan base, particularly in the east coastal states of Kelantan, Terengganu, Johor, and Kedah. These states are the hardest hit by the HIV epidemic, as they lead in the prevalence count of new HIV cases.

At present, 13 well-known local celebrities have pledged their voluntary support to RRCSP. They are Aaron Aziz (actor), Datuk Siti Nurhaliza (singer), Datin Paduka Umie Aida (actress), Faizal Tahir (singer), Fahrin Ahmad (actor), Dayang Nurfaizah (singer), Owen Yap (news presenter), Winnie K (entertainer), Bob Yusof (singer), Shah Shamshiri (TV presenter), Zainal Alam Kadir (newspaper editor and TV producer) and Anantha and Uthayaa (radio DJ duo).

The RRCSP celebrities are actively involved in the following activities:

- Major fundraising, such as charity concerts, celebrity auctions, public donation campaigns, and endorsement of merchandise items from the Malaysian AIDS Foundation (MAF), the fundraising arm of MAC.
- Special appearances at PLHA empowerment programmes as an expression of support and solidarity with them.
- Public engagement programmes such as talk shows, media interviews, and televised forums representing MAC to talk on HIV and AIDS-related stigma and discrimination.
- TV Public Service Announcements (PSA) annually produced by MAC in conjunction with the World AIDS Day celebration. In every PSA version, RRCSP celebrities and PLHA make it a point to highlight friendly interactions through handshaking, hugging, and other gestures as a way of reinforcing the advocacy to reject stigma and discrimination against PLHA.

Shelter Homes Programme. MAC implements a Treatment, Care and Support Programme (TCSP) in partnership with the Ministry of Women, Family and Community. A large proportion of the TCSP funds are applied to the management and maintenance of shelter homes for men, women, and children living with or affected by HIV and AIDS. Most shelter homes are

rented, except for those properties that belong to the Ministry. These properties are located in residential settings that are conducive for emotional and physical therapy. Each shelter provides complete access to antiretroviral therapy (ART), basic nursing and palliative care, medical referrals, and psychosocial and spiritual support services.

Hospital Peer Support Programme (HPSP). MAC delivers outreach services to hospital clients through HPSP. It provides information and education about ART and adherence, emotional management, and healthy living with HIV. In addition to hospital-based services, MAC's Peer Support workers, who are PLHA themselves, maintain and sustain long-term relationships with their clients beyond the hospital confinement period. They make themselves available for personalised consultation, either through phone calls or through personal visitations. This programme is being implemented by eight partner organisations in six states across Malaysia.

Rehabilitating Marginalised Communities. MAC's engagement with marginalised communities goes beyond HIV and AIDS prevention activities. Its training and re-integration programme is able to provide employment opportunities to a large number of PLHA as well as ex-drug users. Such opportunities enable ex-drug users to leave behind risky behaviours that would otherwise predispose them to HIV infection.

TEMAN Social Integration Project.
Recognizing the range of social, economic, and personal challenges that confront prison inmates who are about to be released, MAC has designed Project TEMAN. It is a strategy to reduce the risk that released inmates might return to their previous criminal behaviour. Project TEMAN will enable the provision of treatment, services, and a programme of support activities to the prisoners during their incarceration and after their release.

Already in its advanced planning stage and to be implemented in collaboration with the Prison Department of Malaysia, Project TEMAN is a harm-reduction initiative. It aims to reduce HIV, sexually transmitted diseases, and Hepatitis B and C infections among prison inmates and provide a continuum of support following their release. The programme is initiated during the last six months of their incarceration period and continues for six month after their release.

Outcomes

The contributions of MAC to Malaysia's drive to achieve the Three Zeros: Zero new HIV infections, Zero new AIDS-related deaths, and Zero discrimination, are well recognised by the government and the communities it works with. Celebrities as special advocates, care-sustaining programmes through shelter homes, and PLHA as outreach workers in hospitals are but some of the significant results of the efforts of MAC. What follows are the details:

- The RRCSP helps MAC raise funds from the public and high-net worth individuals. These funds are used for programming not covered by funds from the government and international donors. More importantly, celebrities speaking against stigma and discrimination and appearing in various media platforms with PLHA are seen to contribute to the better understanding among the public of HIV and AIDS, PLHA, and KPs, thereby improving support against stigma and discrimination.

- More than 700 children and adults infected or affected by HIV and AIDS have access to care, treatment and support through the 22 shelter homes established by MAC.
- About 8,000 PLHA and their family members and friends are being helped to be more prepared and have a better understanding of treatment and the importance of adherence and healthy living with HIV, among others.
- Almost 600 ex-drug users have been employed as outreach workers and administrators, 50 PLHA are now working as full- or part-time hospital peer educators, and 150 marginalised community members and PLHA have gainful employment as caregivers or administrators in shelter homes.

Challenges

What are the key challenges faced by MAC in its work in HIV and AIDS?

Stigma and discrimination. They remain to be the biggest barriers to equitable access to prevention, care, treatment, and support for PLHA, and KPs. Employment for PLHA, in spite of their being trained, continues to remain a challenge, again, fuelled by stigma and discrimination at the workplace that causes the social exclusion of PLHA.

Empowering women. Another major challenge is how to empower women in both rural and urban settings to protect themselves from HIV risks, especially from their spouse or intimate partners.

Continuing funding for HIV and AIDS programming. With the growing number of PLHA and key populations, funds are never enough for programming. Support from the private sector and private individuals are lagging behind due to the local and global economic uncertainties. MAC has also seen Malaysian corporations being more conservative in budgeting for their Corporate Social Responsibility programmes.

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National AIDS Registry Story, Malaysia

Introduction to the Practice

A national HIV and AIDS database that has grown quite large is difficult to manage. This is the case with Malaysia.

The HIV and sexually transmitted infection (STI) Sector of Malaysia's Ministry of Health (MOH) started its data collection when the first case of HIV was reported in 1986. It collected and updated cases coming from the districts and states. With the growing HIV prevalence, the government improved its surveillance system and utilised the case management approach, as mandated under the National Strategic Plan 2006 to 2010. With these changes, by 2009, MOH saw the need to develop the National AIDS Registry (NAR). Its objectives were to streamline and coordinate evidence-based planning, implementation, and monitoring, and to inform decision-making at the local and national levels.

Started as a manually-based system, it eventually shifted to an interactive, web-based operation, enabling case investigators and registry users alike to access cases online, both for uploading data and for analyses and reporting. The web-based NAR became operational in July 2010, after a series of trainings, conducted in stages, of Assistant Environmental Health Officers, District Epidemiologists, AIDS Officers, and personnel from the Health Districts and State Health Office (SHO). NAR's progress is monitored daily by the MOH HIV and STI Sector, in collaboration with the Information Management Division.

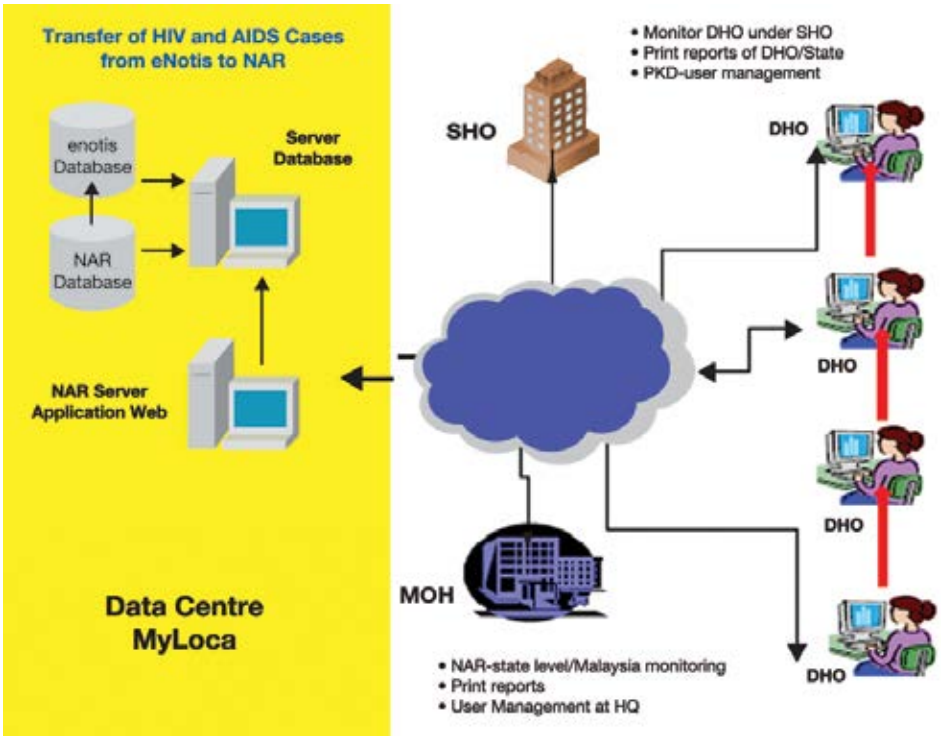
How It Works

The Process Flow

CDC ACT 342, Section 10 (Prevention and Control of Infectious Diseases,1988) mandates notification of all communicable diseases. Thus, reports of infectious diseases are registered in the e-notis system. Cases of HIV and AIDS and AIDS-related deaths are moved to the NAR. These cases are shared with the concerned states and districts. Each case is investigated by the Assistant Environmental Health Officer to obtain epidemiological data that are then encoded and recorded in the case file. Follow-up data are also encoded and added into the case file. Reports can be printed at the District Health Office (DHO), SHO, and MOH.

Under NAR, each case file is complete by itself, telling a story that can be traced back from the first reporting to the current situation of a patient. At any given time, case files can be accessed on demand by authorised users. These comprehensive case files are interactively available at the DHO, SHO and MOH, and serve as a guide for planning preventive and control measures (Figure 1).

Figure 1. The National AIDS Registry and How It Works



The NAR Modules

NAR has seven modules. They are as follows:

1. *Dashboard*
   This module serves as the homepage to users of the system.
   It contains the following statistics:
   i. Number of cases of HIV, AIDS, and AIDS-related deaths for the current year
   ii. Case status of the current month
   iii. Status of results of the current month's investigations
2. *Case Registry and Investigation*
   This is the module where data reported from investigations are located. These data are the sources of monthly and annual reports.
3. *Antiretroviral therapy*
   This module is not connected to any other in the system. Therefore, the user can enter information about a patient's treatment even if the patient's investigation has not yet commenced as long as the patient has already been included in the e-notis system.
4. *Case Search*
   Cases can be searched through this module depending on the searcher's authorised level of access to the data. HIV and AIDS case records can be edited by authorised users but not the clients' outpatient records.

5. *Reports*
   This module allows the user to print the report as follows:
   i. NAR 01 - Distribution of HIV, AIDS, and AIDS-related deaths (detected new and existing) by state
   ii. NAR 02 - Distribution of HIV, AIDS, and AIDS-related deaths (detected new and existing) according to demographic factors
   iii. NAR 03 - Demographic distribution of HIV, AIDS, and AIDS-related deaths (detected new and existing) by sex
6. *Offline Device*
   NAR relies heavily on internet access. But there is an option to input offline investigative information to the system. This can be done using a smart or android mobile device that can upload the information when the device is internet-connected.
7. *Administrator*
   The Administrator's module is used by the system's administrator for monitoring and evaluating the system.

NAR User and Data Security

NAR users are limited to selected MOH health personnel. Each user is provided with a user ID and password. NAR can be accessed only by one user at a time. To enhance security, NAR password encryption was built into the NAR database. Users can only access cases from their respective districts. State users will manage only their state-registered cases. Only MOH users can cover all the cases registered in Malaysia.

NAR Technical Support

NAR technical support team is made up of the MOH HIV and STI Sector and the Information Management Division. NAR technical problems related to HIV and AIDS cases are resolved by officers from the MOH HIV and STI Sector, while NAR system problems are addressed by the Information Management Division.

NAR Monitoring

There is a systematic monitoring by the NAR users. The District Supervisor monitors the district user daily to ensure all cases are being investigated and the information recorded in the NAR. The State AIDS Officer monitors the district NAR user weekly to ensure proper case management has been implemented, while the MOH HIV and STI Sector monitors NAR's progress monthly. NAR's monthly progress achievement reports are mailed to all states to ensure 100 per cent compliance.

Outcomes

The benefits derived from the use of NAR cannot be underscored enough:

- The NAR database allows for a well-directed and evidence-based planning and advocacy for prevention, care, treatment, and support as it is able to present quantifiable data

about the HIV and AIDS situation in the country. The NARS database carries the full and updated information on prevalence, how HIV is spread, status of treatment, and many others.

- NAR data can be used to track trends on the burden of infection and disease in the country.
- NAR safeguards against duplication or overlap in the registration of reported cases. Case files and its investigative data are well-secured but can be easily extracted by users when needed.

In order to achieve its getting to zero goals, Malaysia looks to more innovations. NAR is one of them. It is a real-time registry system that has created an effective link between investigators, decision makers, and implementers. It is fast, reliable, and secure. This web-based registry system, which is also a crucial tool in monitoring and evaluating the HIV and AIDS response, is helping tell the real and full story of the HIV and AIDS scenario in the country.

Challenges

NAR is a relatively new initiative. It faces many challenges that may seem difficult but are also seen to contribute to the maturity and stability of NAR. These include:

- Continuous quality training of those involved in NAR. It can help mitigate the high turnover of staff.
- Regularly upgrading the system in view of new or modified information necessitating the addition of new fields, such as on Prophylactic Treatments (Isoniazid and Cotrimoxazole) and a statistics field for ART.
- Improving the integration between NAR and the e-notis systems.

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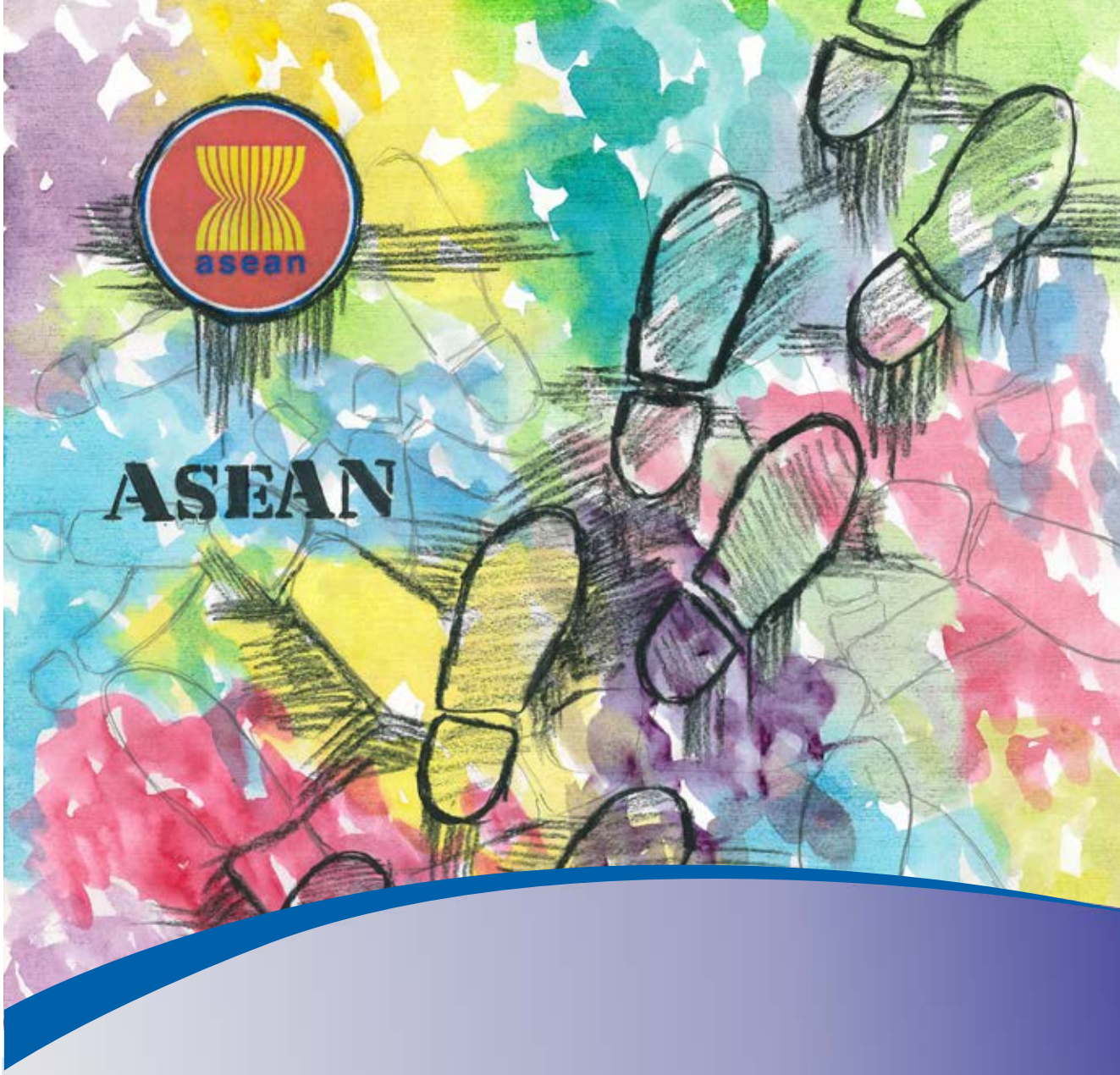

GETTING TO THE THREE ZEROS THROUGH NEW INITIATIVES

A Social Model for A Methadone Maintenance Treatment Programme, Viet Nam

Introduction to the New Initiative

Methadone maintenance treatment (MMT), in which individuals who use opiates receive daily doses of methadone, has been implemented in Viet Nam since 2008. What started as a pilot project in the cities of Haiphong and Ho Chi Minh with six clinics quickly became a nationwide programme of 62 clinics, with more planned in the future. With the surge of interest in methadone as a substitute to opiates, the cost of the programme escalated and the central and city governments could not cope, given their limited resources. Thus, in 2011, a social model for the Methadone Programme was introduced in Haiphong. It was a model aimed at mobilising resources from the government and the patients. It was based on the premise that patients and their families would be willing to participate in a cost-sharing scheme with the government to meet the patients' demands for an opiate substitution programme that worked.

The response from the patients and their families to the social model pilot was positive that in 2012, when the Government of Viet Nam approved Decree No. 96/ND-CP dated 15 November 2012 allowing for methadone to be given to people who use opiates, followed by the Ministry of Health Circular No. 12/TT-BYT dated 12 April 2013 as the implementing guidelines to Decree No. 96/ND-CP, mandating that an MMT clinic be opened in a district with at least 250 people who use opiates, new clinics were ordered to follow the social model.

How It Works

Patients in the waiting list of an MMT clinic that offers free MMT are informed of the socialised scheme. The clinic staff explains that patients can opt to pay for a part of the treatment that will allow them to access MMT in a socialised clinic. Those who agree to pay are referred to the nearest socialised clinic. Those who are not willing or cannot afford to pay can get their MMT in the free clinic.

The social model's cost-sharing works as follows: The patient/family pays Vietnamese Dong (VND) 10,000 per day for methadone, which they can pay daily or monthly. The government subsidises each patient of MMT for VND 5,000 per day plus the cost of supplies.

Organising the expansion of the socialised clinics involves:

1. **Preparation (2013 to 2014)**
    a. Develop the plan, including advocacy and behaviour change communication (BCC) components, for scaling up the social model to other provinces/cities. The plan is guided by researches and reports on the social model implementation in Haiphong and its effectiveness at patient, family, and community levels.
    b. Develop the guidelines for implementing the socialised clinics.
    c. Update the training manuals used in Haiphong.

2. **Implementation (2014 to 2015)**
    a. Train the staff who will be assigned to work in the socialised clinics
    b. Set up the socialised clinics in provinces and cities
    c. Implement the advocacy campaign aimed at local decision makers to continue their support for the social model MMT clinic
    d. Implement the BCC plan aimed at patients and families
    e. Provide technical support and supervision to the socialised clinic staff

The scale-up is expected to generate additional results such as:

- Promulgation of legal documents related to MMT and the social model of clinics
- Additional evidence on the effectiveness of the social clinic model of MMT
- Improved access to MMT by people who use opiates

Aside from the cost-sharing of patients/families and government, other resources for the socialised clinics' expansion are provided by the Viet Nam Authority of HIV/AIDS Control, the Unites States President's Emergency Plan for AIDS Relief (PEPFAR), the World Health Organization, the United States Agency for International Development, the Centers for Disease Control and Prevention, and FHI 360.

The social model for MMT will be made available nationwide, with 60 clinics planned by the end of 2015.

Possible Challenges

The two biggest possible challenges to the social model programme expansion are:

- The continuous availability of methadone beyond PEPFAR, whose funds are used to import the drug Methadone is not produced in Viet Nam
- The limited number of doctors qualified to dispense MMT

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Active Case Management Network: Towards Eliminating MTCT and Paediatric HIV, Thailand

Introduction to the New Initiative

In response to the global Getting to Zero and Thailand's own goal of the elimination of mother-to-child transmission (eMTCT), the Ministry of Public Health (MOPH) is embarking on a new project called "Active Case Management for eMTCT and Paediatric Cure". Inspired by the recent exciting report of possible functional HIV cure of the Mississippi baby through early infant diagnosis (EID) and early initiation of antiretroviral therapy (ART), the new project will build on MOPH's highly successful national programme for prevention of mother-to-child transmission (PMTCT). This programme continues to achieve high uptake of HIV testing in pregnant women (99 per cent) and provision of antiretroviral (ARV) drugs for HIV-infected pregnant women (95 per cent) and their exposed babies (99 per cent), resulting in a decreasing trend of mother-to-child transmission (MTCT) of 2.75 per cent in 2012. The new project will further benefit from Thailand's fully scaled up nationwide EID programme and the revised recommendation to initiate ART in all HIV-infected infants (age < 1 year), started since 2010.

The United Nations Childrens' Fund (UNICEF)-MOPH EID evaluation report of 2008 to 2011 reported that an estimated 100 to 140 infants were newly infected with HIV each year through MTCT. Furthermore, approximately 30 per cent of HIV-exposed infants did not receive EID; only about half of HIV-infected infants were identified during the first year of life and about half of those identified were initiated ART within one year of age. According to the 2004 study, Child Mortality and HIV Infection in Africa: A Review, by Newell, M. L., H. Brahmbhatt, the mortality rate of HIV-infected infants can be as high as 32 per cent in the first year of life and 53 per cent in the second year.

With increased availability of ART, both the number of new cases and child mortality rate have decreased but children with HIV and their families continue to cope with HIV as a chronic, highly stigmatised and transmittable illness. Thus, if functional HIV cure can be achieved, it will greatly improve the quality of life of people affected by HIV as well as realise an economic advantage for the country in the form of cost-savings from life-long ART.

The goal of the new project is to virtually eliminate MTCT by achieving a rate of <2.0 per cent and to reduce new HIV infection in children as a response to Thailand's Getting to Zero target. For HIV-infected infants, the goal is for the early initiation of ART within the first few months of life to save lives and possibly to achieve functional HIV cure.

Its specific objectives are:

- By 2014, to develop and implement an Active Case Management Protocol for the early identification of HIV-infected infants and to link them to HIV care for early initiation of ART
- By 2016, to increase the coverage of early infant diagnosis by 85 per cent and early initiation of ART before six months of age by 80 per cent

- To promote adherence to treatment and care for HIV-infected children
- To assess risks associated with continuing mother-to-child transmission, identify gaps, and improve the service in order to prevent new perinatal HIV infection in infants

The new project will identify a prospective cohort of HIV-infected infants initiated on ART within one year of age and who, with approval from their parents, can be a part of the paediatric cure research.

The new project will cover all hospitals in the 77 provinces of the country under Universal Health Care Coverage. It will be implemented using existing PMTCT and paediatric HIV quality care networks. It will create multi-level case managers (CMs) and an active case management system within these networks.

Project implementation will be carried out in collaboration with bilateral partners and the following entities:

- The Bureau of AIDS, STD and TB, under the Department of Disease Control, will be the focal point, closely collaborating with the Department of Health (DOH), which oversees the national PMTCT programme and the PMTCT programme managers.
- The Department of Medical Science (DMS) will be responsible for the performance under the project of its network of 15 laboratories doing polymerase chain reaction test (PCR) and providing EID services for the 1,000 hospitals under the Universal Health Care Coverage. Under DMS, the National Health Security Office (NHSO) will provide funds for PCR tests, cluster of differentiation 4, viral load monitoring, antiretroviral (ARV) and other HIV-related cost.
- The Thailand Ministry of Public Health-United States Centers for Disease Control and Prevention Collaboration (TUC) will provide technical and funding support for developing the Active Case Management Protocol, case investigation form, database tracking, and data management and analysis.
- Thai Red Cross AIDS Research Centre (TRC-ARC) and the HIV Netherlands- Australia-Thailand Research Collaboration (HIV-NAT) will provide technical inputs on paediatric HIV cure research, the development of the research protocol, in seeking research grants, and in conducting the research.

Funds for the project will be provided as follows: MOPH for health care personnel and medical costs under the routine system; NHSO for ARV and HIV-related laboratory costs; and TUC for the development of the Active Case Management Protocol and the initial implementation cost.

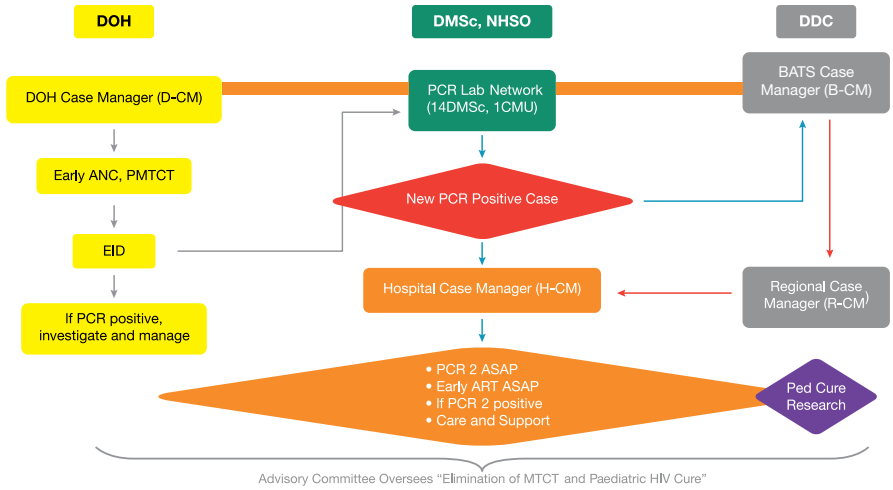
How It Works

Newly HIV-infected children are found in the 77 provinces of Thailand. The Active Case Management Programme will be implemented nationwide (Figure 1).

Through this programme, all HIV-exposed infants will be recommended to undergo EID at one and four months of age. In case the first HIV PCR test is positive, the second test will be repeated as soon as possible. Hospitals will collect blood samples from infants and send

them to any of the network of 15 laboratories for PCR testing. These laboratories will serve as the initiator for the chain of active case management. Case managers (CMs) and health care providers will follow the case management protocol.

Figure 1. Active Case Management Network for eMTCT & Paediatric HIV Cure



The implementation steps will be as follows:

1. **Form the various project committees and the support system and define their roles and responsibilities.**
   a. *Project Working Committee.* Various MOPH departments, bilateral collaboration (TUC), and research partners (TRC-ARC, HIV-NAT) will develop the protocol, the monitoring and evaluation (M&E) system, and the implementation plan.
   b. *Technical Working Committee*.The committee will develop the implementation protocol, the M&E plan, and conduct training for health care providers.
   c. *Advisory Committee.* The committee will oversee the project, support project management, communicate among key stakeholders, provide policy, and revise the national HIV treatment guidelines to support implementation.
   d. *Multi-level CMs (central, regional, and hospital).* The Advisory and Working committees will define the CM roles and responsibilities, as well as oversee their performance.

2. **Develop the Active Case Management Protocol**
   a. *Early identification.* PMTCT case managers who take care of HIV-infected pregnant women will closely follow up HIV-exposed infants after birth and provide EID service according to the national guidelines and Active Case Management Protocol.
   b. *Early notification upon detection of PCR-positive infants.* All 15 PCR laboratories, through their lab CMs, will immediately notify hospitals and central CMs once PCR-positive infants are identified.
   c. *Active management.*
      i. The hospital CM will follow the infants for second PCR test as soon as possible. If the second PCR is confirmed positive, ART will be initiated as soon as possible.
      ii. The central CM will also be notified by the PCR lab CM. The Central CM will work closely with hospital CMs to ensure that the management protocol is followed and to provide support to facilitate the active management. The central CM will

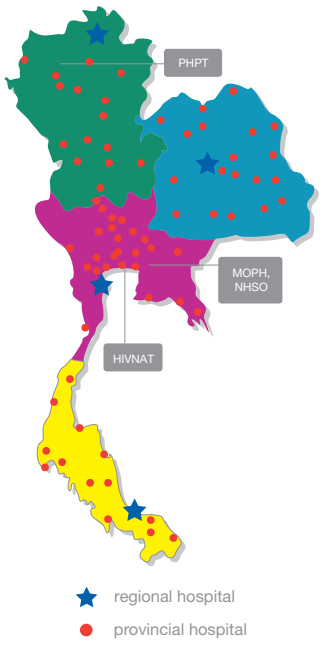
also do the case investigation to determine factors associated with perinatal transmission in that infant and will provide advice to help improve and prevent new perinatal HIV infection if any gaps in the services are detected.

d. *Long-term support plan.* The regional CM will be notified by central CM. The regional CM has the role to provide technical support to hospitals to make sure that ART initiation in young infants happens. Under the paediatric HIV quality care network, the regional CMs have already been networking with and providing technical support to provincial hospitals in their regions. So the initiation of ART and adherence promotion for young infants will just be an addition to reassure the timeliness and quality of long term care.

3. **Roll out of the project.** MOPH will officially inform all hospitals about this new project and provide training to PMTCT and paediatric HIV care providers on the Active Case Management Protocol. Under the existing paediatric HIV care network (Figure 2) in all 77 provinces of Thailand, 4 regional hospitals, where a strong team of paediatric HIV-infectious specialists are available, will continue to provide technical support to less specialised hospitals.

4. **Monitoring, evaluation and research.** For accountability and quality assurance, an M&E system will be developed to track how soon HIV-exposed infants received EID, and are diagnosed, started on ART, and retained in the HIV treatment and care programme. An existing national AIDS programme database will be the key source of information. Registry and follow up data of HIV-infected children will be monitored for clinical progression. An additional case investigation form to assess risk of perinatal HIV-infection for newly identified HIV-infected infants will be implemented. A confidential online tracking system to follow up PCR-positive infants will be developed to monitor overall implementation. The Technical Working Committee and the Advisory Committee will periodically review project data to determine progression and barriers and provide technical and policy support. A research protocol to determine HIV reservoirs in early treated infants and functional cure has been submitted for a United States National Institutes of Health grant. A cohort of early ART infants identified from this project will be invited through their parents to participate in the research.

Figure 2. PMTCT and Paediatric HIV Care Network in Thailand



PHPT: perinatal HIV prevention trial

Four regions are depicted by different colors. Each region has a regional hospital that works with provincial hospitals within its region. These hospitals are under MOPH and receive ART/monitoring support from NHSO. This network will be used for Active Case Management.

Possible Challenges

This early, the project initiators foresee big and possibly continuing challenges during its implementation. These are:

- Finding cases of new HIV-infected infants, as it will require a lot of resources to do so given their small number and their wide distribution
- Initiation of ART as well as maintaining good adherence to treatment and in- care system in very young children
- Retaining infants, through childhood and through adulthood, in the health care system for a long time since HIV is a chronic disease requiring lifelong treatment
- The consistently increasing cumulative number of people living with HIV in the health care system while investment in the health care system itself remains the same, thus, the expected intense competition for priorities in term of resource allocation

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AIDS Zero Portal, Thailand

Introduction to the New Initiative

Thailand has committed to using evidence as a basis for effective responses to HIV and AIDS. However, promoting data use for decision-making as well as translating data into action is not a simple process and faces many challenges. There are a number of barriers to effective use of data including availability, accessibility, complexity, timeliness, relevance, and difficulty in understanding and applying data for programme-planning and decision-making.

Thailand has well-developed surveillance and health information systems. Nonetheless, until recently, data and information from responsible agencies on HIV and AIDS remained fragmented and difficult to access in a timely manner and in a format or form that would enable effective data use. Thus, policy makers, programme managers, and providers are not able to identify gaps, monitor progress, and draw a clear picture of HIV response at the national and sub-national levels.

This paper describes Thailand's experience in the development of the innovation AIDS Zero Portal (AZP). It has transformed complex data from various sources into simpler, user-friendly information while facilitating access and use at national, sub-national, and health facility levels. AZP monitors progress in achieving the set targets and support informed decision-making processes for effective implementation of Thailand's Ending AIDS strategy.

AZP is a ground breaking innovative tool, a first in Asia and the Pacific.

- It translates complex data from various sources, including monitoring and surveillance data, into simplified strategic information that is suited for local use.
- It applies new technology to support inter-operability, real time access, and visualisation of data, facilitating its effective use.
- It consolidates and provides access to data and information pertaining to national, sub-national, and health facility levels in the same system.
- It is a one-stop shop that connects people with nationally agreed, standardised strategic information.

The overall objective of AZP is to consolidate and harmonise the information and reporting systems, present a comprehensive picture of the AIDS response at both the national and sub-national levels, and facilitate the use of data in decision-making for effective, appropriately targeted, and resourced programmes.

Thailand's National AIDS Management Centre initiated AZP in 2013. It jointly developed the innovation with the Department of Disease Control (DDC) and the Ministry of Public Health (MOPH), on behalf of Thailand's National AIDS Committee. Dure Technologies, a Geneva-based company, supported the technology and solution. Technical support came from the Thailand United Nations Joint Team on HIV/AIDS and Thailand Ministry of Public Health-United States Centers for Disease Control and Prevention Collaboration (TUC). AZP was officially launched on 6 June 2014.

The DDC, MOPH, Joint United Nations Programme on HIV/AIDS, United Nations Children's Fund, World Health Organization, and TUC co-financed the development of AZP.

How It Works

AZP is an interactive online tool that provides an easy, real time access to consolidated and harmonised strategic information from various sources into one place. AZP benefits all people particularly policy makers, programme managers, and stakeholders to be able to use information anytime and anywhere. By using AZP, decision-makers at all levels can identify key programme gaps and areas that require improvement and see the hotspots where urgent actions are needed to fast track progress towards achieving global, national, and sub-national targets (Figure 1).

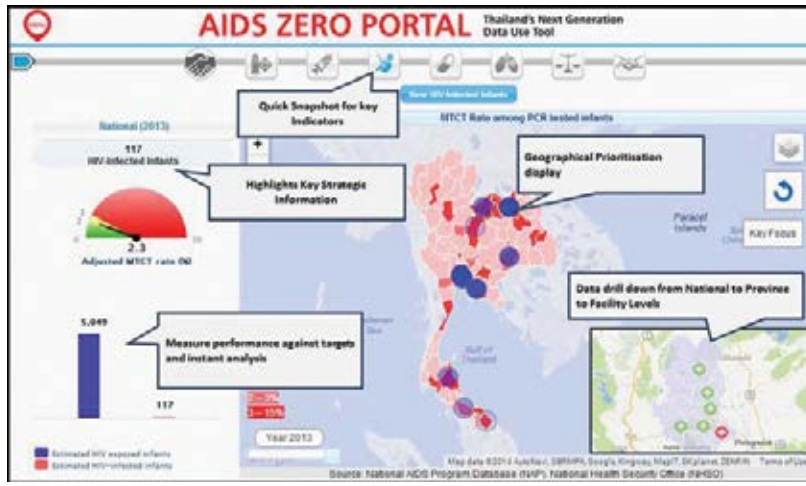
AZP enables instant access to prioritised strategic information using computers, tablets, and mobile devices.

Three main project components implemented in parallel made AZP possible.

1. **Prioritisation and harmonisation of key strategic information.** Seven Technical Working Groups (TWGs) comprised of focal points from HIV organisations, line ministries, civil society, and other key stakeholders worked to prioritise data to be translated into key strategic information. The TWGs also developed nationally agreed indicator definitions and identified data sources in line with the National Strategic Information (including monitoring and evaluation) Plan 2012 to 2016. The indicators and data sources were selected to enable monitoring of progress towards Thailand's Ending AIDS targets.

2. **Development and refinement of information technology.** A feasibility assessment was conducted to understand the nature, strengths and weaknesses of the health information systems in Thailand. The results served as inputs in developing a visualisation framework and system solutions.

Figure 1. AIDS Zero Portal: Key Features



A series of consultations with key stakeholders were undertaken to ensure that the design of the tool is appropriate for the Thailand context. Data flow automation was developed to reduce labour intensity and pursue long-term sustainability of the system, a critical factor to AZP success. Data input in AZP is from existing routine monitoring systems: surveillance, surveys, and various programmes in the health facility and community-based systems. AZP is capable of automated integration of data from various sources; the systems are being strengthened to permit use of this function to its full capacity.

3. **Mobilisation of high-level political support and endorsement.** Agreement from data owners to systematically share data is critical to successful, sustainable performance of AZP. Throughout the course of implementation, the project worked to mobilise high-level political support through model demonstration and working sessions with concerned department heads, and pre-testing at national and provincial levels.

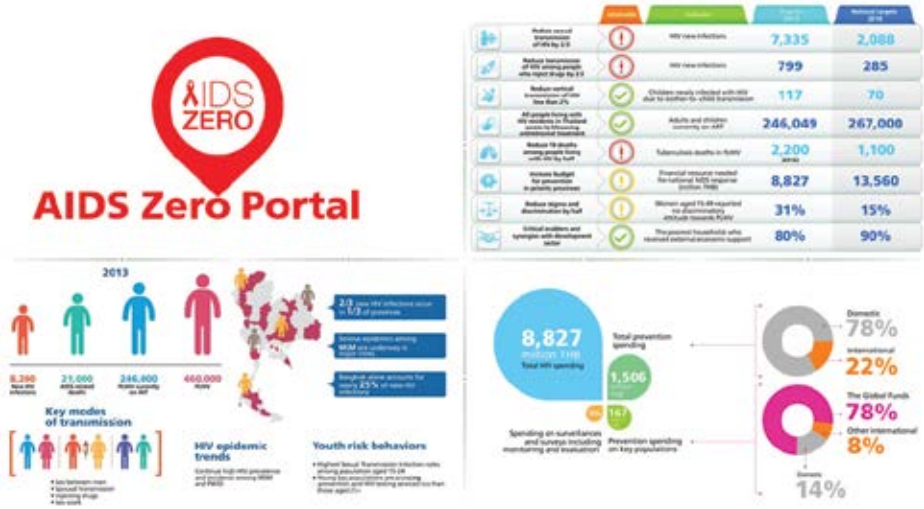
The portal www.aidszeroportal.org is where anyone can access the three key areas of strategic information in Thailand: the epidemic, investment, and response (Table 1, Figure 2). The results from the AZP pre-testing at national level and in two provinces showed that the tool was found to be generally attractive and was communicating well the information that was of value to stakeholders at different levels.

The Thailand National AIDS Committee has endorsed AZP as a key tool to monitor progress of the HIV response at the national and sub-national levels. Within a month following its launching, over 1,200 users from national and sub-national levels, as well as guests from more than 10 countries, visited the AZP website.

Table 1. Key Contents in AZP

Key Content	Brief Description
Know Your Epidemic	Provides up-to-date HIV epidemic data to enhance services for target population and geographic prioritisation; reflects current HIV situation, modes of transmission, major risk behaviours, and HIV epidemic trends at provincial and local levels.
Know Your Investment	Offers information on the past and current AIDS spending by programme areas, key populations, and funding source; informs effective and efficient budget allocation and generates increased accountability, ownership, and sustainability of the HIV and AIDS response at national, provincial, and local levels.
Know Your Response	Gives overview of progress of the responses at national and sub-national levels in achieving the national and global targets; highlights areas for programme improvement across the 10 global targets (United Nations General Assembly Political Declaration on HIV/AIDS, 2011) that Thailand committed to achieve by 2015. It likewise helps define strategic priorities beyond 2015 and down the road until ending AIDS by 2030.

Figure 2. Know Your Epidemic, Know Your Investment, and Know Your Response



Possible Challenges

- Nurturing the culture of evidence-informed decision-making requires continuous effort. It is important to maintain the momentum once it is created and to consistently move and advance the process.
- Encouraging and supporting evidence-informed decision-making at sub-national levels, down to service delivery points, require particular attention and time.

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Peer-Provided Testing: An Innovation in HIV Testing and Counselling, Cambodia

Introduction to the New Initiative

The first voluntary counselling and testing (VCT) site in Cambodia was established in 1995. By 2003, there were 51 VCT sites. A dramatic increase in the number of VCT sites occurred between 2005 (109) and 2007 (197). This was a decisive response to the need to manage the impact of the shift from direct sex work in brothels to indirect sex work in entertainment establishments (EEs). Reaching entertainment workers (EWs) who sold sex required new, more creative approaches. The implementation of the law on human trafficking in 2008 further intensified political, legal, and social barriers to reaching and referring sex workers to health services.

Meanwhile, HIV transmission was escalating not only among EWs, some of whom offered sexual services, but also among men who have sex with men (MSM), transgender people (TG), people who use drugs (PWUD), and people who inject drugs (PWID). Non-governmental organisations (NGOs) worked closely with the National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS) to intensify prevention and VCT referral efforts to these key populations (KPs) under the new framework of Continuum of Prevention to Care and Treatment (CoPCT). This new CoPCT framework engaged NGOs and KP peer networks to reach and provide education to people at higher risk, and to support them to access HIV testing, sexually transmitted infections (STI) services, HIV care and treatment, and other health services. In spite of these efforts, the challenges of prevention and referral coverage persisted; coverage of HIV testing was just 65.6 per cent among EWs (STI Survey, 2011), 51 per cent among MSM (Bros Khmer Study, 2010), and 53 per cent among PWID (Drug User Integrated Biological and Behavioural Surveillance, 2007).

To address these challenges, Community/Peer Initiated HIV Testing and Counselling was introduced in 2011. This approach aimed to address the low uptake of HIV testing services among EWs, MSM, and TG. In EEs, EW networks were established by many NGOs. Similar networks were organised for MSM. These peer networks were used to educate and mobilise their members to increase the demand for HIV testing and counselling, and to attend meetings at Drop-in Centres and KP-friendly venues for outreach VCT provided by government health centre staff.

To further intensify testing among KPs, and building on these HIV Testing and Counselling (HTC) initiatives, in 2013, NCHADS called for additional innovations that would increase the role of KPs in testing, thus, virtually de-medicalising it, at the same time, addressing the issues of stigma and discrimination. One such innovation is the outreach and KP-based Peer-Provided Testing whereby peer outreach workers from the ranks of KPs counsel and administer VCT, using a finger prick rapid test kit. It was a bold and ground-breaking innovation in Cambodia, and a first in South East Asia.

Peer-Provided Testing aims to increase the uptake of HIV testing and counselling, and to reduce risk-taking behaviours such as unprotected sex and sharing of contaminated needles

and syringes among KPs, including prisoners. It also strives to minimise loss to follow-up during the process of client referral to VCT sites for confirmatory testing and increase enrolment in pre-antiretroviral therapy (ART) care. Peer-Provided Testing also includes syphilis testing. Peer-Provided Testing is done in meeting points and other venues where KPs feel comfortable in like entertainment centres, drop-in centres, and others.

NCHADS began the implementation of Peer-Provided Testing for KPs in Phnom Penh in April 2013, working closely with Khmer HIV/AIDS NGO Alliance (KHANA) and its network of community-based organisations of KPs and partner NGOs. Within the year, KHANA, under the guidance of NCHADS, quickly expanded to six provinces (Phnom Penh, Battambang, Banteay Meanchey, Sihanouk Ville, Siem Reap and Kampong Cham). By October 2013, 256 peer outreach workers from among KPs were trained and were providing VCT to their peers.

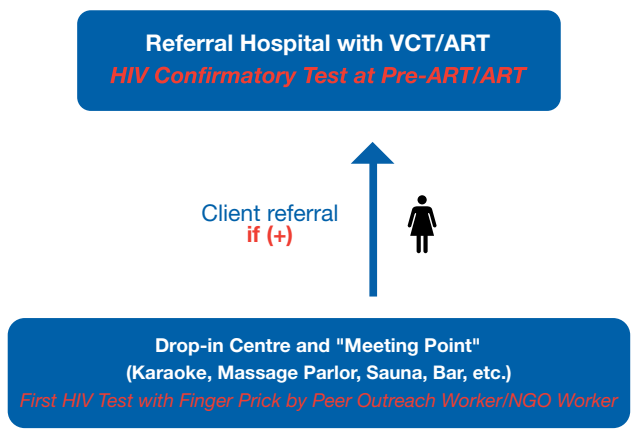
Peer-Provided Testing is continuing. It is supported by the government and various donors such as the United States Agency for International Development and The Global Fund to Fight AIDS, TB and Malaria.

How It Works

A significant feature of Peer-Provided Testing is the task-shifting from VCT health workers to peer outreach workers and NGO staff. The peer outreach workers, designated as lay counsellors, offer pre-test counselling, finger prick testing, and post-test counselling, including referral of first test reactive cases for confirmatory testing. Encouraging clients to enable their partners to access HTC services is also within the scope of post-test counselling.

By using finger prick testing, a client can receive a negative test result or a reactive first test result within 15 to 20 minutes after finger pricking. In case the first test result is reactive, the client is referred directly to a VCT site co-located with the ART site. If the client is confirmed HIV positive at the VCT, he or she can be immediately enrolled in pre-ART care at the ART site (Figure 1).

Figure 1. Outreach HTC Model



In order to prepare for the introduction of the Peer-Provided Testing model, a number of national level documents were developed/ revised.

- Standard Operating Procedures for HIV Testing and Counselling (September 2012) stipulated trained lay counsellors such as NGO staff and peers of KPs could provide pre-test and post-test counselling. Standard Operating Procedures for Boosted Continuum of Prevention to Care and Treatment for Most at Risk Populations in Cambodia (March 2013) indicated provision of HTC and referral services be part of the service package in outreach and Drop-in Centre services for the defined populations. According to the Standard Operating Procedures for Implementation of the Boosted Linked Response between HIV and SRH for Elimination of New Paediatric HIV Infections and Congenital Syphilis in Cambodia (April 2013), finger prick testing is an option for HIV and syphilis testing.
- Training curriculum and materials on HTC using finger prick testing was developed for both peer outreach workers and NGO staff. The curriculum includes sessions on HIV, stigma and discrimination, pre-test counselling including informed consent, and post-test counselling including referral procedures and partner testing. It also covers topics such as privacy and confidentiality, infection control, recording and reporting, and test and material management. Methodologies of the training included lectures, role-play of counselling, and actual practice of finger prick testing. Being a new initiative, continuous improvement of skills is done through field visits, monitoring, and refresher courses.

Finger prick testing conducted by an outreach worker

In each site, training of peer outreach workers and NGO staff is followed by identification of venues (such as Drop-in Centres, or meeting points including bars, saunas, massage parlours, and karaoke bars), provision of equipment and supplies, establishment of detailed referral procedures, and preparatory site visits by NGOs for initiating actual HTC services for the KPs.

Possible Challenges

The Peer-Provided Testing model is expected to increase the uptake of HIV testing and counselling, reduce risk-taking behaviours among KPs, minimise loss to follow-up, and improve enrolment in pre-ART care, as needed. Challenges are also expected. These include:

- Quality assurance of HIV testing and counselling provided by KP outreach workers as lay counsellors and NGO staff
- Client tracking throughout the referral process
- Establishment of robust monitoring and evaluation system for this new approach

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Text "HIV" to 8504, Philippines

Introduction to the New Initiative

One of the major drivers of the epidemic in the Philippines are men who have sex with men (MSM). MSM are usually social media and technology savvy, using social media and mobile phones to meet and connect with other men. Condom use is not very popular among MSM, and the same can be said for HIV testing. With this in mind, and inspired by Michelle Sidebe, executive director of the Joint United Nations Programme on HIV/AIDS, who said: "I want universal access to HIV prevention, care, treatment and support services to be as ubiquitous as mobile phone coverage." (Digital Opportunity, 07 October 2009) the Philippine NGO Support Program (PHANSUP) developed a project that would utilise mobile phones to reach out to MSM.

To better understand the situation of MSM and their use of mobile phones, PHANSUP's Community Engagement Support for the Philippine HIV Response (CES4PHR) programme conducted a series of rapid appraisals and focus group discussions involving MSM from 2012 to 2013. The result was the innovative Text "HIV" to 8504. The project encourages at-risk individuals, primarily MSM, to assess if they are at risk, and if they are, to go for voluntary counselling and testing (VCT) in accessible VCT sites. All these transactions are done through texting. And, because it uses texting, the user is assured of privacy and confidentiality during the risk assessment and referral process.

Text "HIV" to 8504 is being piloted in the cities of Manila, Quezon, Pasay, and Pasig, where majority of new HIV infections in the country come from. On 4 April 2014, the Philippine National AIDS Commission (PNAC) hosted the community launching of Text "HIV" to 8504 campaign. Health officials joined PHANSUP and Globe Telecom (Globe) representatives in demonstrating the use of the information risk self-assessment and referral (i-RAR) platform. The demonstration was followed by a four-week media campaign using print, broadcast, and online channels.

PHANSUP funds the project, with mobile solution and platform support from Globe, one of the largest private mobile technology companies in the country. Programmatic inputs and guidance are provided by PNAC.

How It Works

Text "HIV" to 8504 uses short-messaging service (SMS), more popularly known in the Philippines as texting. It works on both analogue and smart phones and does not require internet connection. The use of texting was deemed to be the appropriate technology to enable people from all socio-economic levels to participate.

Getting started required designing, developing, and setting up an SMS-based and website-linked i-RAR; linking i-RAR to participating public and non-governmental organisation (NGO)-run HIV counselling and testing centres; and promoting Text "HIV" to 8504 to its primary targeted audience, the MSM community, through PHANSUP and CES4PHR partners, PNAC members, and NGOs involved with MSM, HIV, and related health matters.

Demonstrating how Text "HIV' to 8504 works during the community launch jointly sponsored by PNAC and PHANSUP

Text "HIV' to 8504 works as follows:

1. The mobile phone user types HIV, presses the access number 8504 and then the icon for SEND on his mobile phone. This automatically triggers a message to be sent to Globe, the host of the platform. The number 8504 refers to the country's national AIDS law.
2. Globe calls back the mobile phone user through its automated Interactive Voice Response (IVR) system that is connected to the i-RAR, and starts the HIV risk self-assessment process, a health communication standard from the Department of Health (DOH). The mobile phone user selects his responses using the phone's keypad. Relevant HIV and AIDS information are then provided through the IVR based on the selected responses.
3. When the IVR detects HIV risks through the responses, the mobile phone user is advised to seek counselling and testing, asks for the mobile phone user's location, and then sends the name, address, and contact information of participating testing clinics nearest to the mobile phone user's location.
4. If HIV risk is not detected, the IVR sends a message encouraging the mobile phone user to seek more information about HIV by sending data of helplines operated by the DOH and PNAC, and websites, such as PinoyLifeGuide.org. Participating websites also contain the self risk-assessment and responses materials equivalent to the i-RAR's IVR script and algorithm. This is an option for MSM who would like to use the internet instead of the mobile phone SMS.

Possible Challenges

- While Text "HIV" to 8504 is accessible to any Globe mobile phone subscriber, it is not so for the subscribers of other telecom companies. As a proposed solution, the National AIDS/STI Prevention and Control Program of DOH will work with PHANSUP on an initiative to make Text "HIV' to 8504 operable in all mobile networks nationwide.
- The success of Text "HIV" to 8504 hinges on its ability to be known to MSM so they can use the service. At the moment, its promotion is limited to a select number of NGOs and their government partners. The proposed solution is for PHANSUP and PNAC to jointly develop a social marketing framework to intensify the project reach.
- Globe's support is for the initial 12 months where Text "HIV" to 8504 is free to its subscribers in Metro Manila. After this period, it plans to charge subscribers the regular texting fee, which could reduce the number of users.

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ASEAN CITIES GETTING TO ZEROS

The highest level of political commitment was given by the Association of Southeast Asian Nations (ASEAN) Leaders to the ASEAN initiatives on HIV and AIDS when they adopted the ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths. This Declaration, adopted in November 2011 during the ASEAN Chairmanship of Indonesia, was endorsed initially by the ASEAN Health Sector through the Health Ministers and Senior Officials.

The commitments and targets of this Declaration were operationalised at the local level through the ASEAN Cities Getting to Zeros project. This project translates the Declaration into action at the local level. It has enabled cities to identify their gaps and needs, identify solutions, and implement them in a sustainable manner.

Overview of the ASEAN Cities Getting to Zeros

In 2011, Indonesia, during its ASEAN Chairmanship, hosted the international symposium "Getting to Zero New HIV Infection, Zero Discrimination, and Zero AIDS Related Deaths". Some of the key recommendations generated from the symposium were:

- Consider reviewing/adjusting the Fourth ASEAN Work Programme on AIDS (AWP IV) to explore opportunities to implement the ASEAN Declaration
- Consider the development of mechanisms by ASEAN Member States (AMS) to provide technical assistance to each other under AWP IV
- Consider the development of common regional proposals for the implementation of the ASEAN Declaration under AWP IV

Subsequently, Indonesia suggested the development of a regional proposal to implement a comprehensive set of interventions for "getting to three zeros" by establishing partnerships among priority cities across AMS. The regional proposal was eventually approved. It was launched during the forum "Cities-Partnership Meeting on ASEAN Getting To Zeros" held back-to-back with the 11th ASEAN Health Ministers Meeting on 3 July 2012 in Phuket, Thailand. The forum was attended by leaders from nominated cities and key stakeholders, including the ASEAN Task Force on AIDS (ATFOA).

The ultimate goal of the ASEAN Cities Getting to Zeros project is the realisation of an ASEAN with Zero New HIV Infections, Zero Discrimination, and Zero HIV Related Deaths by 2015 in selected cities/districts in AMS under the implementation of AWP IV.
ASEAN Cities Getting to Zeros selection criteria:

- Epidemic status and HIV burden
- Availability of baseline information
- Existing local response
- Local commitment and leadership
- Existing capacity to manage project and monitor progress
- Good chance of replication

ASEAN Member State	Participating City/District
Cambodia	Battambang
Indonesia	Badung, Denpasar, and West Jakarta
Lao PDR	Hardxayfong District, and Saysettha District of Vientiane Capital
Malaysia	Malacca
Myanmar	Mawlamyaing
Philippines	Quezon City
Thailand	Payao, Bangkok
Viet Nam	Can Tho City, and Danang City

Eight AMS, and 13 cities/districts, eventually agreed to participate in the ASEAN Cities Getting to Zeros: Cambodia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand, and Viet Nam. Indonesia has been designated the Lead Country.

In support of the project, Indonesia developed the document ASEAN Cities Getting to Zero: Cities Partnership, Implementation Mechanism. It articulated a conceptual framework; strategies to achieve the three zeros; core interventions; a guide on site selection; roadmaps for strategy formulation, implementation, and coordination; and monitoring and evaluation.

Other support mechanisms that were developed were:

- Assessment and Planning Tool. The user-friendly tool assists participating cities/districts in obtaining baseline data, conducting rapid assessment of the environmental, external, and internal factors, developing appropriate strategic interventions and key indicators for area monitoring and evaluation, and utilising the investment approach/thinking in deciding on key priority interventions.
- Orientation workshop for ATFOA and master trainers. After the workshop, the master trainers held echo workshops in their respective cities/districts.

Expansion of ASEAN Cities Getting to Zeros

One of the accomplishments of the Getting to Zeros project was the recruitment and training of local champions who facilitated local coordination and multi-sectoral collaboration. The champions included city mayors, district heads, local health officials, community leaders, government councillors, and local legislators. The engagement of local champions has influenced other local chief executives such as mayors and district heads to join the project. Malaysia and the Philippines are just two of the AMS where more cities have committed to be part of ASEAN Cities Getting to Zeros.

ASEAN Cities Getting to Zeros was one of the inspirations for the forthcoming global strategy focused on cities.

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APPENDIX:
ASEAN DECLARATION OF COMMITMENT: GETTING TO ZERO NEW HIV INFECTIONS, ZERO DISCRIMINATION, ZERO AIDS-RELATED DEATHS

1. We, the Heads of State/Government of the Association of Southeast Asian Nations (hereinafter referred to as "ASEAN"), namely Brunei Darussalam, the Kingdom of Cambodia, the Republic of Indonesia, the Lao People's Democratic Republic, Malaysia, the Republic of the Union of Myanmar, the Republic of the Philippines, the Republic of Singapore, the Kingdom of Thailand and the Socialist Republic of Viet Nam, on the occasion of the 19th ASEAN Summit in Bali, Indonesia reviewing comprehensively the progress achieved in the decade since the adoption of the 2001 ASEAN Declaration on AIDS and the implementation of the 2007 ASEAN Commitments on HIV and AIDS;

2. Reaffirming the commitment of ASEAN Member States to accelerate progress in achieving the Millennium Development Goal 6 (MDG 6), which specifically refers to halting and reversing the spread of HIV and AIDS, and other related MDGs by 2015; and the 2010 High Level Plenary Meeting United Nations General Assembly on MDGs entitled: Keeping the Promise: United to Achieve the Millennium Development Goals;

3. Confirming our commitment to Resolutions 66/10 and 67/9 of the 66th and 67th Sessions of the United Nations Economic and Social Commission for Asia and the Pacific, respectively, and the outcome of the 2011 United Nations General Assembly High Level Meeting on AIDS entitled, the "Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS" which reaffirmed the 2001 Declaration of Commitments on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS and called for efforts to end the epidemic with renewed political will and strong, accountable leadership, and to work in meaningful partnership with all stakeholders at all levels to implement bold and decisive actions;

4. Guided by the ASEAN Charter which entered into force in December 2008, and with a strong commitment to accelerate the establishment of the ASEAN Community by 2015 through the implementation of the Blueprints of the ASEAN Economic Community (AEC), ASEAN Political Security Community (APSC) and the ASEAN Socio-Cultural Community (ASCC);

5. Emphasising that under the ASCC Blueprint, concrete actions have been provided to improve our capability to control communicable diseases including HIV and AIDS, and particularly in reducing the transmission of HIV and the impact of the epidemic on individuals, community and society;

6. Acknowledge the relevant outputs of the 10th ASEAN Health Ministers Meeting (AHMM) last July 2010 held in Singapore that outlined goals, targets and activities for the regional collaboration on health, including HIV and AIDS initiatives through the Strategic Framework on Health Development (2010-2015);

7. Recalling that accelerated liberalisation of trade will enhance the region's competitiveness and realise welfare gains for our peoples in the long run, and that efforts are also needed to ensure that access to affordable health care is not undermined and health policies will be equitable and pro-poor, as noted in the Declaration of the 7th ASEAN Health Ministers Meeting adopted on 22 April 2004;

8. Concerned that the HIV epidemic continues to threaten the realisation of an ASEAN Community, with socio-economic consequences that pose a formidable challenge in our community-building and our efforts to ensure access to affordable health care;

9. Noting the finding from ASEAN's first regional report on HIV and AIDS of 2010 which observed that in the region, the HIV epidemic continues to affect more than 1.5 million people affecting Member States with varying intensity; that HIV prevalence remains high among key affected populations, including sex workers and their clients, people who inject drugs, and men who have sex with men and transgender population, while other populations continue to be vulnerable (such as partners/spouses of key affected populations, migrant and mobile populations, children and youth, women and girls, people in correctional institutions, and specific occupational groups like uniformed services, people in conflict and disaster-affected areas), and that to be effective, AIDS responses must deliver focused, evidence-informed interventions that address the particular risks and vulnerabilities faced by these populations;

10. Welcoming the finding that progress has been made in the region in the AIDS response, and that in some of the Members States the number of new HIV infections has declined with combined implementation of proven evidence-based interventions in prevention, treatment and care; noting the reduction in HIV prevalence rates in Cambodia, Myanmar and Thailand; noting also the efforts of other Member States on harm reduction, comprehensive condom use programming; use of TRIPS flexibilities and other prevention, treatment, care and support initiatives;

11. Welcoming the findings of recent studies that demonstrate that access to HIV treatment significantly reduces the risk of HIV transmission to a partner; and, that access to affordable medicines in the context of epidemics such as HIV is fundamental to the full realization of the right of everyone to enjoy the highest attainable standard of physical, social and mental health;

12. Concerned that intellectual property, trade policy barriers and social aspects such as stigma and discrimination, are hindering prevention activities on HIV and AIDS, access to HIV treatments and treatments for co-infections and opportunistic infections, as well as pose as serious threats to the quality of life and livelihood of people living with and affected by HIV;

13. Further acknowledging that the number of HIV infections could have been averted among newborn children with the implementation-proven strategy on prevention of mother-to-child transmission;

14. Realising that an effective response to HIV requires relentless efforts and continued commitment by all stakeholders in implementing comprehensive responses to prevent and reduce the number of new infections, and to provide appropriate treatment, care and support to key affected populations and other vulnerable groups;

15. Concerned that women and girls account for a high proportion of new infections, recall our commitment to the declarations and the outcomes of conferences on women and children such as the UN General Assembly Resolution 48/104, 1993 on the Declaration on the Elimination of Violence Against Women; the Beijing Declaration on the Fourth Conference on Women; the Beijing Plus Five; and, the Hanoi Call to Action for Children and HIV/AIDS in East Asia and Pacific Region, 2006, that aimed to undertake further responses.

Do hereby declare and renew our commitments to:

16. Work towards an ASEAN with Zero New HIV Infections, Zero Discrimination and Zero HIV Related Deaths by:
    a. Reducing sexual transmission of HIV by 50 percent by 2015;
    b. Reducing transmission of HIV among people who inject drugs by 50 per cent by 2015;
    c. Scaling up antiretroviral treatment, care and support to achieve 80 percent coverage for people living with HIV who are eligible for treatment, based on WHO HIV treatment guidelines;
    d. Eliminating new HIV infections among children and substantially reducing AIDS-related maternal deaths by 2015; and
    e. Reducing by 50 percent tuberculosis deaths among people living with HIV.

17. Commit to work towards zero new HIV infections in ASEAN through the following:
    a. Acknowledge that prevention is the cornerstone of regional, national and international HIV responses and ensure that adequate financial resources are provided for scaling up evidence-based and targeted prevention programmes for key populations-at-risk;
    b. Ensure that national prevention strategies comprehensively target populations at higher risk, such as people who use drugs, sex workers, and men having sex with men, including transgender people, and that systems of data collection and analysis about these populations are strengthened;
    c. Develop and scale up community-led HIV prevention services to reduce sexual transmission of HIV and to address stigma and discrimination;
    d. Implement and expand risk and harm reduction programmes, where appropriate and applicable, for people who use drugs, taking into account the World Health Organization, United Nations Office on Drugs and Crime and UNAIDS Technical Guide for countries to set targets for universal access to HIV Prevention, treatment and care for injecting drug users in accordance with national legislations;
    e. Accelerate efforts to virtually eliminate parent-to-child transmission of HIV and preventing new paediatric HIV infections and eliminate congenital syphilis by 2015;
    f. Encourage and support the active involvement of key affected populations and vulnerable groups including young people, civil society and other community representatives as well as local governments in planning, implementing and evaluating responses;
    g. Promote access to timely and effective anti-retroviraltreatment, as prevention strategy;
    h. Address the social protection, sexual and health needs of key affected and vulnerable populations; and
    i. Expand and promote access to HIV testing, including provider-initiated HIV testing that is voluntary, confidential and rights-based.

18. Commit to work towards zero AIDS related deaths through the following:
    a. Accelerate efforts to achieve the goal of universal access to antiretroviral treatment by 2015, with the target of 80 percent coverage of people living with HIV who are eligible, based on World Health Organization HIV treatment guidelines to increase life expectancy and the quality of life.

b. By 2015 improve treatment coverage, equity, effectiveness and efficiency by:
    i. Fully implementing the most recent WHO guidelines and adopting the Treatment 2.0 approach that includes point of care diagnostics and treatment monitoring, decentralised and simplified service delivery and involvement of PLHA networks in service delivery;
    ii. Addressing key obstacles such as drug stockouts, financial barriers, stigma in health services, loss to patient follow-up, and access barriers for migrant and refugee populations;
    iii. Securing and expanding access to affordable and effective HIV diagnostics, ARV and OI drugs, through the full use of existing flexibilities under the Trade-Related Aspects of Intellectual Property Rights Agreement, which are specifically geared to promoting access to and trade of medicines, including in particular the use of compulsory licensing to enable manufacturing or parallel importation of generic drugs;
    iv. Addressing barriers, regulations, policies and practices that prevent access to affordable HIV treatment by promoting generic competition in order to help reduce costs associated with life-long chronic care;
c. Expand efforts to combat HIV co-morbidities such as tuberculosis and hepatitis through integrated delivery of HIV and tuberculosis services in line with the Global Plan to Stop TB, 2011-2015; developing as soon as practicable approaches of prevention and treatment of hepatitis C; and rapidly expanding access to appropriate vaccination for hepatitis B;

19. Commit to work toward Zero HIV related Discrimination through the following:
    a. Promote the health, dignity and human rights of people living with HIV and key affected populations by promoting legal, political and social environments that enable HIV responses, including by establishing multi-stakeholder partnerships among the health sector, law enforcement and public security, academia, faith-based leaders, local government leaders, parliamentarians, workplace, civil society and other relevant stakeholders, with a view to removing legal and punitive barriers to an effective response, and to reduce stigma and discrimination;
    b. Initiate as appropriate, in line with national priorities a review of national laws, policies and practices to enable the full achievement of universal access targets with a view of eliminating all forms of discrimination against people at risk of infection, living with HIV and key affected populations;
    c. Pledge to eliminate gender inequalities and gender-based abuse and violence especially by protecting and promoting the rights of women and adolescent girls, strengthening national social and child protection systems, empowering women and young people to protect themselves from HIV, and have access to health services, including, inter alia, sexual and reproductive health, as well as full access to, comprehensive information and education;

20. Commit to ensuring financial sustainability, national ownership and leadership for improved regional and national responses to HIV through the following actions to take forward our commitments:
    a. Develop, update and implement evidence-based, comprehensive, country-led national strategic plans and establish strategic and operational partnerships with stakeholders at the national and community levels to scale up HIV prevention, treatment, care and support by 2015;

b. Mobilise a greater proportion of domestic resources for the AIDS response in line with national priorities, from traditional sources as well as through innovative financing mechanisms, in the spirit of shared responsibility and national ownership and to ensure sustainability of the response;
c. Reduce inefficiencies in national responses by prioritizing high impact interventions, reducing service delivery costs, and streamlining monitoring, evaluation and reporting systems to focus on impact, outcomes, cost-efficiency and cost-effectiveness;
d. Strengthen the mechanisms of South-South collaboration, especially ASEAN to ASEAN sharing of expertise, inter-regional cooperation, in the provision of technical assistance and support to build capacity at the regional and national levels;
e. Strengthen the role of ASEAN bodies responsible for health, that is, the ASEAN Health Ministers Meeting, Senior Officials Meeting on Health Development and the ASEAN Task Force on AIDS in enhancing cross-sectoral and multi-stakeholders coordination by facilitating the meaningful participation of all relevant key stakeholders, including that of public and private sector, and under the coordination of the ASEAN Socio-Cultural Community Council, with the view to effectively implement regional responses to HIV consistent with ASEAN's regional and international commitments;
f. Tasks the relevant ASEAN bodies responsible for health to effectively implement the Fourth ASEAN Work Programme on HIV which was adopted by the ASEAN Health Ministers;
g. Continue to support Global Fund to Fight AIDS, Tuberculosis and Malaria as a pivotal mechanism for achieving access to prevention, treatment, care and support by 2015; recognize the programme for reform of the Global Fund, and encourage Member States, ASEAN Dialogue Partners, the private sector, business community, including foundations and philanthropists to provide the highest level of support for the Global Fund, taking into account the funding targets to be identified at the 2012 midterm review of the Global Fund replenishment.

21. Task the concerned ASEAN Sectoral Ministerial Bodies as well as other relevant bodies to implement this Declaration including mobilising resources, and monitor its progress; Encourage all ASEAN Member States to support these ASEAN Sectoral Bodies in accomplishing this Declaration through maximum efforts by such appropriate instruments as may be necessary and consistent with their respective national laws and policies. Adopted in Bali, Indonesia, this Seventeenth Day of November in the Year Two Thousand and Eleven in a single original copy, in the English language.

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LIST OF DRAWINGS

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