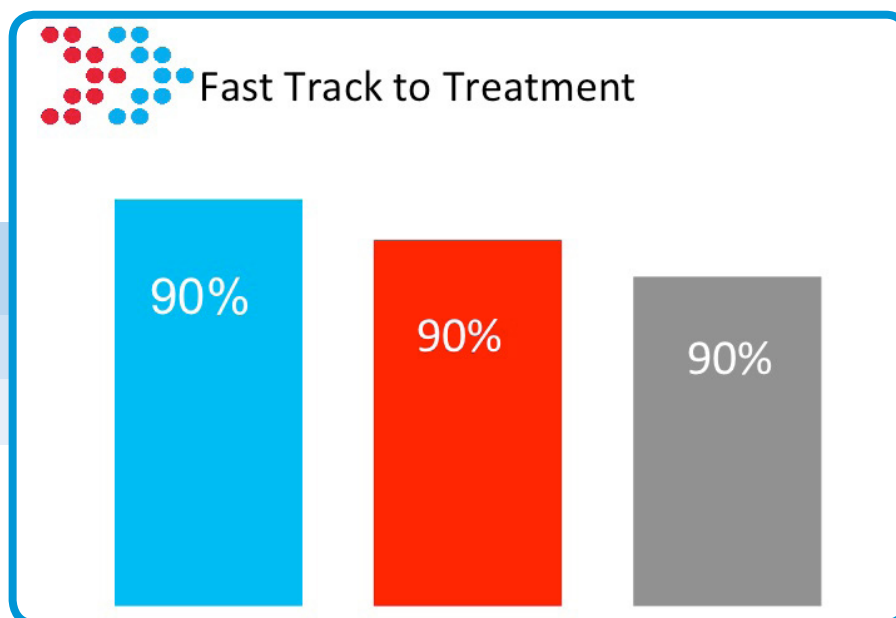


National HIV/AIDS and STI Programme Managers Meeting for Selected Asian and Pacific Island Countries in the Western Pacific Region



1–2 July 2015
Manila, Philippines



**NATIONAL HIV/AIDS AND STI PROGRAMME MANAGERS' MEETING FOR
SELECTED ASIAN AND PACIFIC ISLAND COUNTRIES**
1 - 2 July 2015, Manila, Philippines



**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC**



REPORT

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REPORT

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FOR SELECTED ASIAN AND PACIFIC ISLAND COUNTRIES
IN THE WESTERN PACIFIC REGION**

Convened by:

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC**

**JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
REGIONAL SUPPORT TEAM FOR ASIA AND THE PACIFIC**

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NOTE

The views expressed in this report are those of the participants who attended the National HIV/AIDS and STI Programme Managers Meeting for Selected Asian and Pacific Island Countries in the Western Pacific Region and do not necessarily reflect the policies of the World Health Organization and the Joint United Programme on HIV/AIDS.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific and the Joint United Nations Programme on HIV/AIDS Regional Support Team for Asia and the Pacific on behalf of the participants of the National HIV/AIDS and STI Programme Managers Meeting for Selected Asian and Pacific Island Countries in the Western Pacific Region from 1 to 2 July 2015 in Manila, Philippines.

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<p>Keywords: HIV Infections / Acquired immunodeficiency syndrome / Anti-retroviral agents / Sexually transmitted diseases / National Health Programs</p>

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
AIM	Asia Impact Model
ACM	active case management
APCOM	Asia Pacific Coalition on Male Sexual Health
ARV	antiretroviral
ART	antiretroviral therapy
ATFOA	ASEAN Task Force on AIDS
CHAI	Clinton Health Access Initiative
EID	early infant diagnosis
ELISA	enzyme-linked immunosorbent assay
E-PMS	electronic patient monitoring system
EPP	Estimation and Projection Package (HIV/AIDS)EQA external quality assurance
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HTC	HIV testing and counselling
IPT	isoniazid preventive therapy
KHANA	Khmer HIV/AIDS NGO Alliance
M&E	monitoring and evaluation
MSM	men who have sex with men
MTB	<i>Mycobacterium tuberculosis</i>
NASPCP	National AIDS and STI Prevention and Control Program
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NGO	nongovernmental organization
NRL	National (Serological) Reference Laboratory
PEPFAR	United States President's Emergency Plan for AIDS Relief
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
QMS	quality management system
SDG	Sustainable Development Goals
STI	sexually transmitted infection
TasP	(antiretroviral) treatment as prevention
TB	tuberculosis
UC	Universal Coverage (Thai health insurance scheme)
UHC	universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAAC	Viet Nam Authority of HIV/AIDS Control
WHO	World Health Organization
YVC	Youth Volunteer Corps

EXECUTIVE SUMMARY

A National HIV/AIDS and STI Programme Managers Meeting for Selected Asian and Pacific Island Countries in the Western Pacific Region was held in Manila, Philippines from 1 to 2 July 2015.

The objectives of the meeting were:

- (1) to review and discuss progress towards the recommendations of the 2013 National HIV/AIDS and STI Programme Managers Meeting, the 2015 universal access targets and Millennium Development Goal 6;
- (2) to review and discuss the quality of HIV strategic information systems;
- (3) to review and discuss global HIV and STI strategies, targets and priority actions for Member States for 2016–2021; and
- (4) to explore transitional and long-term financing options to ensure continued progress towards HIV and STI goals.

Over the last two years, countries have made significant progress in scaling up access to HIV prevention, diagnosis, treatment and care services. However, a number of challenges remain that require urgent action in order to “fast-track” the response towards reaching the 90-90-90 treatment targets,¹ achieving a 75% reduction of new infections and zero discrimination by 2020, and ending the AIDS epidemic by 2030.²

Late diagnosis of HIV infection continues to represent a substantial barrier to scaling up HIV treatment; nearly half of the key populations in the Western Pacific Region are not aware of their HIV status. An unacceptably high proportion of people living with HIV (PLHIV) are not effectively linked to care, and as a result of these gaps in the treatment cascade, the proportion of PLHIV who achieve viral suppression is low. An alarming rise of new infections among key populations, in particular men who have sex with men (MSM) and transgender people, has been registered.

Transitioning from external to national funding for HIV services has started in most low- and middle-income countries. HIV programmes are nearly fully funded by national resources in high- and some middle-income countries. Strategic information was critical to inform country investments as well as discussions on transitional and long-term financing options for HIV. The quality of health information systems varies and further investments are needed in some countries. Current health information systems are not equipped to report on the treatment cascade in the Region.

¹ By 2020, 90% of all children and adults living with HIV will know their HIV status, 90% of all children and adults with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90% of all children and adults receiving antiretroviral therapy will have viral suppression. In: *Fast-Track: Ending the AIDS epidemic by 2030*. Geneva: Joint United Nations Programme on HIV/AIDS; 2014.

² The 2020 target of fewer than 500 000 new HIV infections translates into a 75% reduction of new infections by 2020. A 90% reduction (fewer than 200 000 new HIV infections) by 2030 would mean the end of the AIDS epidemic as a public health threat. In: *How AIDS changed everything — MDG6: 15 years, 15 lessons of hope from the AIDS response*. Geneva: Joint United Nations Programme on HIV/AIDS; 2105.

The meeting participants reaffirmed the conclusions and recommendations from the 2013 national HIV/AIDS programme managers meeting,³ and agreed on a set of further recommendations and concrete action points.

Recommendations to Member States:

- (1) In light of decreasing donor support, countries should look for alternative sources of financing, including applying principles of universal health coverage (UHC), to ensure sustainability of HIV programmes.
- (2) The transition from external to national financing requires efficient use of funds and evidence-based resource allocation. With the introduction of the principles of UHC, determining financial flow and a prioritization of interventions will take place and should ensure that HIV remains a priority. (Box 1).
- (3) Efforts geared towards reaching the 90-90-90 targets and related prevention and stigma targets by 2020 should be intensified. Community-based testing, as detailed in the 2015 testing guidelines of the World Health Organization (WHO), is required in order to reach the first 90 target, in particular for hard-to-reach populations. Continued efforts are also needed to strengthen linkages to care and treatment and achievement of viral suppression for those already diagnosed and on treatment.
- (4) Delivery of quality-assured HIV testing and treatment monitoring should be strengthened. Use of new technologies for point-of-care viral load monitoring should be explored in order to expand access to affordable HIV viral load monitoring.
- (5) With the expansion of antiretroviral treatment (ART), it is important for countries to implement regular HIV drug-resistance surveys in combination with the monitoring of early warning indicators. Funding for these surveys should be incorporated in the national annual work plans.
- (6) Countries should continue to build comprehensive HIV surveillance systems. Scope and capacity need to be expanded for monitoring HIV risk behaviours as well as generating and using local-level data. In an environment of declining funding, generating improved and higher-quality data to inform effective policy and investment decisions must be a priority (Box 2).
- (7) Countries should, at the minimum, use the 10 core indicators recommended by WHO to monitor the 90-90-90 targets (Box 2).^{4,5}
- (8) Recommending antiretroviral (ARV) pre-exposure prophylaxis (PrEP) for sexually active MSM⁶ should be considered as an additional prevention tool to contain the HIV epidemic among this key population (Box 3).

³ Meeting Report: National HIV/AIDS and STI Programme Managers Meeting for Asian Countries in the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific; 2013.

⁴ Consolidated strategic information guidelines for HIV in the health sector. Geneva: World Health Organization; 2015.

⁵ Metrics for monitoring the cascade of HIV testing, care and treatment services in Asia and the Pacific. Manila: World Health Organization Regional Office for the Western Pacific; 2014.

⁶ Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015.

Recommendations to WHO, Joint United Nations Programme on HIV/AIDS (UNAIDS) and partners:

- (1) WHO, UNAIDS and international partners should support processes in countries for identifying financial resources that can serve as alternatives to external donor funding.
- (2) WHO should clarify UHC principles⁷ to HIV stakeholders as countries are concerned of escalating health costs. WHO should be able to explain how the principles of UHC could help sustain and further expand the HIV responses.
- (3) WHO, UNAIDS and partners should develop further guidance on how HIV can be considered when planning for UHC and how to transition from external to national funding. This should include high-level and multisectoral advocacy for increased allocation of domestic funding and would require determining the financial flow and prioritization process while increasing efficiency in terms implementation/provision and financing of HIV services (Box 1).
- (4) In order to reach the first 90 target, WHO, UNAIDS and partners should support country stakeholders in the implementation of the WHO guidelines on consolidated HIV testing services.⁸
- (5) WHO should increase its technical support for strengthening the delivery of quality-assured HIV diagnosis and treatment monitoring (e.g. laboratories, community-based testing) guided by WHO prequalification programmes. WHO should work with countries to assess the feasibility of new point-of-care technologies for HIV viral load monitoring.
- (6) WHO should identify technical and financial resources to help support countries to implement regular periodic HIV drug-resistance surveys and monitor early warning indicators as part of the national framework for treatment monitoring.
- (7) WHO and UNAIDS should continue working with countries to build comprehensive HIV surveillance systems, progressively expand scope and capacity to monitor HIV risk behaviours and build capacity to use local-level data. WHO and UNAIDS should promote sustained investment for data management to ensure that prioritization and financing decisions are based on high-quality data (Box 2).
- (8) WHO, UNAIDS and partners should assist Member States by advocating for the harmonized 10 indicators to monitor the 90-90-90 targets with standardized definitions, drawing from the global WHO consolidated strategic information guidelines⁴ and regional metrics⁵ (Box 3). WHO and partners should support the development of electronic registers and evaluate innovative methods to collect such data in a coordinated fashion.
- (9) WHO, UNAIDS, researchers and regional civil society organizations should work with key stakeholders at the country level to carefully design demonstration projects for the integration of PrEP into combination prevention for MSM (Box 3).

⁷ Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.

⁸ Consolidated guidelines on HIV testing services. Geneva: World Health Organization; 2015.

Box 1: Action points on HIV financing and UHC

- a. Conduct analyses of required resources considering prioritization, streamlining and integration.
- b. Set national targets and plan for financial transition. The analysis process should also be integrated into the national development plan.
- c. Consider expanding funding sources including establishment of trust funds, public-private partnerships, corporate social responsibility and taxation.
- d. Consider including or expanding coverage of HIV services through national health insurance plans.
- e. WHO, UNAIDS and partners should support high-level advocacy for better pricing of commodities, especially ARVs.
- f. National and/or regional systems of registration and procurement of commodities including ARVs and HIV test kits should be established.

Box 2: Action points on strategic information

- a. Invest in capacity-building of district and subdistrict levels to collect and analyse data and develop local-level treatment cascades. Given their important role in collecting data, service delivery staff should fully understand the definitions and purpose of the indicators, know how to collect unique counts, and be aware of data management and reporting requirements. To address high staff turnover, simplified training materials and standard operating procedures can be used for easy facilitation of trainings.
- b. Data on key populations are critical for the HIV response in Asia and the Pacific, yet population size estimates, particularly of MSM and transgender people, are still lacking. Data collection must be undertaken in partnership with civil society organizations to ensure confidentiality and help overcome criminalization. Data repositories of behavioural surveys among key populations should be established, to include raw data, in order to avoid duplicative surveys and to increase the use of data through secondary data analysis. Behavioural social scientists may be engaged to translate behavioural data into programmatic and policy actions.
- c. Strong coordination mechanisms should be required to harmonize and coordinate the fragmented data management system. Potential coordination solutions include ministerial-level decrees and a functional national strategic information technical working group.
- d. Countries should increasingly apply electronic systems to track patients across services and facilitate data collection, reporting, analysis and sharing. Data entry, workload, electronic data system and network infrastructure requirements need to be taken into account.
- e. Unique identifiers are needed to avoid duplicative counts and track patients across services. Member States should consult with civil society organizations on the best use of identification numbers, unique identifier codes, and biometrics.
- f. Reports on HIV-negative cases, currently missing from case reports, must be collected in order to obtain prevalence data through case-based surveillance. Laboratory data systems should be linked with patient data system to facilitate HIV-negative case reporting.
- g. Early warning indicators for HIV drug resistance should be part of surveillance systems rather than managed only within the care and treatment programmes.

- h. UNAIDS and WHO can facilitate better use of data through more Asia-specific epidemic models, and less frequent updates of the model software, and simplified global reporting. Updates to SPECTRUM/EPP and AIM⁹ should be less frequent given that obtaining national and government consensus after analysis is time consuming. Likewise, the Global AIDS Response Progress Report should be simplified, aligned with the global indicators, and not changed annually given that data collection system changes require longer periods of time.

Box 3: Action points on use of ARV PrEP by Member States, WHO, UNAIDS and partners

- a. Prepare WHO, UNAIDS and APCOM communication packages with clear messages regarding PrEP.
- b. Develop specific/operational guidance on PrEP including guidance on how to deliver services and how to monitor the impact.
- c. Provide more evidence on cost-effectiveness to convince governments and communities. Create cost-effectiveness models based on data from low-prevalence countries.
- d. Enhance data on levels of risk among MSM and other key populations to identify priority subpopulations who can benefit from PrEP, and identify sites where PrEP could potentially be implemented.
- e. Support the design of demonstration projects to answer implementation questions relevant for the safe roll-out of PrEP.

⁹ SPECTRUM/EPP is a combined software package developed by Avenir Health and East-West Center and endorsed by the UNAIDS Reference Group on Estimates, Modelling and Projections. The Estimation and Projection Package (EPP) estimates and projects HIV prevalence, and SPECTRUM models consequences of the HIV epidemic, specifically through the AIDS Impact Model (AIM). Consequences of the HIV epidemic include number of PLHIV, new infections, AIDS deaths, as well as new cases of tuberculosis and AIDS orphans. AIM is used by UNAIDS to make regional and national estimates. SPECTRUM/EPP can be downloaded from <http://www.unaids.org/en/dataanalysis/datatools/spectrumepp>.

1. INTRODUCTION

A National HIV/AIDS and STI Programme Managers Meeting for Selected Asian and Pacific Island Countries in the Western Pacific Region was held from 1 to 2 July 2015 in Manila, Philippines. Since 2002, the World Health Organization (WHO) has convened meetings for national HIV/AIDS and STI programme managers and development partners to discuss technical and programmatic issues and strategic directions of particular relevance to countries in the Western Pacific Region. The last meeting was held in 2013 and was also jointly organized by WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support Team for Asia and the Pacific.

In 2015, WHO Member States will report on their achievements towards global commitments including the Millennium Development Goals (MDGs), the UNAIDS *Getting to zero: 2011-2015 strategy* and the WHO *Global health sector strategy on HIV/AIDS (2011–2015)*. The General Assembly of the United Nations is now working with governments, civil society organizations and other partners to build on the momentum generated by the MDGs and carry off an ambitious post-2015 development agenda. In line with these efforts, WHO and UNAIDS are developing new global HIV/AIDS strategies in the context of universal health coverage (UHC).

Thus, the 2015 meeting was envisaged as a forum for programme managers and partners to review national and regional progress towards HIV and sexually transmitted infection (STI) goals and implementation of the recommendations from the 2013 meeting. It would also allow them to comment on the WHO and the UNAIDS draft global HIV strategies for 2016–2021 and to discuss national and regional priority actions, such as improving strategic information systems, enhancing programme planning and implementation, exploring suitable financing options and accountability mechanisms, and identifying the challenges of and opportunities for using antiretroviral (ARV) pre-exposure prophylaxis (PrEP) in Asia.

This meeting was part of a joint WHO–UNAIDS operational plan.

1.1 Objectives

- (1) To review and discuss progress towards the recommendations of the 2013 National HIV/AIDS and STI Programme Managers Meeting, the 2015 universal access targets and MDG 6.
- (2) To review and discuss the quality of HIV strategic information systems.
- (3) To review and discuss global HIV and STI strategies, targets and priority actions for Member States for 2016–2021.
- (4) To explore transitional and long-term financing options to ensure continued progress towards HIV and STI goals.

1.2 Meeting participants

The meeting was attended by 69 participants from 10 countries and areas, including national HIV/AIDS and STI programme managers and representatives from governments, WHO, UNAIDS, other international organizations and civil society organizations based in the Region. Participating countries included Cambodia, China, Fiji, Hong Kong Special Administrative Region (China), Japan, the Lao People's Democratic Republic, Malaysia, Mongolia, Papua New Guinea, the Philippines and Viet Nam.

1.3 Programme

Participants reviewed progress towards the recommendations of the 2013 National HIV/AIDS and STI Programme Managers Meeting, the 2015 universal access targets and MDG 6. They also examined global, regional and country developments in the following areas: moving towards UHC, measuring the HIV response and progress through the prevention and treatment cascade, unpacking the 90-90-90 targets,¹⁰ improving access to and quality of HIV and syphilis testing for reliable results, and prevention and surveillance of HIV drug resistance.

A presentation and technical update were made on ARV PrEP to outline concerns by a regional civil society organization. Subsequently, participants were divided into four groups for thematic discussions. The four topics were: (1) feedback on global HIV strategies and priority actions to fast-track response in the next six years; (2) strategic information: monitoring and evaluating impact of interventions along the continuum of care (prevention and treatment metrics); (3) determining financial flow and prioritization process; and (4) combination HIV prevention: Do we need ARV PrEP in Asia? Each group had an opportunity to discuss each of the four topics, specifically identifying bottlenecks, constraints, challenges, and suggesting possible solutions to move forward. After the group work, the rapporteur for each topic summarized the points discussed including recommendations, conclusions and priority actions.

There was a plenary session on scientific developments in the field of HIV, and the final session – also held in plenary – was a presentation and discussion on the meeting’s conclusions and recommendations. The agenda of the two-day meeting can be found in Annex 1.

2. PROCEEDINGS

2.1 Opening session

Dr Nobu Nishikiori, Coordinator, Stop TB and Leprosy Elimination Unit, WHO Regional Office for the Western Pacific, welcomed meeting participants and delivered opening remarks on behalf of the WHO Regional Director, Dr Shin Young-soo.

Dr Shin remarked that 2015 is an important year for the global development community. United Nations agencies are working with governments, civil society organizations, development partners and other stakeholders to build on the momentum of the MDGs to carry out an ambitious post-2015 development agenda. Moreover, WHO is currently developing three new 2016–2021 global strategies for HIV, STIs and viral hepatitis. The new global HIV strategy will guide future regional action in the Western Pacific Region.

He noted that HIV prevalence among the general population across the Region remains low but continues to be unacceptably high and is even increasing in key populations. High rates of new syphilis infections are being recorded among men who have sex with men (MSM), and high rates of HIV/hepatitis C and HIV/TB co-infections are also being registered among people who inject drugs (PWID). He stressed that we must do better in the prevention and control of HIV and STIs.

When wrapping up his remarks, Dr Shin urged participants to use this opportunity to discuss how we can integrate HIV efforts into the broader health and development agenda without losing sight of public health goals. He also asked participants to address two key questions during the meeting. First, how we can remove the barriers keeping people from seeking HIV and STI information and

¹⁰ The targets are: 90% of adults and children living with HIV know their HIV status; 90% of adults and children who know their status are on treatment; and 90% of adults and children on treatment have suppressed viral load.

services? And second, how can we deliver the services more efficiently and avoid catastrophic health expenditures for individuals and families?

Steve Kraus, Director, UNAIDS Regional Support Team for Asia and the Pacific, opened his remarks by thanking Dr Shin and the WHO Regional Office for the Western Pacific for their leadership and for organizing the joint meeting. Mr Kraus stressed that we should all be proud of our collective achievements but much more needs to be done to reach the ambitious goal to end AIDS by 2030.

Mr Kraus emphasized that to put Asia and the Pacific on track to end AIDS by 2030, countries need to accelerate efforts in the next five years to ensure that by 2020: (1) 90% of adults and children living with HIV know their HIV status; (2) 90% of adults and children who know their status are on treatment; and (3) 90% of adults and children on treatment have suppressed viral load.

Priority actions to achieve the 90-90-90 targets of the UNAIDS Fast-Track Strategy in the Region include: rapidly scaling up access to HIV testing and treatment in both health facilities and communities, and implementing and enforcing antidiscrimination and protective laws. With regards to scaling up access to HIV testing and treatment, it was also stressed that we need to support countries to diversify testing approaches and service delivery modalities, with a focus on key populations and with engagement of the community.

Dr Vicente Belizario, Undersecretary for Technical Services, Department of Health, Philippines, welcomed meeting participants on behalf of the Ministry of Health. Dr Belizario highlighted action taken by the Philippine Government in the response to AIDS and areas where additional work was required. He confirmed that HIV is a priority for the Government of the Philippines. Dr Belizario wished participants a successful meeting and emphasized that the success of the meeting would be enhanced for each participant if they were to identify three priority actions points to focus on upon their return to their countries and organizations.

2.2 Taking stock: Epidemiology and response

2.2.1 Regional action on HIV and hepatitis in the Western Pacific

Ying-Ru Lo, Coordinator, HIV, Hepatitis and STI, WHO Regional Office for the Western Pacific

Over 90% of the 1.3 million people living with HIV (PLHIV) in the 37 countries and areas that comprise the Western Pacific Region live in four countries: Cambodia, China, Malaysia and Viet Nam. The countries with the greatest number of new HIV infections are China, Malaysia, the Philippines and Viet Nam. Only 32% of PLHIV were receiving ART at the end of 2013. Treatment coverage among key populations was even lower. This represents a missed opportunity to harness the benefit of antiretroviral therapy (ART) for prevention of transmission and deaths.

During 2014–2015, WHO focussed on monitoring the implementation of the global HIV health sector strategies. WHO led national AIDS programme reviews in five countries: Cambodia, the Lao People's Democratic Republic, Mongolia, the Philippines and Viet Nam. Moreover, WHO provided support to roll out consolidated 2013 guidelines on the use of ARVs and strengthening of strategic information systems. This included providing support for estimations, projections, epidemiological analysis and integrated biological behavioural surveillance; monitoring the treatment cascade in seven countries; strengthening HIV case surveillance; and implementing new HIV drug-resistance surveillance protocols.

The prominent implementation challenges in the Region include: low testing coverage; poor linkage between testing and care leading to delayed diagnosis and treatment initiation, and inadequate retention in care. HIV surveillance and monitoring and evaluation systems were insufficiently equipped to report on the treatment cascade and evaluate the impact of treatment.

Hepatitis has emerged as a major public health priority in the Region. Mortality from viral hepatitis in the Western Pacific Region is now higher than that of HIV, tuberculosis (TB) and malaria combined. The Western Pacific Region accounts for approximately 39% of global mortality due to hepatitis, or more than 1500 deaths every day, the majority due to chronic hepatitis B and C. Liver cancer is the second most common cause of cancer deaths in Asia and the Pacific, and approximately 78% of liver cancer cases are the result of chronic viral hepatitis B or C.

Building on the success of hepatitis B immunization programmes, it is now time to address hepatitis more comprehensively to include prevention and treatment of hepatitis B and cure of hepatitis C. We can use lessons learnt from HIV to establish a public health approach for viral hepatitis B and C screening, diagnosis and treatment.

Conclusions:

- 1) Use lessons learnt from HIV to establish a public health approach for viral hepatitis.
- 2) Consolidate efforts to find innovative ways to increase access to HIV and hepatitis diagnosis.
- 3) Improve linkages between HIV testing and care and treatment services, retention in care and viral load monitoring and make similar efforts for viral hepatitis.
- 4) Accelerate efforts to implement current HIV and hepatitis prevention interventions.
- 5) Strengthen strategic information for HIV and hepatitis.
- 6) Ensure that both HIV and hepatitis are considered under UHC.

2.2.2 Epidemiology and response to STIs in the Pacific

Madeline Salva, Medical Officer, HIV, Hepatitis, STI and Gender, WHO Representative Office for the South Pacific

Ms Salva began her presentation with an overview of the economic, geographic, ethnic and cultural features of the 22 Pacific island countries in the Western Pacific Region. Gross domestic product (GDP) varies among countries – from low income to upper-middle income – and disparate total populations range from 50 to 7.32 million inhabitants. Geographic and cultural/ethnic groups also distinguish the 22 Pacific island countries: Melanesia (five countries), Micronesia (seven countries) and Polynesia (10 countries). The high costs of commodities and services in the Pacific island countries are attributed, in part, to transportation and transaction costs. Generally speaking, the populations of Pacific island countries hold very strong religious beliefs, practices and affiliations.

Reports submitted by ministries of health to the Secretariat of the Pacific Community (as a Global Fund Principal Recipient) from 2011 to 2014 showed varying positivity rates for chlamydia (range: 7–32%), gonorrhoea (range: 0–4.2%) and syphilis (range: 0.1–7.2%) among antenatal clinic attendees. Several ministries of health are currently validating 2014 STI data and these reports should be released before December 2015.

Collecting quality data on STIs in Pacific island countries is a challenge. Only 11 of the 22 countries track STIs (i.e. chlamydia, gonorrhoea, syphilis) through programme reports. Reporting forms are available, but they are not consistently used. Data are not disaggregated by age and sex. The frequency of reporting is erratic and typically “tagged to a Global Fund reporting period”. Syndromic management of STIs is being implemented, but syndromic reporting is not normally practised.

Ministries of health and other important stakeholders in the subregion are aware of the need to change the way STIs are being diagnosed, managed, tracked and reported in Pacific island countries. To this end, they have developed the GETREAL priority action agenda (Box 1)).

Box 1 STI prevention and control strategic approaches, Pacific island countries

G	Generate timely information.
E	Engage leaders from all sectors, including Pacific religious leaders, as well as beneficiaries in all stages of planning and programming.
T	Test early and treat early people with HIV and other STIs.
R	Reach out to communities, women and their partners and key populations at higher risk, including young people.
E	Establish continuum of prevention, treatment, care and support services.
A	Address barriers in accessing services.
L	Lobby for more domestic resources beyond health.

2.2.3 Leaving no one behind: Fast-tracking the response

Vladanka Andreeva, Regional Strategic Intervention Adviser, Prevention and Treatment, UNAIDS Regional Support Team for Asia and the Pacific

Dr Vladanka Andreeva commenced the presentation by asking participants a rhetorical question: “Fifteen years from now, would you rather live in a world with more or less HIV infection?” The point behind the question was to stress that the choice is a real one. Ending AIDS is a viable target, but the decisions and actions of policy- and decision-makers in response to AIDS in Asia and the Pacific will determine whether or not the threat of AIDS as a public health threat will be over by 2030.

The Fast-Track targets for 2020 and 2030 were reviewed (Box 2).

Box 2 Fast-track targets

By 2020	By 2030
90% of people living with HIV knowing their HIV status, 90% of people who know their status receiving treatment and 90% of people on HIV treatment having a suppressed viral load	95% of people living with HIV knowing their HIV status, 95% of people who know their status receiving treatment and 95% of people on HIV treatment having a suppressed viral load
500 000 New infections among adults	200 000 New infections among adults
Zero discrimination	Zero discrimination

Source: Ending the AIDS epidemic by 2030 (2014). UNAIDS, Geneva. Available at http://www.unaids.org/en/resources/documents/2014/fast_track .

When setting and taking action to achieve the Fast-Track targets, due attention should be paid to ensuring that “no one is left behind” and to the following principles:

- building solid political commitment for ambitious HIV prevention, treatment and human rights targets for 2020 and beyond;
- detailed understanding of local situation – focus services and resources on the locations and populations most affected;

- discarding what does not work, adopting new ways of delivering services including community service delivery, fostering innovation and adopting new technologies and methods;
- HIV service delivery in the intensity and quality needed to reach the ambitious targets within the short time frame of the next five years; and
- people centred, zero discrimination.

An update was provided on the drafting of the *UNAIDS Strategy for 2016–2021: Fast-tracking to zero*. The aspirational vision of “zero new HIV infections, zero discrimination and zero AIDS-related deaths” was kept to guide the collective efforts in the post-2015 era. The UNAIDS global HIV strategy consists of three strategic directions (with corresponding goals): (1) HIV prevention (less than 500 000 new infections); (2) treatment, care and support (less than 500 000 AIDS-related deaths); and (3) human rights and gender equality (everyone lives a life free from HIV-discrimination). Also, in line with the Sustainable Development Goals (SDGs), the global HIV strategy aims to end AIDS by 2030 through relevant five action areas: (1) ensure healthy lives; (2) reduce inequality to access; (3) achieve gender equality and empowerment; (4) promote inclusive societies; and (5) strengthen the means of implementation.

UNAIDS is consulting widely with key stakeholders on the global HIV strategy through a variety of mechanisms, including: global and regional face-to-face consultations and virtual consultations with all engaged Member States, co-sponsors, civil society organizations and international and regional partners. The key next steps are: present first draft in July 2015; hold second virtual consultation to review draft; and present final strategy for the consideration and approval of the UNAIDS Programme Committee Board in October 2015.

Conclusions:

- 1) Fast-track the response to scale up access to prevention and treatment services through innovative service delivery models in the next five years.
- 2) Introduce funding transition plans supported by bridge funding options.
- 3) Develop country ‘investment cases’ for HIV.
- 4) Focus resources where most infections are occurring.
- 5) Protect funding for civil society.
- 6) Create an enabling legal environment that supports effective programmes.
- 7) Integrate biomedical interventions into UHC.
- 8) Develop new financing streams.
- 9) Reduce the costs of HIV drugs and other commodities.
- 10) Ensure reliable future access to affordable HIV drugs.

2.2.4 WHO global strategies on HIV, hepatitis and STIs

Andrew Ball, Senior Adviser, Department of HIV and Global Hepatitis Programme, WHO Headquarters

WHO is working simultaneously on the development of three separate, yet interlinked, global strategies for HIV, viral hepatitis and STIs. The three strategies are being developed in response to World Health Assembly resolutions and discussions. The expected adoption of the SDGs in September 2015 at the United Nations General Assembly is influencing the direction and content of each of these strategies. The SDGs will replace the MDGs that have guided the global health response over the past 15 years. SDG 3 – *Ensure healthy lives and promote well-being for all at all ages* – is likely to address critical health issues. It is anticipated that SDG 3 will have a set of targets, including: (1) end epidemics of AIDS, TB, malaria and neglected tropical diseases and combat hepatitis and other communicable diseases; (2) ensure universal access to sexual and reproductive health-care services; and (3) achieve UHC, including financial risk protection and access to health-care services and essential medicines and vaccines. UHC is cross-cutting and as

such will probably feature in all future WHO global health strategies, including the strategies on HIV, viral hepatitis and STIs.

In addition, the HIV treatment cascade metrics can be used as an organizing framework for health services. It can be used to monitor the provision of essential services, identify gaps and challenges and plan to improve the delivery of services across the entire continuum of HIV prevention, diagnosis, treatment and care. This cascade model will be used as an organizing framework for all three strategies. Finally, the WHO global HIV strategy will be fully aligned with the UNAIDS global HIV strategy for 2016–2021, currently under development, and is adopting the 90-90-90 Fast-Track targets for ending the AIDS epidemic by 2030.

The WHO global HIV strategy for 2016–2021 will adopt five strategic directions in order to address five critical questions. What is the situation we face? What interventions need to be delivered? How can we optimally deliver the priority interventions? How can we cover the costs? How can we change the trajectory of the response?

Strategic Direction 1: Information for focus, action and accountability: The focus is on understanding the epidemic – who is affected, where and how the transmission is occurring, the response and national strategic planning.

Strategic Direction 2: Interventions for impact – The What: The focus is on defining the essential package of HIV interventions that cover vulnerability and risk reduction; prevention of HIV transmission and acquisition; expansion of HIV testing; ART; care of common co-infections and comorbidities; and chronic care.

Strategic Direction 3: Delivery for equity and quality – The How: The focus is on adapting the HIV services cascade for different populations and locations; strengthening human resources; ensuring quality of commodities, interventions and services; linking and integrating services and programmes; engaging communities; creating an enabling environment; and targeting special settings.

Strategic Direction 4: Finance for sustainability: The focus is on raising additional funds through public and private domestic funding and external sources; establishing pooling mechanisms to provide financial risk protection, such as through taxation and health insurance schemes and efficiencies in procurement; and optimizing the use of resources by improving the efficiency and effectiveness of services and reducing the costs of medicines, diagnostics and other commodities.

Strategic Direction 5: Innovation for acceleration: The focus is on moving beyond existing technologies and approaches to strengthen cascade approaches and to innovate medicines, diagnostics, devices, services and systems.

To date, three drafts of the WHO global HIV strategy have been produced. WHO has convened several consultations – face-to-face and online – with stakeholders to discuss these drafts, including regional consultations in Sao Paulo, Johannesburg, Copenhagen, Beirut and New Delhi. A consultation planned for 2 July 2015 in Manila is the last planned regional consultation. The next steps will be to produce the fourth draft, hold a Member State consultation in October 2015, and submit a revised draft to the WHO Executive Board for approval in January 2016. If the HIV strategy is approved by the WHO Executive Board, it will be considered for approval and adoption at the World Health Assembly in May 2016.

The WHO global strategies on viral hepatitis and STIs will have similar structures, using the UHC framework and services cascade model as organizational frameworks. They will also be considered by the Executive Board and World Health Assembly in 2016.

2.3 Moving towards UHC

2.3.1 Ensuring financial protection for prevention and treatment of HIV

Xu Ke, Coordinator, Health Policy and Financing, WHO Regional Office for the Western Pacific

Xu Ke began the presentation with an overview of the concepts of UHC and health systems strengthening and of the action framework of *Universal Health Coverage: Moving Towards Better Health*. The presenter explained that the action framework for UHC consists of five action areas or components – quality, efficiency, equity, accountability and resilience – and described the defining features of each component.

Xu Ke noted that sustainability is a concern for all priority health programmes: external funding is unpredictable and declining in this Region. Decreases in donor funding will not automatically trigger an increase in domestic resources as budget allocation requires a complex negotiation process, and a dramatic change is not likely to happen from one year to the next. Interruptions of current treatment regimens have impacts on the whole population.

The need to strengthen health systems to be able to sustain the priority communicable diseases was highlighted, and it was stressed that action to ensure sustainability should be focussed on improving efficiency and mobilizing more domestic funding. Key actions to improve efficiency are as follows: coordinate and integrate service delivery and financing to reduce fragmentation; prioritize services and identify key populations; prioritize public health concerns; and channel external funding through existing national financing mechanisms.

Discussion points:

- 1) How to organize population-based and individual-based services to handle these diseases?
- 2) What are the options for financing priority programmes, e.g. vertical, fully integrated or some combination?
- 3) How to balance the system and program level efficiency?
- 4) How to balance equity among the whole population and among a specific group of population?
- 5) How to balance short-term gain and long-term sustainability?

2.3.2 Framework for HIV and UHC: ASEAN Task Force on AIDS (ATFOA)

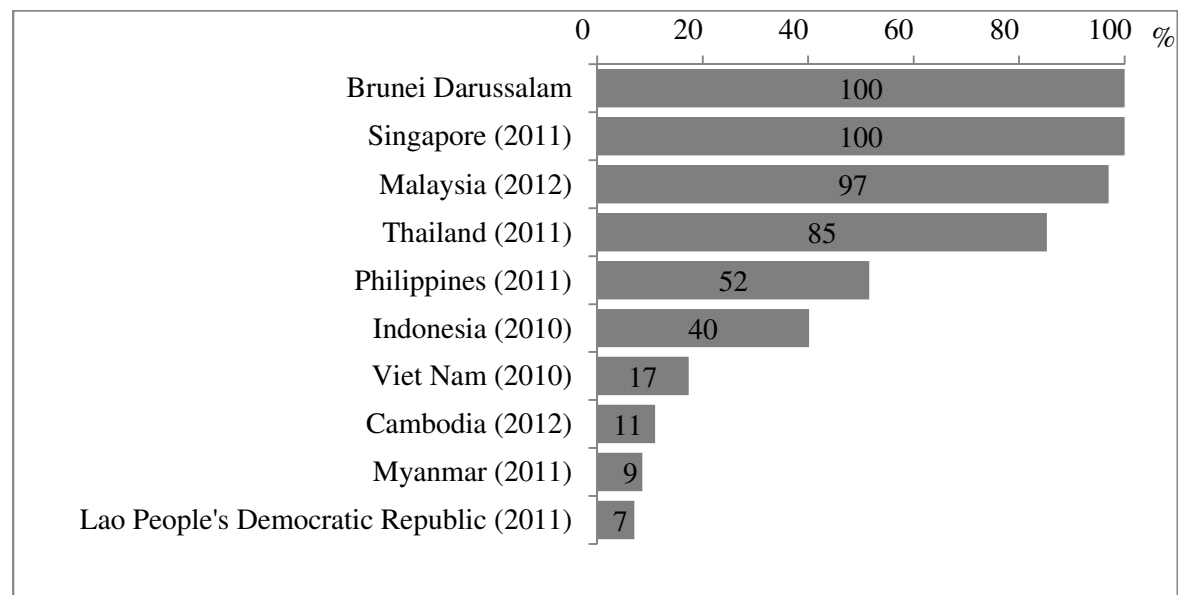
Sha'ari Ngadiman, Deputy Director of Disease Control and Head of HIV/STI Sector, Ministry of Health, Malaysia, Chair of ATFOA

In his presentation, Dr Ngadiman explained why ATFOA was working towards the inclusion of HIV products and services in UHC in ASEAN Member States.

About 3.7 million people are at high risk for HIV in ASEAN Member States – about 640 000 sex workers, 2.5 million MSM and 640 000 PWID. There are about 1.7 million PLHIV (2013) in ASEAN Member States, one third of whom are women. Approximately 46% of adults are eligible for ART, but only 57% of eligible adult PLHIV are receiving ART. More needs to be done to get more PLHIV on ARV treatment.

Domestic spending on HIV has been steadily increasing for most of the 10 ASEAN Member States in recent years, with fewer than five receiving substantial donor funds (Figure 1).

Figure 1. Domestic spending on HIV as a percentage of overall expenditure on HIV in ASEAN Member States, 2009–2012



However, increasing domestic spending on HIV alone may not lead to sustainability. Dr Ngadiman posited that any change of government could affect the level of funding for HIV, and consequently, a strategy for achieving sustainability should be to finance HIV within UHC. Including HIV within UHC would help ensure sustainability of national responses to HIV regardless of change of government and bring stability to the flow of HIV products and services.

ATFOA has developed a roadmap for the integration/strengthening of HIV/AIDS services into UHC. Key actions outlined in the roadmap include drafting a working paper as basis for discussion at the 22nd ATFOA meeting in Myanmar, and ATFOA members deliberating on the steps to taking leading up to the 23rd ATFOA meeting in Manila. ATFOA will hold consultations with major stakeholders involved in HIV response and UHC, and will organize and conduct cost-effectiveness studies on averting AIDS-related deaths and new HIV infections to bolster the justification for inclusion of HIV/AIDS products and services in UHC. Meanwhile, ASEAN Member States with existing UHC programmes will continue to work on integrating and strengthening HIV/AIDS services.

2.3.3 Thailand's approach to sustainable financing for HIV and ending AIDS

Petchsri Sirinirund, Adviser to the Department of Disease Control, Ministry of Public Health, Thailand

Thailand introduced ART in 1992, but until 2000, only a small proportion of PLHIV had access to treatment primarily because of limited budgets. By 2006, however, ARVs became part of the Thai Universal Coverage (UC) health insurance scheme, and by 2013, 80% of PLHIV who needed ART were receiving it.

Several factors influenced the Government of Thailand's decision to include ART under UC including: strong advocacy from nongovernmental organizations (NGOs) and civil society for treatment access; Thailand's ability to produce generic GPO-vir, a low-cost first-line ARV; a solid health infrastructure; and the use of compulsory licensing. Another major impetus was the development of a policy paper wherein an evidence base case for including ART within UC was made.

Other milestones in Thailand's response to AIDS came in 2012. The scientific discoveries and policy issues presented at the International AIDS Conference in July 2012, which showed that earlier ART could reduce HIV transmission by 98% (HPTN 052), had a marked influence on government officials, scientists and civil society organizations who were leading the response to AIDS in Thailand. A national consultation on the strategic use of ARVs in August 2012 culminated in the establishment of the following five working groups: (1) modelling – cost-benefit/effectiveness for treatment as prevention (TasP); (2) scale-up of HIV testing and counselling (HTC); (3) task-shifting for HTC, adherence; (4) Option B+ (immediate ART for HIV-infected mother); and (5) PrEP. Each working group was tasked with advancing work in their respective areas. The efforts of the working groups culminated in the revision of national guidelines on the diagnosis, treatment and care for PLHIV. Subsequently, the National AIDS Committee approved the new guidelines and ultimately the proposal to end AIDS in Thailand (June 2013).

Convincing decision-makers of the proposed approach to “ending AIDS in Thailand”, however, was a challenge. Many key players did not understand technical concepts such as disability-adjusted life years. However, they did seem to be persuaded when the messaging was simplified to focus on “returns on investments”.

2.3.4 Transitioning the HIV/AIDS programme in Viet Nam: A health systems perspective *Socorro Escalante, Team Leader (Health Systems), WHO Representative Office in Viet Nam*

Viet Nam, a rapidly developing middle-income country, is heavily reliant on international funding for its National AIDS Programme. In 2012, international sources of funds accounted for 68.2% of national AIDS spending, while public sources accounted for 31.8%. The heavy dependence on international funding sources is more pronounced for ART. In 2014, funding from the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund respectively supported 52% and 42% of people on ART, with public funds covering the remaining 6%.

Key HIV-related functions are still being managed by donors, and some services are delivered as projects instead of being fully integrated into the health system. Overall, HIV-related services are duplicative and their delivery is uncoordinated.

Viet Nam has commenced a five-year transition from a predominately donor-funded and -led HIV/AIDS programme to a domestically funded and owned approach to HIV and AIDS that is fully integrated into the country's health system. Three principles are guiding the transition: (1) equity and efficiency: sustaining current level of services while expanding coverage; (2) structure and system driven and shaped by needs and appropriate response to challenges, rather than by the sources of financing; and (3) maximization of investments already made.

Several health system challenges will need to be addressed during the transition: finding and putting the required financing in place; merging three parallel service delivery systems into one (i.e. PEPFAR, Global Fund and government); revising government policies and laws to address issues of patent and drug registration which are impediments to procurement of ARV; revising laws mandating the conduct of clinical trials for registration of new medicines; procuring ARVs in general (which can be quite complex) as well as decentralizing procurement; decentralizing HIV services to district levels and below; and reconfiguring and developing a benefits package within UHC.

Moreover, some health-care workers currently providing HIV-related services are directly contracted by the government, while others are contracted by other donor-funded entities. Salaries and the terms and conditions of service vary, sometimes markedly. During the transition period, all health-care workers – including terms and conditions of service and contracts – need to be brought into the national health system. In addition to the challenge of the transition itself, the Government

of Viet Nam has to cope with the expanding health demands of its population and the concomitant competition on resources and coverage for services within the health system.

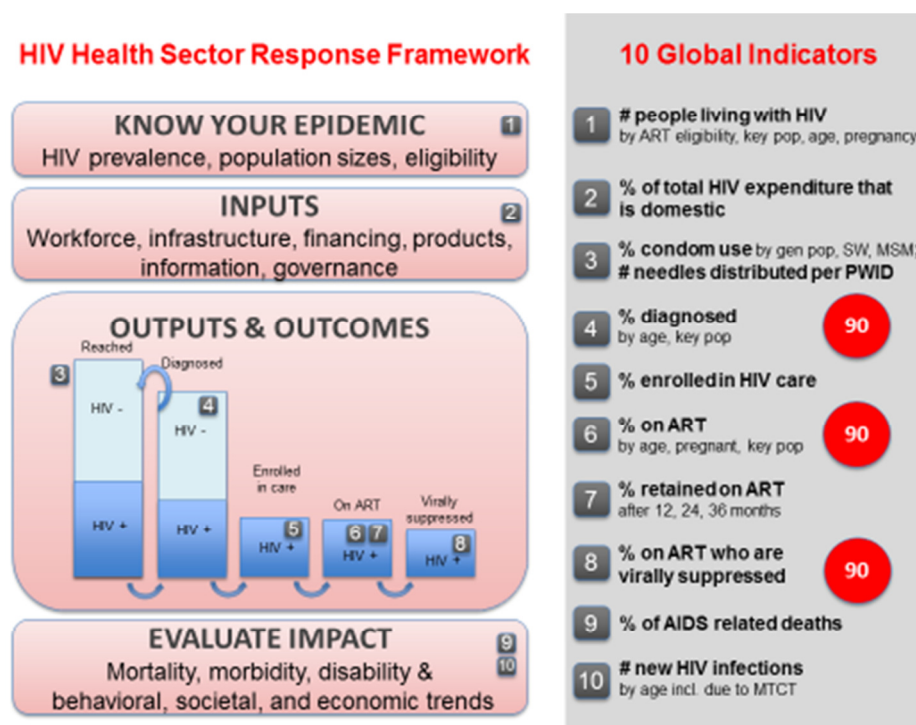
2.4 Fast-tracking the response

2.4.1 Measuring the HIV response and progress: prevention and treatment cascade

Linh-Vi Le, Epidemiologist (Strategic Information), HIV, Hepatitis and STI, WHO Regional Office for the Western Pacific

Ms Le presented highlights from the recently released WHO *Consolidated strategic information guidelines for HIV in the health sector*, noting that the objectives of the guidelines were to consolidate and update existing monitoring and evaluation (M&E) guides; to provide an overview of prevention, care and treatment services; to highlight essential components of strategic information; to prioritize and define core indicators; and to define effective strategic information. In the guidelines, WHO recommends 50 indicators for national M&E, and among those, 10 core indicators should provide key information needed to improve the HIV response (Figure 2). WHO recommends adhering to the definitions provided in the guidelines when reporting to ensure compatibility across countries and across years within a country.

Figure 2. HIV health sector response framework and core global indicators for measuring HIV response



Source: *Consolidated strategic information guidelines for HIV in the health sector*. Geneva: World Health Organization; 2015.

The main challenges in measuring the HIV response in the Western Pacific Region were presented as follows:

(1) Size estimates of key populations

- (a) More resources are needed to obtain geographic-specific size estimates for subnational and subprovincial programming.

(b) Decreased funding limits survey options and methodological approaches for size estimation.

(c) Lack of clarity of subpopulation estimates makes it difficult to target interventions.

- Estimates of both low- and high-risk men who have sex with men (MSM) are usually lacking which leads to imprecise epidemic modelling.
- Traditional methods of enumeration tend to miss sex workers who solicit clients from non-traditional venues such as the Internet.

(2) Surveys and surveillance

(a) Decreased funding requires shifting from resource-intensive and rigorous surveys to existing sentinel surveillance or case reporting, which are thought to produce less reliable data.

(b) Reliance on programmatic data is increasing, but issues with quality limit the usefulness of data for monitoring the epidemic.

- Service providers may not know or may not accurately record risks.
- Collecting risk data may make people vulnerable to discrimination and discourage them from using HIV services.
- Programme data are biased due to self-selection of clients for HIV testing.

(3) HIV testing and linkages to care

(a) Repeated HIV testing and lack of unique personal identifiers inflate testing numbers, and limited means to obtain unique counts come with issues.

- Unique identifier codes are increasingly being applied but can be inaccurately recorded or inflated.
- Concerns around fingerprinting technology need to be addressed in order to apply this technology.
- Shifting from anonymous to confidential, name-based testing needs full assessment of implications.

(b) Case-reporting data can be used to determine number of individuals tested, but most systems currently cannot provide reliable data because of difficulties with:

- capturing accurate risk data;
- mapping HIV-positive cases (testing is not done where they reside);
- retaining testing records at testing sites for validation; and
- reporting number of people tested (denominators are missing).

(c) Monitoring testing coverage and patient linkage to care will be more difficult as community-based testing and self-testing become more available.

(4) Longitudinal patient outcomes

(a) Electronic information systems greatly facilitate cohort analysis, but they have limited applications if ART services are decentralized to community clinics that lack hardware.

(b) Monitoring loss to follow-up often requires special studies to investigate and estimate how many patients were lost to follow-up, transferred or died.

(c) Drug-resistance surveillance loses precedence to other strategic information activities as funding shrinks.

- Early warning indicators, which are important for improving quality, need high programme coverage in order to be used for drug-resistance monitoring.
- Replacing surveys with routinely collected viral load data requires viral load testing for all ART patients and resistance testing for those who are failing.

(d) Viral load testing is not widely available and often target patients with indications of treatment failure

(5) Measuring impact

(a) Incidence rates are difficult to obtain.

- Longitudinal cohort studies are costly and time consuming.
- Utilizing a limiting-antigen avidity assay on cross-sectional samples requires large samples sizes that are difficult to achieve in concentrated epidemics, and a separate study is needed to determine the country-specific proportion of false recent infections (longstanding infections misclassified as recent infection).
- Epidemic modelling that is mainly used to estimate incidence is affected by the quality of survey data.
- Indirect estimation can be conducted using HIV prevalence in young, recently exposed populations, but existing surveys capture only a small number of young people.

(b) Mortality is the clearest indicator of programme success, but it is challenging to estimate.

- Few countries have high-quality civil registration systems.
- Sample vital registration with verbal autopsy (SAVVY) is cost-effective compared to a full national civil registration system, but it is still resource intensive.
- Epidemic modelling is affected by the quality of survey data.

2.4.2 Planning, monitoring and evaluating progress towards ending the AIDS epidemic
Amala Reddy, Regional Programme Adviser, Strategic Information, UNAIDS Regional Support Team for Asia and the Pacific

The numerators and denominators of the 10 global indicators to monitor the HIV response are derived from survey and programmatic data and from modelling (estimates of PLHIV). The quality and utility of the modelling inputs (i.e. HIV surveillance data, population size estimates and risk behaviour data) vary among countries in the Western Pacific Region. Most countries, however, have good HIV prevalence surveys (i.e. HIV Sentinel Surveillance Surveys [HSS] and Integrated Biological and Behavioural Surveys [IBBS]). Most countries in the Region have also surveyed risk behaviours among two or three key populations. Data availability on size estimates of certain key populations (e.g. male sex workers, transgender people and clients of sex workers), however, are lacking in some countries (Table 1).

Table 1. Data on size estimates of key populations (2005–2013)

Country	Key populations with size estimates				
	PWID	FSW	MSM	MSM & TG	FSW clients
Brunei Darussalam	NA	NA	NA	NA	NA
Cambodia	2012	2009	2008	NA	2007
China	2011	2011	2011	NA	2009
Fiji	NA	2012	NA	2012 (TGSW)	NA
Japan	NA	NA	NA	NA	NA
Lao People's Democratic Republic	2011	2010	2011	2010 (MSM, TG)	2010

Malaysia	2009	2010	2009	2010 (MSW, TG)	2009
Mongolia	NA	2006	2006	NA	NA
Papua New Guinea	NA	2005	NA	NA	NA
Philippines	2011	2011	2011	2011 (TG)	2011
Republic of Korea	NA	NA	NA	NA	NA
Singapore	NA	NA	2011	NA	NA
Viet Nam	2013	2013	2013	NA	2011

FSW, female sex worker; NA, not applicable; PWID, people who inject drugs; TG, transgender; TGSW, transgender sex worker.

Source: Prepared by www.aidsdatahub.org.

Modelling inputs are available in many countries, but there are problems with their validity. The quality of HIV surveillance data varies; representativeness of subnational and different subpopulations need to be considered; and analysis and trends are needed at various levels. With regards to population size estimates, while the quality of the data is variable – but generally good enough – the representativeness of different risk subpopulations is questionable.

There are also problems with the data from facilities and programmes on the ground with regards to the numerators of indicators. For example, HIV case reporting exists in all countries, but it greatly varies in terms of data compilation, synthesis and utilization. In terms of programme statistics, there are quality issues – e.g. over- and under-counts, duplicate counts, overlapping catchments of multiple projects, and there is a lack of disaggregated data at the response level, although these must be collected in countries.

Conclusions

- 1) Strengthen HIV and AIDS case reporting systems in light of data needs for the 90-90-90 targets.
- 2) Strengthen reporting and collection of data from prevention and treatment programmes at national and subnational levels (cities).
- 3) Issue guidance on use of unique identifier codes to monitor individuals through the continuum of prevention, care and treatment.
- 4) Strengthen collection of data related to access to services.
- 5) Improve data analysis, triangulation and synthesis by dedicated teams at national and subnational levels.
- 6) Improve availability of disaggregated data by modes of transmission, age, gender and geographical location to inform planning and focus.
- 7) Encourage South–South collaboration in areas of technical expertise.
- 8) Consider data as a public good.

2.4.3 Active HIV case management

Ly Penh Sun, Director, National Centre for HIV/AIDS, Dermatology and STDs

The National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) in Cambodia established its active case management (ACM) programme with support from WHO, UNAIDS, Clinton Health Access Initiative (CHAI) and the United States Centers for Disease Control and Prevention (CDC) in 2013. ACM is being implemented at the national, provincial and district levels. A standardized data collection tool is utilized and coordination among the various ACM-stakeholders is provided by the ACM Technical Working Group. The objectives of NCHADS' ACM programme are to minimize lost to follow-up immediately after HIV diagnosis, and to maximize retention and adherence to treatment along the HIV cascades.

Cases requiring active follow-up include: (1) all cases found positive at HTC sites (i.e. voluntary confidential counselling and testing, provider-initiated testing and counselling (PITC) for TB, PITC for early infant diagnosis (EID), community peer-initiated testing and counselling for key

populations; (2) all cases newly enrolled in pre-ART (adults and children); (3) HIV-positive pregnant women and their HIV-exposed children; (4) sexual partners of PLHIV on pre-ART/ART who have not been tested in the last six months; (5) discordant couples (PLHIV on pre-ART with HIV-negative partner); and (6) cases on ART at risk of drop-out, death and low adherence, including people with TB/HIV co-infection, and isoniazid preventive therapy (IPT) and suspected TB treatment failure.

The challenges faced by NCHADS in carrying out ACM have been identified as: (1) limited scope – only part of the cascade (*reactive to pre-ART enrolment*); (2) limited coverage – implemented in only 14 of 33 operational districts; (3) high total cost – but cost-effectiveness is being identified; (4) lack of coordination among data systems; (5) undefined responsibility for reporting and analysing at subnational and field levels; and (6) lack of completeness of recording actions taken for losses.

The lessons learnt to date are as follows: (1) in key populations, cases of “hiding identity” are the most difficult cases to find; (2) it is very common for members of key populations to come back and present themselves as members of the general population; (3) transport support (incentive) is effective in motivating most people to come back for their results; and (4) building trust and ensuring confidentiality by the provider helps minimize client loss to follow-up.

2.4.4 Electronic patient monitoring system in Viet Nam

Vo Hai Son, Head, Division on Monitoring and Evaluation and Laboratory, Viet Nam Authority of HIV/AIDS Control, Ministry of Health

Viet Nam made the decision to develop an electronic monitoring system for HIV patients for several reasons. First, the number of patients receiving ART is increasing, and many site managers felt that it is becoming impossible to monitor patients using a paper-based system. Second, the paper-based system requires too much time and labour to maintain, it cannot easily provide the data required by various donors, and the quality of the data cannot be guaranteed.

The Viet Nam Authority of HIV/AIDS Control (VAAC) took the lead and coordinating role in the development of the electronic patient monitoring system (e-PMS). A technical working group was formed to advise VAAC on the development of the e-PMS and to help ensure coordination during implementation of the system itself. In addition to the VAAC, WHO, CDC, USAID, and CHAI are members of the working group. The development and pilot testing of e-PMS took place in seven provinces. A scale-up of e-PMS is planned for 2015 to 2017.

Feedback from health workers utilizing the e-PMS has been mainly positive. They report that it is simple to use, it works off-line as well as on-line, it takes fewer than 60 seconds for the E-register to capture information for one patient during each visit, and it saves a lot of time for making routine reports compared to the paper-based system. e-PMS is also valued because of its capacity to “link the transfer-in/out among sites” and it makes it relatively easy to monitor treatment outcomes.

Decision-makers and managers also appreciate the functionality and features of the e-PMS including online reporting for national and provincial levels and development partners based on their authorization and the availability of patient’s data that are synchronized and managed centrally in a national database.

To help ensure the sustainability of e-PMS, VAAC and members of the working group are providing training on e-PMS and the development of training toolkits for trainers and out-patient clinic staff.

2.5 Unpacking the 90-90-90 targets

2.5.1 Cascade of HIV testing, care and treatment services and evaluating impact: clinical and operational aspects of the three 90s

Naoko Ishikawa, Scientist, HIV, Hepatitis and STI, WHO Regional Office for the Western Pacific

The 90-90-90 targets provide an opportunity to review and set new national targets and develop a strategy and actions required to improve the cascades of testing, care and treatment. New national targets, strategies and actions must be based on critical analysis to be effective and efficient. Countries can expect to receive new or revised WHO guidelines to assist them soon. The WHO *Consolidated guidelines on HIV testing* were released in July 2015, and an update of the ART guidelines is planned for later in 2015.

When determining the strategy and actions required to expand HIV testing services, we need to consider how to reach those who are in need or unreached. The following actions should receive due consideration: community-based HTC (e.g. Cambodia, China) – Test for triage; HIV testing by lay provider (e.g. Papua New Guinea) – Using rapid test; and HIV self-testing (e.g. China).¹¹

With regards to improving the quality of HIV testing, the following actions should be considered: determine testing strategy and algorithm; recommend re-testing to confirm HIV-positive status prior to treatment initiation as false-positive results could be high in our Region because prevalence is low; and strengthen quality assurance systems.

The efficiency of resource allocation would be enhanced if high-quality epidemiological data and programme data were available at both the national and subnational levels, and greater attention were paid to cost-effectiveness considerations.

Concerning treatment, countries must consider when to start ART. The “Strategic Timing of AntiRetroviral Treatment” (START) study showed the benefits of immediate treatment, which will have implications for new guidelines. Countries will also need to decide what regimen to start with and/or switch to; lab monitoring – viral load monitoring, frequency (i.e. 6 or 12 months) and the role of CD4; same day / rapid ART initiation; frequency of clinic visits; linkage and adherence support; task-shifting; and assessment and management of depression and cardiovascular diseases.

The approach to viral load suppression is another key consideration. Clearly viral load monitoring is preferred to monitor and diagnose treatment failure. When determining the steps required to scale up viral load testing, countries should review WHO guidance, do an assessment of needs and resources, develop national algorithm for monitoring; and plan for a phased scale-up.

It was also noted that the most common gaps identified to date are: failure to identify PLHIV (this suggests that greater investments in HIV testing services are needed); and failure to enrol those diagnosed into care and treatment (this diminishes the impact of investing in HIV testing). Moreover, it was recommended that countries should ensure that people already identified as HIV positive were linked to care and treatment, and that those already on treatment achieved viral load suppression.

2.5.2 Building the case for community-based HIV testing: The experiences of KHANA and implementing partners in Cambodia

Choub Sok Chamreun, Executive Director, KHANA

The HIV epidemic in Cambodia is a concentrated epidemic. The key populations are sex workers, MSM, transgender people, and PWID, mostly in urban areas. Khmer HIV/AIDS NGO Alliance

¹¹ WHO does not formally recommend HIV self-testing yet, but with more experience and evidence on the efficacy of this intervention forthcoming in the next few years, it could be an option.

(KHANA) is a partner organization of the International HIV/AIDS Alliance and works closely with partners and communities in running the largest community-based HIV programme in Cambodia. KHANA and implementing partners cover 22 out of the 25 provinces in Cambodia, reaching close to 50 000 members of key populations in 2013 (70% of estimated population size nationally) with prevention, care and support services.

KHANA and its partners deliver a package of services through outreach in entertainment venues and other hotspots. A core component of this package of services, HTC, uses finger-prick testing instead of phlebotomy because it is a convenient and easy-to-use test that saves time and money. KHANA has found that finger-prick testing potentially mitigates many of the factors that discourage key populations from getting tested, including: time spent travelling to and from testing sites, time lapse between test and results, financial strain of travelling to and from testing site and missing work, increased anxiety associated with waiting for results, and concerns about anonymity.

Challenges and lessons learnt by KHANA and its partners with regards to community-based HTC are as follows: (1) there is a high level of acceptability of finger-prick testing among key populations; (2) ACM of new HIV cases to strengthen linkage to care and treatment; the quality of counselling and testing procedures needs to be improved to increase clients' trust and confidence, and to implement best practice; (3) there is a need to continue to work with health service providers, venue owners, police and local authorities in strengthening the enabling environment; (4) the physical environment at hotspots makes it difficult to implement point-of-care testing; (5) bottlenecks in the supply chain need to be addressed to ensure adequate availability of test kits; (6) more attention and resources need to be spent on retention of peer outreach workers and lay counsellors to maintain consistency of service delivery and quality.

With regards to reaching highest-risk individuals, traditional hotspot-based outreach may not be sufficient, understand and deliver relevant services to individuals with the greatest need and at highest risk; and there is a need to sharpen targeting of high-risk venues and individuals, and test innovative outreach strategies and tools tailored to specific epidemiological and social contexts.

2.5.3 Diagnosing TB co-infection and effective use of resources

Cornelia Hennig, STOP TB Programme, WHO Regional Office for the Western Pacific

The Western Pacific Region carries 18% of the global TB burden, reporting around 1.6 million TB cases every year, 110 000 deaths due to TB, 71 000 cases of drug-resistant TB and 24 000 TB/HIV co-infected patients. The Region presents the full spectrum of TB epidemiology: high, intermediate and low TB burden. High-burden countries in the Region are Cambodia, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam. Since 1990, the Region has witnessed a 45% reduction in incidence, a 51% reduction in prevalence and a 72% reduction in mortality. Overall, the Region has an impressive 85% treatment success. The Western Pacific Region is on track to achieve the TB-related Millennium Development Goals and other international targets by 2015.

Highlights of the recently endorsed (2014) end TB strategy and targets of TB, prevention, care and control after 2015 were presented. Very similar to HIV, WHO aims to end the global TB epidemic by 2035 with three ambitious targets: 95% reduction in mortality; 90% reduction in TB incidence; and zero affected families facing catastrophic costs due to TB.

Regarding HIV/TB co-infection, the significance of a 2012 WHO policy recommendation was stressed, namely: WHO-endorsed rapid molecular tests (GeneXpert MTB/RIF) should be used rather than conventional microscopy; culture and drug susceptibility testing (DST) should be used as the initial diagnostic test in adults and children suspected of having multidrug-resistant TB or HIV-associated TB. GeneXpert is a multi-disease platform and viral load testing is available, offering opportunities for enhanced TB/HIV programme collaboration and integration. In addition,

GeneXpert tests are accessible under concessional pricing, making their use also affordable in high-burden countries.

2.5.4 Summary: Analysis of gaps in laboratory and testing systems in selected countries of the WHO Western Pacific Region

Sue Best, Director, National Serology Reference Laboratory, Australia

WHO commissioned the National Serology Reference Laboratory (NRL), Australia to undertake a laboratory gap analysis with the following aims: determine gaps in laboratory systems; recommend activities for strengthening; and gather information on testing for HIV, syphilis, and hepatitis C virus (HCV) and hepatitis B virus (HBV). Laboratories in seven countries were included in the study: Cambodia, Fiji, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam. Two questionnaires were administered. One looked at laboratory support systems – quality, regulation of diagnostics, and external quality assessment (EQA), and the other looked at tests, testing and algorithms. The questionnaires were completed by ministries of health, WHO, and laboratory personnel.

The gap analysis of laboratory systems found the following: systems varied from country to country; no country had uniformly implemented a laboratory quality management system (QMS); three countries had laboratories seeking accreditation; and test-kit regulation is greatest for HIV tests and least for HBV and HCV test kits. Out of seven countries, four had implemented EQA for HIV, four for HBV and HCV; and two for syphilis. Participation in EQA was either not mandatory or was mandatory but not enforced. There is a difference between requirements for “for profit” and “not for profit” laboratories with respect to EQA participation.

Concerning gaps in laboratory testing, the main findings were as follows: reliable test kit procurement was periodically a problem everywhere; all countries had HIV algorithms in place (two countries were using 2-test algorithms, while others were using 3-test algorithms). Six out of seven countries used at least two tests for syphilis; national testing strategies for HBV and HCV did not exist in six and five countries, respectively; four out of seven countries reported HBsAg results from only one test; only two out of six countries required confirmatory HCV antibody testing; and one country did not test for HCV.

The gap analysis confirmed that it is essential to improve the quality of national and subnational laboratory systems in countries to support the roll-out of community-based testing and ensure quality testing. Support was also recommended for: basic QMS implementation; development of national EQA scheme and enforcement of mandatory participation; development of national strategies and guidelines for HBV, HCV and syphilis testing (build on HIV model); policies and systems for test kit regulation and procurement; and scale-up of HIV viral load testing.

Ms Best also discussed validation of testing algorithms. NRL, Australia is concerned about inappropriate combinations of tests being used in algorithms – i.e. tests that are poorly manufactured, tests that are unfamiliar but cheap, and tests that are relabelled as different brands. Clearly, more attention needs to be paid to validating testing algorithms, which would require: having access to adequate data; examining data for good test combinations; conducting pre-implementation testing as necessary; validation in the field; and monitoring.

Conclusions:

- 1) Countries should set up and strengthen basic laboratory QMS, implement national EQA scheme and enforce mandatory participation, and development of national strategies to strengthen laboratory testing
- 2) Countries should develop policies and systems for test regulation.
- 3) HIV viral load testing should be scaled up in the Region to be an essential part of looking at viral suppression and completing the treatment cascade.

- 4) More attention should be paid to validation of HIV testing algorithms to an extent consistent with the performance information available on the candidate test kits for the algorithm when used alone and when combined.

2.5.5 Revision of HIV diagnostic algorithm in Philippines

Gerard Belimac, Programme Manager, National AIDS and STI Prevention and Control Program (NASPCP), Disease Prevention and Control Bureau, Department of Health

In 2013, the Philippines Department of Health made the decision to revise their HIV testing algorithm out of concern that the current algorithm was not fit for purpose. People who were testing HIV positive on the first test had to wait a long time for a confirmatory test. This extended waiting period was one of the reasons cited for low programmatic accomplishment regarding people testing for HIV and knowing their result.

The process of developing a new algorithm commenced with a validation study, which was carried out as collaborative process involving the National Reference Laboratory San Lazaro Hospital STD AIDS Cooperative Central Laboratory (NRL-SLH/SACCL), Department of Health, Philippines, WHO and NRL, Australia. The objective of the study was to determine a good combination of screening tests (two or three) to be used as a confirmatory test in lieu of Western Blot. In addition, it was stipulated that the combination(s) should be at par with the specificity of current Western blot algorithm.

The following HIV confirmatory testing algorithm was recommended for validation at NRL-SLH/SACCL, the Philippines: (1) use of three rapid diagnostic tests for key populations (e.g. MSM, transgender people, PWID) to be pilot-tested in 10 sites; and (2) use of two immunoassays and one rapid diagnostic test for the general population. Validation of the new algorithm is ongoing and should be completed by the end of 2015.

The main challenges to date in determining a new HIV confirmatory testing algorithm for the Philippines were identified as: limited technical partners on laboratory systems in-country; competing financial priorities of NASPCP; varying degrees of commitment from partners (other government agencies); and the need for WHO prequalification of HIV test kits.

2.5.6 HIV testing algorithm development and implementation in Viet Nam

Phan Thi Thu Huong, Deputy Director-General, Vietnam Authority of HIV/AIDS Control, Ministry of Health

Viet Nam's Ministry of Health decided to adopt an HIV testing algorithm for the following reasons: limited access to confirmatory testing in-country; poor quality of test kits (around 30 test kits on the Ministry of Health's registered list with suboptimal pre-market evaluation); poor quality of testing (i.e. without testing algorithm laboratories used test kits in various orders); and the 90-90-90 targets require a proactive expansion of HIV testing.

The identification of an HIV testing algorithm in Viet Nam included the following key steps: evaluation of 11 HIV test kits (seven rapid tests, two SERODIA® tests, two enzyme-linked immunosorbent assays [ELISA]); establishment of a national working group; selection of candidate test kits for algorithm; development of a protocol for HIV-testing-algorithm validation study (with technical support from NRL, Australia, WHO and CDC); field assessment for site selections; training of district and provincial laboratory staff; data analysis; and formulation of recommendation for national algorithm for approval.

The validation study aimed to develop an HIV testing algorithm for HIV diagnosis. The specific objectives were to validate various HIV testing algorithms that can be used at different levels of health facilities (e.g. high throughput: >40 specimens/week; low throughput: <40 specimens/week),

and to assess operational feasibility of conducting rapid HIV testing algorithms at district laboratories.

Four study sites were selected, namely: Hanoi, Quang Ninh, Ho Chi Minh City and Binh Duong. Eleven district laboratories and four provincial laboratories participated in the study. Selection of the test kits to be used in the study commenced with a review of available information, including: Ministry of Health's HIV test-kit registration list; WHO prequalification list and reports on HIV test kits; results of HIV test-kit evaluations conducted by the National Institute of Hygiene and Epidemiology (Viet Nam); Global Fund and PEPFAR procurement lists; and test kits that were commonly used in provinces. Six test kits were selected for the validation study: two ELISAs – SD HIV 1/2 ELISA 3.0 (Standard Diagnostics, Republic of Korea) and Murex HIV Ag/Ab Combination (DiaSorin, Italy), and four rapid tests – SD BioLine HIV 1/2 3.0 (Standard Diagnostics, Republic of Korea), Double Check Gold HIV 1&2 (Alere, Waltham, MA, USA), Determine HIV-1/2 (Alere, Waltham, MA, USA) and VIKIA HIV 1/2 (bioMérieux, Marcy-l'Étoile, France).

The study found that all four rapid test algorithms had 100% sensitivity and 100% specificity. Among 232 positive samples and 2269 negative samples, there was no misclassification of false-positive or false-negative results by any of the four algorithms. It was concluded that rapid test algorithms could be used at district level for HIV confirmation.

The roll-out of national testing algorithms and expansion of HIV testing are underway. National testing algorithms were approved in February 2015. Decentralization of confirmatory HIV testing to district laboratories commenced in 2015, with pilots under way in 13 districts in five provinces. This will be expanded in 2016. In addition, community-based HTC was piloted in 2015 and will be rolled out more widely in 2016.

It was emphasized that validating the rapid and ELISA test kits in different subpopulations is important and could be made uniform across the Region. Lessons learnt could be shared with countries having similar HIV micro-epidemics among key populations.

2.5.7 The road map for monitoring and surveillance of HIV drug resistance: Western Pacific Region, 2014–2018

Po-Lin Chan, Senior Adviser, Hepatitis and HIV/AIDS, WHO Representative Office in China

Because of the scarcity of information on HIV drug resistance, there is a need to strengthen surveillance and monitoring of drug resistance in the Western Pacific Region. To support this effort, governments led the development of the *Road map for surveillance and monitoring of HIV drug resistance in the Western Pacific Region (2014–2018)*, in collaboration with a broad range of local stakeholders and WHO, based on the updated 2012 *WHO Global strategy for the surveillance and monitoring of HIV drug resistance*. The country-owned process resulted in national plans that were developed based on gap analyses, feasibility and costs of implementation. This included prioritization of surveys focusing on sustainability and integration with existing population-based national surveys. Seven countries are included: Cambodia, China, the Lao People's Democratic Republic, Malaysia, Papua New Guinea, the Philippines and Viet Nam.

Priority activities have been identified and planned for each country, with corresponding expected outcomes at the end of 2018. Six strategic approaches have been formulated to establish, strengthen and sustain regional and national capacities in HIV drug-resistance surveillance and monitoring in the Region. The six strategic approaches are as follows: (1) facilitate integration of HIV drug resistance surveillance and monitoring with national strategic plans for HIV, and within the broader framework for public health surveillance in countries; (2) harmonize implementation of quality-assured HIV drug resistance surveillance and monitoring surveys; (3) strengthen partnerships and regional networking to support HIV drug resistance surveillance; (4) accelerate support to build regional and national capacities, knowledge dissemination and use of data for

public health actions; (5) promote investment and strengthening of regional and national laboratory capacities; and (6) facilitate research and innovations.

The seven countries included in the road map are at different stages and have varying capacities for public health surveillance and monitoring of HIV drug resistance. Most have substantial technical, financial and human resources challenges. Despite these challenges, all have articulated their commitment to continue and sustain the effort on surveillance and monitoring of HIV drug resistance. The key lessons learnt to date regarding the implementation of the road map are the need to: facilitate integration of HIV drug resistance within national plans for HIV and public health surveillance; harmonize implementation of HIV drug resistance; strengthen partnership and cooperation for HIV drug resistance; strengthen national capacities, knowledge dissemination and use of data for public health action; promote investment and strengthening regional and national laboratory capacities; and facilitate research and innovations.

Conclusions:

- 1) All countries should articulate a costed action plan for HIV drug-resistance routine surveillance, which should be carried out once every three years.
- 2) Early warning indicators need to be integrated as part of the national framework for monitoring programme quality.
- 3) Funding for these surveys should be incorporated into the national annual plans.
- 4) Capacities for epidemiological and statistical analysis need some support in the Region, and WHO is working towards strengthening its technical support.

2.5.8 HIV drug resistance surveillance in Japan

Yoshimura Kazuhisa, AIDS Research Center, National Institute of Infectious Diseases, Japan

In Japan, a system for the mandatory reporting of newly diagnosed HIV-1 infected cases has been managed by the Ministry of Health, Labour and Welfare. Since 1984, the number of newly diagnosed cases has increased yearly, until it plateaued at about 1500 cases per year in 2007. Though the increase in the number of new cases has levelled off, no sign of reduction has been observed thereafter. For 2010–2012, the major risk population in Japan was MSM (subtype B infected). Estimated incidence of HIV was 0.02% in the general population and 1.2% in the MSM population.

As of 2009, Japan has reported a total of 9040 cases of HIV-positive people. Among those, 6296 cases were on treatment, almost 70%. Drug-resistant prevalence in treated cases was around 1.5%. This is quite low compared to the United States of America and European countries, where HIV drug resistance is estimated at around 10%. In 2014, the rate of HIV cases on ART in Japan increased to almost 90%.

Prevalence of drug-resistant cases increased rapidly after introduction of ART in 1997, and made up over 70% of the treatment failure cases in 1999. And then the cases decreased year by year. The reduction of drug-resistant cases among treatment failure cases can be attributed to improved pharmacokinetics of ARVs, reduced pill burden, high genetic barrier of new drugs, and available pre-treatment genotyping.

Somewhat paradoxically, however, the prevalence of transmitted drug-resistant HIV cases in Japan increased from 5.9% in 2003 to 11.0% in 2014. While detected drug-resistant mutations varied widely, T215X, M46I/L, and K103N mutations had been detected every year, suggesting these mutations were stabilized and have become circulating strains.

Some transmission clusters were area-limited and mutation-specific. Also, genetic diversity was higher inside cities than between cities, suggesting transmissions were more active within the area-limited communities. These findings suggest they might be good target populations for prevention intervention.

Conclusions:

- 1) Monitoring of HIV drug resistance among subpopulations and intra-city populations can be done programmatically to determine the choice of ARVs, but it is also important to study the clustering of the genotypes and mutations.
- 2) Mostly, HIV drug resistance is increasing, but the development of acquired drug resistance can be arrested if the quality of the ARV roll-out programme is high.
- 3) Sources of funding for intense monitoring of HIV drug resistance still need to be found..

2.6 New priority global strategies, targets and priority actions

2.6.1 Combination HIV prevention: Do we need ARV PrEP in Asia?

Ying-Ru Lo, Team Leader HIV/STI, WHO Regional Office for the Western Pacific

PrEP is the use of ARVs by HIV-uninfected persons to prevent the acquisition of HIV infection. In July 2014, WHO released *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* and the new 2015 WHO *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV*.¹²

There are several reasons why PrEP should be considered in Asia, where HIV prevalence among MSM is very high. Asia has the largest proportion of new HIV infections globally, and this will likely increase in the coming months and years. Recently completed Phase III PrEP trials using daily oral tenofovir-based pills have demonstrated that the drug offers several advantages as a first-generation PrEP agent. As of June 2015, at least six clinical trials have demonstrated PrEP efficacy in diverse geographic and risk populations. It is potent, safe and relatively easy to use (i.e. low pill burden, no food restrictions and few drug interactions). Tenofovir-based combinations are also relatively affordable at less than US\$ 1 per day for treatment.

PrEP is an important component of prevention to achieve the goal of controlling the HIV epidemic, and the low number needed to treat to prevent one HIV infection makes PrEP a viable and cost-effective intervention in high-risk populations. Wider adoption of PrEP as a prevention measure will bring challenges at the programmatic and health system level: programmatic challenges – cost of drugs; prioritization of populations; and demand-driven versus daily dosing; and health system challenges – stigma, criminalization and access to health services for MSM; lack of consumer education and demand creation; determine HIV testing and re-testing algorithms; design service delivery and programme monitoring; and adherence interventions.

Conclusions:

- 1) Because of the high incidence of HIV among MSM and the high effectiveness of PrEP, it is time to explore how to implement this strategy.
- 2) WHO and UNAIDS has a joint grant on PrEP from the Bill and Melinda Gates Foundation.
- 3) Future grant from the Bill and Melinda Gates Foundation will focus on Sub-Saharan Africa.
- 4) UNITAID¹³ has called for proposals on PrEP implementation research. The submission due date is 3 July 2015.
- 5) PrEP is an opportunity for more frequent HIV testing among high-risk MSM and early treatment of HIV infection.
- 6) PrEP could have a major impact on the HIV epidemic among MSM in Asia.

¹² Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015.

¹³ UNITAID was established in 2006 by Brazil, Chile, France, Norway and the United Kingdom to provide an innovative approach to global health (<http://www.unitaid.eu/en/who/about-unitaid>, accessed on 9 November 2015).

2.6.2 (PrEP)aration: Exploring the feasibility of PrEP for self-identified gay men, other MSM and transgender people in Asia

Inad Quinones Rendon, Advocacy Capacity Development Officer, Asia Pacific Coalition on Male Sexual Health

The Asia Pacific Coalition on Male Sexual Health (APCOM), together with Youth Voices Count, developed a technical brief of the WHO key population guidelines and conducted an online survey to assess values and preferences for the guidelines between September 2014 and February 2015. Respondents were network members from APCOM and Youth Volunteer Corps (YVC).

Key findings from the survey are: VCT is the intervention most ready for implementation; PrEP and ARV post-exposure prophylaxis (PEP) are the interventions least ready for implementation; and community-based and community-led delivery of services garnered strong support. Respondents wanted to see greater support for community empowerment.

With regards to PrEP, the key survey findings are: PrEP is a valuable part of a broad response to HIV in the Region; emphasis on the need to further discuss PrEP with particular attention to its application in the Region; there is a need to provide more information and education about the use and effect of PrEP and to address the stigma and fear associated with it; there is a scarcity of data on the short- and long-term effects of the administration of PrEP in the Region; and the roll-out of PrEP should include supporting pilot projects and trainings with governments, health-care providers, and communities.

A regional dialogue exploring the feasibility of PrEP for self-identified gay men, other MSM and transgender people in Asia was held from 23 to 25 September 2015 in Bangkok, Thailand. APCOM actively participated in the dialogue along with other stakeholders, including: WHO, UNAIDS, UNDP, UNICEF, USAID, FHI 360¹⁴, and the Thai Red Cross.

2.6.3 What are the new scientific developments in HIV?

Sharon Lewin, Director, Doherty Institute, The University of Melbourne and Consultant Physician, Alfred Hospital, Melbourne, Australia

Understanding new scientific developments in HIV will be important in the long term for the global community including for HIV programme managers, civil society organizations and development partners. The presentation focused on two areas: (1) immune activation on ART, and (2) HIV cure or "remission".

Conclusions:

- 1) Persisting inflammation while on ART is multifactorial. Multiple interventions are being tested. The best strategy is prevention through early ART.
- 2) Long-lived latently infected cells are major barriers to prolonged HIV remission.
- 3) Multiple strategies are being tested to achieve HIV remission including early treatment, activating latency, boosting immunity and gene therapy.
- 4) Ongoing (early) access to ART for all needs to remain a top priority.
- 5)

2.7 Discussions

On the second day of the meeting, participants were divided into four groups for thematic discussions focussing on: problem analysis to identify bottlenecks, constraints and challenges; and

¹⁴ FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions (<http://www.fhi360.org/about-us>, accessed on 9 November 2015).

possible solutions to generate actions for the way forward. The discussions helped formulate the recommendations and action points of the meeting. The topics discussed were as follows:

- Topic 1: Feedback on global HIV strategies and priority actions on HIV to fast-track the response in the next six years
- Topic 2: Strategic information: Monitoring and evaluating impact of interventions along the continuum of care (Prevention and Treatment Metrics)
- Topic 3: Determining financial flow and prioritization process
- Topic 4: Combination HIV prevention: Do we need ARV PrEP in Asia?

2.7.1 Feedback on global HIV strategies and priority actions on HIV to fast-track the response in the next six years

The participants discussed constraints and challenges in carrying out each of the five strategic directions put forth in the draft WHO Global Health Sector Strategy on HIV. The group then compiled a list of priority actions that countries, civil society organizations, UNAIDS and WHO should consider adopting in order to have a major impact on the HIV response in the next 5 years and the next 10 years. The key discussion points, as listed in Annex 3, are being considered by WHO.

2.7.2 Monitoring and evaluating the impact of interventions along the continuum of care (prevention and treatment metrics)

The participants identified key challenges to the collection and optimal use of strategic information and priority actions that countries, civil society organizations, UNAIDS and WHO should consider to improve the quality, collection, relevance and use of strategic information.

The participants suggested a number of actions to decrease fragmentation of responsibilities and roles, in particular between national and subnational levels and peripheral-level health-care workers, to improve coordination of data collection, use and sharing. Moreover the participants recommended improving the quality of information through standardization of data collection and reporting and strengthening of capacity for data analysis and use at all levels. Solutions presented included establishing a national strategic information technical working group in countries where national coordination is lacking, and involving provincial representation at annual workshops to facilitate national–subnational communication. For countries where HIV data collection is fragmented due to vertical systems within HIV programmes and between different health sectors, ministerial-level decisions to establish a multisectoral strategic information committee will be required to improve coordination. More training on data analysis and use for grassroots health-care workers, including outreach workers, was proposed to address disinterest at the service-provider level. Shifting responsibility for data analysis from the central to the grassroots level would increase data ownership and improve attention to data quality. Central-level outreach to civil society organizations was suggested for countries lacking data on key populations.

The group discussed detailed issues and actions around enhancing surveillance and monitoring systems to provide the information needed at each level of the health system. The following actions were proposed: increasing use of case reporting and programme data to supplement data, specifically use of programmatic mapping to obtain population and subpopulation size estimates; pursuing national unique identifier codes with biometrics or name-based reporting and electronic systems to efficiently track clients and patients; improving laboratory record-keeping and reporting for surveillance purposes; and integrating early warning indicators data into surveillance systems. The group thought the use of existing data could be improved and proposed engaging behavioural social scientists to help interpret data, and building data repositories and providing

access to further epidemiologic data. Countries identified a need for guidance to help prioritize surveys and determine periodicity.

Moreover, methods to improve subpopulation estimates were reviewed. Countries with large populations advocated that city-level care and treatment cascades were more useful than national cascades to inform more targeted HIV responses. Countries with low-level HIV epidemics or limited survey data had trouble disaggregating data and using epidemic modelling tools for their country context.

2.7.3 Determining financial flow and prioritization process

Participants shared their country experiences with HIV financing, including current and future challenges and potential solutions. The level of domestic funding allocated to HIV varies between countries. Opportunities to use available resources more efficiently – e.g. pooled procurement and central procurement and integrated service delivery – were discussed.

Challenges in making the shift from external to domestic funding for HIV services were discussed. Overall, national HIV programmes are considered expensive and the process to transition to domestic funding is long and involves multiple processes and stakeholders. In some countries, limited information on national health accounts and discussions among stakeholders hampers the shift to domestic funding. In most countries, national funding is limited to treatment but does not include prevention and service delivery. Donors often have poor exit strategies and such strategies depend on political priorities and willingness to increase national allocation to health. Within that, another process would consider allocation to HIV among other competing health priorities.

When considering what was needed to move towards greater domestic funding, participants agreed that establishing national health insurance and including HIV treatments as part of the benefit package were important steps in most low- and middle-income countries. They also recognized the need for multisectoral advocacy aimed at convincing high-level policy-makers to increase domestic funding, to lower prices for commodities and ARVs and to expand sources of funding through taxation and innovation methods.

2.7.4 Combination HIV prevention: Do we need ARV PrEP in Asia?

Participants discussed the extent to which stakeholders in their country were aware of PrEP. Responses varied. At one end of the spectrum, one country has incorporated PrEP in a national strategic plan and another country has undertaken a PrEP study. At the other end, awareness about and interest in PrEP was low among key populations and government policy-makers in many countries.

Several participants indicated that they needed additional information and a greater understanding of the implications of the new WHO recommendation on PrEP for HIV-negative individuals to prevent HIV acquisition before they could seriously consider implementing this recommendation. Frequently mentioned concerns included the availability and costs of ARVs approved for PrEP, the cost-effectiveness of PrEP, procurement and regulatory issues, and possible side effects of the ARV drugs. Some participants also believed that the demand for PrEP in their countries was low and that it was not clear how PrEP would be implemented (i.e. for which population, where, when, for how long) and who would pay for the ARVs and re-testing. Moreover, tenofovir in combination with emtricitabine is not registered in most countries.

While some participants felt that their country or community was not ready for PrEP, others felt they were ready to commit to a phased introduction of PrEP, starting with demonstration projects. Participants from Malaysia, the Philippines and Viet Nam expressed interest in participating in a demonstration project but would require prior national community and stakeholder consultation. In Malaysia, PrEP for MSM or prevention of sexual transmission is being discussed as part of the National Strategic Plan on Ending AIDS, Malaysia 2016–30. Once approved, this could translate into national guidelines in Malaysia.

2.8 Closing remarks

Dr Ying-Ru Lo delivered the closing remarks on behalf of WHO. She thanked all participants and noted the valuable contributions to the meeting made by those who presented or served as facilitators. Dr Lo emphasized that while HIV prevalence among general populations across the Region remains low, it continues to be unacceptably high and even increasing in key populations. High rates of new syphilis infections occur among MSM and high rates of HCV/HIV and TB/HIV co-infections are also registered among PWID. She stressed that we must do better in the prevention and control of HIV and STIs, and that the recommendations from this meeting will help. Dr Lo also underlined the importance and value of strong cooperation between WHO and UNAIDS.

Dr Vladanka Andreeva delivered the closing remarks on behalf of UNAIDS. Dr Andreeva emphasized that to put Asia and the Pacific on track to end AIDS by 2030, countries need to accelerate efforts in the next five years to ensure that 90% of people living with HIV know their HIV status, 90% of people who know their status are on treatment, and 90% of people on treatment have suppressed viral load. Priority actions to achieve the 90-90-90 targets in the Western Pacific Region include: rapidly scaling up access to HIV testing and treatment in health facilities and communities; and implementing and enforcing antidiscrimination and protective laws. Moreover, when scaling up access to HIV testing and treatment, it is imperative that we support countries to diversify testing approaches and service delivery modalities, with a focus on key populations and with engagement of the community.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

The meeting produced the following conclusions:

- (1) Countries have made impressive progress in the Western Pacific Region in scaling up HIV prevention, testing, care and treatment, yet significant challenges remain.
- (2) Countries have identified a number of inefficiencies in the HIV services cascade.
- (3) There is a need to integrate HIV efforts into the broader health and development agenda without losing sight of public health goals.
- (4) We have to make rapid progress by 2020 and not allow increases in new infections that will have a heavy financial toll and lead to expanding costs for HIV prevention and treatment.
- (5) Controlling the HIV epidemic by 2030 is an achievable goal. No single existing intervention has the ability to stop HIV transmission among key populations and their partners. A successful programme requires a combination of structural, biomedical and behavioural interventions that are mutually reinforcing, continually evaluated, and tailored to the needs and risks of specific groups.

Particular issues highlighted included:

- (1) Implementing and enforcing antidiscrimination and protective laws to eliminate stigma, discrimination and violence against MSM, transgender people, sex workers and people who use drugs is crucial to ending AIDS.
- (2) There is a need to prioritize a rapid reduction in new infections and focus the response on those populations and locations most affected by HIV epidemics.
- (3) Given the scientific evidence of the effect of earlier treatment initiation on improved health outcomes – not only for PLHIV, but for the larger community as well – we urgently need to scale up access to HIV testing and treatment.
- (4) To scale up testing, we need to ensure an optimal combination of HIV testing in health facilities and communities.
- (5) Greater community participation in delivery of services including outreach, HIV testing and treatment is essential to improve coverage of key affected populations.
- (6) When setting and taking action to achieve the Fast-Track targets, due attention must be paid to ensuring that “no one is left behind”.
- (7) Hepatitis has emerged as a major public health priority in the Region, and it is important to use lessons learnt from HIV to establish a public health approach for viral hepatitis in the Region. Moreover, there is a need to improve linkages between HIV testing and HIV care and treatment and make similar efforts for viral hepatitis. It is also important to ensure that HIV and hepatitis, both, are considered under UHC.
- (8) Systems and human capacities for the collection, analysis, reporting and utilization of strategic information must be strengthened. Building a comprehensive HIV surveillance system requires a progressive expansion of the scope and capacity of HIV strategic information systems to collect and analyse data on HIV risk behaviours and social determinants, modes of transmission, incidence and prevalence, morbidity and mortality, co-infections and comorbidities, service coverage and quality, and costs.
- (9) Strengthening the reporting and collection of data from prevention and treatment programmes at national and subnational levels (cities) is urgently required.
- (10) Whenever necessary, the M&E components of national HIV strategies should be revised to ensure that countries monitor and report on the recently announced “10 core indicators”.
- (11) Countries need to increase their domestic investment in HIV, strengthen country ownership of the AIDS response and take a long-term sustainable view of ongoing investment in the AIDS response. Development of a financing plan to guide the transition from an externally funded to a domestically funded HIV plan would enable countries and donors to plan and implement such a transition more efficiently.
- (12) Rapid and continued scale-up of treatment makes the surveillance and monitoring of HIV drug resistance an even greater priority. Monitoring of HIV drug resistance is essential for understanding the quality of ARV treatment programmes and the efficacy of currently recommended first- and second-line treatment regimens in countries.
- (13) It is essential to improve the quality of national and subnational laboratory systems in countries and this will help improve the roll-out of community-based testing and ensure quality.

3.2 Recommendations

3.2.1 Recommendations for Member States

- (1) In light of decreasing donor support, countries should look for alternative sources of financing, including applying principles of UHC, to ensure sustainability of HIV programmes.
- (2) The transition from external to national financing requires efficient use of funds and evidence-based resource allocation. With the introduction of the principles of UHC, determining financial flow and prioritizing interventions should ensure that HIV remains a priority (Box 1).
- (3) Efforts geared towards reaching the 90-90-90 targets by 2020 should be intensified. Community-based testing, as detailed in the WHO 2015 testing guidelines, is needed to reach the first 90 target, in particular for hard-to-reach populations. Continued efforts are also needed to strengthen linkages to care and treatment and achievement of viral suppression for those already diagnosed and on treatment.
- (4) Delivery of quality-assured HIV testing and treatment monitoring should be strengthened. Use of new technologies for point-of-care viral load monitoring should be explored in order to expand access to affordable HIV viral load monitoring.
- (5) With the expansion of ARV treatment, it is important for countries to implement regular HIV drug-resistance surveys in combination with the monitoring of early warning indicators. Funding for these surveys should be incorporated in the national annual work plans.
- (6) Countries should continue to build comprehensive HIV surveillance systems. Scope and capacity need to be expanded for monitoring HIV risk behaviours as well as generating and using local-level data. Despite shrinking funding, investment for data management is a priority to ensure high-quality data collection and analysis (Box 2).
- (7) Countries should, at the minimum, use the 10 core indicators recommended by WHO to monitor the 90-90-90 targets (Box 2).
- (8) Recommending ARV PrEP for sexually active MSM should be considered as an additional prevention tool to contain the HIV epidemic among this key population (Box 3).

3.2.2 Recommendations for WHO, UNAIDS and partners

- (1) WHO, UNAIDS and international partners should support processes in countries for identifying financial resources that can serve as alternatives to external donor funding.
- (2) WHO should clarify UHC principles to HIV stakeholders as countries are concerned of escalating health costs. WHO should be able to explain how the principles of UHC could help sustain and further expand the HIV responses.
- (3) WHO, UNAIDS and partners should develop further guidance on how HIV can be considered when planning for UHC and how to transition from external to national funding. This should include high-level and multisectoral advocacy for increased allocation of domestic funding and would require determining the financial flow and prioritization process while increasing efficiency in terms implementation/provision and financing of HIV services (Box 1).

- (4) In order to reach the first 90 target, WHO, UNAIDS and partners should support country stakeholders in the implementation of the WHO guidelines on consolidated HIV testing services.
- (5) WHO should increase its technical support for strengthening the delivery of quality-assured HIV diagnosis and treatment monitoring (e.g. laboratories, community-based testing) guided by WHO prequalification programmes. WHO should work with countries to assess the feasibility of new point-of-care technologies for HIV viral load monitoring.
- (6) WHO should identify technical and financial resources to help support countries to implement regular periodic HIV drug-resistance surveys and monitor early warning indicators as part of the national framework for treatment monitoring.
- (7) WHO and UNAIDS should continue working with countries to build comprehensive HIV surveillance systems, progressively expand scope and capacity to monitor HIV risk behaviours and build capacity to use local-level data. WHO and UNAIDS should promote sustained investment for data management to ensure that prioritization and financing decisions are based on high-quality data (Box 2).
- (8) WHO, UNAIDS and partners should assist Member States by advocating for the harmonized 10 indicators to monitor the 90-90-90 targets with standardized definitions, drawing from the global WHO consolidated strategic information guidelines and regional metrics (Box 3). WHO and partners should support the development of electronic registers and evaluate innovative methods to collect such data in a coordinated fashion.
- (9) WHO, UNAIDS, researchers and regional civil society organizations should work with key stakeholders at the country level to carefully design demonstration projects for the integration of PrEP into combination prevention for MSM (Box 3).

Box 1: Action points on HIV financing and universal health coverage

- a. Conduct analyses of required resources considering prioritization, streamlining and integration.
- b. Set national targets and plan for financial transition. The analysis process should also be integrated into the national development plan.
- c. Consider expanding funding sources including establishment of trust funds, public-private partnerships, corporate social responsibility and taxation.
- d. Consider including or expanding coverage of HIV services through national health insurance plans.
- e. WHO, UNAIDS and partners should support high-level advocacy for better pricing of commodities, especially ARVs.
- f. National and/or regional systems of registration and procurement of commodities including ARVs and HIV test kits should be established.

Box 2: Action points on strategic information

- a. Invest in capacity-building of staff at district and subdistrict levels to collect and analyse data and develop local-level information for the treatment cascades. Given their important role in collecting data, service delivery staff should fully understand the definitions and purpose of the indicators, know how to collect unique counts, and be aware of data management and reporting requirements. To address high staff turnover, simplified training materials and standard operating procedures can be used for easy facilitation of trainings.
- b. Data on key populations are critical for the HIV response in Asia and the Pacific, yet population size estimates, particularly of MSM and transgender people, are still lacking. Data collection must be undertaken in partnership with civil society organizations to ensure confidentiality and help overcome criminalization. Data repositories of behavioural surveys among key populations should be established, to include raw data, in order to avoid duplicative surveys and to increase the use of data through secondary data analysis. Behavioural social scientists may be engaged to translate behavioural data into programmatic and policy actions.
- c. Strong coordination mechanisms should be required to harmonize and coordinate the fragmented data management system. Potential coordination solutions include ministerial-level decrees and a functional national strategic information technical working group.
- d. Countries should increasingly apply electronic systems to track patients across services and facilitate data collection, reporting, analysis and sharing. Data entry, workload, electronic data system and network infrastructure requirements need to be taken into account.
- e. Unique identifiers are needed to avoid duplicative counts and track patients across services. Member States should consult with civil society organizations on the best use of identification numbers, unique identifier codes, and biometrics.
- f. Reports on HIV-negative cases, currently missing from case reports, must be

collected in order to obtain prevalence data through case-based surveillance. Laboratory data systems should be linked with patient data systems to facilitate HIV-negative case reporting.

- g. Early warning indicators for HIV drug resistance should be part of surveillance systems rather than managed only within the care and treatment programmes.
- h. UNAIDS and WHO can facilitate better use of data through more Asia-specific epidemic models, less frequent updates of the model software, and simplified global reporting. Software updates to SPECTRUM and AIM should be less frequent given that obtaining national and government consensus after analysis is time consuming. Likewise, the Global AIDS Response Progress Report should be simplified, aligned with the global indicators, and not changed annually given that data collection system changes require longer periods of time.

Box 3: Action points on use of ARV PrEP by Member States, WHO, UNAIDS and partners

- a. Prepare WHO, UNAIDS and APCOM communication packages with clear messages regarding PrEP.
- b. Develop specific/operational guidance on PrEP, including guidance on how to deliver services and how to monitor the impact.
- c. Provide more evidence on cost-effectiveness to convince governments and communities. Create cost-effectiveness models based on data from low-prevalence countries.
- d. Enhance data on levels of risk among MSM and other key populations to identify priority subpopulations who can benefit from PrEP, and identify sites where PrEP could potentially be implemented.
- e. Support the design of demonstration projects to answer implementation questions relevant for the safe roll-out of PrEP.

ANNEXES

Annex 1. Agenda

Day 1 – Wednesday, 1 July 2015

Time	Topic	Presenter
08:00–08:30	Registration	
08:30–09:00	Opening session <ul style="list-style-type: none"> • WHO Regional Office for the Western Pacific • UNAIDS Regional Support Team for Asia and the Pacific • Host country 	<p>Shin Young-soo, Regional Director, <i>WHO Regional Office for the Western Pacific, to be delivered by Takeshi Kasai, Director, Programme Management</i></p> <p>Steve Kraus, Director, <i>UNAIDS Regional Support Team for Asia and the Pacific</i></p> <p>Vicente Belizario, Undersecretary, Office for Technical Services, Department of Health (through WHO Philippines)</p>
09:00–09:30	Objectives of the meeting Introduction of participants Group photo	Ying-Ru Lo <i>WHO Regional Office for the Western Pacific</i>
09:30–10:00	<i>Coffee/tea break</i>	
10:00–11:00	Regional action on HIV, hepatitis and STIs in Asia and the Pacific (15 min including Q&A) Epidemiology and response to STIs in the Pacific (10 min) Fast-tracking the HIV response (15 min including Q&A) The global WHO strategies on HIV and STIs (20 min including Q&A)	Ying-Ru Lo Madeline Salva, <i>WHO Representative Office in the South Pacific</i> Vladanka Andreeva, <i>UNAIDS Regional Support Team for Asia and the Pacific</i> Andrew Ball, <i>WHO Headquarters</i>
11:00–12:30	Moving towards universal health coverage (UHC): Ensuring financial protection for prevention and treatment of HIV (15 min) Framework for HIV and UCH, the ASEAN Task Force on HIV (15 min) Thailand's approach to sustainable financing for HIV and ending AIDS (15 min) Transitioning from external to domestic funding: A health systems perspective (15 min)	Xu Ke, <i>WHO Regional Office for the Western Pacific</i> Sha'ari Ngadiman, <i>Ministry of Health, Malaysia</i> Petchsri Sirinirund, <i>Ministry of Public Health, Thailand</i> Socorro Escalante, <i>WHO Representative Office in Viet Nam</i>

Time	Topic	Presenter
12:30–14:00	<i>Lunch break</i>	
14:00–15:00	<p>Fast-tracking the response Measuring the HIV response and progress through the prevention and treatment cascade (20 min):</p> <ul style="list-style-type: none"> • Introduction to the cascade and indicators, and the WHO strategic information guidelines; explanation of numerators and denominators for indicators, which would comprise programmatic data from on the ground to modelling estimates • Quality and reliability of existing data; data gaps; and moving forward through use of unique identifiers, stronger programmatic monitoring, etc. <p>Country examples and realities:</p> <ul style="list-style-type: none"> • Measuring and achieving high coverage with ICT enhanced solutions (10 min) • Unique health identifiers and HIV: Active HIV case management (10 min) • Electronic patient monitoring system (10 min) <p>Questions and answers (10 min)</p>	<p>Linh-Vi Le, <i>WHO Regional Office for the Western Pacific</i></p> <p>Amala Reddy, <i>UNAIDS</i></p> <p>Elvin Marcello, <i>Ministry of Health, Philippines</i> <i>Ministry of Health, Cambodia</i> Dr Vo Hai Son, <i>Viet Nam Authority of HIV/AIDS Control</i></p>
15:00–15:30	Coffee/tea break	
15:30–16:30	<p>Unpacking the 90-90-90 targets: Cascade of HIV testing, care and treatment services and evaluating impact (viral load) (15 min) Guidelines and innovative interventions from HIV testing, service delivery, testing modalities and approaches in the community (15 min) Creating demand through community-based testing approaches (15 min)</p>	<p>Naoko Ishikawa, <i>WHO Regional Office for the Western Pacific</i> Stephen Mills, <i>FHI 360</i> Choub Sok Chamreun, <i>Khmer HIV/AIDS NGO Alliance (KHANA)</i>,</p>
16:30–17:30	<p>Improving access to and quality of HIV and syphilis testing for reliable results</p> <ul style="list-style-type: none"> • 2015 laboratory gap analysis in seven countries and validation of HIV testing algorithms (15 min) • Validation of HIV testing algorithms in the Philippines (10 min) • HIV testing algorithm development and the decentralization of confirmatory testing plans in Viet Nam (10 min) 	<p>Sue Best, <i>National Serology Reference Laboratory, Australia</i> Gerard Belimac, <i>AIDS Programme Manager, Philippines</i> Phan Thi Thu Huong, <i>Viet Nam Authority of HIV/AIDS Control</i></p>
17:30–18:00	<p>Prevention and surveillance of HIV drug resistance</p> <ul style="list-style-type: none"> • Regional action plan for HIV drug resistance surveillance and new protocols • HIV drug resistance surveillance in Japan 	<p>Polin Chan, <i>WHO China</i></p> <p>Yoshimura Kazuhisa, <i>National Institute of Infectious Diseases, Japan</i></p>
18:00–18:30	WHO-UNAIDS Secretariat meeting	
18:30–20:00	<i>Welcome reception</i>	

Day 2 – Thursday, 2 July 2015

Time	Topic	Presenter
Objective 3: To review and discuss global HIV and STI strategies, targets and priority actions for Member States for 2016–2021		
08:00–08:30	Antiretroviral pre-exposure prophylaxis	Ying-Ru Lo and Inad Rendon, <i>Advocacy Officer, APCOM</i>
08:30–10:00	Introduction to the parallel sessions: Parallel break-out sessions	Facilitators
10:00–10:30	<i>Coffee/tea break</i>	
10:30–12:30	Parallel sessions (continued)	Facilitators
12:30–13:30	<i>Lunch break</i>	
14:00–14:30	What are new scientific developments in HIV?	Sharon Lewin, Director, <i>Doherty Institute, WHO Collaborating Centre for Viral Hepatitis and WHO Hepatitis B Reference Laboratory</i>
14:30–15:00	Parallel sessions reporting back groups 1 and 2	Rapporteurs
15:00–15:30	<i>Coffee/tea break</i>	
15:30–16:00	Parallel sessions reporting back groups 3 and 4	Rapporteurs
16:00–17:00	Conclusions and recommendations	
17:00	Closing	

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Annex 3. Feedback on global HIV strategies and priority actions on HIV to fast-track response in the next six years

Questions discussed were as follows:

- What are the key bottlenecks, constraints and challenges to delivering and focussing on each of the five strategic directions in the draft WHO Global Health Sector Strategy on HIV?
- What priority action should countries, UNAIDS, WHO and civil society take in each of the five strategic directions in the draft WHO Global Health Sector Strategy on HIV to have a major impact on the HIV response in the next five years and the next 10 years?

Strategic Direction 1: Information for focus and accountability

Actions for improving the quality and utility of data, strategic information systems and capacities to utilize data and information more effectively should include:

- selecting better indicators;
- establishing better baseline data to monitor progress against the 10 core indicators;
- harmonizing indicators utilized by donors, Global Fund, PEPFAR, etc.;
- improving the collection of data through health information systems;
- enhancing the role of communities in the collection, analysis and use of data;
- collecting better data from key populations and at the subnational and city level;
- presenting strategic information in ways that enable key stakeholders – i.e. populations, civil society organizations, local governments and city mayors – to use that information for action and to set or influence policy;
- including early warning indicators for drug resistance in national surveillance plans; and
- integrating HIV more effectively into national health information systems.

Strategic Direction 2: Interventions for impact

Key interventions for achieving maximum impact should include:

- packaging information and messaging to better target young MSM (e.g. by age, by risk);
- increasing emphasis on testing including community-based services and self-testing;
- providing guidance on new diagnostic technologies (point of care test/viral load monitoring);
- placing more emphasis on PrEP;
- stepping up hepatitis C testing and treatment;
- screening more effectively for hypertension and diabetes; and
- promoting integrated active case management.

Strategic Direction 3: Delivery for quality and equity

Actions for enabling delivery for quality and equity should include:

- strengthening community systems for service delivery through capacity-building;
- delivering more effective training for service providers on PLHIV (including using patient experts), stigma and discrimination;
- integrating and coordinating services between various service providers for key populations;
- packaging services for MSM (e.g. oral HIV test, “Test & Treat”, condoms plus lab); and
- offering a more comprehensive package of support to PLHIV in resource-constrained settings;
- decentralizing ART initiation and delivery follow-up;
- developing national plans to strengthen laboratories and lab systems (including staff);

- addressing the issue of requiring parental/guardian consent for testing and provision of services to minors (under 15 to 18 years depending on national laws and regulations)
- adapting programme implementation tools and guidance to regional and local contexts; and
- undertaking more operational research.

Strategic Direction 4: Financing for sustainability

Actions to help achieve sustainable financing should include:

- providing technical support to countries for the development of transitional financial plans, HIV investment cases, costed national strategies and the elaboration of Fast-Track plans at national and subnational levels;
- increasing technical and financial support for civil society organizations to reach the 90-90-90s targets;
- strengthening the financial sustainability of surveillance plans;
- ensuring greater availability of generic drug products;
- lowering prices for diagnostics and commodities including second- and third-line ARVs and hepatitis C treatment;
- exploring alternative sources of funding and work with parliaments and ministries of finance;
- using TRIPS' flexibilities more frequently;
- advocating for ASEAN to adopt the Fast-Track 90-90-90 targets and ASEAN countries to commit to reaching the 2020 and 2030 targets for ending AIDS;
- exploring UHC, health insurance and private health insurance; and
- integrating HIV into national health plans and budgets.

Strategic Direction 5: Innovation for acceleration

Innovation actions for accelerating the response to AIDS should include:

- addressing retention and adherence to prevention issues more effectively;
- developing an efficacious and cost-effective oral HIV test; and
- offering dual/triple tests (e.g. HIV/syphilis/hepatitis B and C).

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