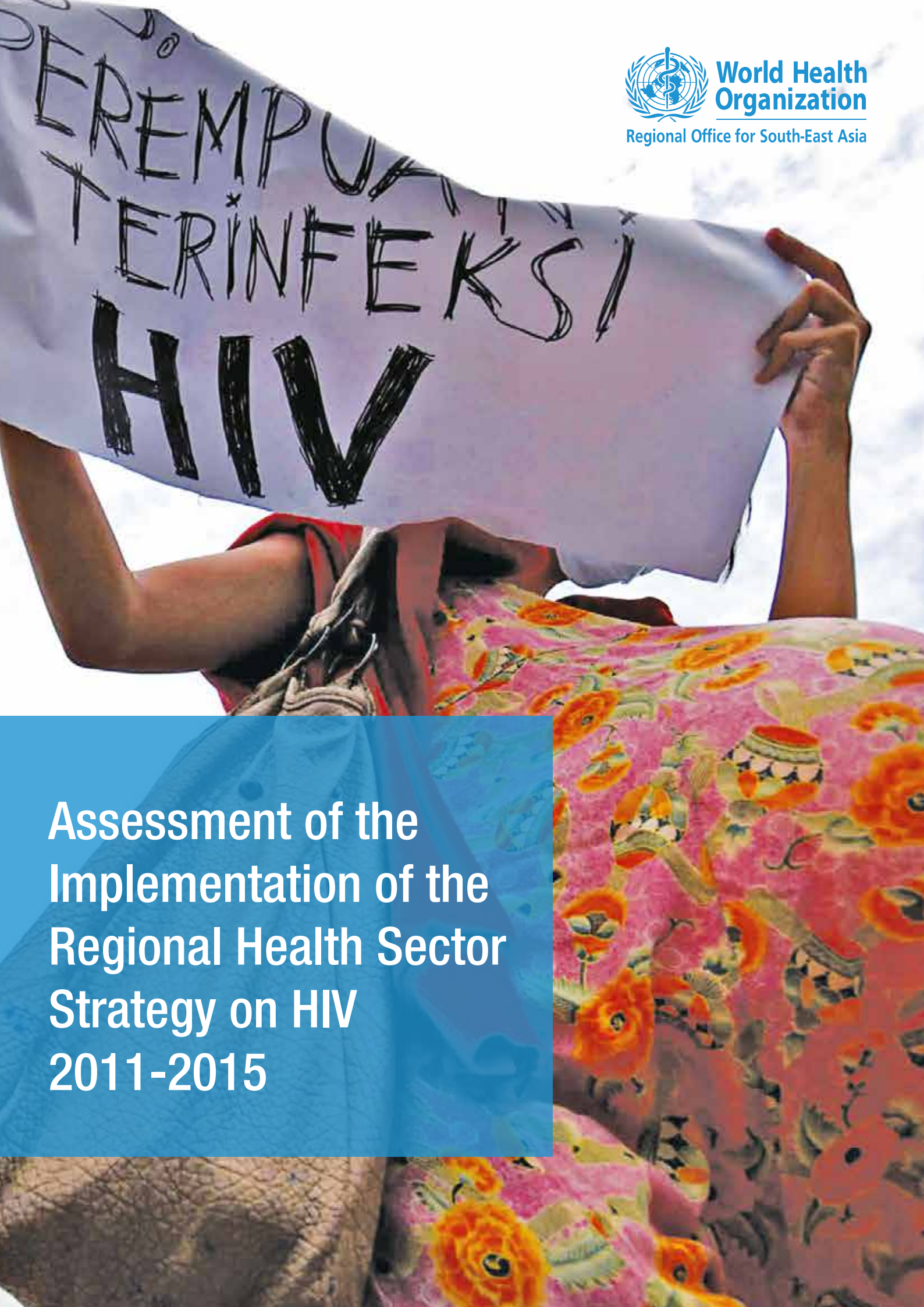


World Health Organization
Regional Office for South-East Asia

Assessment of the Implementation of the Regional Health Sector Strategy on HIV 2011-2015

Assessment of the Implementation of the Regional Health Sector Strategy on HIV 2011-2015

World Health Organization
Regional Office for South-East Asia

WHO Library Cataloguing-in-Publication data

World Health Organization, Regional O ce for South-East Asia.

Assessment of the implementation of the regional health sector strategy on HIV 2011-2015.

1. HIV 2. Health Services 3. Tuberculosis 4. Maternal-Child Health Services 5. Communicable diseases

ISBN 978-92-9022-524-9 (NLM classi cation: WC 503)

Printed in India

FOREWORD

The WHO South-East Asia Regional Health Sector Strategy on HIV 2011–2015 was endorsed by the Member States of the Region with the aim of securing universal access to HIV prevention, diagnosis, treatment and care towards the achievement of Millennium Development Goal (MDG) 6 and other HIV-related goals.

Impressive work has been done, more in some countries, and to a lesser extent in others. HIV prevention programmes have reached more key population groups. Condom use among sex workers is reaching high levels in some countries. More people living with HIV have been tested and linked to health services. Approximately 1.2 million people living with HIV (PLHIV) were receiving antiretroviral treatment in 2014, with a regional coverage of 36%. Countries with dual epidemics of HIV-TB have made substantial progress in implementing collaborative activities.

However, major gaps remain: only half of the people living with HIV know their status. The coverage of HIV treatment for prevention of mother-to-child transmission (PMTCT) remains low. Stigma and discrimination, though lower than before, continue to hamper access to services for populations that need them the most. Health systems capacity, while better than before, still needs to be augmented to realize the goal of ending AIDS by 2030.

As we move from MDG to the era of Sustainable Development Goals, sustained and focused efforts will be needed to fast track the HIV prevention, care and treatment interventions towards an AIDS-free world and HIV-free generation. Reviews and evaluations are cornerstones of evidence-based planning and programming. The observations and recommendations of this review will help inform the next set of strategies and interventions for WHO support to Member States in realizing the common goals. It would help in designing contextual intervention packages that use the framework of universal health coverage and service delivery mechanisms that are integrated and responsive to the emerging health-care needs of all populations, especially those most in need.

Dr Poonam Khetrapal Singh
Regional Director

CONTENTS

FIGURES

BOXES

TABLES

ACRONYMS

ANC ..... antenatal care
ART ..... antiretroviral therapy
ARV ..... antiretroviral
EID ..... early infant diagnosis
FSW ..... female sex worker
GARPR ..... Global AIDS Response Progress Reporting
HSS ..... HIV sentinel surveillance
IBBS ..... integrated HIV biological and behavioural surveillance
KP ..... key population
M&E ..... monitoring and evaluation
MCH ..... maternal and child health
MDG ..... Millennium Development Goal
MMT ..... methadone maintenance therapy
MSM ..... men who have sex with men
NACO ..... National AIDS Control Organization (India)
NACP ..... National AIDS Control Programme
NGO ..... nongovernmental organization
NHSO ..... National Health Security Office (Thailand)
NSP ..... needle and syringe programme
OST ..... opioid substitution therapy
PEP ..... post-exposure prophylaxis
PITC ..... provider-initiated testing and counselling
PLHIV ..... people living with HIV
PMTCT ..... prevention of mother-to-child transmission
PrEP ..... pre-exposure prophylaxis
PWID ..... people who inject drugs
SDG ..... Sustainable Development Goal
STI ..... sexually transmitted infection
SUFA ..... strategic use of antiretrovirals
SW ..... sex worker
TasP ..... treatment as prevention
TB ..... tuberculosis
UHC ..... universal health coverage
UNAIDS ..... Joint United Nations Programme on HIV/AIDS
UNODC ..... United Nations Office on Drugs and Crime
VCT ..... voluntary counselling and testing
VL ..... viral load
WHO ..... World Health Organization

WORLD HEALTH ORGANIZATION SOUTH-EAST ASIA REGION

HIV STRATEGY 2011-2015

PEOPLE LIVING WITH HIV

2010

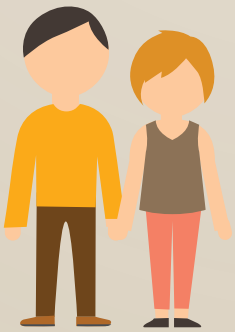
3.4 MILLION

Regionwide HIV prevalence remains at **0.3%**

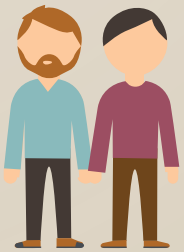
2015

3.5 MILLION

99% of people living with HIV are in five countries



1 in 2 of the people living with HIV know their status

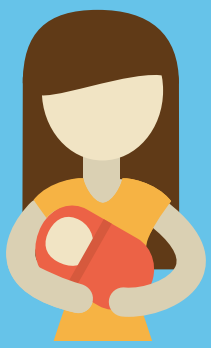


STIGMA and discrimination are still widespread

ANTIRETROVIRAL THERAPY COVERAGE (ART)

2010
20%

2015
39%



The coverage of ART and antiretrovirals (ARVs) for prevention of mother-to-child transmission is still far too low

NEW HIV INFECTIONS

2010
200 000

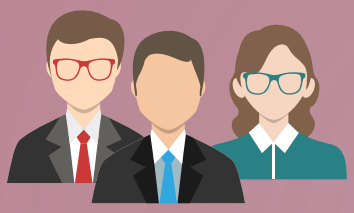
2015
180 000

AIDS RELATED DEATHS

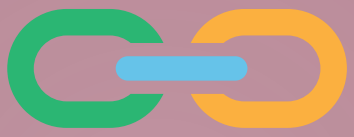
2010
170 000

2015
130 000

THE WAY FORWARD



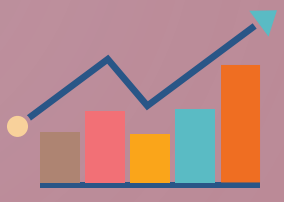
Continuing political commitment and resources



Linking the HIV and universal health coverage

Harnessing the power of affected communities

Involivng all stakeholders



Strengthening data collection

EXECUTIVE SUMMARY

The World Health Organization (WHO) South-East Asia Region is home to a quarter of the world's population and includes two of the world's most populous countries: India and Indonesia. The 11 countries that comprise the Region have huge social, economic and physical differences, which account for the wide variations in the HIV epidemics across the Region. The epidemic and the health sector response varies widely among and within Member States. Over 99% of people living with HIV (PLHIV) are in five countries: India, Indonesia, Myanmar, Nepal and Thailand.

In 2011, when the Regional Health Sector Strategy on HIV, 2011–2015 was launched, the overall adult HIV prevalence in the South-East Asia Region was low – just 0.3% – but this figure belies the huge number of people affected. There were an estimated 3.5 million people living with HIV, including 1.2 million women aged 15 years and above. Despite a declining trend, an estimated 200 000 people became newly infected with HIV while 170 000 died of AIDS-related causes by end of 2010.

Certain population groups have long been disproportionately burdened with the disease, and faced stigma and discrimination serious enough to impede their access to HIV services. At the end of 2010, about 675 000 PLHIV were receiving antiretroviral therapy (ART) – just 20%[1] of the estimated total PLHIV. Coverage of ART among people living with HIV varied from 5% in Indonesia to 50% in Thailand.

The WHO Regional Health Sector Strategy on HIV, 2011–2015 was developed with the overarching aim of assisting Member States to achieve universal access to prevention, diagnosis, treatment and care, which would contribute to the achievement of Millennium Development Goal (MDG) 6 and other health-related goals. The Strategy described the future directions and focus of work for HIV programmes and WHO in the health sector response to the HIV epidemic.

The Regional Health Sector Strategy's targets were consistent with the WHO Global Health Sector Strategy for HIV 2011–2015, but focused on the priorities of 10 countries of WHO's South-East Asia Region, and built on what had been achieved prior to 2011. In turn, the key elements of the Regional Strategy were adopted at the national level and tailored to country conditions across the Region. Seven of the Region's countries have national strategies that straddle the time frame of the 2011–2015 WHO Regional Strategy.

A combination of desk review and country-level questionnaires were used to evaluate the output, outcomes and impact of the WHO Regional Strategy. The data used for this report are subject to a range of limitations and constraints that prevent this evaluation from being comprehensive. However, it pulls together the best available evidence, with a focus on WHO's contribution, for the purpose of offering better technical support to countries during the upcoming 2016–2021 Regional strategy and action plan.

Five years on, most countries have adapted the WHO global and regional HIV strategies and guidelines on HIV prevention, care and treatment. Access to and coverage of HIV services have expanded substantially in many countries: 1.39 million people living with HIV, or 39% of the total number estimated, were receiving ART at the end of 2015. Overall, the epidemic in the Region has stabilized. The Regionwide prevalence remains at 0.3%. Despite a 44% reduction in new infections from 2001 to 2015, new HIV infections have plateaued between 2010 and 2015.

Major gaps exist in HIV services, and health system weaknesses impede delivery of these services. Only about half of the people living with HIV know their status. The coverage of ART and antiretrovirals (ARVs) for prevention of mother-to-child transmission (PMTCT) is still far too low at the regional level. Stigma and discrimination are still widespread in society and in health-care settings, which hinder access to much-needed health services by the most affected and vulnerable populations. The capacity of the health system in many countries is yet to be strengthened adequately to deliver services. Only a substantial shift in efforts will make it possible to reach the fast-track goals and fulfil the targets of the Sustainable Development Goals. Recommendations for future action include: continuing political commitment and resources for HIV prevention, care and treatment; recognizing the inherent linkages between the AIDS response and efforts to achieve universal health coverage; harnessing the power of affected communities to reach key populations with HIV services with a targeted approach; being inclusive to ensure that all stakeholders are involved; and strengthening data collection and use at the granularity level for programmatic actions.

[1] The denominators of ART coverage are the estimated number of PLHIV in all situations and in different years of this report. It should be noted, however, that the CD4 count thresholds are different in different years according to WHO recommendations.

INTRODUCTION

Table. 1. HIV at a glance in the WHO South-East Asia Region, 2015 vs 2010

	2010	2015
People living with HIV	3,400,000	3,500,000
HIV prevalence	0.3%	0.3%
AIDS-related deaths	170,000	130,000
New HIV infections	200,000	180,000
No. of people receiving ART	674,000	1,387,000
ART coverage	20%	39%

Looking back, looking ahead

The World Health Organization (WHO) South-East Asia Region is home to a quarter of the world's population and includes two of the world's most populous countries: India and Indonesia. The 11 countries that comprise the Region could hardly be more geographically, demographically and politically diverse. The huge social, economic and physical differences have also led to wide variations in the HIV epidemics across the Region.

In 2011, when the Regional Health Sector Strategy on HIV, 2011–2015 was launched, the overall adult HIV prevalence in the South-East Asia Region was low – just 0.3% – but this figure belies the huge number of people affected. There were an estimated 3.5 million people living with HIV (PLHIV), including 1.2 million women aged 15 years and above. Despite a declining trend, an estimated 200 000 people became newly infected with HIV, while 170 000 died of AIDS-related causes in 2010.

Between 2011 and 2015, the epidemic and the health sector response varied widely among and within Member States. Over 99% of PLHIV were in five countries: India, Indonesia, Myanmar, Nepal and Thailand. These countries, with HIV epidemics concentrated among key populations (KPs), such as sex workers (SWs), men who have sex with men (MSM) and people who inject drugs (PWID), also had a high tuberculosis (TB) burden. In 2011, the HIV prevalence among adult populations was below 1% in all countries except Thailand. Indonesia, Myanmar and Thailand had significant HIV epidemics among PWID. In the remaining countries (Bangladesh, Bhutan, Maldives, Sri Lanka, Timor-Leste), the HIV epidemics were at a low level. The Democratic People's Republic of Korea has not reported any cases so far.

Certain population groups – female sex workers (FSWs), MSM, PWID and transgender people – have long been disproportionately burdened with the disease, and faced stigma and discrimination serious enough to impede their access to HIV services. At the end of 2010, about 674 000 PLHIV were receiving antiretroviral therapy (ART) – just 20% of the estimated total. Coverage of ART among PLHIV varied from 5% in Indonesia to 50% in Thailand.

Despite the progress to that point, much remained to be done to sustain the HIV response beyond 2011 and rapidly scale up access to prevention, treatment and care. What was clear was the need to embed the HIV response in the broader global health and development agenda, recognize its role in achieving broader health outcomes, and utilize the inherent linkages between HIV and other aspects of health, such as TB, maternal child health, and sexual and reproductive health and rights. Thus, the Regional Health Sector Strategy on HIV, 2011–2015 was developed by the WHO Regional Office for South-East Asia to guide the health sector response to HIV in Member States to achieve universal access to prevention, treatment and care services.

Five years on, the epidemic in the Region has stabilized. The Regionwide prevalence remains at 0.3%. The estimated number of PLHIV increased slightly to 3.5 million in 2015, including 1.3 million women aged 15 years and above. Five countries with concentrated HIV epidemics still account for 99% of the regional HIV burden, and heterogeneity between and within countries still exists. There were 180 000 new HIV infections and 130 000 AIDS-related deaths in the Region in 2015. Despite a 44% reduction in new infections from 2001 to 2015, new HIV infections have plateaued between 2010 and 2015. New HIV infections and AIDS-related deaths declined in India, Nepal, Myanmar and Thailand, but showed a rising trend in Indonesia. On the other hand, AIDS-related deaths increased 6% from 2001 to 2010, but decreased from 2010 to 2015, which may indicate an impact of increased ART coverage.

While HIV prevalence declined among FSWs, prevalence among other KPs remains stubbornly high and rising. However, the scale up of ART was impressive during this period – 1.39 million PLHIV were receiving treatment at the end of 2015. Thailand and Myanmar showed significant expansion in access to ART for PLHIV. Regionwide antiretroviral (ARV) coverage increased to cover 39% of PLHIV (Table 1).

Fig. 1. Vision, goals and guiding principles of the AIDS response

VISION

ZERO

NEW INFECTIONS
AIDS RELATED DEATHS
DISCRIMINATION

GOALS

- Universal access to comprehensive HIV prevention, treatment and care;
- Achievement of MDG 6 and other health-related goals (MDGs 3, 4, 5 and 8) and associated targets

GUIDING PRINCIPLES

- Long-term, sustainable HIV response through strengthening health and community systems, tackling the social determinants of health that both drive the epidemic and hinder the response;
- Protecting and promoting human rights and promoting gender equity;
- Integration between HIV and other health services, improving both impact and efficiency.

As the period covered by the Regional Strategy ends and a new regional plan of action for 2016–2021 is in development, it is time to assess Member States' key achievements in the AIDS response, and identify the gaps and challenges they face; the extent to which WHO's Regional HIV Strategy has been incorporated into national HIV responses, and the impact of WHO's work on the countries' HIV responses. The WHO Regional Office for South-East Asia conducted a review of implementation of the Regional HIV Strategy, with the following objectives:

1. Review, assess and evaluate the progress towards achieving the stated goals and targets of the Regional Strategy and the outcomes;

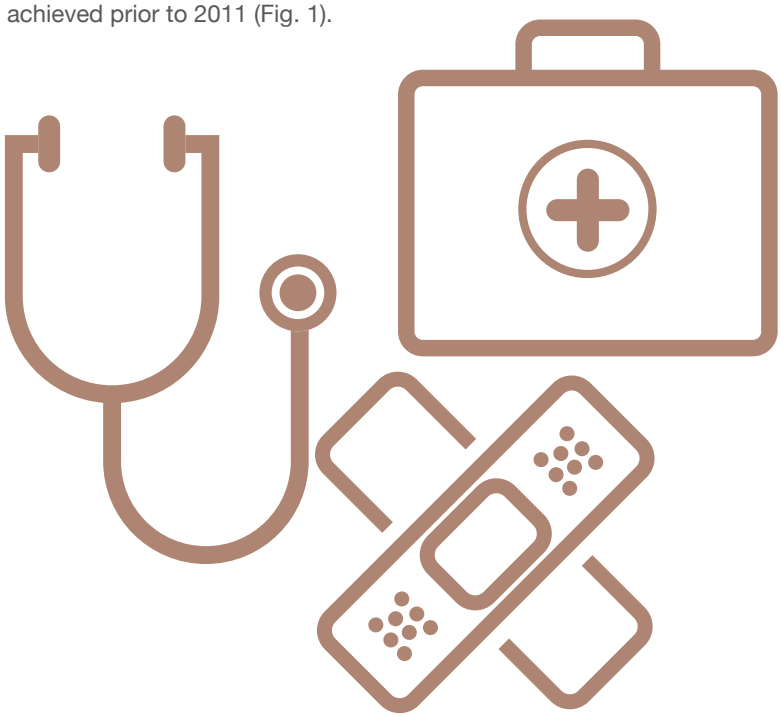
2. Assess how WHO has contributed to achieving the goals and targets, and contributed to Millennium Development Goal (MDG) 6[2] and other health-related MDGs[3], particularly in the areas of advocacy, policy guidance and technical support to Member States;

3. Identify technical challenges, issues and gaps in implementing the Regional Strategy at country and regional levels; and

4. Make recommendations for the development and implementation of the next Regional HIV Strategy 2016–2021.

The Regional Health Sector Strategy on HIV, 2011–2015

The WHO Regional Health Sector Strategy on HIV, 2011–2015 was developed with the overarching aim of assisting Member States to achieve universal access to prevention, diagnosis, treatment and care, which would contribute to the achievement of MDG 6 and other health-related goals. The Strategy described the future directions and focus of work for HIV programmes and WHO in the health sector response to the HIV epidemic. Its targets and strategic directions were consistent with the WHO Global Health Sector Strategy for HIV, 2011–2015, but focused on the priorities of the 11 countries of WHO's South-East Asia Region and built on what had been achieved prior to 2011 (Fig. 1).



[2] MDG 6: Combat HIV/AIDS, malaria and other diseases. Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS. Target 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it. Target 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.
[3] MDGs 3, 4, 5 and 8.

The Regional Strategy has four main strategic directions and key interventions, with country actions and WHO contributions to address specific aspects of each intervention (Fig. 2). This assessment focuses primarily on key interventions as stipulated in strategic directions 1 and 2 due to the limited data available on interventions for the other two strategic directions.

Fig. 2. Key interventions in the Regional Strategy

STRATEGIC DIRECTION 1:

Optimizing HIV prevention, care and treatment outcomes;

Strategic direction 1

1.1 Prevention to key populations
- Condom promotion
- Sexually transmitted infection (STI) services
- Harm reduction

1.2 Antiretrovirals (ARVs) for prevention

1.3 Elimination of mother-to-child transmission of HIV and syphilis
- HIV testing
- ARVs for mother–child pair
- Early infant diagnosis

1.4 Blood and injection safety

1.5 Expansion of HIV testing and counselling

1.6 Optimizing antiretroviral therapy
- Access to treatment for all people living with HIV
- Reduction in comorbidities
- Adherence and retention in treatment
- Treatment monitoring

STRATEGIC DIRECTION 2:

Strengthening strategic information systems for HIV and research;

Strategic direction 2

2.1 Surveillance among key populations

2.2 Programme monitoring and evaluation

2.3 HIV drug-resistance monitoring

2.4 Implementation research

STRATEGIC DIRECTION 3:

Strengthening health systems for effective integration of health services; and

Strategic direction 3

3.1 Enhance service delivery
- Community-based
- Task-shifting

3.2 Integration of services

3.3 Sustainable financing

STRATEGIC DIRECTION 4:

Fostering a supportive environment to ensure equitable access to HIV services.

Strategic direction 4

4.1 Gender equality and health equity

4.2 Strengthen links between HIV programme and other health areas

4.3 Resource mobilization

METHODOLOGY

Implementation of the WHO Regional Strategy was evaluated through a combination of desk review and country-level questionnaires sent to both national programme managers/ technical staff and to WHO country offices. Documents reviewed included technical documents, national HIV strategies/plans, and other relevant guidelines and policies on specific aspects of the HIV response, as well as national AIDS programme country progress reports through the Global AIDS Response Progress Reporting (GARPR)[4].

Each national programme manager or responsible officer completed a questionnaire detailing policies, developments and progress in HIV prevention; testing and counselling; treatment, care and support; strategic HIV information; and health systems and HIV. WHO country office staff also completed a questionnaire on the technical support, activities and deliverables provided by WHO country and regional offices, as well as headquarters. Country offices also provided examples of their successful HIV interventions.

This report sought to assess the relevance, effectiveness, efficiency, impact and sustainability of the Regional Strategy. In assessing relevance, the exercise sought to elucidate whether or not the Regional Strategy and WHO support to countries was in line with the priorities of Member States, and consistent with the Global Strategy. In terms of effectiveness, the review looked at the extent to which the Strategy had been put into action at country level. The data for this section are derived from quantitative and qualitative surveys completed by national programme managers and WHO country offices on the HIV response. To assess efficiency, the review sought to ascertain the degree of progress towards achieving universal access to prevention, care and treatment services. The information presented in this section is derived from regional and national data on the HIV epidemic and response, 2011–2015.

A "traffic light" grading system was used to summarize progress made under each major area of the HIV response. The grading is subjective in nature, but aims to visually highlight achievements, challenges and varied responses across countries.

- Green: denotes met/on track to meet targets; good programme coverage; and/or evidence of successful implementation of interventions.
- Yellow: denotes progress is lagging; targets could still be achieved with intensified and accelerated action; and/or coverage and quality of programmes need to improve.
- Red: denotes targets are unlikely to be met; and substantial overhaul of the response may be required.

Crosshatched "traffic lights" indicate that there are significant variations in the response, including in quality and equitable coverage, and across countries/regions.

The data used for this report are subject to a range of limitations and constraints that prevent the evaluation from being comprehensive. Some of the questionnaires were not complete, and some responses might be subjective and need to be validated or updated; the epidemic estimations as generated by Spectrum modelling might need to be interpreted with caution, especially for huge countries such as India and Indonesia. Community system and response have not been assessed systematically. Nevertheless, the report pulls together the best available evidence, with a focus on WHO's contribution, for the purpose of offering better technical support to countries under the forthcoming 2016–2021 Regional strategy and action plan.

[4] Unless otherwise noted, the data for this report are from GARPR 2011–2015, which are available at: http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx

MAJOR FINDINGS

Table 2. National HIV strategies and their alignment with the WHO Regional Health Sector Strategy on HIV, 2011–2015

COUNTRY	BANGLADESH	INDIA	INDONESIA	MALDIVES	MYANMAR	NEPAL	SRI LANKA
TIME FRAME	2011—2015	2012—2017	2010—2014	2014—2018	2011—2015	2011—2016	2013—2017
STRATEGIC DIRECTION 1:							
Condom promotion	✓	✓	✓	✓	✓	✓	✓
STI services for key populations	✓	✓	✓	✓	✓	✓	✓
Harm reduction	✓	✓	✓	✓	✓	✓	
PMTCT expansion	✓	✓	✓	✓	✓	✓	✓
Post-exposure prophylaxis	✓			✓		✓	✓
Blood and injection safety	✓	✓	✓	✓	✓	✓	✓
HIV testing expansion	✓	✓	✓	✓	✓	✓	✓
ART expansion	✓	✓	✓	✓	✓	✓	✓
STRATEGIC DIRECTION 2:							
Better strategic information systems	✓	✓	✓	✓	✓	✓	✓
STRATEGIC DIRECTION 3:							
Integration of HIV and other health services	✓	✓	✓	✓	✓	✓	✓
Better service delivery models	✓	✓		✓	✓	✓	✓
Community system strengthening	✓	✓	✓	✓	✓	✓	✓
HIV response financing		✓	✓			✓	✓
STRATEGIC DIRECTION 4:							
Gender equality	✓	✓	✓	✓	✓	✓	✓
Address stigma and discrimination	✓	✓	✓	✓	✓	✓	✓

Coherence of the global, regional and national strategies

The Regional Health Sector Strategy on HIV, 2011–2015 for South-East Asia is consistent with the WHO Global Health Sector Strategy on HIV/AIDS, 2011–2015. It was developed with the same aims: to halt and reverse the spread of HIV as part of the broader MDGs; and for the health sector to collaborate with other sectors in order to tackle the social, economic, cultural and environmental issues that shape the epidemic and access to health services.

In line with the WHO Global Health Sector Strategy, the Regional Strategy takes as its basis the fact that HIV is an integral part of the broader global health and development agenda. Its four strategic directions match those of the Global Strategy.

In turn, the key elements of the Regional Strategy have been adopted at the national level, tailored to country conditions across the Region. Seven Member States have national strategies that straddle the time frame of the 2011–2015 WHO Regional Strategy (Table 2). Nepal's strategy adopts components that are entirely in line with the Regional Strategy, but all the other six countries closely match it, with only one or two areas where they do not fully match. In 2013, the Minister of Health of Indonesia endorsed a new regulation in the HIV AIDS Control Programme, substituting the one endorsed in 2002. The new regulation became the turning point for implementation of the National AIDS Control Programme within the national health system. Further, in 2015, the updated National HIV AIDS Action Plan 2015–2019 was developed in line with the Global Strategy.

Strategic direction 1: Optimizing HIV prevention, care and treatment outcome

1.1 HIV prevention among key populations

1.1.1 Condom promotion for key populations

The condom programme has been the cornerstone of HIV prevention interventions to KPs. Of the five countries with concentrated epidemics, four (India, Indonesia, Myanmar and Thailand) have mature condom programmes for KPs, with high condom use among MSM and FSW (Table 3).

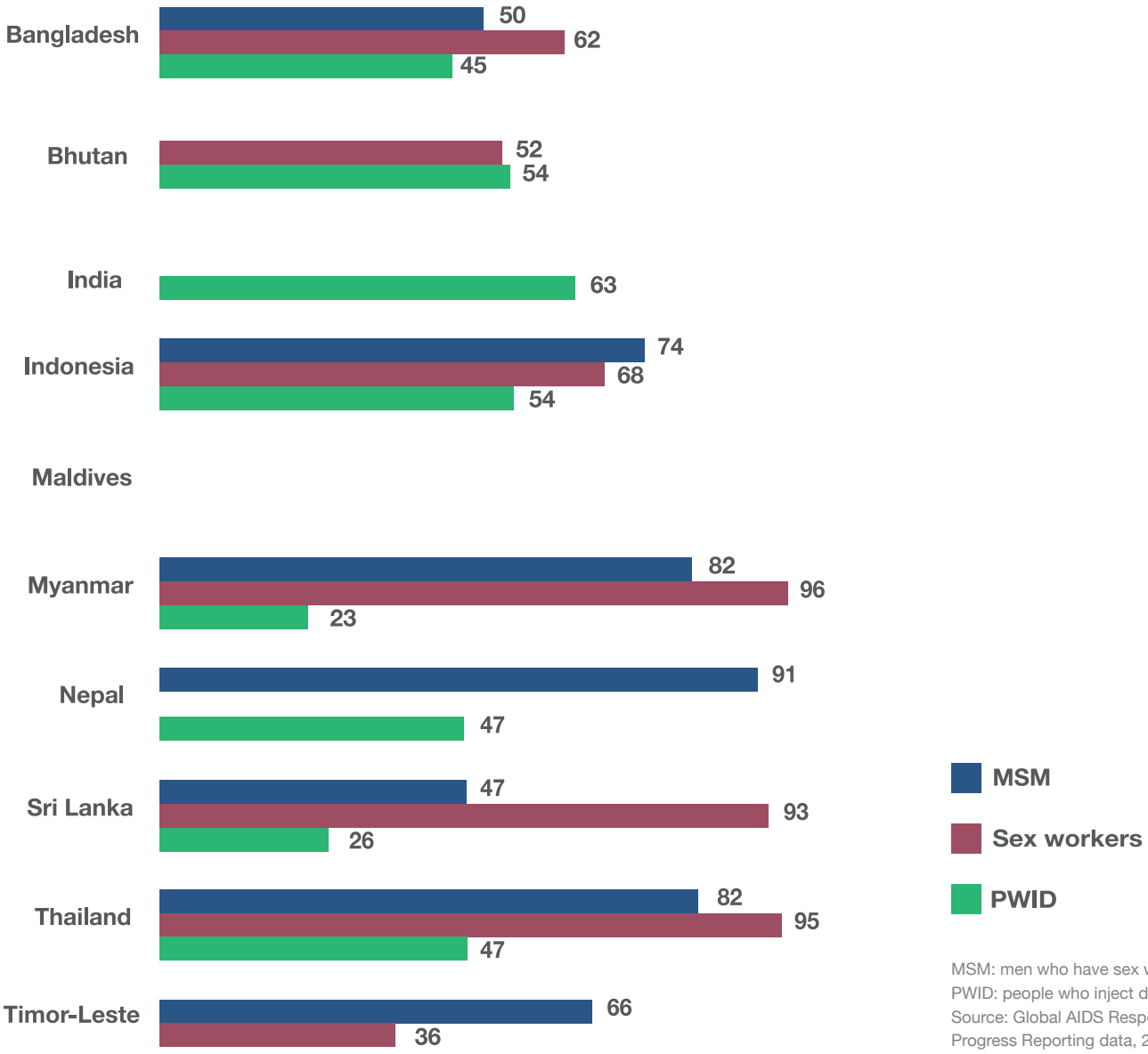
Reported condom use among KPs varies widely across the Region (Fig. 3). Among MSM, for example, reported condom use is relatively high in India Indonesia, Myanmar, Nepal and Thailand, but below 50% in Bangladesh and Sri Lanka. Condom use among SWs is generally higher, with reported use above 90% in India[5], Myanmar, Sri Lanka and Thailand. However, condom promotion programmes targeting PWID have not had strong results: India reports the highest rates for the Region, at 77% condom use with paid sex partner at last sex.

Table 3. Condom programmes for key populations in countries with concentrated epidemics among key populations

INDIA		Mature condom programme; limited data on condom use
INDONESIA		Condom programme in priority provinces; condom use <80% for all key populations
MYANMAR		Mature condom programme; high condom use among MSM and sex workers
NEPAL		Condoms part of combination HIV prevention; mixed trends in condom use
THAILAND		Mature condom programme; high condom use among MSM and sex workers

[5] National Integrated Biological and Behavioural Surveillance 2014–2015, National AIDS Control Organization (NACO), India. http://naco.gov.in/upload/2016%20Data/SIMU/IBBS%20Report%202014-15.pdf (accessed on 15 May 2016).

Fig. 3. Reported condom use (percentage) among key populations (latest available data, 2010–2014)



MSM: men who have sex with men; PWID: people who inject drugs | Source: Global AIDS Response Progress Reporting data, 2011–2015

1.1.2 Screening and treatment for sexually transmitted infections

Screening and treatment services for sexually transmitted infections (STIs) among KPs are widely available in four of the five priority countries in the Region (Table 4a). Indonesia conducts routine screening targeted at priority provinces, STI clinics and specifically FSWs via mobile clinics. Myanmar provides HIV services for FSWs, MSM and PWID, include awareness-raising and HIV education through drop-in centres at hotspots, which also act as referral spots for HIV testing and counselling, and STI treatment services. To improve the coverage of STI screening and treatment, WHO has helped low-epidemic countries update their guidelines, and provided technical and financial support. In India, WHO has supported efforts to strengthen the strategic information system for STI (Table 4b).

Table 4a. STI services for key populations in the Region

INDIA	Screening widely available for sexually transmitted infections (STIs)
INDONESIA	Routine screening at STI clinics and mobile clinics (for female sex workers) in priority provinces
MYANMAR	STI services widely available in AIDS/STI clinics and syndromic management of STI by basic health staff
NEPAL	STI screening and treatment part of HIV prevention programmes for key populations
THAILAND	STI screening and treatment in most hospitals

Table 4b. WHO support to STI services for key population

BANGLADESH	• Udating guidelines • Advocacy for guideline adoption
INDIA	• Evaluating STI surveillance system and STI patterns • Supporting Gonococcal Antimicrobial Susceptibility Programme (GASP)
INDONESIA	• Case study on STI interventions
SRI LANKA	• Updating guidelines • Advocacy for guidline adoption • Financial and technical support for implementation • Supporting research
TIMOR-LESTE	• Advocacy • Train-the-trainers programmes on etiological management of STIs for designated ART/STI doctors • Developing guidelines on etiological management of STIs and transalting these into Tetun

ART: antiretroviral therapy; STI: sexually transmitted infection

Box 1.
Indonesia: For female sex workers, lokalisasi approach in condom promotion works

Condom promotion interventions were conducted in five brothel-based sex work settings. They were aimed at empowering FSWs to increase their use of condoms and access to health services, and to promote a demand for condom use among high-risk men in sex work. In a review of five reportedly high-performing lokalisasi (localization) interventions, interviewees (FSWs, owners and managers of sex establishments, health workers and outreach teams) at four of the five study sites graded the degree of condom support and usage, and use of STI/HIV services and access as strong or very good (see Table). The majority of respondents rated empowerment, enabling and coverage aspects as strong. Condom use during last sex with a client increased in the past decade in four of the five study sites and, as a consequence, the prevalence of HIV/STIs isdeclining.

Lessons learnt

- Structural barriers to condom use still exist, e.g. tax incentives to conceal SWs in some areas and owners who still support clients who refuse to use condoms.
- Control of sexual transmission of HIV and STIs is feasible in direct sex work settings in Indonesia.
- Community engagement through working groups leads to better results in all of these areas.
- A combination of good condom promotion programming, clinical services with regular check-ups, sustained outreach and involvement of SWs and other stakeholders is important for better results.

Looking to the future

- Assess and strengthen interventions in other lokalisasi as an immediate priority to slow sexual transmission.
- Consider offering routine screening and treatment to pimps, regular partners (and regular clients if possible) who often do not use condoms and are a likely source of reinfection for SWs.
- Strengthen the capacity to analyse and use routine data, including condom distribution and use trends; analysis of screening data on cervicitis, syphilis and pelvic inflammatory disease; analysis of data on attendance rates and outreach contacts.
- Build capacity at the national and provincial levels to conduct trend analysis using survey data to validate findings from routine monitoring.

SITE	CONDOM SUPPORT AND USE				STI/HIV SERVICES AND ACCESS				EMPOWERMENT, ENABLING, COVERAGE			
DENPASAR	15	15	16		17	18	16		12	16	15	
JAYAPURA	15	16	12		17	18	14		11	15	12	
MALANG	17	16	16		18	18	18		13	16	16	
SURABAYA*		15	12			15	16			9	12	
TANJUNG PINANG	13	12	13		17	18	16		18	16	16	

*incomplete – unable to meet with sex workers to assess

STRONG (15–18)	GOOD (10–15)	WEAK (<10)	MISSING

1.1.3 Harm reduction – opioid substitution therapy and needle and syringe programme

Of the 10 Member States, all but three have an opioid substitution therapy (OST) programme in place for PWID (Table 5a). Thailand has 140 OST sites across the country, including some community-based sites. Myanmar has recently scaled up its service provision for PWID – in 2014, the government allocated US$ 1 million for methadone maintenance therapy (MMT). Indonesia has a harm reduction programme for PWID in place in priority areas only. It is difficult to evaluate the progress of the OST programmes given the lack of data on people in need of OST. Needle and syringe programmes (NSPs) are ongoing in six of the 10 countries. WHO support in this area has been limited in countries (Table 5b).

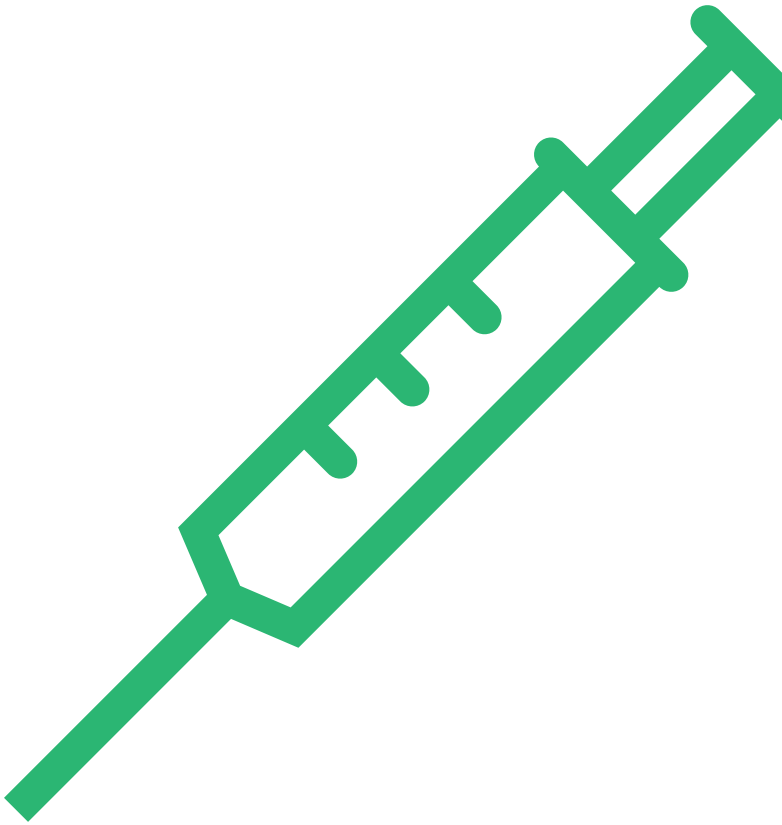
Table 5a. Harm reduction interventions for people who inject drugs

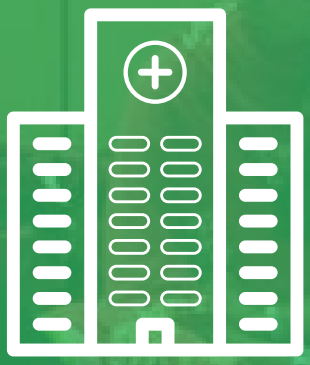
	OST sites	People receiving OST	Needle and syringe programme sites	Needles distributed per PWID
BANGLADESH	4	487	88	224
BHUTAN	-	-	-	-
INDIA	178	18000	401	240
INDONESIA	90[a]	2529	232	44
MALDIVES	1	26	0	-
MYANMAR	35[b]	7872	51	168
NEPAL	15	640	60	36
SRI LANKA	0	0	0	-
THAILAND	140[c]	3646	42	14
TIMOR-LESTE	-	-	-	-

[a] In priority provinces
[b] HIV testing and one-stop services at some sites
[c] Includes community-based sites

Table 5b. WHO support for harm reduction interventions

BHUTAN	-	**Piloting programme** using buprenorphine substitution to assess efficacy, sustainability and outcomes for injecting and non-injecting opioid users
INDONESIA	-	Conducting **a review** of harm reduction/methadone maintenance therapy services
MYANMAR	-	**Technical support** of MMT
	-	Strengthening **coordination with organizations** providing HIV services to key populations
SRI LANKA	-	**Advocacy** for harm reduction programmes
TIMOR-LESTE	-	**Developing** MMT standard operating procedures





Box 2.
Piloting opioid substitution therapy with methadone in Dhaka, Bangladesh

Bangladesh's HIV epidemic is concentrated among KPs, mainly PWID, and available evidence points to risk behaviours among this population. The United Nations Office on Drugs and Crime (UNODC), and the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) are working jointly with the Government of Bangladesh to introduce OST for PWID.

A pilot programme was launched in 2010 to reduce risk behaviours, psychological distress and drug dependency. Services offered via MMT clinic included:

- general medical services
- counselling
- psychiatric and support services
- free HIV testing and treatment
- referral for TB screening and treatment.

The pilot programme helped to successfully wean away 11 clients from drug dependence and remain drug-free for at least four months. In some cases, earlier attempts to recover using conventional detoxification and rehabilitation services had failed. Other notable features of the pilot have been a high retention rate (80%) and the requirement for relatively low doses of methadone for stabilization. Clients were stabilized on an average dose of 49 mg in the maintenance phase.

Looking to the future

It is expected that another MMT clinic will be started soon at a drop-in centre providing NSPs and other harm reduction services to PWID in Dhaka. This will be supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), managed by Save the Children and implemented by CARE Bangladesh, with technical assistance from ICDDR,B and UNODC. Based on the success of the OST pilot project, the Ministry of Health and Family Welfare has incorporated the OST programme in its health sector programme as well.

1.2 Antiretrovirals for prevention

Even though recommendations on post-exposure prophylaxis (PEP)[6] have been available in all countries for years, there are limited data on its implementation (Table 6). PEP is implemented nationwide in India, Thailand and Myanmar, while implementation is limited in Indonesia and Sri Lanka. In India, due to supply chain issues, PEP is not available at sites without ART services. As evidence emerged, WHO recently recommended ARV pre-exposure prophylaxis (PrEP)[7] as an additional HIV prevention tool. Thailand is planning to scale up PrEP after it has piloted it in three sites. WHO has been supporting several countries in updating their guidelines on PEP and is supporting PrEP research in India and Thailand (Table 7).

Table 6. Antiretroviral prophylaxis: guidelines and implementations

	Pre-exposure prophylaxis	Post-exposure prophylaxis
BANGLADESH	X	Recommended
BHUTAN	X	Recommended
INDIA	X Implementation science resesarch approved at two sites	Recommended for health staff and victims of sexual assault ¥ Implemented nationwide
INDONESIA	X Implementation science research planned	Recommended for health staff Limited implementation
MALDIVES	X	Receommended for health staff and in case of sexual exposure to HIV
MYANMAR	X	Recommended for health staff and victims of sexual assault ¥ Implemented in health facilities
NEPAL	X	Recommended
SRI LANKA	X	Recommended for health-care workers and rape victims, and following condom rupture for serodiscordant couples Limited implementation in private sector
THAILAND	•	Recommended ¥ Implemented nationwide
TIMOR-LESTE	X	Recommended for health-care workers and rape victims

✓ **RECOMMENDED** X **NOT RECOMMENDED**

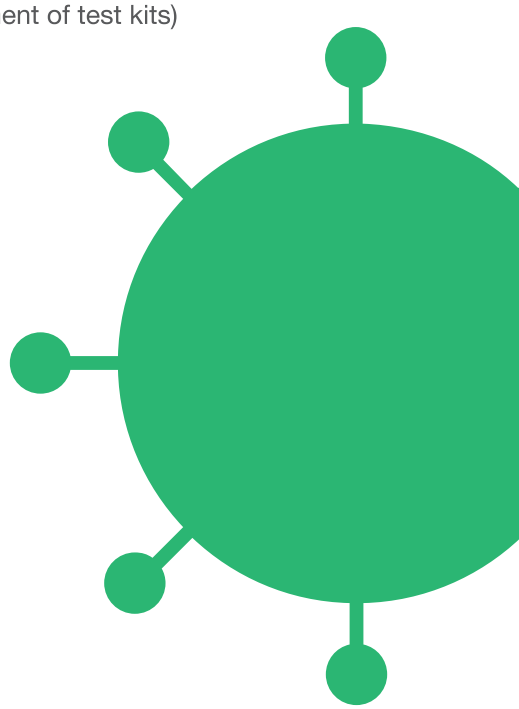
[6] Since the early 1990s, in many countries ARV medicines have been prescribed for PEP following occupational exposure to HIV. This practice has since been extended to non-occupational situations, primarily for cases of sexual assault (http://www.who.int/hiv/pub/guidelines/PEP/en/, accessed 17 May 2016).

[7] PrEP is the use of an ARV medication to prevent the acquisition of HIV infection by uninfected persons. PrEP may either be taken orally, using an ARV drug available for treatment of HIV infection (tenofovir plus emtricitabine), or topically as a vaginal gel containing tenofovir. The efficacy of oral PrEP has been shown in four randomized control trials and is high when the drug is used as directed. The efficacy of the gel has been shown in one trial and is moderate (http://www.who.int/hiv/topics/prep/en/)

Table 7. WHO support for implementation of PrEP and PEP

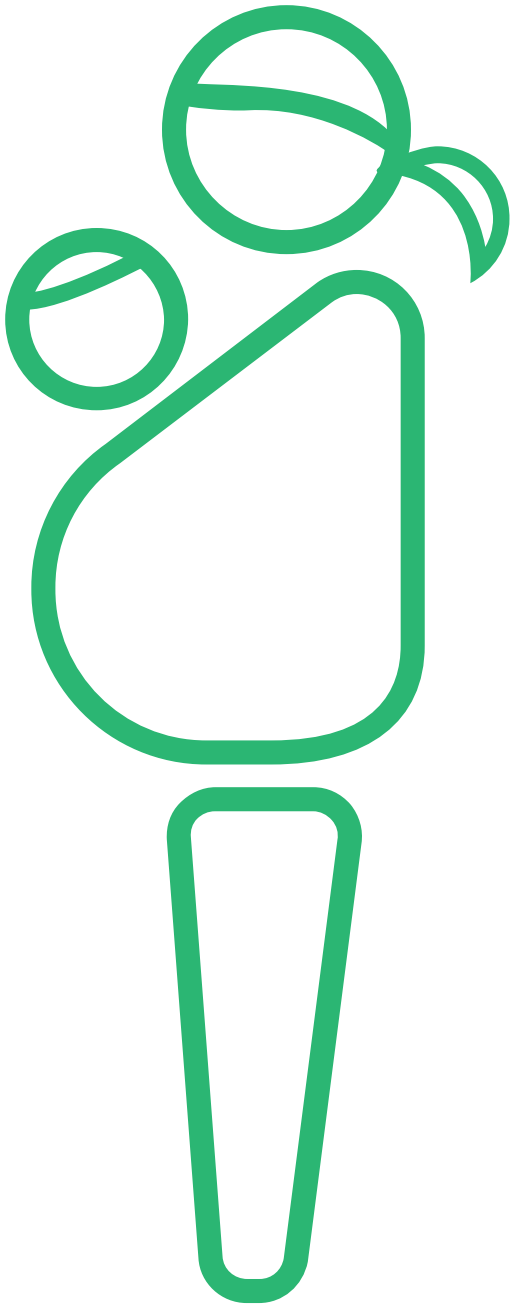
BANGLADESH	-	**Updating guidelines** on post-exposure prophylaxis (PEP)
BHUTAN	-	**Updating recommendations** on PEP
INDIA	-	Supporting **implementation reserach** on pre-exposure prophylaxis (PrEP)
	-	**Updating guidelines** on PEP
	-	**Training** on PEP guidelines
INDONESIA	-	**Advocacy** for PrEP
	-	**Updating guidelines** on PEP
SRI LANKA	-	**Updating guidelines** on PEP
THAILAND	-	Supporting **implementation research** on PrEP (procurement of test kits)

PEP: post-exposure prophylaxis; PrEP: pre-exposure prophylaxis



1.3 Prevention of mother-to-child transmission of HIV and congenital syphilis

Thailand leads the Region in prevention of mother-to-child transmission (PMTCT) of HIV. By 2015, the country had successfully reduced mother to child transmission of HIV to 1.91%. The country's PMTCT programme comprises universal implementation of HIV and syphilis testing, Option B+ and early infant diagnosis (EID), implemented in all government hospitals. With such a strong and successful PMTCT programme already in place, Thailand has met all EMTCT criteria in accordance with the global criteria, and been validated elimination of mother to child transmission of HIV and syphilis in June 2016. However, the other countries are lagging behind.



1.3.1 HIV testing and counselling for pregnant women

Bhutan, India, Myanmar and Thailand all provide universal access to provider-initiated testing and counselling (PITC) for pregnant women, while Bangladesh, Indonesia, Nepal, Sri Lanka and Timor-Leste prioritize HIV testing in high-prevalence areas (Table 8). Regardless of the HIV testing strategy, HIV testing in antenatal care (ANC) is low in all countries except Thailand, posing a unique challenge for scaling up PMTCT services.

Table 8. HIV testing for pregnant women

	Policy	Coverage 2010	Coverage 2014
BANGLADESH	PITC with geographical prioritization	<1%	<1%
BHUTAN	Universal PITC	-	-
INDIA	Universal PITC with focus on high-prevalence states; decentralized testing	21%	38%
INDONESIA	PITC with geographical prioritization	<1%	5.8%
MALDIVES	PITC	-	-
MYANMAR	Universal PITC	21%	51%
NEPAL	PITC with geographical prioritization	11%	22%
SRI LANKA	PITC	-	45%
THAILAND	Universal PITC	100%	99.8%
TIMOR-LESTE	HIV testing in ANC in six districts	-	19%

Source: UNAIDS Global AIDS Response Progress Reporting, 2011–2015
ANC: antenatal care; PITC: provider-initiated testing and counselling
* Coverage is defined as the number of pregnant women receiving an HIV test as a percentage of estimated number of pregnant women.

Box 3.
Sri Lanka: Success in managing syphilis infection among pregnant women

Almost 95% of pregnant women in Sri Lanka register for antenatal services before 12 weeks of pregnancy and 99.8% have institutional deliveries. During the past two decades, the annual number of newly diagnosed cases of syphilis decreased markedly, and remained at 0.02% among pregnant women from 2010 to 2014.

The Ministry of Health has long identified management of syphilis among pregnant women as a significant public health issue, and testing has been offered since the 1950s. When a pregnant woman registers for ANC in the public health services, syphilis testing is offered as part of routine screening. When pregnant women test positive for syphilis, they are referred for repeat testing and treatment, and they and their partners are followed up until delivery. All babies born to mothers with syphilis are given prophylactic penicillin. If congenital syphilis cannot be excluded, babies are admitted to the paediatric ward for daily penicillin injections for 10 days.

Smooth functioning of the programme depends on the involvement of several stakeholders, and the links between maternal and child health and STI clinics are maintained through regular reviews and in-service training. Continuing advocacy among key players, including the authorities, is also an essential component of the programme.

There is still room for improvement, notably the quality of testing, reporting and data management in the private sector, and reporting of stillbirth data related to syphilis.

Box 4.
Bhutan: Integrated HIV, syphilis and hepatitis B testing facilities in a primary health-care package

Although Bhutan continues to report a low prevalence of HIV, there has been a consistently increasing trend of new HIV infections reported every year. The average annual number of reported cases over the past five years is 25 cases. This increase has been attributed to the scaling up of HIV testing and counselling services in all the hospitals, and the free-standing voluntary counselling and testing (VCT) centres in four major towns. With a dedicated VCT focal person, the HIV testing and counselling facilities in hospitals have been integrated with maternal and child health clinics, with the primary aim of ensuring that every pregnant woman is offered a package service of testing for HIV, syphilis and hepatitis B.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates for Bhutan put the cumulative number of cases at 500 in 2009 and 1100 cases by the end of 2013. However, as of late 2015, there were only 470 cases. Considering the estimated number and the total diagnosed as of date, there is still a detection gap of almost 36%. With this in mind, in 2013, the Ministry of Health decided to integrate HIV testing and counselling into primary health-care services.

Standard operating procedures were developed, including guidance on procurement and supply chain management. Additional health workers were trained in all four regions and 20 districts on the use of rapid diagnostic tests for HIV, syphilis and hepatitis B. Supplies were made available with the support of the United Nations Development Assistance Framework workplan, and training costs were met through the Global Fund and WHO support.

Three months later, the HIV testing and counselling services were initiated in basic health units. The next step is to review current practices in the primary health-care centres and strengthen services based on the findings. Bhutan aspires to achieve universal coverage of HIV testing and counselling services by the end of 2016.

1.3.2 Antiretroviral therapy for pregnant women living with HIV

Option B+ is a policy in all the countries. While some countries are implementing it nationwide, others have opted for a phased implementation starting with high-prevalence areas. Option B+ is at varying stages of implementation across the Region (Table 9)[8]. Thailand leads the way with over 98% coverage followed by Myanmar at 88% in 2015, up from 33% in 2010. India and Nepal have lower coverage at 47% and 41%, respectively. Indonesia achieved only 11% ART coverage for PMTCT in 2015.

Table 9. Antiretroviral therapy for pregnant women living with HIV

	Policy	Coverage 2010	Coverage 2015
BANGLADESH	Option B+ (since August 2013) Phased implementation	12%	16%
BHUTAN	Option B+ (since 2014)	n/a	n/a
INDIA	Option B+ (since December 2013) Nationwide implementation since 2014	n/a	47%
INDONESIA	Option B+ (since December 2011)	15%	11%
MALDIVES	Option B+ (since 2015)	n/a	n/a
MYANMAR	Option B and Option B+ (since 2014) Phased implementation	33%	88%
NEPAL	Option B+ (since 2014) Phased implementation in high-prevalence districts	8%	41%
SRI LANKA	Option B+ (since January 2014) Nationwide implementation since 2014	10%	36%
THAILAND	Option B+ (since November 2014) Nationwide implementation since 2014	79%	98%
TIMOR-LESTE	Option B+ (since 2014) Phased implementation	n/a	n/a

Source: UNAIDS Global AIDS Response Progress Reporting, 2011–2015

* Coverage is defined as the number of HIV-positive pregnant women receiving antiretrovirals as a percentage of the estimated number of HIV-positive pregnant women

[8] Option B+: lifelong ART for all HIV-positive pregnant women regardless of CD4 count

Fig. 4. Percentage of infants born to HIV-positive women receiving an HIV test within 2 months of birth

Source: UNAIDS aidsinfoonline

1.3.3 Early infant diagnosis

Countries in the Region face numerous challenges to scaling up EID (see Annex. Only Thailand has made major strides in EID for HIV, increasing coverage from 61% in 2011 to 91% in 2014, and making testing available in all government hospitals (Fig. 4). In most other countries, coverage remains extremely low, although there have been recent improvements in Bangladesh and Sri Lanka. Indonesia is conducting pilot studies for EID in selected districts, but is grappling with limited availability of virology testing due to high costs and human resource constraints. Similarly, in India, procurement and availability of testing kits for infant diagnosis is a challenge. Nepal is currently collecting blood samples from five service sites, which are currently sent out to Bangkok for diagnosis. There are plans to expand EID in Indonesia, where demonstration pilots are currently being implemented, including pilot dried blood spot testing in selected districts.

WHO has provided considerable support to all countries to strengthen their PMTCT services, especially for updating guidelines and implementing Option B+. WHO has also provided support for monitoring and evaluation (M&E), data system development and pilot projects (Table 10).

Table 10. WHO support to countries for PMTCT services

BHUTAN	-	Updating guidelines on PMTCT
INDIA	-	Advocacy for inclusion of HIV and syphilis in ANC package
	-	Updating guidelines on PMTCT
	-	Development of National Strategic Plan
	-	Implementation and scale up of Option B+
	-	Monitoring progress and programme review
	-	Data system development for PMTCT cascade monitoring
	-	Development of patient tracking system
INDONESIA	-	Updating guidelines on PMTCT
	-	Pilot project on integrating PMTCT services in ANC at four demonstration sites
	-	Mobilizing financial resources for elimination of HIV and congenital syphilis
MYANMAR	-	Technical support for PMTCT programme implementation
SRI LANKA	-	Advocacy
	-	Technical support for programme implementation
	-	Training of MCH staff on PMTCT
THAILAND	-	Guidance development on elimination of congenital syphilis
	-	Training support for early infant diagnosis
	-	Supported national consultations on Option B+ for PMTCT
TIMOR-LESTE	-	Advocacy and establishment of ANC syphilis screening programme

* ANC: antenatal care; CS: congenital syphilis; MCH: maternal and child health; PMTCT: prevention of mother-to-child transmission

1.4 Blood and injection safety

All countries have developed blood and injection safety policies and practise these. Four countries report 100% compliance with the policy of screening all blood units for HIV (Table 11a). WHO has provided support to countries to strengthen their programmes (Table 11b).

Table 11a. Blood and injection safety policies

BANGLADESH	- HIV screening of all blood units (100% compliance) - Use of disposable syringes and safe disposal
BHUTAN	- HIV screening of all blood units (100% compliance) - One person one syringe policy
INDIA	- HIV screening of all blood units - Action plan for blood safety monitoring is needed
INDONESIA	- Blood screening implemented nationwide - Injection safety implementation at hospital level - Limited implementation of needlestick injury surveillance
MYANMAR	- Universal precaution measures in all health facilities - HIV screening of all blood units
SRI LANKA	- HIV screening of all blood units (100% compliance) - Use of disposable syringes and safe disposal
THAILAND	- Universal precaution measures in all health facilities
TIMOR-LESTE	- HIV screening of all blood units (100% compliance) - Disposable needles and syringes used

Table 11b. WHO support for blood and injection safety

BANGLADESH	-	Updating guidelines
	-	Advocacy for safe injection practices
BHUTAN	-	Updating guidelines on blood and injection safety
INDIA	-	Updating guidelines on blood and plasma transfusion
	-	Technical assistance for blood donor support, component preparation, blood screening and distribution
INDONESIA	-	Support to the government's state-of-the-art blood banks
	-	Establishment of plasma fractionation centre
	-	Supporting the establishment of a National Blood Committee and endorsement of government regulation on blood services
	-	Developing guidelines for blood donation and blood products
	-	Mobilizing resources for blood safety
SRI LANKA	-	Updating guidelines
	-	Funding and technical support for programme implementation
	-	Supporting research
TIMOR-LESTE	-	Mobilizing resources for implementation

1.5 Expand HIV testing and counselling

HIV testing and counselling policies differ across countries – India, Maldives, Myanmar and Thailand offer HIV testing for all populations while the remaining countries have prioritized HIV testing in high-prevalence areas and/or for high-risk populations (Table 12). The use of rapid testing kits enables same-day results, and access to these tests kits has been scaled up. Community-based counselling and testing is also promoted in many countries to increase accessibility. Most countries use a three-test algorithm. In Thailand, 80% of estimated PLHIV have been diagnosed, and the country is on track to achieve the UNAIDS 90–90–90 target of 90% of PLHIV diagnosed by 2020[9]. The estimated proportion of PLHIV diagnosed is 67% in India and 66% in Nepal.

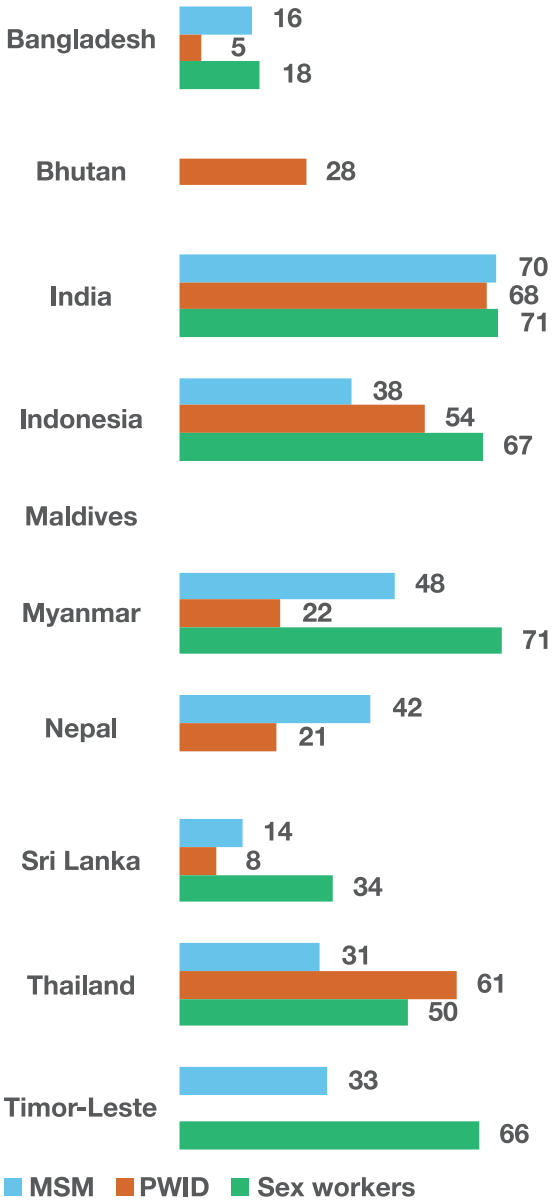
Table 12. HIV testing policy and implementation in the Region

BANGLADESH	- Geographically prioritized PITC at drop-in centres, OST clinics, ANC sites, TB sites; 3-test algorithm
BHUTAN	- Geographically prioritized PITC with risk-based targeting at STI clinics, ANC, TB clinics, all district hospitals and four health information service centres; 3-test algorithm
INDIA	- PITC nationwide at integrated counselling and testing centres, STI, TB clinics; 3-test algorithm
INDONESIA	- Geographically prioritized and for KPs, TB/STI/hepatitis patients, pregnant women and patients with OI symptoms in ANC, TB, OST and STI clinics, mobile clinics for KPs, and piloted at workplace; 3-rapid test algorithm
MALDIVES	- PITC in all hospitals, drop-in centres, reproductive health service centres and at 2 VCT sites in NGOs
MYANMAR	- PITC nationwide in all level health facilities (ANC, TB, STI and ART clinics) and outreach for KPs; 3-test algorithm
NEPAL	- Geographically prioritized PITC and VCT and for key populations; 3-test algorithm
SRI LANKA	- VCT for general population, prisoners and at workplace; - PITC for pregnant women, KPs, STI clinic attendees, and TB patients. HIV testing available in all MCH and STI clinics
THAILAND	- Universal for all populations in all settings; 3-test algorithm
TIMOR-LESTE	- HIV testing in some ANC, TB and STI clinics; community-based testing for KPs; 3-test algorithm

Source: WHO Regional Office for South-East Asia country fact sheets
* Diagnosed is defined as the number of people living with HIV who have been diagnosed positive as a percentage of the estimated number of people living with HIV
ANC: antenatal care; KP: key population; MCH: maternal and child health; OI: opportunistic infection; OST: opioid substitution therapy; NGO: nongovernmental organization; PITC: provider-initiated testing and counselling; STI: sexually transmitted infection; TB: tuberculosis; VCT: voluntary counselling and testing

[9] UNAIDS 90–90–90 targets: 90% of the estimated PLHIV diagnosed, 90% of diagnosed PLHIV on ART and 90% of PLHIV on ART with viral suppression

Fig. 5. Percentage of key populations who received an HIV test in the past 12 months and know their results



Source: UNAIDS aidsinfoonline (latest available data between 2011 and 2014)
MSM: men who have sex with men; PWID: people who inject drugs

HIV testing for key populations varies widely across the Region, according to the latest available surveillance data from 2011 to 2014 (Fig. 5). Rates of HIV testing for SWs are highest in India and Myanmar at 71%, but stand at only 50% in Thailand, a country that in the past has been upheld as a strong example of brothel-based condom programming. Testing rates for this KP in both Sri Lanka and Bangladesh are lagging behind other countries in the Region. India has also achieved relatively high levels of HIV testing for PWID (68%), MSM (70%) and SWs (71%), but elsewhere the results are less impressive.

Box 5.
Timor-Leste: Breaking down barriers to HIV testing for key populations

Timor-Leste is classified as a low-prevalence country for HIV. Current estimates suggest that there are approximately 542 people living with HIV, with an adult prevalence of 0.09%[10]. However, for a small country with 1.17 million people, the situation can change rapidly if there is even a small gap in programming[11]. Typically, in low HIV-prevalence settings, the proportion of PLHIV is higher among KPs than among the general population. If this is not reflected in the available data, it suggests that those at increased risk are not being reached with HIV testing services, which are the gateway to treatment, care and support.

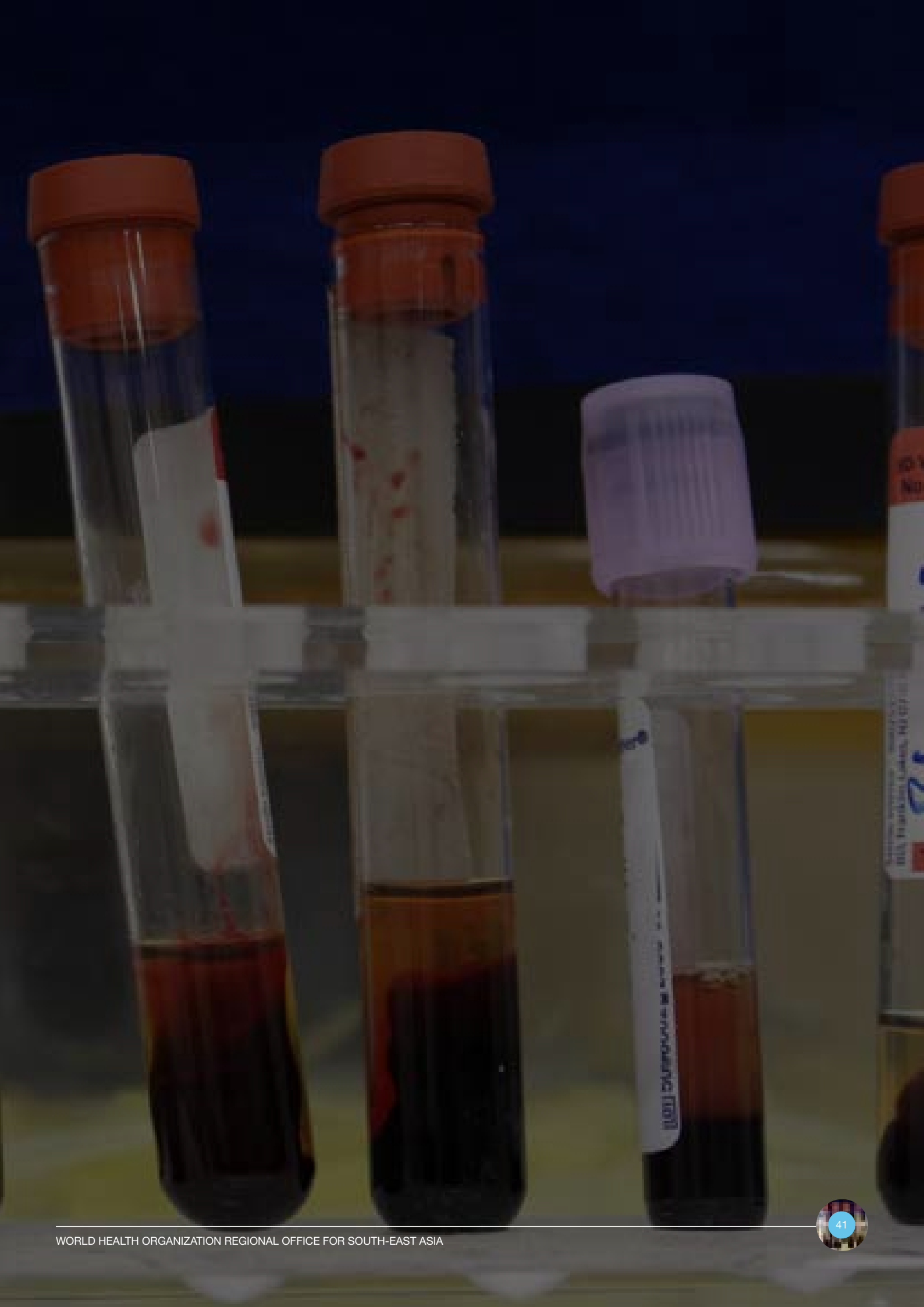
This was the case in Timor-Leste, where uptake among FSWs and MSM was low. In response, the national HIV/AIDS and STI control programme, with active support from WHO, piloted community-based HIV testing for KPs in five districts of Timor-Leste from April 2014. This led to the testing of 3809 FSWs and MSM because they were reached at their place of work or in hotspots. Overall, this led to a 300% increase in HIV testing, from 8416 tests in 2013 to 33 768 in 2014[12].

The National AIDS Programme worked together with the nongovernmental organization (NGO) Fundasaun Timor Hari'i and representatives from KP groups on which hotspots to target and where HIV testing could be facilitated. The next step was to train counsellors and technicians from the community who could conduct HIV testing in a field setting, put systems in place and implement a quality assurance system for HIV testing and data collection. An initial pilot in the capital Dili provided excellent results and the initiative was then scaled up to all five districts: Dili, Baucau, Covalima, Bobonaro and Oecusse.

The following factors led to better uptake of testing services:

- trained peer counsellors and testing technicians from the community
- static and mobile testing facilities
- flexible operating hours
- linkages with drop-in centres
- group counselling and testing
- stable staffing.

[10]National HIV/AIDS and STI Control Programme, Ministry of Health, Timor-Leste. Global AIDS Response Progress Report, 2015.
[11]Provisional total 2015. General Directorate of Timor-Leste, October 2015 (http://www.statistics.gov.tl/the-ceremony-launching-preliminary-results-of-census-population-and-housing-2015/, accessed on 28 November 2015).
[12]National HIV/AIDS and STI Control Programme, Ministry of Health, Timor-Leste. Global AIDS Response Progress Report, 2015, page 21.



Countries across the Region have called upon WHO for support in expanding HIV testing and counselling services, from reviews of existing services, epidemic modelling, and training on M&E in Indonesia, to technical support for programme implementation in Myanmar (Table 13).

1.6 Optimize antiretroviral therapy

1.6.1 Access to treatment for all people living with HIV

Of the 10 countries, two (Thailand and Maldives) recommend ART irrespective of CD4 count for all PLHIV, which is consistent with the latest 2015 WHO guidelines (Table 14). Seven countries recommend ART at the level of the 2013 WHO guidelines – CD4 count <500 cells/mm3 and irrespective of CD4 count for PLHIV coinfected with TB or hepatitis B, pregnant women and serodiscordant couples. Myanmar and Sri Lanka additionally recommend ART for all KPs. Indonesia, which recommends ART at the level of the 2010 WHO guidelines, offers ART irrespective of CD4 count for KPs and in geographical areas with a high prevalence. Provision of ART is being decentralized in some countries, including Indonesia and Myanmar (Table 15). With high levels of ART coverage in place, Thailand's focus has been on ensuring equity of access, with all three of the country's national health insurance schemes now offering harmonized and full access to ART.

The number of people on ART is increasing across the Region but ART coverage among all PLHIV remains woefully low in most countries, with the exception of Thailand, which achieved 64% coverage in 2015 (Fig. 6).

Table 13. WHO support for testing and counselling

BANGLADESH	-	Training of trainers (ToT) on HIV testing
BHUTAN	-	Updating guidelines on HIV testing
INDIA	-	Supported development of state road maps for creating facility-integrated ICTC at all primary health centres
	-	Dissemination of WHO guidance on HTC
INDONESIA	-	Supported development of road map, which included rapid scale up of HIV testing and treatment in high-burden districts
	-	Updating guidelines on HIV testing
MYANMAR	-	Development of HIV testing guidelines and testing algorithm
	-	Technical support for programme implementation
SRI LANKA	-	Developing policy
	-	Funding and technical support for programme implementation
	-	Procurement of rapid diagnostic test kits for use among KPs
	-	Supporting training programmes on HTC

HTC: HIV testing and counselling; ICTC: integrated counselling and testing centre; PHC: primary health centre; ToT: train the trainers

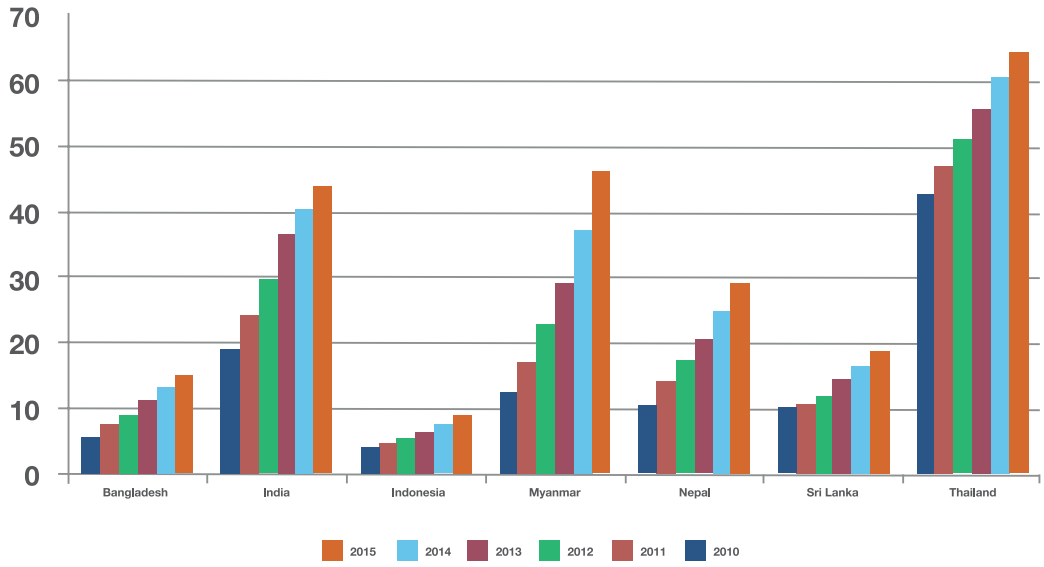
Table 14. Eligibility criteria for antiretroviral therapy

	Policy	
BANGLADESH **BHUTAN** **NEPAL** **TIMOR-LESTE**	CD4 count <500 cells/mm^3	TB patients, people coinfected with hepatitis B, pregnant women, serodiscordant couples, children <5 years
INDIA	CD4 count <350 cells/mm^3 (<500 cells/mm3 approved)	TB patients, people coinfected with hepatitis B, pregnant women, children <5 years
INDONESIA	CD4 count <350 cells/mm^3	TB patients, people coinfected with hepatitis B, pregnant women, key populations (KPs), serodiscordant couples, children <5 years, all people living with HIV in high-prevalence areas
MALDIVES **THAILAND**	Irrespective of CD4 count	TB patients, people coinfected with hepatitis B, pregnant women, key populations (KPs), serodiscordant couples, children <5 years, all people living with HIV in high-prevalence areas
MYANMAR	CD4 count <500 cells/mm^3	TB patients, people coinfected with hepatitis B, KPs, serodiscordant couples, children <5 years
SRI LANKA	CD4 count <500 cells/mm^3	TB patients, people coinfected with hepatitis B, pregnant women, KPs, serodiscordant couples, children <5 years

Table 15. Number of antiretroviral therapy centres and sites

	ART centres
BANGLADESH	11 ART centres
BHUTAN	5 ART centres
INDIA	519 ART centres (including facility-integrated ART centres), 70 ART centres for second-line ART 870 Link ART centres
INDONESIA	465 ART centres; ART decentralization to primary health centres
MALDIVES	1 ART centre at Indira Gandhi Memorial Hospital
MYANMAR	184 adult and 108 paediatric ART centres; ART decentralization began in 2013
NEPAL	53 ART centres
SRI LANKA	13 ART centres
THAILAND	949 adult and 675 paediatric ART centres
TIMOR-LESTE	7 ART centres

Fig. 6. ART coverage (percentage) among people living with HIV



Source: UNAIDS aidsinfoonline

Treatment coverage continues to vary widely across the Region and reflects the degree of political commitment, financial resources and programme efficiency in the respective countries. Thailand and India are increasingly funding their AIDS response domestically, but donor funding – risky and unpredictable – dominates the financing landscape for Myanmar, Nepal and Bangladesh. Thailand, Nepal and Myanmar have significantly increased treatment coverage, but in Indonesia only 9% of estimated PLHIV are receiving ART. India, the world's largest producer of generic ARVs, has been able to get 925 000 PLHIV on treatment, but they account for only 44% of all those in need (2015 data).

Expanding ART coverage is one of the main areas where WHO played a significant role (Table 16). WHO disseminated its treatment guidelines and provided support to countries for updating their national guidelines. WHO also supported implementation science research in some countries, and provided funding, training and technical support for implementation of the national guidelines.

Thailand does not recommend routine CD4 count for ART monitoring, while most of the countries recommend it every 6 months, in line with the WHO recommendation. Routine viral load (VL) monitoring is recommended in all countries except India and Myanmar, where VL is done in cases of suspected treatment failure. WHO supported India's National AIDS Control Organization (NACO) in prioritizing PLHIV for VL testing (validating viral testing through the GeneXpert machine), and in developing a phased implementation plan for roll-out of VL testing. In Myanmar, WHO supported emergency procurement of reagents for CD4 and VL testing.

Table 16. WHO support for improved access to antiretroviral therapy

BANGLADESH	Updating guidelines Training of trainers on ART management
BHUTAN	Updating guidelines
INDIA	Updating guidelines and training material Supported ART decentralization by developing operational guidelines Training workshops to build capacity Expansion plan and training for new second-line centres supported by WHO Technical support for ART assessment, continuous improvement in quality of services, forecasting and supply chain management of ARV drugs Road map for addressing HIV drug resistance Pharmacovigilance programme for ARV drugs
INDONESIA	Development of, training for, dissemination of ART guidelines Development of road map for scale up of HIV treatment in high-burden districts Funding for conducting consultation meetings to finalize guidelines Facilitated roll out of Strategic use of ARVs (SUFA) programme in 75 priority districts, provided direct technical support for implementation of SUFA in several provinces Mobilized WHO financial resources for test-and-treat study for PWID Mobilized external funding (DFAT) for test-and-treat study on key populations
MYANMAR	Development and dissemination of ART guidelines Technical assistance for HIV drug resistance surveillance Joint rapid assessment of the HIV treatment programme in 2013 Rapid assessment of ART decentralized site in 2015
SRI LANKA	Updating guidelines Funding, training and technical support for programme implementation Training for clinicians on revised treatment guidelines
THAILAND	Technical assistance for guideline development Development of app for smartphones for the new guidelines Supported the costing and cost–benefit analysis of treatment for all Supported national consultations on SUFA Implementation science support to the Thai Red Cross TasP+PrEP Project
TIMOR-LESTE	Supported introduction of new ART guidelines in July 2014 Supported with supply of paediatric ARVs when country had a stock-out

ART: antiretroviral therapy; ARV: antiretroviral; DFAT: Department of Foreign Affairs and Trade; KPs: key populations; PrEP: pre-exposure prophylaxis; PvP: pharmacovigilance programme; PWID: people who inject drugs; SUFA: strategic use of ARVs; TasP: treatment as prevention

1.6.2 Adherence and retention

Overcoming the challenge of treatment access is a significant achievement, but retaining people on treatment can be a struggle for countries. Several countries in the Region have taken steps to address this. India, for example, launched an intensified loss-to-follow-up tracing drive, together with community-based organizations across the country (Table 17). NGOs and community-based groups also play a key role in retaining patients in Indonesia, Myanmar and Nepal. The 12-month retention rates are high in all countries (>70%).

WHO supported a wide range of initiatives in India to improve adherence to and retention on ART. WHO provided support to NACO for pharmacovigilance and data validation. WHO also provided support for building the capacity of state officials in preparing and analysing the retention cascade for their states, and strategies to plug the losses at each site.

Table 17. Adherence and retention support for antiretroviral therapy

		Retention	
		2011	2014
BANGLADESH	Community-based support by NGOs	84%	87%
BHUTAN	Unique identifier to follow up and track patients	89%	87%
INDIA	NACO launched an intensified 'loss to follow up' tracking drive with community-based organizations	-	74%
INDONESIA	Communities engaged in outreach, monitoring people on ART and adherence support	68%	71%
MALDIVES		67%	100%
MYANMAR	Peer counsellor and PLHIV network assist in adherence counselling, defaulter tracing, and peer counselling	87%	82%
NEPAL	Community care centres and community home-based care programme run by NGOs do follow up visits to maintain adherence	82%	84%
SRI LANKA	People living with HIV organizations involved in providing adherence support and retention on ART	78%	91%
THAILAND		83%	83%
TIMOR LESTE	Community networks provide support	83%	82%

Data indicate 12 months retention. ART: antiretroviral therapy; NACO: National AIDS Control Organization; NGO: nongovernmental organization; PLHIV: people living with HIV

Box 6. Myanmar: Expanding coverage of antiretroviral therapy

Since the start of the national ART programme in 2005, Myanmar has made impressive achievements in scaling up ART across the country. In 2014, approximately 85 600 PLHIV (out of an estimated 190 000 PLHIV) were receiving ART, with an ART coverage of 45%, as compared to 2009, when only 21 000 people were on ART.

The HIV response has contributed to community and public health systems strengthening through human resource capacity building, decentralization of services, coordination between civil society and the public health system, and strengthening laboratory capacities along with equipment to carry out investigations for monitoring patients. The response also encompasses close collaboration between the HIV and TB programmes.

The country planned to attain universal ART coverage for all eligible patients by 2015 through rapid adaptation of the global guidance followed by strategic planning and programming as a key feature of ART scale up. The National AIDS Programme has begun orientation of partners according to the WHO Consolidated Guidelines of 2015 to prepare for early adaptation and roll-out.

Further actions are needed in terms of diagnostics and treatment simplification through decentralization of services and improved quality of care. This will strengthen linkages between testing and treatment and retention in care.

Box 7. Nepal: Targeting universal coverage with ART by 2015

Nearly 39 000 people of all ages were estimated to be living with HIV in Nepal in 2014. Nepal's ART programme was initiated at two centres in 2004. By 2014, there were 53 sites providing ART to 10 407 PLHIV, with a focus on those districts with the highest number of PLHIV.

Nepal's scale up has been successful for several reasons:

- political commitment, partners' support, adaptation of WHO recommendations, use of fixed-dose combinations since 2009;
- enhanced capacity of health staff for clinical management and counselling;
- phasing out of ARVs with many side-effects;
- increased supply of CD4 machines to clinics;
- establishment of HIV testing and counselling sites targeting KPs;
- uninterrupted supply of ARVs to sites;
- implementation of TB/HIV collaborative activities; and
- scaling up of ART to reach unreached populations based on the size estimation of KPs.

Another innovative approach that contributed to increased provision of ART was the involvement of KPs in various aspects of the planning and implementation of ART services. In addition, social care units were established at ART sites with the engagement of PLHIV advocating positive prevention, tracing loss to follow up, and conducting adherence counselling to those on treatment.

Expansion of ART services has not only contributed to HIV control activities, but it has also empowered the national and district health systems in laboratory and logistics management through provision of equipment and additional cold room facilities.

Looking into the future, Nepal is planning to adopt the recommendations of the latest guideline on ART, that is, test and treat all who are diagnosed. Measures will be taken to implement community testing and scale up PMTCT to cover all pregnant women by 2015, which is nearly 700 000 women.

Strategic direction 2: Strengthening strategic information systems for HIV and research

Between 2010 and 2014, strategic information on the HIV epidemic and response in the Region has improved. HIV prevalence surveys were conducted among KP groups in eight countries. The five countries with concentrated epidemics have conducted periodic serological and behavioural surveys in recent years (Table 18), which provide important information on the epidemic, and offer an important basis for programme monitoring and evaluation. STI estimation and programme data from the Global AIDS Response Progress (GARP) reporting have also improved but STI surveillance is lagging behind.

Table 18. Serological and behavioural surveys of key populations

Female sex workers	Serological survey (latest year)	HSS (2010–11), IBBS (2014–15)	IBBS (2013)	HSS (2014)		
	Behavioural survey (latest year)	IBBS (2014–15)	IBBS (2013)	BSS (2008)		
	Periodicity	HSS – bi-annual IBSS – undefined	Every 2–3 years	HSS – annual BSS – undefined		
MSM	Serological survey (latest year)	HSS (2010–11), IBBS (2014–15)	IBBS (2013)	HSS (2014)		IBBS (2014)
	Behavioural survey (latest year)	IBBS (2014–15)	IBBS (2013)	IBBS (2009)		IBBS (2014)
	Periodicity	HSS – bi-annual IBSS – undefined	Every 2–3 years	HSS – annual IBSS – undefined		Every 2–3 years
PWID	Serological survey (latest year)	HSS (2010–11), IBBS (2014–15)	IBBS (2013)	HSS (2014)	IBBS (2011)	IBBS (2014)
	Behavioural survey (latest year)	IBBS (2014–15)	IBBS (2013)	IBBS (2014)	IBBS (2011)	IBBS (2014)
	Periodicity	HSS – bi-annual IBSS – undefined	Every 2–3 years	HSS – annual IBSS – undefined	Every 2–3 years	Every 2–3 years

BBS: HIV biobehavioural surveillance; HSS: HIV sentinel surveillance; IBBS: integrated HIV biobehavioural surveillance

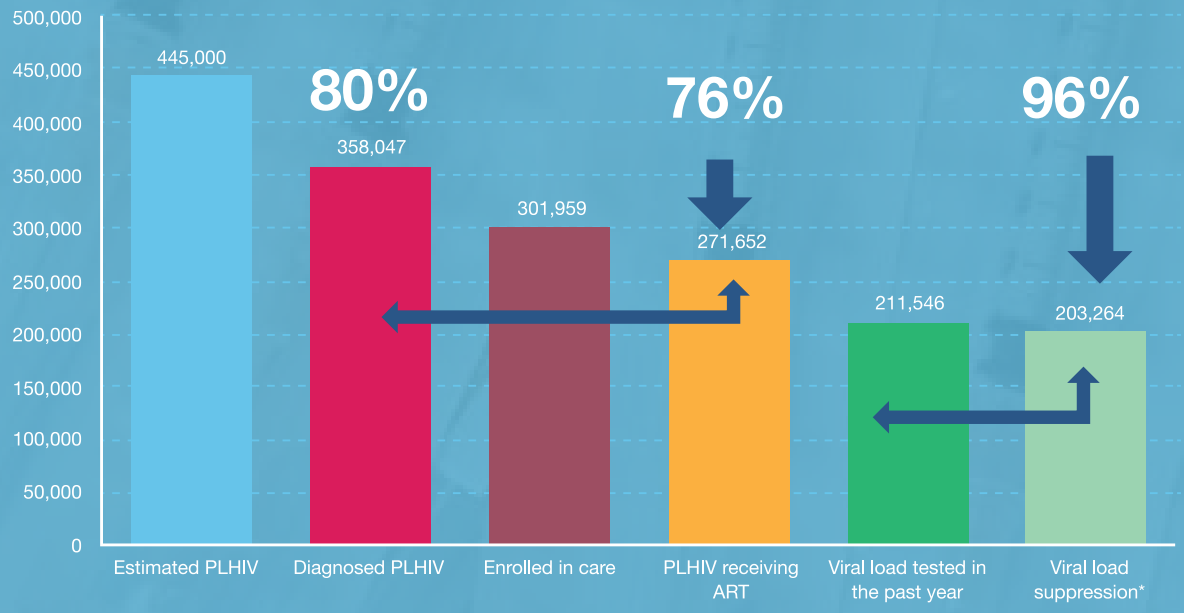
All countries in the Region measure and monitor the continuum of HIV care and treatment services at the national level. A series of activities by WHO have focused on HIV cascade analysis and use of data to improve the HIV testing, care and treatment programmes in countries. The Asia Pacific regional metrics on monitoring the cascade of HIV testing, care and treatment services, jointly published by the WHO South-East Asia Region and Western Pacific Region, provides useful guidance for measuring and tracking the HIV cascade of services in the Region. A regional workshop on strategic information on HIV, hepatitis and STI was organized in 2015. Data collection, analysis, data use and coordination have been significantly strengthened through these capacity-building activities.

Box 8. Thailand: On track to reach the 90–90–90 targets

Thailand is making good progress towards achieving the 90–90–90 targets[13]. In 2014, an estimated 80% of 440 000 people living with HIV knew their HIV status; 76% of people with diagnosed HIV infection had been linked to services; among those people receiving ART, 96% had achieved viral suppression. The analysis indicates that Thailand will likely reach the 90–90–90 targets ahead of the fast track targets in 2020.

Cascade analysis has helped Thailand develop strategies for the way forward, including expanding HIV testing services, and immediate treatment to all people who are diagnosed with HIV. The analysis has also intensified prevention efforts, including provision of PrEP to KPs. The National Health Security Office (NHSO) and the National AIDS Programme have agreed to systematic sharing, analysis and use of the HIV case-based information that they collect[14].

Thailand will reach the 90-90-90 targets ahead of the Fast Track targets in 2020



Source: National Health Security Office Thailand, 2015

[13]90–90–90: by 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained ART; and 90% of all people receiving ART will have viral suppression.
[14]Thailand National Operational Plan Accelerating Ending AIDS, 2015–2019. Thailand National AIDS Committee

For example, Indonesia has developed guidance for monitoring the national Strategic Use of ARVs (SUFA) project based on the Metrics for monitoring the cascade of HIV testing, care and treatment services n Asia and the Pacific. This recognizes the importance of case-based surveillance to generate quality data for monitoring the cascade of HIV services. Cascade monitoring, already conducted at the national level, is being introduced at the district level.

The Region is increasingly leveraging the use of information technology to improve the current information management systems. Health information systems in countries are moving from paper-based to electronic systems for data collection and reporting (e.g. HIV/AIDS and STI web-based application system [SIHA] in Indonesia). India also collects regular programme data through an electronic database. In Myanmar, an individual-based HIV patient monitoring and case-based surveillance system is being actively explored using an electronic platform (such as DHIS2), which is planned in the context of overall health information systems strengthening in the country. In Thailand, a web-based national routine clinical monitoring system is established, which is implemented in all government hospitals and some private hospitals under health insurance schemes. Also, Thailand has launched the "AIDS Zero Portal" that consolidates complex data from existing sources at one place and translates it into simplified, interactive, visualized real-time, easy-to-use information.

Table 19. WHO support to countries to strengthen strategic information systems

INDIA	Supported the use of a strategic information management system programme for performance monitoring, programme reviews, annual reports, GARP reporting, data triangulation and district epidemiological profiling; Advocated for case reporting and patient tracking; Provided support for capacity building of staff on monitoring and evaluation (M&E) tools at 32 ART centres in eight states; and through training on HIV sentinel surveillance (HSS) and integrated HIV biobehavioural surveillance (IBBS); and Advocated to review the National AIDS Control Programme (NACP) IV and establish a road map for integrating HIV services into the mainstream health system after 2017.
INDONESIA	Supported the M&E framework for SUFA, and conducted and engaged in the M&E of implementation of the framework in some priority districts; Supported HSS, epidemic modelling and size estimation of KPs; supported IBBS implementation in 2013; Conducted an assessment of the HIV case-based surveillance system to understand the situation and gaps, and identify ways forward; and Conducted an external review of the health sector response to HIV (2011).
MYANMAR	Conducted an assessment of the HIV case-based surveillance system to understand the situation and gaps, and identify ways forward; and Provided systematic support to develop the electronic patient monitoring system and HIV case-based surveillance and monitoring system.
SRI LANKA	Conducted a mid-term review of the national HIV/AIDS Programme (2014).
THAILAND	Partnered with the National AIDS Management Centre in the development of the AIDS Zero Data Portal and iMonitor+; and Undertook strategic information analysis (epidemiology and costing).
TIMOR-LESTE	Supported publication of quarterly surveillance data on HIV; Supported the second round of HSS in the fourth quarter of 2013 and initiation of IBBS in 2014; Supported size estimation of KPs; and Led the HIV programme review in 2013.

Strategic direction 3: Strengthening health systems for effective integration of health services

3.1 Integration of HIV services with TB, maternal and child health, harm reduction and viral hepatitis treatment services

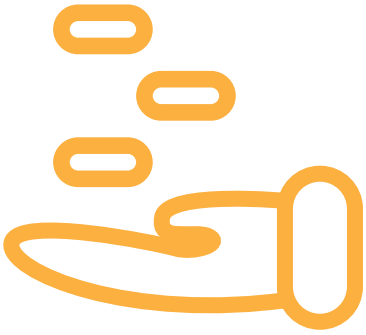
Thailand leads the Region in terms of integration of HIV with other health services. PMTCT services have been in place as part of maternal and child health care since 2003; there is routine HIV screening for TB patients and vice versa. HIV clinics also conduct screening for hepatitis B and C. The process of integration is under way in some other countries such as in Myanmar, where HIV and TB collaborative services and a one-stop service under the MMT programme are being scaled up with the aim of complete country coverage by 2016. In Indonesia, HIV screening is available for TB patients, with isoniazid preventive therapy available in some districts.

WHO action: service integration

- In India, WHO conducted advocacy to review the country's AIDS policy and establish a road map for integration of HIV into the mainstream health system after 2017.
- In Indonesia, WHO supported resource mobilization for TB and HIV collaborative activities, and the initial implementation of isoniazid preventive therapy.
- In Thailand, WHO provided financial support for the Thai National AIDS Foundation for community engagement.

3.2 Sustainable financing

The latest available data from eight countries show that domestic resources account for more than 50% of the AIDS funding in only four countries: Thailand, India, Sri Lanka and Bhutan. The extent of domestic funding also varies widely across the Region, from 87% in Thailand (2011 data) to <4% in Nepal (2007 data) (Fig. 7). In India, the government finances the HIV response, but data show a significant decline in financing. Moreover, HIV is not included in the country's universal health coverage strategy. Indonesia and Myanmar have included HIV in their universal health coverage strategy.



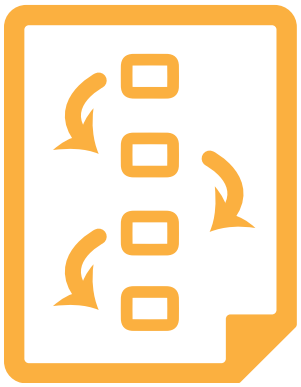
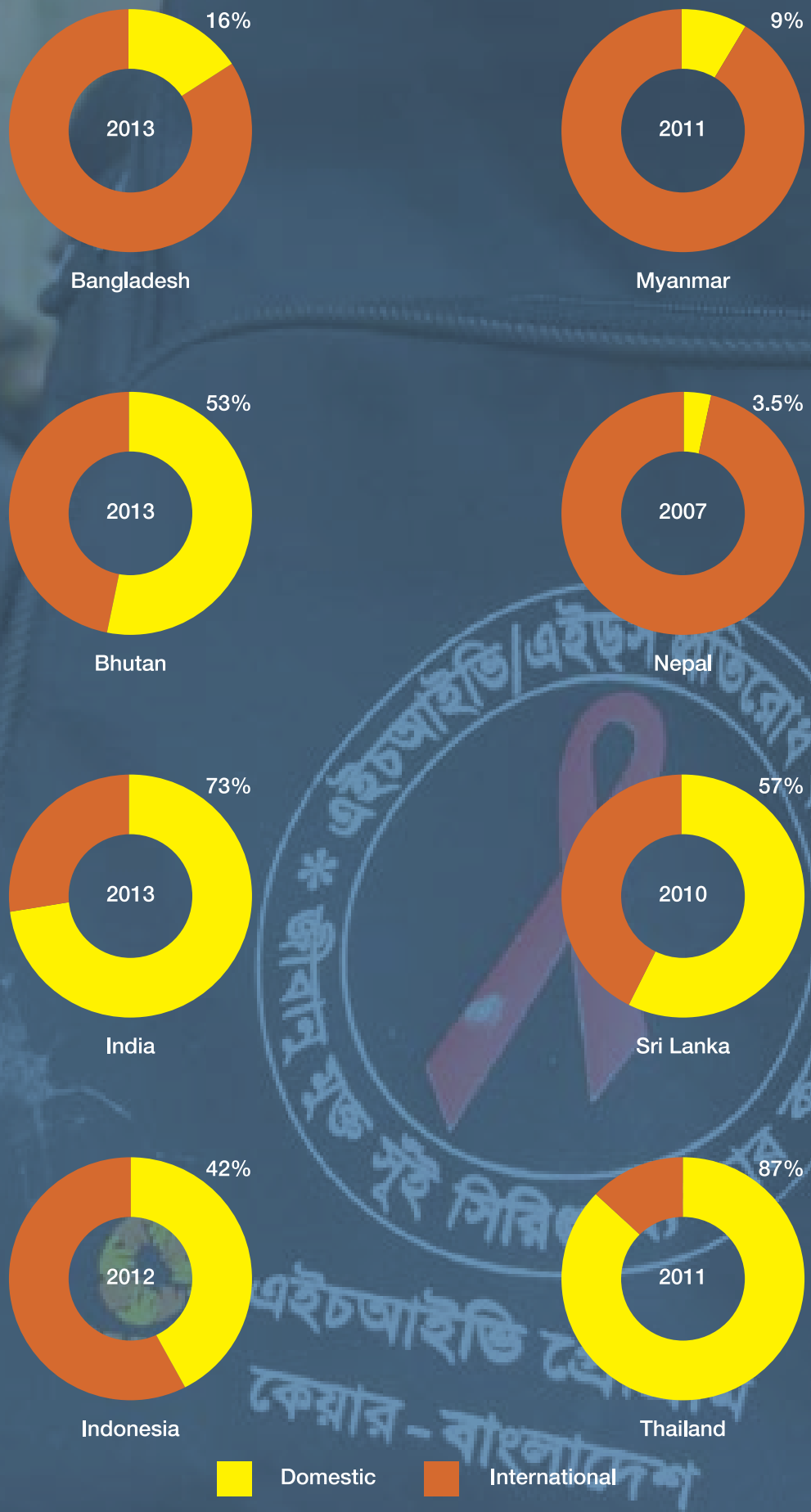


Fig. 7. Domestic versus international funding for the AIDS response



Source: aidsinfoonline.org, 2015

Strategic direction 4: Fostering a supportive environment to ensure equitable access to HIV services

Equitable access to HIV services is an issue of human rights and gender equity. Although none of the key countries in the Region have laws that present obstacles for women and girls to access HIV services, they do not have any institutional measures to overcome gender inequalities that put girls and women at an increased risk of HIV and restrict their access to services. In terms of the human rights of KPs, stigma and discrimination continue to undermine the HIV response across the Region.

While Bangladesh, India and Nepal have amended their laws to create a third gender option on official documents, lack of recognition for transgender people creates major obstacles to accessing health care, including HIV services. In India, Indonesia, Myanmar and Thailand, laws present obstacles to reaching MSM, PWID, FSWs and prisoners (Table 19).

Table 20. Existence of punitive laws in countries of the Region

	Laws present obstacles for women and girls	Criminalization of sex work	Criminalization of same-sex relations	Death penalty for drug offences	Detention centres for PWID
BANGLADESH	✓	✓	✓	✓	X
BHUTAN	X	✓	✓	X	X
INDIA	X	X	✓	✓	X
INDONESIA	X	X	X	✓	✓
MALDIVES	X	X	✓	X	X
MYANMAR	X	✓	✓	✓	✓
NEPAL	X	X	X	X	X
SRI LANKA	X	X	✓	✓	✓
THAILAND	X	✓	X	✓	✓
TIMOR LESTE	X	X	X	X	X

Box 9. India: WHO as a catalyst for updating national HIV strategies and guidelines

WHO has played both a technical and advocacy role in multiple facets of India's HIV response.

WHO supported the updating and implementation of India's national ART guidelines, based on the WHO 2013 HIV treatment recommendations. It assisted with estimates of ARV drug requirements for the programme and with assessments of ART centres to better understand the gaps and challenges in ART provision across the country. WHO also supported the training of physicians on the new guidance. These changes in the national ART guidelines led to earlier treatment with a one-pill-a-day fixed-dose combination, which in turn improved treatment adherence.

India's efforts to eliminate parent-to-child transmission of HIV and syphilis were also supported by WHO, with changes to the national policy so that it was in line with WHO's recommended Option B+ – lifelong ART for pregnant women living with HIV. WHO also advocated for the nationwide scale up of the programme, as more than half of the pregnant women living with HIV are in low-prevalence areas.

In 2014–2015, WHO supported the estimation of syphilis prevalence in pregnant women and related adverse outcomes in India, which was used as a basis for developing the national strategy and operational guidelines for the elimination of congenital syphilis. The new guidelines were launched in February 2015. HIV and syphilis testing are now included as part of the essential ANC service package, and there is an action plan for integrating these in 2015.

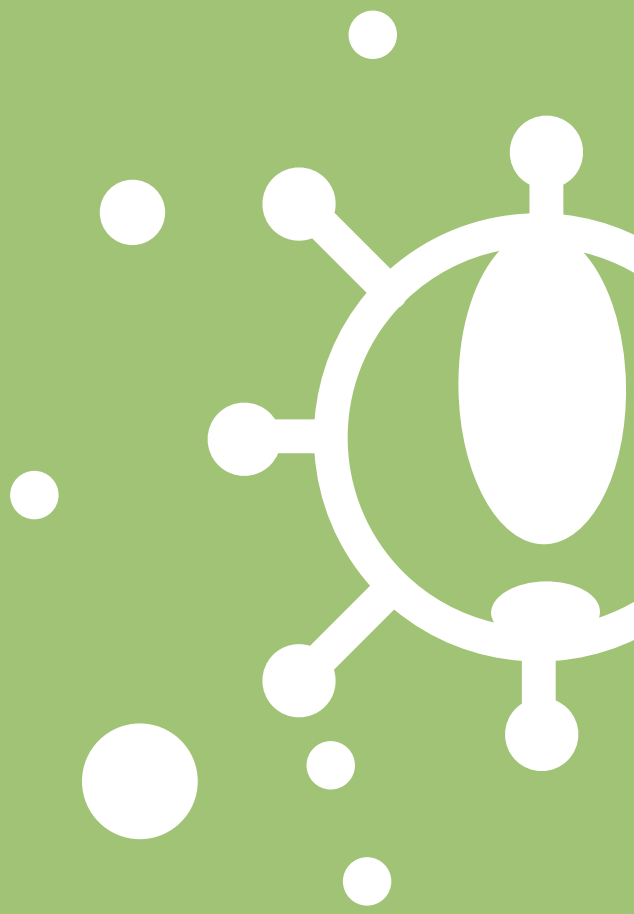
WHO developed a tool to help the state health societies plan procurement of test kits and penicillin, and also supported the revision of the training manual for health-care workers to include the latest updates on elimination of parent-to-child transmission of HIV and syphilis. WHO has been instrumental in developing the M&E framework for elimination of congenital syphilis and integrating key syphilis indicators into the broader health management information system.

As a result of WHO's advocacy for implementation of the 2015 WHO consolidated testing services guidelines, a national consultation was organized by the National AIDS Council to revise the national HIV testing guidelines to support the target of 90% testing coverage.

WHO contributed indirectly to the massive scale up of the ART programme in India. With 850 000 patients on ART in 2015, India has become the second largest ART programme in the world. HIV drug resistance has to be monitored nationwide and measures have to be taken to prevent the emergence of resistance. In this respect, WHO has been instrumental in building national capacity to collect and use early warning indicators for HIV drug resistance and other indicators for quality improvement, and in defining a road map for surveillance of HIV drug resistance.

These national guideline updates and related service delivery changes provide an unprecedented opportunity to "achieve an AIDS-free generation" in India.

IMPACT DURING IMPLEMENTATION OF THE REGIONAL STRATEGY



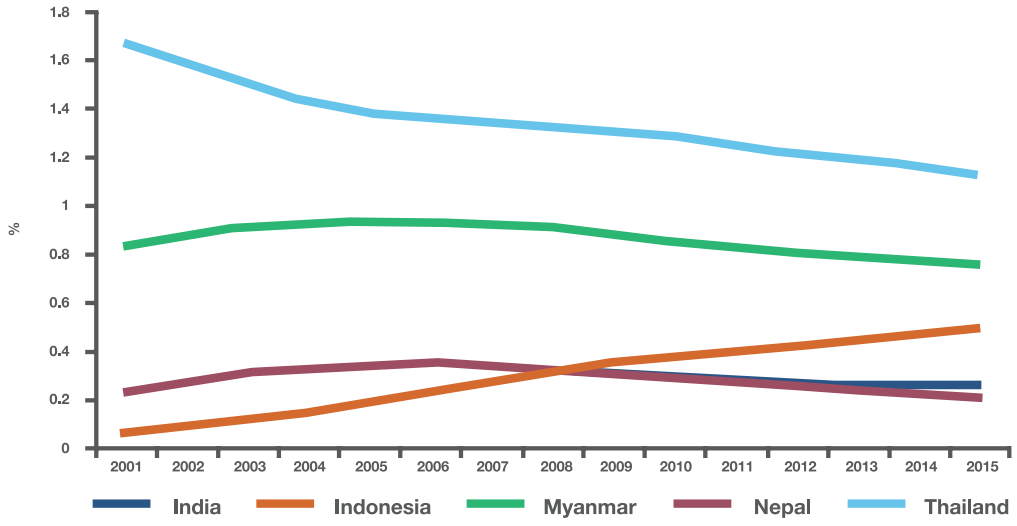
HIV prevalence trends

HIV prevalence among the adult population (15 years and above) remained low and stable across the Region. India, Myanmar and Nepal have prevalence rates of 0.26%, 0.8% and 0.2%, respectively, which have remained almost the same since 2011. In Indonesia (0.5% prevalence in 2015), HIV prevalence shows a rising trend. HIV prevalence in Thailand is 1.6% and has declined from 2% in 2001 (Fig. 8).

Data on HIV prevalence among the three main KPs at increased risk of HIV (FSWs, PWID and MSM) are shown in Fig. 9. Existing data show that PWID have the highest prevalence in all five countries. Although there is an established, evidence-based comprehensive package of HIV prevention interventions for PWID, condom usage and implementation of NSPs and OST continue to be low. Only India and Bangladesh have attained the global standard of 200 needles per year distributed to every PWID, and Thailand is the only country able to show evidence of a decline in incidence among PWID, at 19% in 2014 versus 25% in 2012. Data from Myanmar show a relatively stable but high-level epidemic, ranging from 18% to 23% between 2011 and 2014. Elsewhere, prevalence among PWID ranges from 6.3% in Nepal to 7.14% in India, to 36.4% in Indonesia.

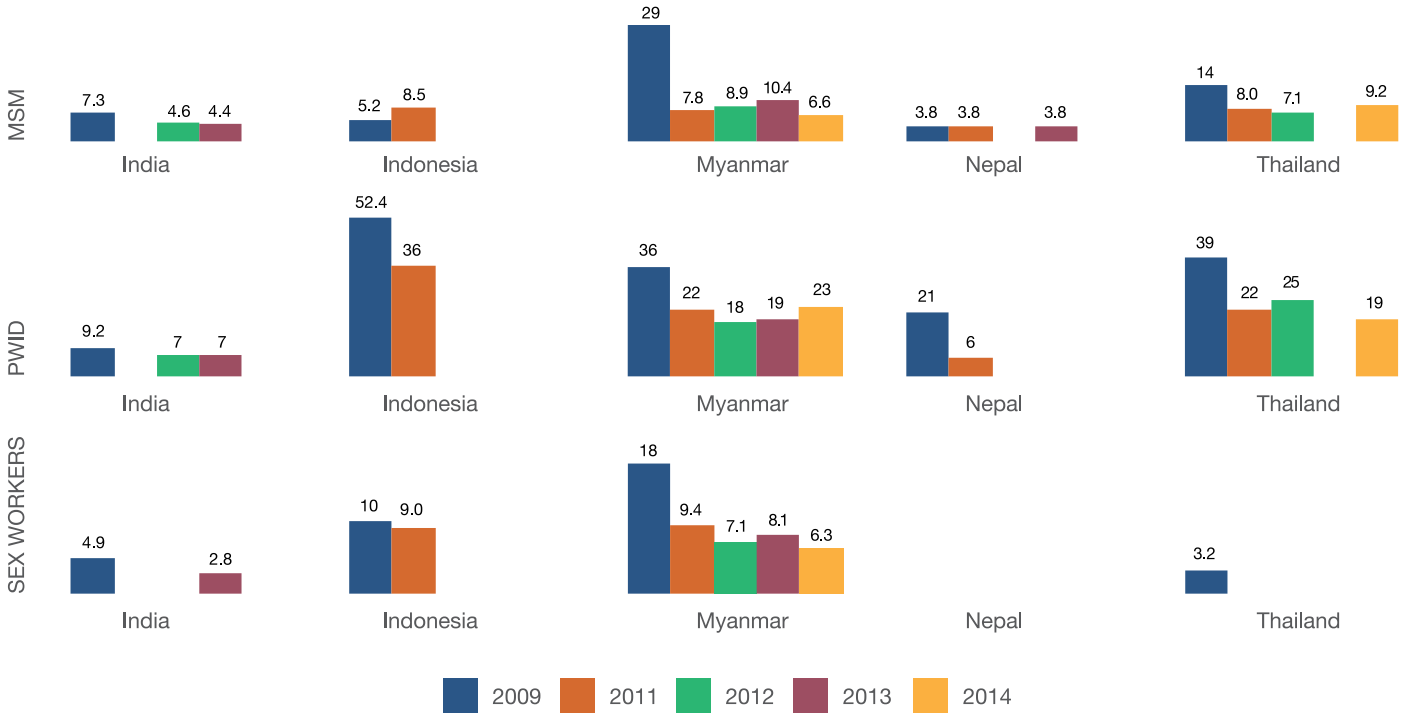
For MSM, prevalence between 2011 and 2014 across the five countries ranged from a low of 3.8% in Nepal to a high of 6.6% in Myanmar. FSWs showed high levels of condom use during their last sexual encounter and consistent condom use in some countries, but they remained a KP regionwide. India recorded the lowest prevalence among FSWs at 2.8%, while the highest was in Thailand at 9.2%.

Fig.8. Trends in HIV prevalence in the five countries with concentrated epidemics



Data source: For India: NACO, MOH India, India HIV Etimations 2015. Other countries: UNAIDS/WHO, Global HIV Estimates, 2016.

Fig. 9. HIV prevalence among key populations, 2009–2014



New HIV infections

The estimated number of new HIV infections plateaued over the period 2009–2015 in the Region. India, Nepal, Myanmar and Thailand demonstrated a 19-50% reduction in new HIV infections in 2015 compared to 2009. These countries also recorded a reduction in new HIV infections among children. However, in Indonesia, there was an increase in new infections, particularly in paediatric HIV infections, during the same period (Fig. 10). This is indicative of gaps in the AIDS response, and the unsatisfactory coverage of HIV testing and treatment. In India, although there was a 66% reduction in new infections from 2000 to 2015, there were 86 300 new infections in 2015, including 10 400 new HIV infections among children, according to 2015 NACO data (TABLE 20). One of the factors is the late presentation of PLHIV for ART. For example, in Myanmar, the median CD4 cell count at baseline was 128 cells/mm3[15]. As a result, treatment as prevention (TasP) has not been fully exploited.

AIDS-related deaths

AIDS-related deaths have been declining over the years in the Region (Fig. 10), but vary widely among countries (Table 21). AIDS-related deaths peaked at 210 000 in 2005 and declined to 130 000 in 2015 (28% decline since 2009). While India, Myanmar, Nepal and Thailand have all recorded reductions in AIDS-related deaths since 2009, the number of deaths has more than doubled in Indonesia, from 14 400 in 2009 to 35 300 in 2015.

Fig.10. New HIV infections and AIDS related deaths in the Region.

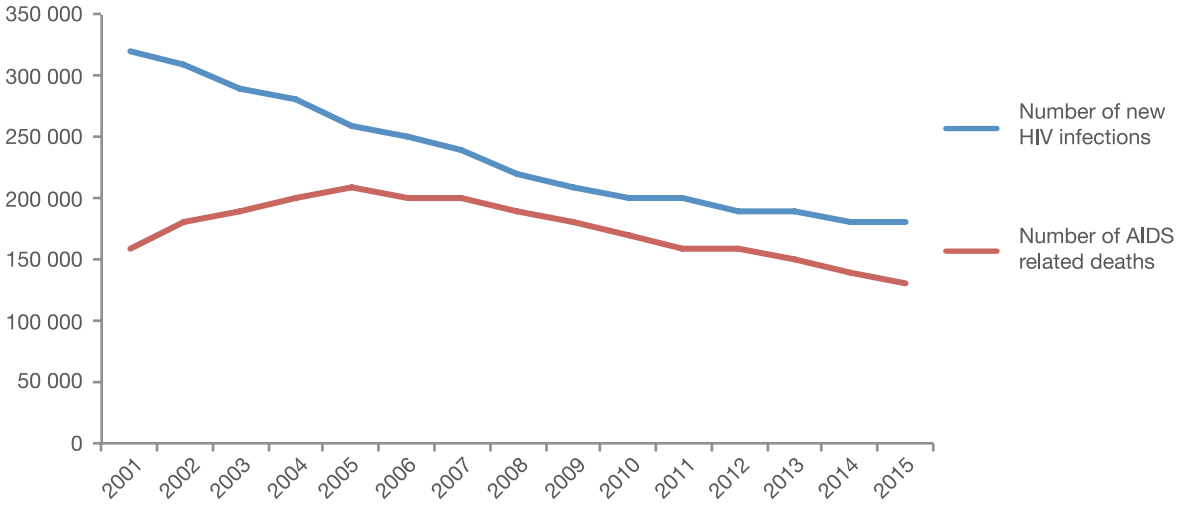


Table 21. Estimated new HIV infections and paediatric infections in five countries

	Estimated No. new HIV infections (2015)	Change since 2009	Estimated no. new HIV infections in children (2015)	Change since 2009
INDIA	86 300	-19%	10 400	
INDONESIA	73 000	+7%	4950	+48%
MYANMAR	118 000	-30%	757	-60%
NEPAL	1 300	-50%	107	-62%
THAILAND	7 000	-44%	86	-68%

Note: Percentages in green show % decrease in new HIV infections from the 2009 baseline and percentages in red show % increase in new HIV infections from the 2009 baseline.

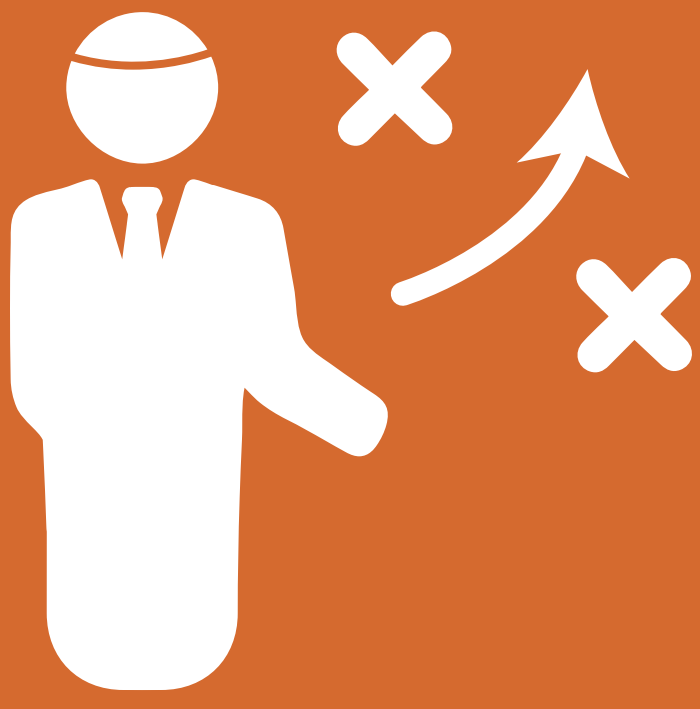
Table 22. AIDS-related deaths in the five high-burden countries

	AIDS-related deaths (2015)	Change since 2009
INDIA	67 600	-46%
INDONESIA	35 300	+146%
MYANMAR	9 700	-40%
NEPAL	2 300	-7%
THAILAND	14 200	-28%

Note: Percentages in green show % decrease in new HIV infections from the 2009 baseline and percentages in red show % increase in new HIV infections from the 2009 baseline.

[15]Oo AS, Myint MK, Soe KT, Thu A, Aung Y, Thant KZ. Clinical outcomes of patients on anti-retroviral therapy. Myanmar Health Science Research Journal. 2015;27(2):94–9.

LESSONS LEARNT AND THE WAY FORWARD



Countries have made progress in implementing the Regional HIV Health Sector Strategy 2011–2015. Most countries have adapted the WHO global and regional HIV strategies and guidelines on HIV prevention, care and treatment. The access and coverage of HIV services have expanded substantially in many countries: 1.39 million PLHIV, or 39% of the total number estimated, were receiving ART at the end of 2015. Overall, the epidemic in the Region has stabilized. The Regionwide prevalence remains at 0.3%. New HIV infections and AIDS-related deaths have declined slightly or plateaued over the period.

Major gaps exist in HIV services: only about half of those who are infected with HIV have been diagnosed, and only 39% of PLHIV were on ART by the end of 2015; access to and coverage of HIV prevention services for KPs, particularly for PWID and MSM, continue to be low; the continuing existence of punitive laws for some behaviours poses barriers to and constraints in access to services by KPs.

There is much to learn from the AIDS response over the past five years. Although the AIDS response in the South-East Asia Region has not been optimal in some countries, it has also undeniably demonstrated that it is possible to successfully implement the programme and achieve the desired results. Regionwide, major gaps exist in HIV services. A “business as usual” approach will lead to more of the same. Only a substantial shift in efforts will make it possible to reach the fast-track goals and fulfil the targets of the Sustainable Development Goals (SDGs).

The fast-track targets set for 2020, based on the fast-track strategy, are ambitious when viewed against the current situation. There must be a steep decline in the number of new HIV infections and deaths to achieve the 2020 targets. This demands continued political commitment, leadership and governance for national HIV programmes.

1. The HIV response is inextricably linked to universal health coverage

Universal health coverage (UHC) is an aspirational goal – all people can access and use the promotive, preventive, curative, rehabilitative and palliative health services they need, and which are of sufficient quality to be effective, without suffering financial hardship. The WHO Global health sector strategy on HIV for 2016–2021positions the HIV responses in the context of UHC. As countries commit to achieving the ambitious goal of UHC, they need to decide their own approach and define the package of benefits. The HIV response, in the long run, has to be part of the UHC package when governments design their UHC strategies and packages, which should include the continuum of HIV prevention, care and treatment services.

2. Communities are at the centre of the HIV response

Key populations comprise not just FSWs, PWID, MSM and TG. Other groups that are particularly at risk for HIV in this Region include prisoners, documented and undocumented migrant workers, and mobile populations. Children and adolescents are underserved by the current AIDS response. KPs at increased risk of HIV are by their nature hard to reach, and for those living with HIV, it is challenging to retain them throughout the prevention and treatment cascade. There are multiple barriers to a sustained, successful HIV response, including legal environments, and cultural, social and political factors.

For interventions targeting KPs, actively involving the affected community in the design, implementation and monitoring of programmes substantially increases the likelihood that they will succeed. As HIV becomes a chronic manageable disease, services can be decentralized to where the health system interacts with those most in need of services. This approach can reduce costs, improve reach, and reduce HIV risk and vulnerability. HIV interventions can also be expanded to incorporate broader health and social outcomes. This scale up must occur across the entire continuum of prevention, testing, care and treatment services, and must address the stigma, discrimination and legal barriers that increase vulnerability to HIV.

3. Expansion of HIV testing services is the key to achieving the fast-track goals

To achieve the UNAIDS three 90s fast-track goals, HIV testing services must be radically expanded to KPs, pregnant women and infants born to HIV-infected mothers. The latest WHO treatment guidelines recommend immediate ART after a diagnosis of HIV. However, only about half of the PLHIV know their HIV status, and HIV diagnosis proves to be one of the major bottlenecks for the HIV responses in many countries. WHO has published guidelines on HIV testing services, and recommends strategies to scale up HIV testing services, including HIV testing through trained lay providers. Countries need to explore ways of expanding HIV testing among different populations through innovative approaches. To achieve the goal of elimination of mother-to-child transmission, HIV testing of pregnant women has to be expanded, and EID has to be provided so that HIV prophylaxis and treatment services could be provided in a timely manner.

4. Continuing political commitment and sustainable financing are crucial for long-term success

Recognizing the importance of the HIV response for universal health coverage and achievement of the SDGs, governments must overcome HIV fatigue and maintain their political commitment to HIV prevention and control. The current heavy reliance on external sources of funding for the AIDS response is not sustainable, due to a combination of shrinking aid budgets and growing economic prosperity, which is reducing the number of countries eligible for certain sources of funding, such as from the Global Fund. Countries must examine ways to compensate for this, including an increase in domestic funding and exploring innovative funding mechanisms.

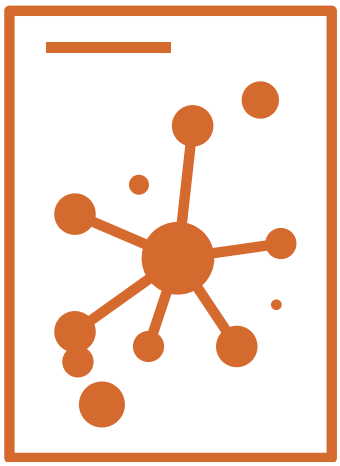
Meanwhile, continued efforts must be made to sustain resource allocation for HIV and consolidate existing gains. At a time when external funding for HIV is waning, more domestic funding is required.

It is also crucial to continue to lobby for affordable ARV drugs and related commodities, and to use improved procurement mechanisms and ensure greater availability of generics to maximize cost–effectiveness.

5. The AIDS response must target locations and communities guided by the most granular and robust data

Thirty years into the AIDS response, there is a substantial body of evidence to demonstrate which biomedical interventions and critical enablers are the most effective. In a region largely characterized by concentrated HIV epidemics, it is vital to target the AIDS response to the most affected communities and locations. This can be best achieved by working directly with the affected communities, which should be guided by data gathered with sufficient granularity to allow for disaggregation by age, gender and geographical location.

Data collection continues to be very weak in many settings in the Region. This is a severe impediment to an effective AIDS response. By harnessing available information and communication technology tools, health information systems can be improved to ensure more accurate and comprehensive epidemiological data, stronger health systems with more robust management, and continuity of care across multiple settings and locations.



6. Everyone must be invited

Both the public and private sectors of the health system have a role to play in ensuring the success of the AIDS response. This can help to address health system bottlenecks and build the capacity of health systems to scale up testing, uptake of and retention in treatment, procurement and supply system, laboratory system and human resources. This requires efforts to bridge the gulf between the public and private sectors, particularly in the area of data and information collection and sharing.

HIV has never been merely a health issue. In many ways, it is fundamentally a human rights issue. Despite progress in breaking down the barriers to access for HIV services, stigma, discrimination and punitive laws all continue to undermine the Region's AIDS response. As well as its key role as a technical and normative agency, WHO together with other partners and stakeholders have powerful roles to play as advocates for a rights-based, people-centred approach to the AIDS response.

It is crucial to address structural barriers to service access through strong partnerships between the government and civil society, invest more in training and capacity building of community health workers, and provide financial and technical support for community-based organizations.

The successful implementation of the Regional Action Plan for HIV will contribute to the attainment of the post-2015 health goal – SDG 3 in the Region. UHC provides a framework that promotes a long-term, sustainable response, which will be bolstered by strengthening health systems and community responses.

An assessment has been conducted to evaluate the implementation of the WHO South-East Asia Regional Health Sector Strategy on HIV, 2011–2015, through a combination of desk review and country-level questionnaires to both national programme managers/technical staff and WHO country offices. The output, outcomes and impact of HIV programmes in Member States have been reviewed and analyzed during the implementation of the WHO Regional Strategy. The purposes are to inform the development of the next regional plan of actions for HIV and provide more effective technical support to Member States.

World Health Organization
Regional Office for South-East Asia

World Health House Indraprastha
Estate Mahatma Gandhi Marg
New Delhi-110002, India

ISBN 978-92-9022-524-9