Addressing AIDS in ASEAN Region
First Regional Report on HIV & AIDS
The Association of Southeast Asian Nations (ASEAN) was established on 8 August 1967. The Member States of the Association are Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam. The ASEAN Secretariat is based in Jakarta, Indonesia.

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Addressing AIDS in ASEAN Region

First Regional Report on HIV & AIDS
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Abbreviations and Acronyms

AEM  Asian Epidemic Model
AHMM  ASEAN Health Ministers’ Meeting
AIDS  Acquired Immune Deficiency Syndrome
AMS  ASEAN Member States
ART  Antiretroviral therapy
ARV  Antiretrovirals
ASCC  ASEAN Socio-Cultural Community
ASEAN  Association of Southeast Asian Nations
ATFOA  ASEAN Task Force on AIDS
AWP  ASEAN Work Programme (on HIV and AIDS)
CUP  (100%) Condom Use Programme
EU  European Union
FTA  Free Trade Agreement
GFATM  The Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA  Greater Involvement of People Living with HIV and AIDS
HIV  Human Immunodeficiency Virus
IDU  Injecting drug users
KAP  Key affected populations
MDG  Millennium Development Goals
MMT  Methadone Maintenance Therapy
MSM  Men having sex with men
NGO  Non-governmental organisation
NSEP  Needle and Syringe Exchange Programme
OST  Opioid substitution therapy
PHAMIT  Prevention of HIV/AIDS among Migrant Workers in Thailand
PLHIV  People living with HIV
PMTCT  Prevention of mother-to-child transmission
STI  Sexually-transmitted infections
SW  Sex workers
UA  Universal Access
UNAIDS  The Joint United Nations Programme on HIV/AIDS
UNGASS  United Nations General Assembly Special Session (on HIV and AIDS)
WHO SEARO  World Health Organization - South East Asia Regional Office
WHO WPRO  World Health Organization - Western Pacific Regional Office
With 33 million people estimated to be living with HIV after three decades since the very first case of HIV was reported, we are now seeing a myriad of innovative approaches and partnerships being developed to contain and reverse the HIV epidemic. However, it continues to pose as a very important threat to health development worldwide. ASEAN is not spared of the ill-effects of the pandemic. According to the first ASEAN Regional Report on HIV and AIDS, which is the consolidated 2010 United Nations General Assembly Special Session on AIDS (UNGASS) reports of 10 Member States, some 1.5 million ASEAN people was estimated to be living with HIV. As our 2015 vision of an ASEAN community draws near, we re-examine the status of HIV epidemic in the region and the important progress in our efforts to reverse the epidemic. This is consistent with the goal of the ASEAN towards a people-centred and socially responsible community where the well-being, livelihood and welfare of the people are enhanced, as guided by the ASEAN Socio-Cultural Blueprint.

The HIV epidemic in ASEAN shows a range of heterogeneities along similar epidemic patterns. Around seventy-five per-cent of reported HIV cases were from key affected and vulnerable groups of population, such as people who inject drugs (PWID), men having sex with men (MSM) and sex workers (SW) and their clients. Intimate partners of these groups, at risk youths, institutionalized persons, military and mobile populations are among the most vulnerable populations.

In 1993, after receiving mandate from the 4th ASEAN Summit in Singapore, the ASEAN Task Force on AIDS (ATFOA) was established to promote regional cooperation and partnership in combating HIV and AIDS by strengthening regional response capability as well as providing a platform for cooperation with other regional, international and civil society organizations. The 7th ASEAN Summit in Brunei Darussalam and the 12th ASEAN Summit in Cebu, Philippines highlighted the strong determination of the ASEAN political leadership of ASEAN Member States to address HIV and AIDS by signing the ASEAN Declaration on HIV and AIDS in 2001 and the ASEAN Commitment on HIV and AIDS in 2007 respectively.

In this report, we are now seeing positive results of such strong political will in significant reduction in HIV prevalence in few of our Member States. From an earlier 1.6 million estimate in 2006, the number of people living with HIV has been reduced to 1.5 million as of 2009. People needing anti-retro-viral treatment have better access than before, with few Member States reaching the Universal Access target of 80 percent.

However, the HIV continues to increase in geographical packets especially among population with higher risk-taking behaviours. While effectiveness of harm reduction as a strategy had been demonstrated in few Member States, there is still a big proportion of injecting drug users not being covered. Similarly, lacking of or inadequate programmes to reduce new HIV transmission among sex workers and their clients and MSM threaten the early achievements in promoting safe sex behaviours and condom use. Such known effective intervention needs supportive policy and enabling environment in order fully cover hard to reach injecting drugs users, sex workers and MSM.
We all take pride in coming up with the first regional report on HIV and AIDS that can better guide our national policy makers, regional multilateral and bilateral partners and the civil society organizations in crafting innovative interventions and effective partnerships. Such endeavors contribute to fulfillment of ASEAN level commitment and achievement of Millennium Development Goals (MDGs). The report also includes the Fourth ASEAN Work Programme on AIDS (2011-2015), which is guided by the ASEAN Framework on Health Development and the ASCC Blueprint.

Lastly, I wish to thank the ATFOA, the SOMHD and relevant sectoral bodies who contributed so generously in the development of this report. We extend special gratitude to UNAIDS for financial contribution to the publication of this report. We encourage strategic partnerships and development of inter-sectoral and multi-stakeholders linkages among ASEAN, multilateral, bilateral and civil society organizations to provide long lasting solutions to HIV and AIDS.

SURIN PITSUWAN

Secretary-General of ASEAN
Acknowledgements

This publication highlights the importance of having a consolidated information of 2010 United Nations General Assembly Special Session on AIDS (UNGASS) among the 10 ASEAN Member States in a collaborative process. The report acknowledges contributions of ASEAN Member States, organizations and individuals in the development and production of the first regional report on HIV and AIDS in ASEAN. Firstly, the Focal Points of the ASEAN Task Force on AIDS (ATFOA) of Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam for taking the leadership in conceptualization and development of the report and the Senior Officials Meeting on Health Development (SOMHD) for collective support to this undertaking of the ATFOA.

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Executive Summary

Overview

ASEAN is an inter-governmental organization composed of 10 Member States, namely, Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam. South East Asia regional grouping is home to about 600 million people of diverse ethnicities, cultures, religions, languages, modes of government and levels of development.

The ASEAN Task Force on AIDS (ATFOA) consolidated the 2010 UNGASS Reports of the 10 ASEAN Member States to come up with the First ASEAN Regional Report on HIV and AIDS. The reported estimates and service statistics covers the period of 2007-2009, depending on available information during the UNGASS reporting period. The report aims to review the HIV status and to reflect on the progress of the response in view of the goal of reversing the HIV epidemic and mitigating its impact in the region. It also serves as a tool for advocacy and support the development of the Fourth ASEAN Work Programme on HIV and AIDS (2011-2015).

AIDS Epidemic and Response in South East Asia

There are 1.5 million people estimated to be living with HIV in ASEAN region. This is lower than the 1.6 million reported by UNAIDS in 2006. As of 2009, national HIV prevalence range from less than 0.1% (Philippines, Singapore, and Brunei) to 0.7% in Cambodia and Thailand. Prevalence rates are mostly decreasing, although Philippines and Lao PDR has reported an increase of over 25% since 2001. The epidemics in ASEAN region show a range of heterogeneities along similar epidemic patterns. It can be described as either in latent, increasing, maturing and declining epidemics. Reports from the Commission on AIDS Report described the HIV epidemic in the counties in the region as follows:

- High prevalence of risk behaviors but declining HIV prevalence due to successful prevention, especially among sex workers (Thailand, Cambodia, and Myanmar);
- Moderate risk, especially among drug injectors (Malaysia, Indonesia and Viet Nam);
- Low prevalence but evidence of increasing spread (Philippines and Lao PDR);
- Low prevalence of risk behavior but increased concern about migrant populations (Brunei and Singapore.)

Key Affected Populations

As in the rest of Asia, the main drivers of the epidemic are unprotected sex with multiple partners and needle sharing in injecting drug use. Around seventy-five percent of all HIV infections are reported among key affected populations (KAP) such as sex workers, men who have sex with men, transgenders and people who inject drugs. Other vulnerable populations include intimate partners of these groups, at risk youths, institutionalized persons, the military and mobile populations.

People who inject drugs continue to have the highest levels of prevalence compared to other KAPs, albeit declining over the years. With 20-40% of the injecting population becoming HIV positive, it will provide a steady “pool” of infections if effective prevention measures such as clean needles and condoms are not put in place. Hepatitis C as a co-infection is another health challenge faced by people who inject drugs.
HIV among IDUs appears to be declining in Cambodia, Thailand and Viet Nam and increasing in Indonesia. Cambodia, Lao PDR and Philippines have reported significant number of transmissions through sharing of contaminated needles in recent years. Indonesia, Malaysia, Myanmar and Viet Nam have instituted known effective programmes to address HIV transmission among injecting drug use, which includes needle and syringe exchange and Opioid Substitution Therapy.

HIV prevalence rates among sex workers has slowed down and is generally in decline, from 20-38% in 2000, to 5-18% in 2006-2008. ASEAN Member States such as Cambodia, Myanmar and Thailand have been cited for implementing a comprehensive programme, including condom use. Some sub-populations of sex workers (those who have been trafficked, those who also inject drugs, or those who may be younger in age) may have generally higher vulnerability. Clients of sex workers are a large group, but are not well characterized, and are not generally included in surveillance. They are thought to constitute the largest infected population group in the region. The percentage of Asian men who buy sex on an occasional or regular basis is estimated to be huge, at around twenty percent (20%).

There is wide range of variation of HIV prevalence among men who have sex with men (MSM) in the region, ranging from 1% in the Philippines to 29% in Myanmar, with large variations between sub-populations and with the highest rates of prevalence found in urban centres. Transgender population is also highly vulnerable. They have shown even higher rates of HIV in comparison with MSMS in the same country mostly because of associations with sex work. However, the epidemic among MSM has great potential to grow as documented in similar situations across the globe.

The coverage of effective prevention programmes across key affected populations is still below the indicated Universal Access targets (at 80%) in each country. The expansion and implementing effective intervention strategies targeted towards key affected populations is directly affected by enabling programme and policy environment.

Other vulnerable groups in the region who can also be affected include migrants and mobile populations, at-risk youth, intimate partners of the key affected populations and partners of those living with HIV, and other population and occupation groups such as prisoners, military personnel, and truck drivers. It is important to note that only a sub-set of these population are at higher risk for HIV, particularly those who practice high risk behaviours such as unprotected sex with multiple partners and sharing of injecting equipment.

Treatment and care programmes are also in varying levels of development across the region. Anti-retroviral treatment of PLHIV has expanded significantly in the last few years. The use of generic medicines has increased the treatment coverage in most of the ASEAN Member States. However, such programme also faces challenges in longer term availability of generic medications, as well as addressing stigma and discrimination.

National and per capita spending has increased but mostly from external sources, notably the Global Fund to Fight AIDS Tuberculosis and Malaria in many of the Member States. Four ASEAN Member States, Brunei Darussalam, Malaysia, Singapore and Thailand have achieved over 90% domestic funding of HIV and AIDS expenditures. Proportionate spending to address key drivers of the epidemic, i.e. funding effective prevention programmes to avert new infections are needed in order to finance the national strategic plans and sustain national responses.
ASEAN Response to HIV and AIDS

ASEAN Task Force on AIDS (ATFOA) was established to promote regional cooperation in combating HIV and AIDS and strengthening regional response in the ASEAN region. The ASEAN Declaration on AIDS, signed during the 7th ASEAN Summit in Brunei Darussalam in 2001 highlighted the important role of ASEAN in leadership to intensify national response, implementing collaborative activities to support multi-sectoral response and in strengthening regional mechanism to monitor and evaluate including information sharing and involvement of civil society organization. Being a sectoral body under the health development, there is a need to strengthen inter-sectoral dialogue to address cross-sectoral issues that also affects HIV responses.

Three multi-year ASEAN Work Program on HIV and AIDS (AWP) had been developed and implemented by ATFOA through cost sharing mechanisms and collaborative projects with multilateral and bilateral partners. The completion of AWP III in 2010 has created an impetus to review progress and guide the development of AWP IV.

ASEAN Regional Priorities

Based on the analysis of regional data, several issues have been highlighted as priority areas relevant to ASEAN as a region. These issues are:

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

While Member States continue to find ways and means to address HIV and AIDS at the national and community level, ASEAN through ATFOA and other relevant sectoral bodies should provide the necessary platform for regional activities under its work programme.

ASEAN Work Programme on HIV and AIDS IV (2011-2015)

Under the ASEAN Strategic Framework for Health Development (2010-2015), as guided by the ASEAN Socio-Cultural Community Blueprint (2009-2015), the ASEAN Fourth Work Program (AWP IV) on HIV and AIDS, outlined the goals and objectives of reducing the HIV transmission and mitigate the impact of HIV, consistent with the commitments at the ASEAN Summit, the MDG and the UNGASS.
ATFOA through its collaborative mechanisms will implement prioritized regional activities under the following strategic objectives:

1. To promote ASEAN's collective agenda at international and regional platforms utilizing evidence-based epidemiological data and research findings
2. Strengthening the capacity of national ministries and agencies to plan, implement, monitor and evaluate prevention and treatment programs through knowledge sharing among ASEAN Member States
3. To leverage access to affordable HIV related care and treatment.
Introduction 1
1.1. Overview of ASEAN and its Commitments on HIV and AIDS

The ten ASEAN Member States namely Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam comprise 8.6% of the world’s population, with a total estimated population of 588 million people. The South East Asian region or ASEAN region has diverse ethnicities, cultures, customs, religions, language and dialects, modes of government and levels of development.

Association of Southeast Asian Nations or ASEAN was established on 8 August 1967, with end goal of establishing one community, anchored on economic, political security and soci0-cultural pillars. The signing of the ASEAN Charter and its eventual entry into force in December 2008 transformed ASEAN from a regional entity that is a loosely governed coalition to one with a legal standing and moved it towards an adherence to a rules-based approach (Figure 1) [1].

Responding to the call by the Fourth ASEAN Summit in Singapore in 1992, the ASEAN Task Force on AIDS was established to implement regional activities on health and HIV/AIDS aimed at curbing and monitoring the spread of HIV by exchanging information, particularly in formulation of joint policies and programs against the disease. Since then, ATFOA has developed and implemented three multi-year ASEAN Work Programmes on AIDS (AWPs).

ASEAN cooperation on HIV and AIDS is coordinated under ASEAN Health Ministers Meeting (AHMM) and ASEAN Senior Officials Meeting on Health Development (SOM-HD). The 10th AHMM in Singapore endorsed the ASEAN Strategic Framework on Health Development (2010-2015), including HIV and AIDS [4, 5] as Annex 1. ASEAN’s role is governed by the ASEAN Declaration on AIDS, signed during the 7th ASEAN Summit in Brunei Darussalam in 2001, namely (1) leadership to intensify national HIV response; (2) collaborative regional activities to support national multi-sectoral response; (3) strengthening regional mechanism to monitor and evaluate including information sharing and involvement of civil society organization. See Annex 2.
1.2. Rationale for a regional review on HIV and AIDS

The Roadmap for an ASEAN Community (2009-2015), specifically under the ASEAN Socio-Cultural Community (ASCC) Blueprint, has outlined strategies and actions in enhancing the well-being of the peoples of ASEAN, including to addressing health development concerns such as HIV and AIDS. [2, 3].

The ASEAN Commitment on HIV and AIDS was reaffirmed by ASEAN Leaders during the 12th ASEAN Summit in 2007 in Cebu, Philippines. Annex 3. Most of the ASEAN Member States (AMS) developed the 2010 country-driven targets to Universal Access (UA) to HIV Prevention, Treatment and Care as a mid-point to achieving the Millennium Development Goals (MDGs) by 2015.

From 2006 to 2010, implementation of the AWP III was anchored on the following focus areas:

i) leadership development;
ii) regional actions in priority areas such as access to antiretroviral (ARV) drugs for people living with HIV (PLHIV), mobility and HIV, prevention of mother-to-child transmission of HIV (PMTCT), and tuberculosis;
iii) integration of HIV with development priorities;
iv) non-programme strategies such as improved collaboration; and
v) monitoring and evaluation via the ASEAN Secretariat.

Towards completion of AWP III, ATFOA identified the need to come up with the first ASEAN Regional Report on HIV and AIDS by consolidating the 10 UNGASS Reports of Member States and the Fourth AWP to cover 2011-2015.

The main objectives of the ASEAN Regional Report includes:

i.) to consolidate HIV programme reports considering ASEAN Member States belongs either to WHO SEARO and WHO WPRO;
ii.) to review the ASEAN region’s status and progress vis-à-vis the ASEAN Summit Declarations, the Millennium Development Goals and UN General Assembly Special Session on HIV and AIDS targets;
iii.) to provide strategic information to the development of the next AWP (2011-2015) and supportive role in the monitoring Universal Access to Prevention, Treatment, Care and Support Meeting in Thailand [10].
iv.) to contribute to the development of advocacy tools considering the 10th anniversary of the ASEAN Declaration on AIDS in 2011.

Box 1

Regional Report Development Process

In the preparation of the Report, several sources of information were used. The main basis of the report was the 2010 UNGASS report as officially reported by individual Member States to the UN General Assembly. In addition, regionally published reports were considered, sharing and cross validation of data with the UNAIDS Regional Support Team for Asia Pacific (RSTAP) M & E, review of previous ATFOA Meetings and two consultation meetings to draft the report findings and validate recommendations.

ATFOA Core Group Meeting was organized on 28-29 September 2010 in Bangkok Thailand mainly to appraise the data and information generated from the UNGASS reports. The group was comprised of the Chair (Thailand), Vice Chair (Viet Nam), Past Chair (Singapore), Next Chair (Brunei Darussalam), with ATFOA Philippines and Malaysia as volunteers and the ASEAN Secretariat. The report was then circulated to the all Member States for inputs and recommendations.

A Finalization Workshop was organized 25-26 November 2010 in Phnom Penh Cambodia to present the report, in which multi-lateral and civil society organizations participated. At the 18th ATFOA Meeting and the Senior Officials Meeting on Health and Development (SOMHD) endorsed the regional report.
Overview of HIV Epidemic in South East Asia
Overview of HIV Epidemic in South East Asia

2.1. HIV Epidemic in ASEAN Region

ASEAN Member States (AMS) consist of a population of over 588 million people, making up 8.6% of the world’s population [11]. There are about 1.5 million people living with HIV in ASEAN region, comprising of 1.4 million adults and 0.5 million women. AIDS related death is estimated at almost 78,000 people in 2009. (Table 1 and Figure 2) [12, 13]. The HIV epidemic is varied across ASEAN, and there are also sub-national variations in HIV prevalence (Figure 3).

Table 1: Estimates of people living with HIV, South-East Asia 2009.

<table>
<thead>
<tr>
<th>Country</th>
<th>Total People living with HIV* [Low-High Est.]</th>
<th>Adults (15-49) living with HIV* [Low-High Est.]</th>
<th>HIV prevalence (%)^</th>
<th>Women living with HIV* [Low-High Est.]</th>
<th>Total AIDS related deaths* [Low-High Est.]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei Darussalam</td>
<td>n/a [n/a, n/a]</td>
<td>n/a [n/a, n/a]</td>
<td>&lt;0.1 %</td>
<td>n/a [n/a, n/a]</td>
<td>n/a [n/a, n/a]</td>
</tr>
<tr>
<td>Cambodia</td>
<td>63,000 [42,000-90,000]</td>
<td>56,000 [38,000-82,000]</td>
<td>0.7 %</td>
<td>35,000 [23,000-51,000]</td>
<td>3,100 [1,000-5,600]</td>
</tr>
<tr>
<td>Indonesia</td>
<td>270,000 [200,000-450,000]</td>
<td>270,000 [200,000-450,000]</td>
<td>0.2 %</td>
<td>88,000 [58,000-150,000]</td>
<td>8,300 [3,800-15,000]</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>8,500 [6,000-15,000]</td>
<td>8,300 [5,800-12,000]</td>
<td>0.2 %</td>
<td>3,500 [1,400-5,500]</td>
<td>&lt; 200 [&lt;1,000-500]</td>
</tr>
<tr>
<td>Malaysia</td>
<td>100,000 [63,000-120,000]</td>
<td>100,000 [63,000-120,000]</td>
<td>0.5 %</td>
<td>11,000 [8,600-15,000]</td>
<td>5,800 [4,500-7,700]</td>
</tr>
<tr>
<td>Myanmar</td>
<td>240,000 [200,000-290,000]</td>
<td>230,000 [190,000-280,000]</td>
<td>0.6 %</td>
<td>81,000 [67,000-96,000]</td>
<td>18,000 [15,000-23,000]</td>
</tr>
<tr>
<td>Philippines</td>
<td>8,700 [6,000-15,000]</td>
<td>8,600 [6,000-13,000]</td>
<td>&lt; 0.1 %</td>
<td>2,600 [1,800-3,900]</td>
<td>&lt; 200 [&lt;1,000-500]</td>
</tr>
<tr>
<td>Singapore</td>
<td>3,400 [2,500-4,000]</td>
<td>3,300 [2,400-4,300]</td>
<td>&lt; 0.1 %</td>
<td>1,000 [1,000-1,300]</td>
<td>&lt; 100 [&lt;100-200]</td>
</tr>
<tr>
<td>Thailand</td>
<td>530,000 [400,000-660,000]</td>
<td>520,000 [410,000-640,000]</td>
<td>0.7 %</td>
<td>210,000 [160,000-260,000]</td>
<td>28,000 [21,000-37,000]</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>280,000 [220,000-350,000]</td>
<td>270,000 [220,000-350,000]</td>
<td>0.4 %</td>
<td>81,000 [65,000-100,000]</td>
<td>14,000 [9,500-20,000]</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,503,600</td>
<td>1,466,200</td>
<td>0.26 %</td>
<td>513,100</td>
<td>77,700</td>
</tr>
</tbody>
</table>


*Country reported UNGASS value used except for Indonesia, revised figures submitted by ATFOA Indonesia in Nov. 2010
(further updated data presented in country profile)

^ UNGASS Country Progress Reports, 2010

n/a not available
Overview of HIV Epidemic in South East Asia

Where available, provincial data are presented, based on general population HIV prevalence estimates, sentinel survey sites or prevalence among women attending antenatal services from the latest available year. In the absence of provincial data, the national adult population HIV prevalence is presented.

The HIV epidemic in the region shows a range of heterogeneities along similar epidemic patterns. Based on the 2008 Report of the Commission on AIDS in Asia and more recent trends, these heterogeneities can be grouped as such:

- High prevalence of risk behaviours, but with a declining HIV prevalence due to successful prevention response, particularly prevention of transmission among sex workers.
  - Thailand, Cambodia and Myanmar.
- Moderate risk, namely among injecting drug users (IDU), with varying response success.
  - Malaysia.
  - Indonesia and Viet Nam: expanding epidemic from IDU to sex workers (SW) and MSM.
- Currently low prevalence of risk behaviour but evidence or potential for increasing spread.
  - Philippines: recent rapid expansion in certain sites, showing mixed IDU and MSM transmission.
  - Lao PDR: increasing IDU transmission in border crossing sites.
- Low prevalence of risk behaviour, increased focus on the migrant population.
  - Singapore and Brunei Darussalam.

Figure 3: Map of ASEAN Member States showing HIV prevalence. Source: HIV and AIDS Data Hub and Country UNGASS Progress Reports.
The schematic diagram above is a simplification of the modeled projections of the course of HIV epidemic in Asian countries (Figure 4). These projections, which are constructed using the Asian Epidemic Model (AEM) presented in the 2008 Report of the Commission on AIDS in Asia, indicate that most Asian countries have HIV epidemics that are initially primarily driven by transmissions among IDUs – reflected as the initial peak of infections. From then on, depending on whether there is a substantial presence of risk factors, i.e. high prevalence of high risk behaviours, the epidemic will either remain latent, such as in the case of Singapore and Brunei Darussalam, or expand, such as currently occurring in Indonesia and Viet Nam. Philippines, on the other hand, was until recently showing a latent epidemic pattern, but is now rapidly expanding in certain locations, mostly attributed to HIV transmission among IDUs and MSM. A high prevalence of HIV among the IDU populations, dependent on the size of the IDU population and their injecting behaviour, triggers the rapid spread of HIV. The subsequent spread of infections occurs through sexual transmission among sex workers and their clients as well as among MSM. Such spread leads to the sustainability of the epidemic in a population.

With effective intervention, epidemics can be reversed, as seen in Thailand early on in the late 1990s, as well as in the current declining epidemics of Myanmar and Cambodia. Depending on where countries are in terms of the epidemic phase, reversing the epidemic is possible at any stage provided the appropriate and effective response is in place. An expanding epidemic, for example, need not progress to a maturing one, if effective interventions can be put in place in time. Most countries in the region, however, have moved beyond the initial phases of the IDU-driven epidemic, into an increasingly more sexually-transmitted HIV. This poses greater challenges in halting and reversing the spread of infection.
2.2. HIV Epidemic Affecting Key Populations

High risk behaviours, such as injecting drug use, unprotected sex with multiple partners, such as in commercial sex, continue to be the key factors in the spread of the epidemic. Consistent with the characteristics of concentrated epidemics, it was reported that about 75% of all HIV infections in Asia are estimated to be among key affected populations (KAP), which include IDU, MSM, sex workers (SW) and their clients [14]. The prevalence of HIV among IDUs range from 18.4% in Viet Nam to more than 50% in Indonesia (Figure 5). Although initially the most affected population in many ASEAN member states were the IDUs, currently more countries are reporting higher proportion of new infections to be sexually-transmitted.

![HIV prevalence among sex workers, men who have sex with men and injecting drug users, ASEAN 2008-2009.](image)

Bio-behavioural surveillance in Myanmar, Cambodia, Malaysia and Indonesia all report greater than 10% HIV prevalence among sex workers. Coupled with low condom use, low levels of knowledge of HIV transmission risks and prevention drive a much broader epidemic of sexually acquired HIV in the population, affecting clients of sex workers and subsequently their intimate partners. However, despite most countries reporting mostly sexual transmission of HIV in new infections, as a risk group, IDUs still record the highest prevalence except in Philippines, Brunei Darussalam, Singapore and perhaps Lao PDR.
Philippines and Singapore are the only countries in the region currently reporting the highest HIV prevalence among men who have sex with men compared to other key affected populations in those countries, albeit at much lower rates overall when compared to other countries (Figure 5). High levels of infection among MSM have been reported in other locations—28.8% in Myanmar, 16.7% in Viet Nam and 13.5% in Thailand [15-17].

Injecting drug users

In Thailand, the trend among IDU indicates a clear decrease in prevalence from 47% in 2003 to 29% in 2008, but with a recent increase up to 39% in 2009 [17]. In countries such as Brunei Darussalam and Lao PDR, no IDU prevalence was available in the UNGASS country reports. However, earlier studies conducted before 2004 recorded prevalence estimates of less than 5% in these countries [19]. As a risk group IDUs still have the highest levels of HIV prevalence, albeit declining over the years (Figure 6).

Based on the 2010 UNGASS report of Indonesia there is an increasing HIV prevalence among IDUs. It was reported in 2007 a prevalence of 52%. Injecting drug use also puts the user at risk of hepatitis C. Globally, between 50% - 90% of HIV-infected IDU are also infected with hepatitis C. [20]. The risk of contracting hepatitis C through injecting drug use is higher than that associated with sexual contact and MTCT. Co-infection results in serious liver damage and lower treatment success rates, especially once CD4 cell counts drop below 200. However, early detection has shown encouraging results.
Injecting drug users

<table>
<thead>
<tr>
<th>Country</th>
<th>HIV Prevalence</th>
<th>Reached with HIV prevention program</th>
<th>Tested for HIV &amp; know results</th>
<th>Knowledge on HIV transmission</th>
<th>Condom use at last sexual intercourse</th>
<th>Sterile injecting at last injecting event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei</td>
<td>24.4%</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Cambodia</td>
<td>52.4%</td>
<td>43.4%</td>
<td>44.2%</td>
<td>58.6%</td>
<td>35.8%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>22.1%</td>
<td>7.5%</td>
<td>33.6%</td>
<td></td>
<td>27.8%</td>
<td>83.5%</td>
</tr>
<tr>
<td>Malaysia</td>
<td>36.3%</td>
<td>52.5%</td>
<td>27.3%</td>
<td>49.7%</td>
<td>76.3%</td>
<td>80.6%</td>
</tr>
<tr>
<td>Myanmar</td>
<td>9.2%</td>
<td>11.5%</td>
<td>1.6%</td>
<td>44.8%</td>
<td>22.7%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Philippines</td>
<td>38.7%</td>
<td>*</td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Singapore</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>18.4%</td>
<td>15.4%</td>
<td>17.9%</td>
<td>49.2%</td>
<td>51.9%</td>
<td>94.6%</td>
</tr>
<tr>
<td>Vietnam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Data not available
Dotted red lines indicate the 80% target for Universal Access.

Figure 7: HIV indicators on injecting drug users, ASEAN 2008-2009.
Sex workers

Myanmar reports the highest current prevalence of HIV among sex workers at 18%, however it has also shown a steady decline from its peak of 38% in 2000 (Figure 8 and Figure 9).

Thailand and Cambodia show similar trends, at relatively lower levels of prevalence. Prevalence data from Indonesia indicate a potential increase in the HIV prevalence among direct sex workers in Jakarta.

The percentage of sex workers who reported the use of condoms with their most recent clients ranged from 61% in Malaysia to as high as 99% in Cambodia. However, like IDUs, there seem to be a diverse range of intervention programme reach within the communities. In Malaysia only 12% sex workers in Kuala Lumpur reported having had contact with HIV prevention programmes, compared to 76% in Myanmar.

Figure 8: HIV prevalence trends among sex workers, ASEAN 2000 – 2009.

* lines indicate annual data available. Unlinked markers indicate gaps in reporting years.

The challenge in addressing the HIV situation and implementing intervention strategies targeted towards clients of sex workers lies in the fluidity of definition of the sub-population. Men who visit sex workers are defined in behavioural terms and are not a naturally existing sub-population, yet constitute the largest infected population group in Asia. Surveillance and intervention are therefore difficult, resulting in the inevitable data and response gaps.
Sex workers

Figure 9: HIV indicators on sex workers, ASEAN 2008-2009.

* Data not available
Dotted red lines indicate the 80% target for Universal Access.
Men who have sex with men

There is a wide range of variation of HIV prevalence among MSM in the region, ranging from 1.0% in Philippines up to 29% in Myanmar; as well as the prevalence of high risk behaviour factors (17% condom use in Singapore compared to 87% in Cambodia) (Figure 10).

Most countries, Thailand in particular, also have large sub-national variations where HIV prevalence among MSM tends to be highest in urban centres. There is, therefore, a need to view national-level prevalence with caution, as these may mask the pockets of high prevalence in certain sites. The HIV prevalence among MSM in Bangkok in 2009, for example, was almost double the prevalence recorded nationally (25% and 14%, respectively).

Although UNGASS reporting does not specifically include HIV indicators pertaining to the transgender populations, most South-East Asian countries have significant numbers of transgender persons who are at risk of HIV, mostly due to their association with sex work. Several surveys of the transgender population report the HIV prevalence to be even higher than among MSM in some of the Asian cities, for instance, ranging from 9.3% in Kuala Lumpur (compared to 3.9% among MSM) to as high as 37% in Phnom Penh, Cambodia [21, 22].

Surveillance and data capture of HIV prevalence and behavioural risk factors among MSM are still lacking in most countries, likely attributed to the fact that attention and efforts at addressing MSM are relatively recent. The lack of information means that the true situation and potential risk of HIV among the MSM populations are still largely uncertain. Based on modeled estimates and projections, however, if left unchecked, the HIV epidemic among MSM has the potential to grow and hamper national efforts at reducing the number of new infections and reversing the spread of the epidemic.
Men who have sex with men

<table>
<thead>
<tr>
<th>Country</th>
<th>HIV prevalence</th>
<th>Reached with HIV prevention program</th>
<th>Tested for HIV &amp; know results</th>
<th>Knowledge on HIV transmission</th>
<th>Condom use at last sex with male partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei</td>
<td>4.5%</td>
<td>*</td>
<td>57.9%</td>
<td>68.3%</td>
<td>85.5%</td>
</tr>
<tr>
<td>Cambodia</td>
<td>5.2%</td>
<td>*</td>
<td>44.0%</td>
<td>43.9%</td>
<td>57.3%</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>5.6%</td>
<td>*</td>
<td>33.7%</td>
<td>34.4%</td>
<td>57.3%</td>
</tr>
<tr>
<td>Malaysia</td>
<td>3.9%</td>
<td>*</td>
<td>14.3%</td>
<td>31.7%</td>
<td>20.9%</td>
</tr>
<tr>
<td>Myanmar</td>
<td>28.8%</td>
<td>*</td>
<td>69.1%</td>
<td>81.6%</td>
<td>61.6%</td>
</tr>
<tr>
<td>Philippines</td>
<td>1.0%</td>
<td>29.3%</td>
<td>47.6%</td>
<td>34.4%</td>
<td>31.7%</td>
</tr>
<tr>
<td>Singapore</td>
<td>2.6%</td>
<td>6.8%</td>
<td>43.5%</td>
<td>31.7%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Thailand</td>
<td>13.5%</td>
<td>21.3%</td>
<td>25.5%</td>
<td>64.3%</td>
<td>66.5%</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>16.7%</td>
<td>24.0%</td>
<td>40.7%</td>
<td>64.3%</td>
<td>66.5%</td>
</tr>
</tbody>
</table>

* Data not available
Dotted red lines indicate the 80% target for Universal Access.

Figure 10: HIV indicators on men who have sex with men, ASEAN 2008-2009.
2.3. Other vulnerable populations

Migrants and mobile populations

Millions of people migrate between ASEAN countries annually, providing essential contributions to national workforces and economies. However, factors such as new-found freedoms, disposable income, exploitation or abuse leading to high-risk behaviours combine to make migrants vulnerable to HIV infection [23]. Additionally, cross-border mobility is a growing phenomenon in Asia in general, and true as well within the South East Asia nations. In the Greater Mekong Sub-region (GMS) which consists of Cambodia, Lao PDR, Myanmar, Viet Nam, Thailand and the Yunnan Province of China, for example, increased migration has contributed to the demand for paid sex for these ‘mobile men with money’. Migrant workers are vulnerable to HIV because they may be associated with sexual risk-taking (either buying or selling of sex). Female migrants who are drawn into sex work are particularly affected by the epidemic.

At-risk youth

Another vulnerable group is the sub-set of youth who are more likely than others to have high risk behaviours, or specifically key affected populations who are in the younger age-groups of 15 – 24 years (or in some instances, younger). In the recent UNGASS Country Progress Reports (2010), in ASEAN between 0.1% - 5.4% of young men and women aged 15 – 24 reported having had sexual intercourse before the age of 15. Young people below the age of age 25 constitute a significant percentage of MARPs in Asia. The challenge again is that this is a largely hidden population. It has been reported in several Asian countries that over 60% of sex workers are in this age bracket. Female IDUs are increasingly involved in sex work. In the few countries with studies of young MSM, it is evident that first male-to-male sexual contact for many MSM occurs during adolescence [24]. Prevention programmes targeting youths need to utilise a variety of strategies to match multiple risk factors and circumstances such as age, gender, sexual experience, ethnicity, behavioral risk, and the socio-cultural context. Furthermore, reliable HIV data is a precondition for gaining a solid understanding of the youth population but unfortunately, the data for youth are scarce particularly for those aged <15 years and those categorised as ‘most-at-risk youth/adolescents’ and ‘especially vulnerable adolescents’. These are also sub-populations that have been identified to be difficult to reach.

Intimate partners of those most at-risk and of people living with HIV

In ASEAN, women make up 34% of PLHIV. The majority of these women are intimate partners of high risk men, such as men who are clients of sex workers, IDUs, as well as MSM. In countries like Cambodia and Thailand, the largest number of new infections occurs among married women [25]. The vulnerability of women is compounded by socio-cultural issues such as patriarchic values and in certain communities, the perceived low status of women. This in turn leads to other social issues such as gender-based violence and stigmatization. More directly relevant to the HIV epidemic is the lack of access to HIV and sexual health information, as well as low levels of condom use. Due to the challenges in tracing affected partners, this vulnerable group remains a gap in most intervention programmes, while data and evidence-based assessment of risk are scarce.
A crucial point in understanding the HIV epidemic in Asian countries is to recognize that Asian epidemics are not driven by casual sex among the general population, but more on the percentage of men in the population who visit sex workers. There are also certain sub-groups that have greater tendencies for high risk behaviours related to frequent and unprotected sexual contacts with sex workers. Depending on countries or local circumstances, these sub-groups may include migrants and mobile men, as well as men in certain institutionalized or occupational settings such as the military, seafarers/fishermen and long distance truck drivers.

It is important to note, however, that usually it is only a sub-set of these vulnerable groups that are directly linked to high risk behaviours, and it is this sub-set that concerns the HIV epidemic and intervention efforts. Furthermore, the risks and vulnerabilities are also varied across different populations and circumstances.

Other vulnerability factors for the transmission of HIV include other sexually-transmitted infections (STI) and other health-related concerns such as tuberculosis-HIV co-infections and hepatitis C among IDUs.
Country Response 3
3.1. Universal access to prevention, treatment and care

Through the 2006 UN Political Declaration, global commitment to scale-up access to HIV prevention, treatment, care and support was encapsulated in the goal for Universal Access (Box 3.1). The 2006 targets for Universal Access were initially set to be achieved by 2010. The main target is to reach 80% of key affected populations through comprehensive prevention programmes, which is expected to result in a 60% behavioural change. This change includes the ability of key affected populations to identify prevention methods and to reject misconceptions, condom use among sex workers and MSM, and IDUs reporting safer injecting behaviour. The target for treatment is for ART to be received by 80% of those eligible for it.

Box 2
Universal Access to Prevention, Treatment and Care

Universal Access (UA) is guided by national targets set against key outcome areas – such as antiretroviral therapy (ART) coverage, PMTCT, coverage of prevention programmes for key affected populations and testing coverage. A worldwide commitment has been made to increase access to the most effective HIV interventions needed to manage the diverse epidemics across countries, and improve broader health outcomes. Achieving universal access will also have a significant impact on broader health and development goals such as maternal mortality, poverty and gender equality. This calls for a response that is:

- Comprehensive – that highlights the role of prevention to break the trajectory of the epidemic.
- Participatory – relies on and utilizes the support of all country partners to lead and mobilize (civil society and others).
- Nationally-owned and led.
- Takes AIDS out of isolation towards a more integrated response that addresses AIDS-related issues in a more holistic way.
- Galvanizes broader health and development outcomes (achieving MDGs).

UNAIDS has identified priority areas for its support to countries to achieve their universal access targets. These areas will contribute directly to both the achievement of universal access and will simultaneously enable advancement to the MDGs.

- Reducing sexual transmission of HIV
- Preventing mothers from dying and babies from becoming infected with HIV
- Ensuring that people living with HIV receive treatment
- Preventing people living with HIV from dying of tuberculosis
- Protecting drug users from becoming infected with HIV
- Removing punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS
- Empowering young people to protect themselves from HIV
- Stopping violence against women and girls
- Enhancing social protection for people affected by HIV

Source: UNAIDS, 2010 [26, 27].
Achieving universal access is a critical mid-way point to reaching the Millennium Development Goal (MDG) to ‘halt and reverse the spread of HIV and AIDS’. The 2008 Report of the Commission on AIDS in Asia emphasized that in order to halt and reverse the HIV epidemic in the region, intervention programmes need to induce behaviour change in at least 60% of the target population, and this achievable when effective prevention services for key affected populations reach 80% of the population. The 2008 Commission Report on AIDS in Asia and the UNAIDS Outcome Framework 2010 listed several key areas for intervention.

It is important to note that in the aim to achieve Universal Access, focus must also be put on the quality, effectiveness and impact of programmes, rather than merely being a matter of quantitative response.

3.2. HIV prevention program among key affected populations

Prevention efforts to reach key affected populations such as sex workers, drug users and MSM are still limited. Figure 11 presents the reported percentage coverage of HIV testing among key affected populations in the region, as reported in the 2010 UNGASS Country Progress Reports.

![Figure 11: Percentage key affected populations who tested for HIV and know the results, ASEAN 2008-2009.](image)


3.2.1. Behaviour change

Harm Reduction Programmes

Several ASEAN countries now have some form of needle and syringe exchange programme (NSEP) provision and are prescribing opioid substitution therapy (OST) of some sort (Table 2). However, coverage remains far below levels necessary to have an impact on HIV epidemics. Despite a large proportion of prison populations being people who use drugs, only Malaysia and Indonesia provide limited OST to prisoners. For the Philippines, although there are NSEP sites now set-up, these are attached to independent projects and not part of the government programme. In Cambodia, a trial site for OST was recently set-up in 2010.
Table 2: ASEAN Member States that have one or more NSEP sites and the prescription of opioid substitution therapy for maintenance in and outside of prisons.

<table>
<thead>
<tr>
<th>Country</th>
<th>Needle &amp; syringe exchange programme</th>
<th>Opioid substitution therapy</th>
<th>Opioid substitution therapy in prisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei Darussalam</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Cambodia</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Indonesia</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Malaysia</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Myanmar</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Philippines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Singapore</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Viet Nam</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A tick in this table does not indicate scope, quality or coverage of services.

Source: International Harm Reduction Association, 2009 [28].
A lack of supportive legal and policy frameworks in many countries further impedes the harm reduction response. Several states prohibit possession and/or provision of needles and syringes, methadone and / or buprenorphine. Thailand has endorsed harm reduction policies, and is scaling-up the MMT services as well as policy advocacy at the national level. Indonesia has revised its narcotics law to prioritise drug rehabilitation over imprisonment of drug users. Harm reduction programmes are currently being regulated/integrated under the drug rehabilitation policy. Harm reduction programmes in prisons has started in 2007. Indonesia and Malaysia have experienced marked increases in the number of NSEP sites [18]. In Malaysia, the existing methadone maintenance therapy (MMT) programme was scaled-up since its introduction in 2005 and in 2006 the Needle Syringe Exchange Programme was introduced with the target coverage of 60% of IDUs [22]. In 2007, Malaysia began pilot testing MMT programmes in prisons in addition to ART services, and almost 40% of prisons nationwide now provide this combination of services. In Indonesia, NSEP sites increases from 17 sites in 2005 to 281 sites in 2010 with a target coverage of 60% of IDUs in 2014. MMT programmes are currently available in 10 referral hospitals, 11 satellite hospitals, 32 primary health centres and 8 prisons across Indonesia. Responding to HIV epidemics in prison setting, 114 prisons in 19 provinces has adopted comprehensive HIV and AIDS programme. In the Philippines, with the numbers of IDUs still relatively low, there are three NSEP sites. The Police Statement on Drug Harm Reduction has been drafted and not yet enforced [29].

Condom use programmes

In a 2009 Policy Statement by UNAIDS, UNFPA and WHO, it was stated that “condoms must be readily available universally, either free or at low cost, and promoted in ways that help overcome social and personal obstacles to their use” [30]. Since 1989, the 100% Condom Use Programme (CUP), mostly targeting specifically female sex workers, has been implemented in Thailand, Cambodia, Philippines, Viet Nam, Myanmar and Lao PDR, with variations in the programme components between countries [31]. In Thailand, the programme increased the use of condoms in sex work from 14% in 1989 to over 90% by 1992. Only Thailand and Cambodia implemented the 100% CUP on a nation-wide basis, and this contributed significantly to the decline in the HIV epidemics in these countries. Among the key recommendations of the 2008 Report of the Commission on AIDS include the need to increase the consistent use of condoms during paid sex [32]. More sex work interventions based on peer education should be introduced and scaled-up. Condoms need to be made available, accessible and affordable not only to sex workers and their clients, but also to MSM.
3.3. Reducing risks for vulnerable populations

Migrants

In 2007, all ten ASEAN Member States signed the ASEAN Declaration on the Protection of the Rights of Migrant Workers [33]. There are existing examples of intervention programmes in the region that target migrants and mobile populations. In Thailand, a collaborative project of eight NGOs through the Raks Thai Foundation, called the Prevention of HIV/AIDS among Migrant Workers in Thailand Project (PHAMIT) which was funded by the Global Fund (GFATM) covers over twenty provinces throughout Thailand to prevent the transmission of HIV and to improve the quality of life among migrant workers, their families and sex workers [34]. Since October 2003, the programme has reached 442,000 migrants and more than 20,800 entertainment workers with information about HIV and reproductive health, as well as the distribution of over 6.8 million condoms over a five-year period. Moreover, through this programme, over 155,000 migrant workers have received information on health and labour rights, including regular updates about migrant registration policies [34].

HIV policies in the region need to be strengthened to include HIV workplace policies including pre-departure orientation programmes, HIV testing and access to treatment and healthcare services such as insurance schemes. In the Philippines, the Philippines HIV/AIDS Prevention and Control Act of 1998 acknowledged the need to provide HIV and AIDS education for overseas workers and provide guidelines for voluntary HIV testing [35]. A new counselling referral programme has also been set up for Filipino migrants who tested HIV-positive while overseas.

Tracking the risks and spread of HIV among migrant workers is challenging, especially with the high levels of variations between populations and locations. Thus, the strengthening of surveillance and data collection mechanisms is crucial to the development of strategic HIV prevention, treatment and care services for the migrant populations.
3.4. Prevention of mother-to-child transmission

One of the emerging issues highlighted in the ASEAN Work Programme III (AWP III) which is also part of the UNAIDS priority areas is PMTCT (also referred to as the prevention of parent-to-child transmission) [9]. ASEAN members continue to develop their own strategies. Several countries in the region, such as Malaysia, Thailand, Indonesia, Singapore and Viet Nam are scaling-up their antenatal care screening to reduce mother-to-child transmission of HIV. Based on the 2010 UNGASS reports, the coverage of HIV-positive pregnant women receiving ARV is highly varied, which reflects somewhat the range of services and also the quality of reported data. In countries such as Cambodia and Lao PDR where deliveries occur outside the formal health system, PMTCT provisions are low. In Lao PDR, for example, although ANC services are available and accessible in the urban areas, unfortunately only <25% are able to access the same services in the rural areas. This can be due to several factors such as transportation, long distances (e.g. lack of access roads to villages), lack of knowledge and awareness and attitude to name a few [36]. Challenges related to women’s reproductive health needs and couples infected with HIV are weak referral linkages and low antenatal care and support, weak monitoring of primary prevention and counseling due to limited national capacity and data, and deficiency of confidence and knowledge in contraceptive methods [9].

Three issues govern PMTCT in Asia:

i) availability of institutional services for pregnant women;

ii) uptake of PMTCT in countries with wide antenatal care coverage; and

iii) PMTCT service provision for countries where most deliveries occur outside the formal health system [1].

In some ASEAN countries, where the HIV prevalence is low, such as Lao PDR and the Philippines, PMTCT programmes fall into the category of high cost per infection averted as the cost of screening for PMTCT can be high. Thus such programmes may not be made a priority area for these countries, reflected in the coverage indicators.

![Figure 12: PMTCT coverage compared to the national HIV prevalence, ASEAN countries.](image-url)

*Coverage data not available for Malaysia.

Source: UNGASS 2010 Country Progress Reports.
3.5. Treatment and Care of People Living with HIV

Based on the 2010 UNGASS Country Progress Reports, Cambodia, Lao PDR and Philippines have achieved the targets for universal access to ART for adults, while Myanmar has reported the lowest coverage of 29% among ASEAN countries (Figure 13). Because the increase in newly reported cases, any increase in the number of people receiving ART will be outpaced by new infections if prevention programmes will not expand.

From the 2010 WHO/UNAIDS/UNICEF Progress Report ‘Towards Universal Access’, there are 530,000 PLHIV in need of ART in ASEAN countries, based on 2009 country reports. The figure is higher at 740,000 if based on the 2010 WHO Guidelines. Figure 14 shows the percentage distribution of ART needs among ASEAN countries based on the 2010 WHO Guidelines. As PLHIV in ASEAN countries will make up 40% of PLHIV in need of ART in Asia-Pacific region, substantial additional investment in ART provision is urgently needed.
There are several challenges and barriers to increasing the coverage of ART in the region:

- Cost and affordability of ARV.
- Early initiation of treatment provision results in a greater number of PLHIV in need of treatment.
- PLHIV adherence to treatment – this challenge is further amplified in countries where a large proportion of PLHIV are current IDUs, among whom treatment adherence is known to be very poor. Medical practitioners usually do not put them on treatment for this reason, particularly in view of the risk of drug resistance.
- Competing health priorities.

Box 3

**Cost of ARV and TRIPS Flexibilities**

According to the 2010 WHO/UNICEF/UNAIDS report on Universal Access, countries in all parts of the world are indicating that universal access to treatment is achievable; and East, South and South-East Asia has currently reached 31% coverage for ART [37]. The obstacles faced by most countries in scaling up HIV treatment includes funding shortages, limited human resources, and weak procurement and supply management systems for HIV drugs and diagnostics, as well as other health systems bottlenecks [37]. Countries, and ASEAN as a regional entity, need to explore options on utilizing flexibilities of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) in order to maximize access to affordable ARVs and ultimately ensure the universal access to HIV treatment and care.

The use of TRIPS flexibilities to improve access to medicines is one of several cost containment mechanisms that may be used for patented essential medicines not affordable to the people or the public health insurance schemes. For most ASEAN countries, the domestic pharmaceutical industry is small, usually focused on generic production and traditional medicines. These countries consequently have to pay high prices for imported medicines, and are affected by intellectual property rights, especially TRIPS and TRIPS-Plus standards. Thailand is an exception in that it has substantial capacity to produce generic medicines. The Government Pharmaceutical Organisation (GPO) in Thailand is producing a number of generic ARVs that are not patented in Thailand, or for which the Thai patent has expired [38].

With the use of compulsory licensing, several developing countries have issued compulsory licenses in order to increase access to medicines. In October 2003, Malaysia applied for the ‘Government Use’ provisions in its national law in order to import generic ARVs [39]. As a result, the importation of generic ARV drugs in Malaysia reduced the cost of treatment, for both generic and patented products. By 2004, Indonesia also applied the ‘Government Use’ mechanism for domestic production of several generic ARVs [39]. Currently, however, there are some threats to the issue of compulsory licensing and the use of TRIPS flexibilities, including the European Union Free Trade Agreement (FTA) negotiations with India, currently a producer of generic drugs. There are concerns that the deal could mean tighter intellectual property protection that could reduce access to cheap Indian generic drugs.
3.6. Care and support for people living with HIV

Many PLHIV, especially those from marginalized groups and rural populations, face considerable obstacles to access treatment and comprehensive AIDS care. The lack of psychosocial support for PLHIV and its lack of emphasis in UNGASS reports reflect the level of complacency attached to this avenue of support. Although ART scale-up is assisting in the drive for healthcare infrastructure, treatments for common opportunistic infections are frequently unavailable, and the social support to cope with the health burden placed on the family or mother living with HIV is still somewhat lacking [1].

In 2008, ASEAN reaffirmed its commitment on greater involvement and empowerment of people living with HIV in Vientiane, Lao PDR. (Figure 15)
Foundations for an Effective Response
4.1. Introduction

In the 2008 Report of the Commission of AIDS in Asia, the following elements were highlighted as being crucial to the successful implementation of HIV strategies and programmes [32]

- Behavioural and epidemiological surveillance systems;
- Prioritising and investment in the most effective interventions;
- A suitable mix of focused and integrated approaches in the service delivery mechanisms;
- A supportive legal and political environment;
- Efficient governance structures;
- Strong partnerships with the civil society; and
- The establishment of a national and regional policy and programme analysis unit.

In 2004, UNAIDS endorsed the ‘Three Ones’ principle with the objective of achieving the most effective and efficient use of resources, and to ensure rapid action and results-based management which includes:

- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners;
- One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate; and
- One agreed country-level Monitoring and Evaluation system.

Complementing the Three Ones principle, commitment to the targets of Universal Access and the Millennium Development Goals provide countries with the focus needed for an effective response.

4.2. National Strategic Plan and Coordination Mechanism

A National Strategic Plan for HIV and AIDS is an important and crucial instrument for organising the national, not simply governmental, response to the epidemic. To develop an effective National Strategic Plan, the following are important:

- Governments need to understand the real magnitude of the HIV and AIDS problem in their country;
- A decision on what importance and priority levels are to be attached to actions aimed at reducing the spread of HIV and in mitigating its impact;
- Focusing on strategies that can change the course of the epidemic, and ensuring the resources to implement these strategies are secured and channelled;
- To make the strategies an integral part of the country’s development plan.

By the end of 2010, most ASEAN countries would be in various stages of the development of a new round of the respective National Strategic Plans, and in some cases also the review of the current NSP. Philippines, Cambodia and Lao PDR have conducted a mid-term review to evaluate the progress of the NSP and highlighted the issues to be addressed in the next NSP.

It is important for a national strategic plan to be costed and developed alongside an operational plan. This will also facilitate the evaluation of its impact. Cambodia recently was awarded the Millennium Development Goals Award for excellence in AIDS response through its national leadership, commitment and progress towards the achievement of MDG Goal 6 – Combating HIV, Malaria and other diseases, while adhering closely to the ‘Three Ones’ principles [40]. Cambodia’s successes provide an important opportunity for other countries in the region to learn from its experiences.
ASEAN has key roles in mobilizing political commitment for a coordinated and long-term AIDS response in the region, through consolidated strategies and responses at the regional level. National coordination of the programme implementation is as crucial as the national plan itself. Most of the countries in the region are still faced with challenges when it comes to inter-sectoral collaboration such as addressing the non-health issues of the epidemic. Few countries in ASEAN had initiatives to elevate HIV and AIDS coordination at varying level with differences also in administrative and political mandates. Indonesia for example has created a National AIDS Commission that coordinates with all Ministries.

4.3. Monitoring and Generating Strategic Information

Monitoring and evaluation systems

Monitoring and evaluation of a country’s response provides the information needed to make evidence-based decisions for programme management and improvement, policy formulation, and advocacy. It represents an important tool for the National HIV/AIDS Programmes to promote effective management and accountability for the HIV/AIDS response based on good quality data. For countries that rely heavily on external funding, an effective M&E system is almost always required as part of their performance evaluation.

Although all ASEAN countries except Brunei Darussalam have developed monitoring and evaluation systems, not all follow the principles of the ‘Three Ones’ where instead of having a national level M&E programme, the systems are more in place at the programme level. In order to implement a comprehensive M&E programme, various components need to be in place; Table 3 illustrates some variations in the region in terms of the extend of the M&E systems in the countries.

<table>
<thead>
<tr>
<th></th>
<th>National “One” M&amp;E system</th>
<th>National M&amp;E guidelines</th>
<th>Technical guidance</th>
<th>Staffing</th>
<th>Allocation of M&amp;E costing</th>
<th>Capacity building</th>
<th>Data/information management system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei Darussalam</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
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<td>✓</td>
</tr>
</tbody>
</table>

✓ indicates that the component is present in the country, as reported in the UNGASS 2010 country progress reports.

Among the challenges faced by countries in the implementation of a comprehensive M&E system includes:

- Lack of well-functioning M&E systems and structures in place;
- Shortage of skilled human resources and lack of capacity building;
- Inadequate collection of standardised routine programme monitoring data;
- Lack of a proper data and information management system;
■ Weak data auditing and supportive supervision;
■ Programme targets were set in without the strategy to monitor their progress; and
■ Linkage of using research findings to guide implementation and policy development is limited.

For low prevalence countries, especially high capacity middle income countries such as Malaysia and Singapore, it is perhaps more effective to build on existing health and social sector systems rather than to build on separate HIV monitoring and evaluation systems. For many population groups it is unknown whether the targets have been met, because data is not available to monitor progress, or the population sizes of these target groups are often unknown, rendering ‘percentage’ coverage unknown. In addition, there is a clear need for empirical data on what intervention works and what doesn’t to support national scaling-up plans.

Surveillance and data quality

In the UNGASS 2010 reporting, there are clear gaps in the reporting systems among ASEAN countries. For example, the reporting period and the coverage of surveys vary between countries, while some countries reported data collected outside of the reporting time frame of 2008-2009, such as Cambodia which reported findings from surveys conducted in 2005-2006 (Figure 16). Regular and sustainable second generation surveillance such as the Integrated Bio-Behavioural Surveillance is needed to provide more strategic information on trends and programme reach data. There is still limited data on key affected populations, modes of transmission and the trends over time. Most countries are dependent of case reporting to guide their national responses, and this poses various limitations. Other major data gaps in terms of bio-behavioural surveillance include intimate partners/women, migrants and mobile populations and most at-risk youths. Accurate size estimations of the key affected populations are also a major information gap.

![Figure 16: Data availability from sero-surveillance surveys among key affected populations, ASEAN, 2007-2009.](image)

* a) Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand, Viet Nam
  d) Cambodia, Indonesia, Malaysia, Myanmar, Philippines, Thailand, Viet Nam
  g) Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand, Viet Nam

There are also still inconsistencies in the reporting of indicators despite the UNGASS indicator reporting system being very clearly and strictly defined [41]. There is also the issue of data quality, including the reporting of disaggregated age data and the use of denominators in calculating percentages. These factors sometimes lead to the difficulty in making direct comparisons between countries. Although the quantitative data of UNGASS indicators are relied upon to measure the progress made towards a specific target, the quality of the information and its inclusiveness should also be emphasized. Quantitative data taken at face value can be misleading as the impact and magnitude of the HIV/AIDS situation in each country differs. As indicator data contributes directly to national plans, government and private initiatives, and both domestic and international financial support, a commitment to quality, transparency and effectiveness of initiatives and responses, as well as nationwide research and survey-based data is integral to the goal of HIV/AIDS eradication.

4.4. Civil Society Involvement

The engagement and participation of the civil society in ensuring a multi-stakeholder coordinated response should be in place from the planning stage, particularly in prevention programmes targeting key affected populations and in efforts to address stigma and discrimination.

Civil society involvement in ASEAN countries has improved, with seven countries reporting in the 2010 UNGASS progress reports that active involvement and participation in the UNGASS consultative reporting are ensured, in varying degrees, while no governments indicated the absence of CSO involvement in the latest UNGASS 2010. Indonesia and Malaysia, which previously reported no CSO involvement in 2005, have progressed to active participation in the development of multi-sectoral strategies.

Two key issues that are still facing gaps and challenges with regards to civil society participation in the region are those of funding and governance. The role of the civil society in the formulating of the national budget and financial access is still limited therefore there is still a gap between available funds and needs. In some countries, there is an over-reliance on GFATM funding. There is a need for a long-term financial system to ensure sustainability. In terms of governance, civil societies in some countries are heavily dependent on national-level coordinating mechanisms, which can create an additional level of bureaucracy and in turn impedes immediate responses on processes and policies.

There has been a marked decline in the average national HIV budget on activities implemented by civil society in ASEAN; from 18.3% in 2007 to 9.6% in 2009. Cambodia reported a decrease from 51% in 2007 to 0% in 2009, while Thailand increased its funding allocation from 1.3% in 2007 to 8% in 2009. Lao PDR had the highest fund allocation for civil society programmes at 20% in 2009, although this is almost completely dependent on external funding resources.

4.5. Resource Generation and Utilization

In 2008, the total HIV and AIDS expenditure among ASEAN countries was US$ 505 million, of which 49% were from external funding sources, including the Global Fund, among others. The 2008 Report of the Commission on AIDS in Asia recommended an estimated standard of expenditure for a priority response in Asia that varies from US$ 0.50 per capita to US$ 1.00 per capita for most countries in Asia, depending upon the stage of the epidemic in each country [32]. Figure 17 shows the relationship between per capita expenditure in ASEAN and the burden of disease, represented by the estimated numbers of PLHIV in the countries. The majority of countries show the level of expenditure either within or above the recommended levels, except for Indonesia and Philippines. However, beyond the amount of funds spent, it is very important to also consider the impact of the interventions implemented.
Regionally, about 61% of the HIV and AIDS expenditures are allocated for care and treatment activities, while 24% are allocated for prevention activities (Figure 18). Since most ASEAN countries have relatively low treatment burden, the allocation for care and treatment is high. Prevention programmes, especially those targeting key affected populations, are still very much under-funded. The majority of countries spent less than 10% of total funding on enabling environment, research as well as orphan and vulnerable children. The remaining funds were allocated to programme management and administrative strengthening, which include incentives for human resources as well as social protection and social services. The majority of ASEAN countries only allocated 10%-20% of funding to programme management, except Laos PDR where in 2009 close to US$ 1.5 million (24.4% of total expenditure) was spent on programme management and administrative strengthening.

In terms of the reporting of expenditure data, there has been an improvement in the tracking of expenditure in the region, but the information has not yet been fully utilised for resource allocation. Currently Thailand, Indonesia and Philippines have institutionalized the National AIDS Spending Assessment (NASA), while Cambodia and Viet Nam are on track to do so.

Figure 17: Per capita HIV expenditure, by national HIV burden (number of PLHIV).

Figure 18: Total AIDS expenditure, percentage distribution by programme components, 2009.

* Based on total for six AMS, excluding Brunei, Cambodia, Myanmar and the Philippines, where 2009 data is not available.
The HIV response in many countries in the region is largely supported by international donors. With half of funds in the region being dependent on international sources, the implications of the current global financial situation can therefore be substantial. In the Asia-Pacific region, the percentage of total HIV/AIDS expenditure from national budgets has decreased from 60% in 1996 to 40% in 2004. In the last five years there has been a high dependence on international resources, except in Thailand, Malaysia and Singapore which are almost completely self-funded (Figure 19) [12].

The main external sources of funding include the Global Fund and bilateral agencies. Among ASEAN countries, Thailand has received the highest funding from GFATM, yet it comprised less than 7% of the total national funding (Table 4). Cambodia and Laos PDR on the other hand are relying heavily on funding from GFATM, comprised of about 40% of the total national funding. Even though Indonesia was the third highest recipient of GFATM in 2009, the funding only accounted for 23% of the total national funding. The total international expenditure on HIV and AIDS in Indonesia depends on bilateral funds which accounted for 66% of total expenditure.

Maintaining a proactive multi-stakeholder response with support and resources through internal and external funds in low epidemic countries such as Lao PDR and the Philippines is a major challenge [42] Resources are needed to fund countrywide responses to HIV/AIDS, which is an enormous burden for a developing country. As the HIV prevalence is low in these countries, it is difficult to sustain donors’ interest [43].

Table 4 : Global Fund grant portfolio for South-East Asian recipient countries.

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of HIV/AIDS Grants</th>
<th>Global Rounds*</th>
<th>Grant (USD)</th>
<th>Amount Disbursed (USD)</th>
<th>Amount Unsigned (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>6</td>
<td>1,2,4,5,7</td>
<td>123,030,717</td>
<td>111,049,190</td>
<td>63,502,281 (Round 9)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>7</td>
<td>1,4,8,9</td>
<td>104,837,413</td>
<td>77,951,922</td>
<td>N/A</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>4</td>
<td>1,4,6,8</td>
<td>63,502,281</td>
<td>20,869,128</td>
<td>N/A</td>
</tr>
<tr>
<td>Myanmar</td>
<td>2</td>
<td>2,3</td>
<td>5,837,009</td>
<td>5,837,009</td>
<td>50,152,368 (Round 9)</td>
</tr>
<tr>
<td>Philippines</td>
<td>3</td>
<td>3,5,6</td>
<td>23,977,043</td>
<td>20,666,160</td>
<td>N/A</td>
</tr>
<tr>
<td>Thailand</td>
<td>7</td>
<td>1,2,3,8</td>
<td>210,418,228</td>
<td>174,067,305</td>
<td>N/A</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>4</td>
<td>1,6,8</td>
<td>45,918,204</td>
<td>28,283,276</td>
<td>27,363,443 (Round 9)</td>
</tr>
</tbody>
</table>

* Some countries receive multiple HIV/AIDS grants per GF Round.

Source: Global Fund Fight against AIDS, Tuberculosis and Malaria, 2010
4.6. Knowledge sharing

Collectively, ASEAN has a wealth of experiences in facing the challenges of the HIV epidemic as well as in implementing effective responses. With most countries sharing many common traits in terms of the progression of the epidemic, yet currently at different phases, the successes and lessons learnt from counterparts can be of tremendous importance. For countries that are only recently facing a growth in the spread of the epidemic from a previously latent phase, such as Philippines and Lao PDR, the importance of managing the epidemic while it is still relatively contained within the IDU population is evident from the experiences of many other countries that have seen epidemics spreading through sexual transmission beyond the IDU populations, into the sex worker and client sexual networks. Thus, it is crucial that harm reduction efforts are put in place in a timely manner. In this, Malaysia and Indonesia would have substantial contribution in sharing the experiences in implementing the harm reduction programmes, including the NSEP, Methadone Maintenance Therapy as well as harm reduction in incarcerate settings.

Where the HIV epidemic has already grown to spread through sexual transmission and the risks associated with commercial sex is high, such as Malaysia, Indonesia and Viet Nam, it is important to incorporate the successes and lessons of Thailand, Cambodia and Myanmar in implementing the 100% Condom Use programmes in the planning of the prevention strategies.

Brunei and Singapore, although currently seeing very low levels of infection, are both facing issues in addressing HIV risks and vulnerabilities among the migrant population. A strong network of collaboration with sending countries can be of mutual benefit. Major sending countries of migrant workers such as Indonesia, Cambodia, Myanmar, Lao PDR and Viet Nam may be able to emulate the experiences from Philippines and Thailand (generally as sending and receiving countries, respectively) in strengthening the access of HIV services to migrant workers and providing prevention programmes.
4.7. Enabling environment

An enabling environment is an essential prerequisite to an effective HIV response. As highlighted in the Commission on AIDS in Asia report, national HIV responses tend to be strengthened if community-based and non-governmental organisations are involved in policy development, planning and programme implementation. It is particularly important to include the participation of PLHIV, although in reality such participation is often minimal. It is vital to build capacity and provide support to the civil society particularly the key affected populations and PLHIV.

Also important is the advocacy to various community and religious leaders, in order to include religious authorities and faith-based organisations as stakeholders in HIV response. The same strategy should also be applied in dealing with law enforcement authorities, especially in finding workable and practical solutions to implementing effective intervention despite the existing legal barriers existing in most countries. Malaysia and Indonesia, for example, have managed to implement harm reduction programmes targeting IDUs, against a background of existing anti-drug policies in the countries [18, 22].

Protection of human rights and anti-discriminatory laws

The discrimination of PLHIV continues to take place regionally, if not globally. In ASEAN, the protection of human rights among PLHIV against discrimination still has room for improvement. Only four ASEAN countries have protective laws and regulations addressing PLHIV, although there are more non-discrimination laws or regulations which protect other vulnerable populations than there are in non-ASEAN countries. Cambodia and Viet Nam have legislation on non-discrimination pertaining to HIV/AIDS, while Thailand and the Philippines have general anti-discrimination provisions. Lao PDR has recently adopted the AIDS Law that promotes the prevention of further HIV infection, protects human rights of PLHIV and those who are affected, promotes access to treatment, care and social support, and promotes the non-discrimination and stigmatization of PLHIV.

Although half of ASEAN countries have mechanisms to monitor, record and address human rights issues, national institutions for the promotion of human rights, and monitoring and enforcement mechanisms were few, if any. The effect of legal environments on HIV responses is varied across ASEAN. Legal environments that are protective and empowering help to combat stigma and underpin health promotion efforts in changing behaviour and accessing prevention, testing, and treatment and care services.

A barrier to responding to HIV is the regulations or policies which hinder HIV prevention, treatment, care and support efforts. In countries where the HIV epidemic is disproportionately concentrated among groups such as the transgender population, men who have sex with men, IDUs and women who sell sex – those whose behaviours are criminalised, it is particularly important to assess the role of policing in influencing the vulnerability and risk-taking behaviours of these marginalised populations [21].

The combination of legislation, traditional roles of men and women, and the taboo associated with sex, drug use, sex work, contraception, and homo-, trans- and bisexuality have resulted in the lack of political leadership and evasion of “uncomfortable issues”, such as the fact that one in five Asian men have purchased sex at some point in their lives [32]. An enabling environment must be created through effective policy making, mobilization of key opinion leaders and civil society, education of law enforcement personnel and public awareness to ensure the stigma and discrimination associated with HIV/AIDS are reversed.
Addressing Regional HIV and AIDS Issues in ASEAN
5.1. Regional Policy Framework

ASEAN Summit Declarations and Commitment

In the ASEAN region, leaders manifested their commitments in responding to HIV and AIDS by signing the first ASEAN Declaration on AIDS, during the 7th ASEAN Summit in 2001, in Brunei Darussalam. The declaration was concretized with the adoption of the ASEAN Commitments on HIV/AIDS, during the 12th ASEAN Summit in 2007, in Cebu Philippines. [Annex A and B]. The main elements of the ASEAN Commitment on HIV/AIDS include:

- Mainstreaming and aligning HIV policies and programmes with national development and poverty reduction plans;
- Scaling up prevention and treatment to meet universal access targets, particularly in minimising the spread of HIV among vulnerable populations, including youth and women;
- Putting in place legislation and regulations to end stigma and discrimination against and protect PLHIV, and to ensure they have equal access to health, welfare and educational services;
- Removing obstacles to accessing quality HIV and AIDS prevention products, medicine and treatment commodities;
- Involving PLHIV and civil society organisations to participate actively and meaningfully in the response, including at policy and decision-making levels;
- Strengthening the role of the ASEAN Task Force on AIDS (ATFOA) to effectively implement regional responses to HIV, with multi-sector engagement, including that of the private sector;
- Ensuring the participation of all relevant key stakeholders in efforts consistent with ASEAN’s regional and international commitments; and
- Supporting the mobilisation and allocation of technical, financial and human resources to adequately implement programmes and policies in response to HIV.
ASEAN Socio-Cultural Blueprint

The ASEAN Leaders adopted the Declaration of ASEAN Concord II (Bali Concord II) in Bali, Indonesia on 7 October 2003 to establish an ASEAN Community by 2020, and re-affirmed to accelerate its establishment by 2015, during the 12th ASEAN Summit, 13 January 2007, in Cebu Philippines. The ASEAN Community shall be established comprising of three pillars, namely, political and security, economic and socio-cultural communities, which are closely intertwined and mutually reinforcing for the purpose of ensuring durable peace, stability, and shared prosperity in the region.

The entry into force of the ASEAN Charter in December 2008, paved the way to the development and adoption of the ASEAN Socio-Cultural Community Blueprint (2009-2015). The primary goal of ASCC is to contribute to realizing an ASEAN Community that is people-centred and socially responsible with a view to achieving enduring solidarity and unity among the nations and peoples of ASEAN by forging a common identity and building a caring society, which is inclusive and harmonious where the well-being, livelihood and welfare of the peoples are enhanced.

The ASCC Blueprint envisages the following characteristics: (a) Human Development; (b) Social Welfare and Protection; (c) Social Justice and Rights; (d) Ensuring Environmental Sustainability; (e) Building the ASEAN Identity; and (f) Narrowing the Development Gap.

Under the Social Welfare and Protection, ASEAN is committed to enhancing the well-being and the livelihood of the peoples of ASEAN through alleviating poverty, ensuring social welfare and protection, building a safe, secure and drug free environment and addressing health and development concerns more particularly ensuring access to healthcare and promotion of healthy lifestyles and improving capability to control communicable diseases including HIV and AIDS and other emerging infectious diseases.

Strategic Framework on Health Development

The ASEAN Strategic Framework on Health Development (2010-2015) was endorsed at the 10th ASEAN Health Ministers Meeting, held during 19-23 July 2010, Singapore. This document will serve as a strategic framework on the implementation of ASCC Blueprint on health development. It will provide direction for relevant technical working groups to further develop their respective work plans. This will allow existing health subsidiary bodies/task forces to maintain their ownership by developing their respective work plans. In addition, elaboration of each of focus area requires specific expertise to come up with comprehensive work plans. The document is attached in Annex C.

1) B3. Enhancing food security and safety.
   Strategic objective: to ensure adequate access to food at all times for all ASEAN peoples and ensure food safety in ASEAN Member States.
   Five focus areas: regional standard and procedure, laboratory, capacity building on risk analysis, emergency response to foodborne diseases and food outbreaks, overall coordination.

2) B4. Access to healthcare and promotion of healthy lifestyles
   Strategic objectives: to ensure access to adequate and affordable healthcare, medical services and medicine, and promote healthy lifestyles for the peoples of ASEAN.
   Six focus areas: maternal and child health, increase access to healthcare services, migrant health, promotes ASEAN healthy lifestyle (non-communicable diseases, tobacco control, and mental health), traditional medicine, and pharmaceutical development.
3) **B5. Improving capability to control communicable diseases**

**Strategic objective:** to enhance regional preparedness and capacity through integrated approaches to prevention, surveillance and timely response to communicable and emerging infectious diseases.

**Three focus areas:** prevention and control of emerging infectious diseases, HIV and AIDS, and enhancing regional supportive environment.

4) **B7. Building disaster – resilient nations and safer communities**

**Strategic objective:** to strengthen effective mechanisms and capabilities to prevent and reduce disaster losses in lives, and in social, economic, and environmental assets of ASEAN Member States and to jointly respond to disaster emergencies through concerted national efforts and intensified regional and international cooperation.

**One focus area:** multisectoral Pandemic Preparedness and Response

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Fourth ASEAN Work Programme on HIV and AIDS (2011-2015) was developed by the ATFOA as its last activity under AWP III. Utilizing a mixture of cost sharing and with support from UNAIDS, the following activities were carried out in 2010-2011.

1. **Internal Review of the Implementation of the AWP III (2006-2010).** ATFOA in its 17th Meeting conducted a review of AWP III with further assessment was carried out by the Consultant, ATFOA and ASEAN Secretariat.

2. **Analysis of the 10 UNGASS Reports of ASEAN Member States.** A first attempt to consolidate a regional report on the epidemic and response in ASEAN. It provides individual country profile and a regional analysis of key indicators from country reported accomplishments to 2010 UNGASS.

3. **ATFOA Core Group Planning Meeting.** A detailed deliberation and data appraisal to develop initial recommendations of the regional report. Direction setting for the ASEAN Work Programme IV was developed by previous, current and immediate next Chair of the ATFOA, together with volunteers in Bangkok, Thailand.

4. **AWP IV Finalization Workshop.** Prior to the formal 18th ATFOA Meeting in Phnom Penh, Cambodia, multi-lateral and civil society partners were invited for the presentation of AWP IV. It provided a venue for complementation of activities for 2011-2012.

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**5.3. Review of ASEAN Work Programmes**


Under the First Work Programme on HIV and AIDS, nine activities were implemented through cost-sharing basis between host and participating countries [1] from 2005 - 2010. ASEAN Member States relied on their own resources and the start of the “lead shepherd” model to carry out the activities. This initial endeavour of taking a regional approach to tackle the epidemic produced useful lessons for the planning of future Work Programmes. Lesson from AWP I includes (1) instead of focusing on country level projects, regional level programmes should generate “value added” responses to the epidemic; (2) avoiding projects that are one-off events; (3) needs to build capacity for implementers, ASEAN Secretariat and complementation of staff to effectively complete the projects.
Second ASEAN Work Programme on HIV and AIDS (2002-2005)

The main objective of the Second AWP was to prevent the spread of HIV and mitigate the social and economic impact of the disease in the ASEAN Member States. This Work Programme included three major components that comprised of a) joint action programmes; b) regional activities in support of country programme strategies; and c) a non-programme strategy. Thirteen projects were implemented under these components [6].

Joint actions by Member States made several contributions towards country and regional responses [1]. These included: (1) Assisting Member States to improve the enabling environment for effective responses to the HIV epidemic; (2) Enhancing the involvement of civil society in all ASEAN Member States; (3) Increasing the involvement of PLHIV in national and regional responses to the HIV epidemic; (4) Improving leadership in the response to the HIV epidemic, through collaboration with the Asia Pacific Leadership Forum on HIV and AIDS and Development (APLF); and, (5) Sharing of information and strategies between countries.

Findings from the appraisal review of AWP II noted demonstrable accomplishments, specifically the strengthened leadership in the regional response. The identified challenges and bottlenecks were considered in the development of the next work programme, such as limited flexibility to initiate activity that is deemed strategic along its implementation, the need for more coordination with other partners including CSO, limited initiatives on inherent analysis of gaps, strengths and emerging problems and possible solutions to address it and delays in implementing the work programme.


The Third AWP was designed to tackle issues that could primarily be addressed through regional action and to use existing mechanisms to facilitate Member State’s collaboration, and to deal with emerging challenges. Furthermore, the ATFOA Focal Points and the ASEAN Secretariat envisioned an enhanced multi-sectoral collaboration with non-health government ministries, civil society organisations and the private sector along with strengthening knowledge management and information sharing at country and regional levels.

The overall objective of the Third AWP was to prevent the further transmission of HIV and mitigate the impact of HIV and AIDS, by improving regional responses and enhancing Member States’ development of people centered initiatives. In addition, four specific objectives were defined and operationalised through several projects. An Operational Plan (2007-2008) for the first phase of the Third AWP was developed, and the second phase focused on completing the activities undertaken and planning for the Fourth AWP.

Third AWP highlighted the challenges of undertaking a multiplicity of activities within the context of inadequate capacity and resources (e.g. financial, human and technical) at both country level offices and at the ASEAN Secretariat. However, despite these limitations most activities were implemented. Success is highlighted in the fulfillment of the following:

- undertaking projects within the capacity of the ASEAN Secretariat and ATFOA members
- strengthening programme capacity to develop and implement effective and cost efficient interventions
The Third AWP implementation was facilitated by the following:

1. Long-standing and collaborative approaches in pooling and sharing expertise and knowledge and supporting each other;
2. Nominated lead Member States for identified activities;
3. ASEAN Secretariat support in coordinating and mobilising resources to implement the overall Work Programme; and,
4. Tapping existing opportunities for joint activities regional partners, such as UNAIDS and its co-sponsors.

AWP III identified the following challenges:

1. Resource constraints including funding constrains and the lack of human resources at the ASEAN Secretariat;
2. Strengthening follow through and structure monitoring framework considering annual meeting set-up;
3. Need for strategic partnerships and collaboration with other sectors.

5.4. Regional Platform

ASEAN Task Force on AIDS (ATFOA) was established in 1993 as directed by the 4th ASEAN Summit in Singapore. It aims to promote regional cooperation and partnership in combating HIV and AIDS by strengthening regional response capability and capacity and ASEAN partnership with regional and international and civil society organizations. The updated scope of work as endorsed by 18th ATFOA and the 6th SOMHD Meetings includes:

1. Implement relevant directives emanating from the SOMHD
2. Promote and coordinate with ASEAN Inter-sectoral bodies to provide support to ASEAN Member States to address regional issues affecting implementation of HIV prevention, treatment and care
3. Formulate, adopt and review policies, strategies and programmes for regional cooperation on HIV and AIDS
4. Identify and explore priority areas of current interests for regional cooperation
5. Develop, implement, monitor and evaluate ASEAN Work Programmes on HIV and AIDS
6. Share information, lessons learned and best practices on HIV and AIDS
7. Strengthen and expand mutually beneficial cooperation with partner organizations and other stakeholders
5.5. Identified Regional Issues
Based on the findings of the consolidated regional data, several issues have been highlighted as priority areas relevant to ASEAN as a region. These issues are:

- Achieving Universal Access targets for prevention, treatment and care, with a priority on key affected populations and to address the underlying factors that limit effective response.
- Addressing vulnerable migrants and mobile population considering these are cross border issues for cooperation.
- Creating enabling environment, including policies that addresses lack of access to information and services of injecting drug users, men having sex with men and sex workers and other key vulnerable populations.
- Early detection, antenatal screening and the prevention of parent-to-child transmission of HIV.
- Taking political leadership to scale on important issues that affects vulnerability to HIV infection, such as gender, violence against women and economic opportunities to the most vulnerable populations.
- Supporting and strengthening the role of the civil society to promote collaborative and synergistic partnerships with relevant partners especially at the country level.
- Effective resource generation and utilization that addresses over-dependence on external funds and stabilizing domestic funding especially for effective prevention strategies.
- Access to affordable HIV commodities, especially cheaper anti-retrovirals.
- Knowledge-sharing that harnesses the experience among Member States and linkages to other regions in the spirit of South-South cooperation.
- Effective governance measures built upon sound monitoring systems, utilizing strategic information to guide decision makers and programs on a timely manner.

5.6. Fourth ASEAN Work Programme on HIV And AIDS

Vision
Reversing the spread of HIV in the ASEAN region and contributing to a healthy ASEAN Community.

Goal
Reduction of HIV transmission and mitigation of the impact of the HIV epidemic, consistent with the ASEAN Commitments on HIV and AIDS, MDGs and the UNGASS Declaration of Commitment on HIV and AIDS.

Strategic thrusts and outcomes
The Fourth AWP is underpinned by three strategic thrusts.

- Policy advocacy at regional and global level.
- Strengthening capacity and knowledge sharing among ASEAN Member States.
- Strengthening regional mechanisms to take advantage of available opportunities.
Strategic outcomes

1. ASEAN highly regarded as a well-coordinated regional policy and advocacy body
2. ASEAN Member States established an intra-ASEAN and South-South Collaboration sharing and learning mechanism
3. ASEAN generated regular regional overviews of the epidemic
4. ASEAN established regional mechanism to work with other regional bodies to address issues on HIV prevention, treatment and support

In order to achieve intended outcomes, the three strategic thrusts are operationalised through the following objectives:

1. To promote ASEAN’s collective agenda at international and regional platforms utilising evidence-based epidemiological data and research findings
2. To strengthen the capacity of national ministries and agencies to plan, implement and monitor and evaluate prevention and treatment programmes through knowledge sharing among ASEAN Member States
3. To leverage access to affordable HIV related care and treatment

The Operation Plan for 2011-2012 was agreed using the prioritization criteria by the ATFOA in its 18th Meeting. The strategic framework and the operation plan were approved by the Senior Officials Meeting on Health and Development through ad referendum on 25 March 2011 and during the 6th SOMHD. [Annex D.] The next operational plan will be developed after ATFOA review of the Phase 1 implementation.

Box 4

ATFOA Criteria in Prioritization of Activities under AWP IV

• Addressing multi-national, multi-sectoral, transnational issues;
• Narrow the gaps between ASEAN Member States;
• Sustainability – reflecting ASEAN comparative advantage;
• Build upon existing opportunities;
• Impact on the set goal,
• Practical and doable, consider donor support and to consider country capacity;
• Evidence based
Country Profile 6
Brunei Darussalam

Brunei Darussalam is among the three countries in Southeast Asia to have the lowest prevalence rate of HIV infection, together with Lao PDR and the Philippines. Since the first local case reported in August 1986, HIV prevalence in Brunei Darussalam has remained low at <0.1%. Cumulatively, there are 56 reported cases in citizens and permanent residents up till the end of 2009, where 19 new cases were reported in 2008-2009, representing the highest annual increase with two AIDS-related deaths [46]. These figures, however, do not include the majority of newly reported HIV cases in Brunei Darussalam which occurred among immigrant workers [47, 48]. No mother-to-child transmission has been reported since 1995. A total of five children have been born to three HIV-positive mothers since the past three years. As recorded between 2008-2009, there were about 75% heterosexually-transmitted infections and 25% homosexual transmission with no known intravenous drug use [19]. Of known cases, 85% were among males and 42% were married. Infection among women has stayed low, with no apparent increase in recent years. HIV seroprevalence surveys show low HIV prevalence, even among individuals at high-risk for HIV and other STIs.
National Response

Due to the low number of HIV cases, Brunei Darussalam has yet to develop a National Strategic Plan on HIV/AIDS. However, there is commitment towards achieving the targets of the MDGs which includes ensuring universal and equitable access for better and comprehensive health care services. The Brunei Darussalam AIDS Council (BDAC) was established in 2000 to assist in educating and creating awareness about HIV and AIDS, prevention measures, and to assist those infected and affected with HIV [49]. In 2003, Pembimbing Rakan Sebaya, a youth peer educator group, was formed to motivate youths to practice a positive and healthy lifestyle, and to create awareness on the dangers of HIV and its transmission among youths.

HIV is a notifiable disease under Infectious Disease Order 2003. It is compulsory for all clinicians and national laboratories to report positive cases to the Department of Health Services. As part of the national response, free HIV testing is available at most government health centres and clinics [50]. As reported in December 2008, ten people were receiving ARV [51].

The Ministry of Health of Brunei Darussalam has developed Operational Procedures for Foreign Workers Health Screening with provisions on pre-departure medical examinations for foreign workers seeking employment in Brunei Darussalam according to the national HIV control programme [52]. If a migrant worker is found to be HIV-positive, he/she is not able to obtain a work visa or permit.

Gaps and Challenges

- Increasing trend of STIs (in particular Chlamydia and Gonorrhoea) over the past decade, indicating risky sexual behaviour practices which translates to risk of HIV infection. Currently there is no national policy on sex education in school curriculum.
- There are no formalized groupings or associations that deal specifically with MSM issues. Although MSMs contribute to a quarter of all HIV infections in the country, this population continues to be a difficult group to target.
- Mobility issues remain as Brunei Darussalam is a major destination country for foreign domestic or low-skilled labour.

Strengths and Opportunities

- Among the top three countries in Southeast Asia to have the lowest prevalence of HIV. There is opportunity to include behavioural surveillance on risk factors and behaviours among targeted population e.g. the youth.
- HIV testing is provided free of charge and available at most government health centres and clinics. ART, support and counseling for HIV positive citizens and permanent residents are given free of charge.
- There is opportunity to expand HIV testing to high risk groups e.g. patients presented with STIs.
- As the government provides free education to all of its citizens, there is opportunity to explore the possibility of incorporating education on STIs and HIV/AIDS.
Cambodia

Cambodia has one of the highest rates of HIV infection in the region, yet is now one of the few countries that have demonstrably reversed the HIV epidemic. Between 1997 and 2009 the prevalence of HIV in the adult population fell from 3.0% to 0.7% [53, 54]. In 2009 it was estimated that under 58,000 people aged 15-45 were living with HIV, with 52% of them were women [53]. AIDS-related deaths among adults and children in 2007 was 6,900 [55].

The epidemic in Cambodia is concentrated among sex workers and entertainment workers, men who have sex with men and IDUs (Figure 20). HIV prevalence rates among sex workers are higher in major urban areas than elsewhere. The reduction in prevalence rate amongst FSWs is substantial from the peak of 61.3% in 1998 down to 18.5% in 2001 and 13% in 2006 (Figure 21). The HIV prevalence among IDUs was as high as 24.4%. A survey of IDU found 35.5% shared needles and syringes at last injection despite almost all knew where to obtain clean equipment [53].

Although prevention programmes have had significant results, HIV prevalence among these key affected populations continues to be high and there is a real risk of a second wave of HIV infections within these groups if prevention measures are not sustained [53].

National Response

In September 2010, Cambodia received an MDG award for excellence in the government AIDS response [56]. The country is reported to have already achieved its MDGs related to HIV. The National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS 2006-2010 (NSP 2006-2010) builds on the first National Strategic Plan and includes the Three Ones Principle [53]. The National AIDS Authority (NAA) is the coordinating body of the multi-sectoral national HIV response and sits directly under the Prime Minister’s Office leading the strategic direction and coordinating the efforts of the main players in the response. The National M&E Guidelines were developed in 2008 and in 2009 the National Multi-sectoral M&E Systems Strengthening Costed Plan (2010-2015) was developed. Much of the plan’s activities will be funded by the GFATM Round 9 HIV grant.
The 100% Condom Use Program (CUP) in brothels has proven very successful in the past and a revised new strategy and standard operating procedure is now being implemented as part of the comprehensive prevention care and treatment programme extended to entertainment establishments like karaoke bars, beer gardens massage parlours and men who have sex with men.

In 2007 the PMTCT programme tested 18.8% of Cambodia’s pregnant women for HIV and provided prophylaxis for 10.7% of the total number of HIV-exposed neonates [54]. The number of HIV-positive pregnant women who received ART to reduce the risk of mother to child transmission of HIV increased from 505 in 2007 to 798 in 2009 [53, 55]. 2007 continued to see the rapid scale-up of ART provision (approximately 76% of all PLHIV in need of treatment were on ART) & VCCT (190,401 adults receiving services in the first three quarters of 2007) [54]. Cambodia introduced an approach through the Linked Response Initiative whereby prevention and treatment for HIV and sexual reproductive health that has significantly increased uptake on PMTCT.

Gaps and Challenges

- Challenges remain in reaching out to people who use drugs and in particular IDUs.
- The national response continues to rely heavily on external funding.

Strengths and Opportunities

- Success in 100% Condom Use Programme in the past leads to a new strategy and standard operating procedure to comprehensively cover prevention, care and treatment to all entertainment worker and men who have sex with men.
- Cambodia has been doing well in attracting financial resources from GFATM including through the recent successful Round 9 application.
- The Aids2031 initiative which aims to forecast trends in the epidemic and to evaluate the costs over the next twenty years will be followed by a more cost-effectiveness oriented strategic planning envisaged for the development of the National Strategic Plan 2001-2015 (NSP III).
- The NSP III will incorporate main remedial actions based on the recommendations of the recent Functional Task Analysis (FTA) of the national response and this will inform the preparation of the GFATM Round 10 proposal.
Indonesia

The HIV epidemic in Indonesia varies in intensity and who is impacted across the nation. In 2010, prevalence is estimated at 0.2% among the adult population (15-49 years) and in most parts of the country it is a concentrated epidemic [64]. In the two eastern most provinces, known together as Tanah Papua, it had reached the level of low-level generalized epidemic by 2009 with 2.03% prevalence among general population aged 15 – 49 [65].

Starting in the late 1990s, the majority of infections resulted from unsafe injecting practices. Sexual transmission -- heterosexual, homosexual, and transgender -- was the second major cause of infection. Intensive, systematic & comprehensive harm reduction programming resulted in marked reduction of new infections among people who inject drugs (PWID) while sexual transmission continued to rise in importance. By March 2011 fifty-three percent (53%) of reported AIDS was attributed to heterosexual transmission while injecting drug use accounted for only 38% [63].

Over the years a gradual shift has occurred in the balance of reported AIDS between men and women. In 2006 men accounted for 80.60%, women only 18.66%. By March 2011 the proportion of women had risen to 26.77%.
National Response

The Indonesian National AIDS Strategy for 2003–2007 stressed the role of prevention as the core of Indonesia’s national response to HIV and AIDS, while recognizing the urgent need to scale up treatment, care, and support services. Building upon this framework, the National AIDS Strategy for 2007–2010 set the priority targets of 1) reaching 80% of people most at-risk with comprehensive prevention programs; 2) 60% of the most at-risk population adopting safe behaviors; and 3) providing ARV to 80% of those meeting criteria [73]. Program implementation was focused in 19 strategically selected provinces, home to 80% of Indonesia’s key affected populations including PLHIV. A national mid-term review conducted in 2009 showed progress. The same targets were incorporated in the current National AIDS Strategy 2010-2014 with expansion of the geographic focus to develop a comprehensive response to the epidemic in 137 priority districts across the country’s 33 provinces [74].

As of March 2011, the number of VCT sites in Indonesia had increased from only 25 in 2004 to 388. Care, support, and treatment including ARV services in hospitals and associated clinics started in 25 hospitals in 14 provinces in 2004 [63][67]. The network has grown steadily and now 262 hospitals across the country have appropriately trained staff. In March 2011[63], 207 hospitals and 69 satellite clinics reported provision of ARV on a regular basis to 20,069 people with AIDS in accordance with the nationally-approved treatment protocol [66]. AIDS related death has declined from 46% in 2006 to 21% in 2010 [75]. Services for prevention of mother to child transmission of infection (PMTCT) are available in 79 locations in 22 provinces [75]. In the 3 years (2008-2010) 391 women received a complete course of ARV prophylaxis [66].

Harm reduction programmes have been scaled-up from reaching only 15,476 PWIDs in 2006 or an estimated 7% of the PWID population to reaching 88,704 PWIDs or 48% in 2010 [75]. As of March 2011, methadone maintenance therapy (MMT) was provided through 67 sites (hospitals, public health centers and clinics of the prison system) serving a total of 2,536 active patients [63]. Oral substitution therapy (OST) is also available using buprenorphine. Sterile needle-syringe programs (NSP) are available in community (NGO based) settings and government public health centers and have been rapidly increasing in number in recent years.

Safe injecting practices have increased to 73% in 2010 among PWIDs [72]. By end of 2010, 72 prisons, detention centers of the Department of Law and Human Rights had initiated a comprehensive program of prevention and treatment related to HIV and AIDS. [61]

Scaling up of prevention of HIV infection through sexual transmission is underway using a comprehensive, structural intervention. As of 2011, services were available in 137 districts including 3,619 distribution outlets for male condoms, 1,762 distribution outlets for lubricants and 488 distribution outlets for female condoms [68].
Addressing AIDS in ASEAN Region

Figure 22: HIV prevalence, risks and reach indicators for key affected populations, Indonesia, 2008-2009.

Source: Indonesia UNGASS Report, 2010 [18].

Figure 23: HIV prevalence trends among key affected populations, Indonesia (Jakarta) 2001-2007.


Source: Indonesia, National AIDS Commission Monitoring Data 2011[71]
Gaps and Challenges

- The physical size of Indonesia (more than 5,200 km from east to west), large population (world’s 4th largest) and island diversity (world’s largest archipelago) present major challenges of management and logistics.
- Not withstanding great progress, limitations of community and health infrastructure present challenges to management and acceleration of the response.
- Continuing resistance to condom use in some circles retards acceleration of prevention of infection by sexual means.
- Continuing expansion and sustainability of the national response call for on-going development of local human resources and domestic funding.

Strengths and Opportunities

- The Indonesian government has significantly increased its domestic resources for AIDS-related work, total expenditures rising from US$ 15 million (2006) to US$ 44 million (2010) representing 49% of the total expenditures that year [69][70].
- Strong commitment at the highest levels of government is reflected in public discourse and policy including integration of HIV and AIDS as a cross sectoral concern in the Midterm National Development Plan (2010-2014).
- The government is providing free ARV, anti-tuberculosis drugs, and HIV tests, as well as diagnosis and treatment through referral hospitals.
- There has been considerable progress in creation of a legal and regulatory environment supportive of the comprehensive response to the epidemic with adoption in 2009 of a new narcotics law (law 35/2009) and new health law (law 36/2009).
Lao PDR

The total estimated number of PLHIV in Lao PDR is approximately 8,000, with the current estimated prevalence of adults at 0.2% [42]. The main mode of HIV transmission in Lao PDR is through heterosexual contact (87%), a majority of whom were mobile men working in neighbouring countries. High levels of local and foreign cross border migration correlate with the high notification rate of 19% among migrant workers. Heterosexual transmission of HIV is emerging in urban areas, along with high prevalence of other STIs.

HIV prevalence among FSWs had doubled over the 2001 to 2004 period from 0.9% to 2% and decreasing again to 0.5% in 2008 (Figure 24 and 25). Second-generation surveillance data from 2001 showed under 50% prevalence of chlamydia or gonorrhea among FSWs in entertainment establishments in five provinces [43]. HIV prevalence among IDU is nearly 5%. The prevalence of HIV among MSM appears to differ between locations, with 5.6% in the capital Vientiane compared to 0% in Luang Prabang. HIV prevalence among female migrants was found to be 0.8%, and they reported high risk behaviour such as injecting drug use and almost no condom use with non-regular partners [42].

Knowledge on HIV/AIDS among the general population is low; 23% of respondents in a survey did not know that HIV was transmissible by blood, and more than half did not know it could be transmitted by mother-to-child during pregnancy and breastfeeding [59].

National Response

Since 2008, responses to the potentially growing threat of HIV have resulted in the drafting of an HIV law, funding approval of two GFATM grants focused on treatment and care efforts, continued inclusion of HIV in national policy priorities, the expansion of PLHIV networks and their involvement in policy and program making, and the development of a multi-sectoral monitoring and evaluation five year strategic plan [42]. The National Strategy and Action Plan (NASP) 2006 – 2010 is based primarily on reviews of the NSP 2002 – 2005 as well as the second round of behavioural and sero-surveillance in 2004 [42].

Coverage of PMTCT has remained low in the last two years, 12% in 2008 and 14% in 2009, resulting in 15% of infants born to HIV positive mothers in 2009 being infected with HIV [42].
Lao was one of the first countries in the region to conduct integrated life skills training into the school curriculum with trained teachers [42]. By 2009, 3,000 teachers had been trained and 74% of schools provided life skills-based HIV education within the academic year [42]. The drafting of an HIV Law for all sectors, taking into account the approved HIV policy of December 2009, was completed and presented in the Lao PDR national assembly in June 2010 [42]. There are also human rights policies which forbid discrimination in the workplace, and these are enforced by provincial bodies who interact with PLHIV [42]. According to the Law on Illicit Drugs, drug users are victims and are not considered as criminals. Drug users are thus given access to treatment and health services. Harm reduction programmes have been initiated with the establishment of a National Task Force on Harm Reduction involving also the public security sector. The project implementation began since 2009, with a focus on some selected Northern Provinces.

Gaps and Challenges

- Lao PDR is vulnerable as it is landlocked by neighbours with high prevalence amongst MARPs, combined with increasing mobility among cross border populations.
- There is over dependence on external funds (close to 100%), which poses a challenge to programme sustainability.
- Low development, poverty, low literacy, large numbers and varieties of ethnic groups, food shortages and low availability of comprehensive health care particularly in rural settings where a large population live, add to the challenge.
- There is a lack of data for many population groups to monitor vulnerable populations and progress of activities to ensure priorities remain relevant.

Strengths and Opportunities

- Prevalence among key affected populations is still generally low - there is an opportunity to address these issues and direct resources to monitor and respond to their needs.
- There is an opportunity to learn and engage countries in the region in early harm reduction efforts.
Malaysia

The Malaysian HIV surveillance system reported 87,710 HIV cases and 13,394 AIDS-related deaths as of December 2009. The HIV national prevalence is 0.5%, concentrated mostly among IDUs and female sex workers and their clients. Other groups include MSM and the transgender populations (Figure 26) [22]. The annual number of newly detected HIV cases has been on a steady decline from a peak of almost 7,000 in 2002.

The prevalence rate amongst IDUs has doubled from 11% in 2007 to 22.1% in 2009 (Figure 27). Among FSWs, the prevalence was 10.5% in 2009.

Most reported HIV cases occur among males IDU (75%) of Malay ethnicity. However, the proportion of women who were infected through heterosexual transmission has increased; in 2000, women constituted 10% of new HIV cases, which doubled by 2009.

Peninsular and East (Borneo) Malaysia have notably different transmission dynamics, with the former being mostly IDU-driven with an increasing percentage of heterosexual and homosexual transmission, while East Malaysia shows an increasingly heterosexual trend, albeit at lower levels of infection [22].

National Response

Malaysia has just concluded its 2006 – 2010 NSP, with an allocation of USD 143 million for a period of 5 years. Prevention programmes for MARPs have increased over the last two years. While funding is almost fully granted by the government, the implementation of most prevention programmes involving MARPs are mainly dependent on CBOs and NGOs. Bio-behavioural surveys have only recently been introduced in Malaysia, with the conduct of an integrated bio-behavioural surveillance (IBBS) of IDU, FSW and the transgender population in Kuala Lumpur in 2009 [22].
Malaysia was among the first countries in the region to implement a harm reduction programme for IDUs. The two main programmes for IDU harm reduction in Malaysia are the Needle Syringe Exchange Programme and the Methadone Maintenance Therapy programme. These programmes which are implemented in partnership with NGOs, CBOs and private health practitioners, remain the better funded programmes among all the HIV prevention activities. The context of recent interventions such as the NSEP has provided excellent opportunities to train and build capacity among law enforcement officials as well as religious leaders on HIV related issues such as stigma and discrimination.

In October 2003, Malaysia applied for the ‘Government Use’ provisions in its national law in order to import generic ARVs [39]. As a result, the importation of generic ARV drugs in Malaysia reduced the cost of treatment, for both generic and patented products. First line ART is free for those who need it while the second line regime is also partially subsidised by the Government. Health services in the Malaysian hospital and primary healthcare systems are of high standard, especially those relating to clinical management of HIV. A recent development has been the extension of access to PLHIV in prisons and the implementation of the PLHIV Medicine Assistance Scheme intended to assist poor Malaysians living with HIV to undergo HAART. These up-scaling efforts have resulted in a total of 9,962 PLHIV on ARV by the end of 2009.

Gaps and Challenges

- Inadequate monitoring and evaluation of HIV/AIDS programmes and the NSP. The M&E unit was not established as part of the NSP framework due to the lack of technical expertise. The lack of measurable targets within the NSP framework, coupled with the lack of a dedicated M&E unit, make impact evaluation difficult.
- The rise in sexual transmission would require a further strengthening of commitment from the Government to improve upon programmes which specifically address the issues of sexual reproductive health.

Strengths and Opportunities

- The MOH is committed to continue to support NGO programmes as long as efficient reporting is carried out as required.
- Civil society representation has improved considerably. Religious authorities are also being engaged to address the role of religion in the changing social norms and in addressing HIV.
- Scaling-up of harm reduction programmes are under way to increase reach and coverage.

Myanmar

Myanmar is among the few countries in the region that is showing a decreasing trend in the HIV epidemic. HIV transmission occurs primarily through high risk sexual contact between sex workers and their clients, men who have sex with men and the sexual partners of these sub-populations, as well as among IDUs through use of contaminated injecting equipment, with transmission to sexual partners. The 2009 estimate of HIV prevalence in the adult population is 0.6%. Among key affected populations, surveillance data from 2008 showed HIV prevalence in the sentinel groups at 18.1% in female sex workers, 28.8% in men who have sex with men, and 36.3% in male IDUs (Figure 28) [60]. The prevalence rate among FSWs was increasing from the year 1992 until 2006 when there was a sharp decline in 2007 (15.6%) and has been quite stable with a slight increase in 2008 (18.4%). The prevalence trend among IDUs has also seen a sharp over the years from 62.7% in 2000 to 24.1% in 2002 (Figure 29).

National Response

Myanmar National Strategic Plan on HIV and AIDS, 2006-2010 was developed in 2006 under the leadership of the Ministry of Health, for the first time through a participative process that involved a wide base of partners and stakeholders. The resulting document,
along with its associated budgeted Operation Plan, has provided a prioritized strategic framework and reference for all partners in the national response and a basis for resource mobilization and allocation. The National Strategic Plan is guided by the ‘Three Ones’, the participation of PLHIV and emphasises programme outcomes. It strives to achieve universal access to prevention and care, and scaling up effective initiatives through capacity building.

Figure 28: HIV prevalence, risks and reach indicators for sex workers, men who have sex with men and injecting drug users, Myanmar, 2008-2009. Source: Myanmar UNGASS Report, 2010 [15].


**Gaps and Challenges**

- The government health expenditure is low, with domestic and international financial support inadequate to respond comprehensively to the HIV epidemic. Economic sanctions due to political differences have added to the difficulties in obtaining financial aid, sustaining health sector infrastructure and hospital and medical supplies, leading to problems of procurement of ART and medicines for opportunistic infections, inadequate laboratory service points, and low coverage of prevention services.
- HIV prevention services remain limited, with only 10% of people in need receiving appropriate services in programme delivery areas.
- The population is spread over a wide area with many languages and dialects, with some facing geographical isolation and security concerns due to conflict, mainly in border regions.
- Law enforcement agencies where prevention programmes for key affected populations are on-going are not always fully aware of these programs, and the 100% Targeted Condom Programme addresses this problem through advocacy with local authorities.

**Strengths and Opportunities**

- Previous increases in prevalence have been successfully alleviated by HIV prevention efforts, although the situation continues to require monitoring.
- Through the Myanmar CCM efforts with GFATM, there are initiatives in place to improve prevention services among MARPs, address the multilingual needs of the population, respond to reproductive and sexual health needs of women and adolescents, combat issues of stigma and discrimination and aims to reduce the HIV/TB co-infection burden.
- Although there is still a need for improved data collection and quality, the standard surveillance has been improved and expanded since 2007, resulting in a sample that is more representative of the sub-populations.
Philippines

Philippines is considered to have a latent HIV epidemic that is showing evidence of growing. The prevalence is among the lowest of ASEAN nations, at less than 1% of the adult population, with prevalence among MARPs at 0.47% (although MSM prevalence is 1%), an increase from 0.08% in 2007. About 73% of cases were among males. There have been 4,424 HIV cases reported in the Philippines since 1984.

Unlike many other ASEAN countries, 90% of transmissions in the Philippines were through sexual contact, with only 1% through MTCT and 1% through needles sharing among IDUs. Sexual transmission via male-male sex has been rising, and by 2009 41.8% of transmission was through MSM contact, 31.3% through bisexual contact and 28.9% through heterosexual contact. The 2009 Integrated HIV Behaviour Serologic Studies (IHBSS) show a 900% increase in prevalence amongst MARPs, specifically MSM and IDU.

The prevalence rate among IDUs and FSWs in the Philippines has doubled from the year 2007 (0.1%) to 2009 (0.2%) (Figure 30). Although the prevalence is low, it is still gradually increasing. But the prevalence rate amongst MSM is higher at 1% in 2009, and if not addressed the number can easily be doubled within the next two years.

In 2007, 31% of the total reported HIV infection cases were among Overseas Filipino workers (OFWs). By the end of 2007, 33% of the sero-positive cases among OFWs were seafarers and 17% were domestic workers. Most were male (74%) who acquired HIV through unprotected sexual contact (94%) [29, 35].
National Response

The national response to the HIV and AIDS epidemic is embodied in the AIDS Medium Term Plan IV (AMTP IV: 2005-2010) and the 2009-2010 Operational Plan. The Philippines National AIDS Council (PNAC) was formed in 1982 and is the main implementer of the 4th AIDS Medium Term Plan 2005–2010. The national monitoring and evaluation system which began in 2003 has been developed and tested, and needs to be fully utilised to build a database of information on MARPs and vulnerable populations [29, 61]. The underestimation of affected populations has led to underfunding and lack of coverage [61]. Furthermore, the GFATM-supported programmes and PNAC systems are different, resulting in limited information and difficulty in monitoring progress.

Access to treatment, care and support for PLHIV has seen significant improvement with 13 referral hospitals, however the need for more support for laboratory workups, and improving accessibility to treatment for OFWs living with HIV require increased resources and collaboration between service providers. Although ARV is free, many cannot afford the cost of treatment and other medical needs.

Gaps and Challenges

- **Healthcare system needs to be prepared to respond to increasing numbers of PLHIV.**
- **There is a limited budget allocated solely by the Department of Health.**
- **The frequent change in Philippine leadership results in continuous shifting of commitment and support.**
- **Stigma and discrimination still need to be address, particularly in the context of religion.**

Strengths and Opportunities

- Despite having among the lowest prevalence in the region, Philippines have been relatively vigilant in monitoring the growth and spread of the epidemic among key affected populations. The current increasing trend in cases detected is therefore being responded to and there is an opportunity to halt the progress of the epidemic, provided effective high impact interventions are put in place.
- **The existing monitoring and prevention programmes targeted at Overseas Filipino Workers provide a template for further comprehensive intervention to address issues of HIV among migrants.**
Singapore

The HIV epidemic in Singapore is among the lowest in the region with an estimated national prevalence of 0.1%. The first case of HIV was diagnosed in 1985. Since then, the cumulative total number of HIV-infected Singapore residents has increased from two in 1985 to a cumulative total of 4,159 as of 30 June 2009 [60].

The epidemic in Singapore is predominantly driven by sexual transmission, affecting mostly men. Up to 66% of the 4,159 reported HIV cases were acquired through heterosexual transmission and 28% among men who reported homosexual or bisexual contacts. Because of the strict drug laws in the country, injecting drug use accounted for only 2% of all HIV cases. Figure 32 shows the prevalence rate amongst FSWs (0.3%) and MSMs (2.6%) in the year 2009.

The majority of cases are notified when they are already in an advanced stage of infection. In 2008, 50% of new cases were already in the late stage of HIV infection upon diagnosis. Similarly, in the first six months of 2009, more than half (56%) of new cases were late-stage HIV infections upon diagnosis and 54% of the cases were detected upon testing during the course of some form of medical care while another 21% were detected as a result of some form of health screening. Another five percent were detected through screening programmes in prisons and drug rehabilitation centres.
National Response

To enhance the surveillance and control of HIV, the Singapore Ministry of Health set up a National Public Health Unit in September 2008 which is responsible for maintaining and enhancing the National HIV Registry, carrying out contact tracing and partner notification for newly-diagnosed HIV patients, and conducting HIV-related public health research. HIV and AIDS prevention and education is the mainstay of the national HIV/AIDS control programme. Education programmes has been implemented for secondary school students and is also done for sex workers. Specific educational programmes targeting high-risk heterosexual men and men who have sex with men have also been implemented, in collaboration with community-based organisations. Singapore has also implemented HIV and STD prevention, education and screening programmes for female sex workers. HIV/AIDS patients have access to subsidised inpatient and outpatient care. This includes hospital, radiological and laboratory charges, treatment of complications with standard drugs and consultation fees. Patients are allowed to withdraw up to S$550 per month from their Medisave account for ARV drugs. From 1 February 2010, Medifund assistance was extended to HIV treatment.

Gaps and Challenges

HIV-related stigma and discrimination remains a significant challenge.

Strengths and Opportunities

As an effort to increase testing and early detection of HIV, the government and community partners have been working together to promote the HIV testing message to the general community, as well as those at higher risk of infection, particularly among high-risk heterosexual men and MSM.
Thailand

The first AIDS case in Thailand was reported in 1984. Although still recording among the highest prevalence and number of PLHIV in the region, the national trend in prevalence of HIV infection is one of continuous decline since 1996.

HIV prevalence remains high among key affected populations, particularly IDU, MSM, and indirect sex workers (Figure 33). Among female sex workers, approximately five times as many indirect and street sex workers acquire new HIV and STI infections compared to brothel workers as the 100% Condom Use Programme and similar projects have only been successful among direct sex workers. The prevalence rate has gradually decreased among FSWs from 27.8% in 1996 to 2.8% in 2009 (Figure 34). The same trend can also be seen amongst MSM in Bangkok. Among IDUs the prevalence rate has been increasing from the year 2007 (28.8%) to 2009 (38.7%), while IDUs in Bangkok has even higher prevalence rate from 25.6% in 2007 to 40.5% in 2009.

HIV infection among men who have sex with men (MSM) is highly diverse, and remains high with no indication of declining especially in urban centers and tourist locations. Among IDUs the prevalence of HIV among those attending detoxification centers is still high (30% to 40%) but much lower in Bangkok (24%) and Chiang Mai (11%). Epidemiological and behavioral data indicate that there is a trend of increasing HIV infections among adolescents.

National Response

Thailand’s current National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011 (National AIDS Plan) was developed through broad multi-sector collaboration and approved by the National AIDS Prevention and Alleviation Committee NAPAC which was chaired by the Prime Minister. The National AIDS Plan integrates collaboration from key government partners for 12 years. Presently, the 4th National AIDS Plan 2007-2011 has been established although no budget has been allocated. However, the government partners utilized the plan to design a framework and seek supportive funds of their own including support from the GFATM [17].
HIV prevention programs in Thailand mostly target key affected populations. The national programme is working intensively with all these groups using both domestic and international funding (GFATM).

PMTCT is being implemented in Thailand and HIV testing and counselling at the ANC is mostly provider-initiated. Youth is an important target group under the National AIDS Plan for 2007-2011, most of which is supported by the GFATM.

The Thailand Universal Coverage Policy is to provide full care and treatment coverage for PLHIV which aims to have every Thai with health insurance to expand ART coverage. The increasing number of long-life ART dependence PLHIV is a new challenge to ART goals.

**Figure 33: HIV prevalence, risks and reach indicators for sex workers, men who have sex with men and injecting drug users, Thailand, 2008-2009.**

Source: Thailand UNGASS Report, 2010 [17].

**Figure 34: HIV prevalence trends among key affected populations, Thailand, 1996-2009.**


**Gaps and Challenges**

- Diverse attitudes, beliefs and lifestyles are the challenges for the ineffective youth behavioral change strategy. Sexual education is still a weak point in HIV prevention. There is no core curriculum involving comprehensive sexual education at the national level that is acceptable to the MoE and teachers.
- There are still social and legal barriers to the implementation of harm reduction programmes.

**Strengths and Opportunities**

In support of its Universal Coverage Policy, Thailand has made ART cheaper by manufacturing its own drugs through the Thai Government Pharmaceutical Organization (GPO). The GPO is only producing products that are not patented in Thailand, or for which the Thai patent has expired. And would import drugs that are not available locally through Compulsory Licensing (CL), which is allowed under TRIPS.
Viet Nam

The adult HIV prevalence in Viet Nam remains low at 0.4% in 2009. HIV cases have been reported nationwide in all 63 provinces/cities. As of 31 December 2009, there were 160,019 reported HIV cases and 44,050 deaths due to AIDS-related illnesses. In 2009, there were 15,713 newly-reported HIV cases and 2,010 AIDS-related deaths. People aged 20-39 years account for more than 80% of all reported cases and the proportion of PLHIV aged 30-39 is showing signs of increasing. Men accounted for 73.2% of all reported cases in 2009.

HIV prevalence among IDUs increased during the period 1996-2002 but thereafter decreased from 29% in 2002 to 18.4% in 2009 (Figure 36). An estimated 18.5% of IDU are receiving harm reduction interventions. HIV prevalence among FSWs in the 40 surveyed provinces decreased from 5.9% in 2002 to 3.2% in 2009. HIV prevalence among women attending antenatal clinics and among male military recruits has begun decreasing and continues to be observed at low levels of 0.3% and 0.15%, respectively. While HIV prevalence among MSM has been increasing from 9% in 2006 to 16.7% in 2009.

Only 11% of pregnant women received both an HIV test and their test results. It is estimated that 33% of HIV positive pregnant women receive PMTCT to prevent vertical transmission; links to neonatal follow-up care and ART for the mother are weak.

National Response

In 2008-2009, a growing awareness of the key challenges that were hindering the national response to HIV led to the Government’s decision to evaluate interventions of the National Strategy on HIV/AIDS Prevention and Control from 2004-2010. The findings will inform the development of a more strategic, cost effective and sustainable response in the coming years.
There are currently 27,100 adults and 1,479 children on ART in Viet Nam, which meets less than half of the current need. The MOH estimates that the ART needs by 2011, with the current financial commitments (PEPFAR, GF-6, GF-8, CHAI) for the same year, will leave a gap of 43,509 adult and 3,000 pediatric patients. More than 26% of PLHIV reside in districts that do not have ART services. The National AIDS Program funds 4% of those on treatment and will not be able to prevent treatment interruptions should donor funding fall short. Pediatric ARVs are currently funded by one donor who has indicated their funding will end in 2010. Additionally, other donors have not been able to commit funds past 2012.

Figure 35: HIV prevalence, risks and reach indicators for sex workers, men who have sex with men and injecting drug users, Viet Nam, 2008-2009.

Source: Viet Nam UNGASS Report, 2010 [16].

Figure 36: HIV prevalence trends among key affected populations, Viet Nam, 1994-2009.


Strengths and Opportunities

- HIV prevalence is low among the general population, and has been on the decline among MARPS, other than MSM and primary sexual partners of IDU and PLHIV, who are facing increasing risk.
- Improved commitment and identification of key challenges have resulted in evaluations of the national response to HIV/AIDS, including the establishment of an MMT program and scale-up of treatment and care.
- Reproductive health and HIV prevention is being integrated into the national educational curriculum, and teachers are already seeing positive results as students start talking more openly about HIV.

Gaps and Challenges

- Already marginalized IDUs and female SWs face double stigma with HIV infection and have difficulties in accessing employment, education and social support services.
- Prevention of sexual transmission among MSM and the prevention of intimate partner transmission of HIV are one of the biggest prevention gaps in the current national response.
- In absence of harm reduction to reduce needle sharing and consistent condom use, HIV will be fueled by these two groups and to their sexual partners.
- There are currently insufficient funds to bring to scale effective interventions from 2011-2015 and Viet Nam is still highly dependent on international funds.
- Although national programme management and coordination capacity has improved, the limited capacity of Provincial AIDS Centers (PACs) remains an obstacle and leads to poor coordination of multiple health services and donor-funded projects.
Annexes
ASEAN Declaration on AIDS
7th ASEAN Summit, Brunei Darussalam, 5 November 2001

[1] WE the Heads of State and Government of the Association of South East Asian Nations (hereinafter referred to as ASEAN):

[2] RECALLING that the ASEAN Vision 2020, adopted by the 2nd ASEAN Informal Summit held in Kuala Lumpur in December 1997, envisioned ASEAN as a concert of South East Asian nations, outward looking, living in peace, stability and prosperity, bonded together in partnership in dynamic development and in a community of caring societies;

[3] RECALLING the UN Declaration of Commitment on HIV/AIDS adopted at the 26th Special Session of the General Assembly in June 2001 that secured a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat HIV/AIDS in a comprehensive manner;

[4] DEEPLY CONCERNED that the HIV/AIDS pandemic is a threat to human security and a formidable challenge to the right to life and dignity that affects all levels of society without distinction of age, gender or race and which undermines social and economic development;

[5] RECOGNISING that at least 1.6 million people are living with HIV/AIDS in the ASEAN region and that the number is increasing rapidly through risk behaviors exacerbated by economic, social, political, financial and legal obstacles as well as harmful attitudes and customary practices which also hamper awareness, education, prevention, care, support and treatment efforts, particularly to vulnerable groups;

[6] REITERATING the call of the Hanoi Declaration adopted by the Sixth ASEAN Summit in December 1998 that we shall make sure our people are assured of adequate medical care and access to essential medicines and that cooperation shall be stepped up in the control and prevention of communicable diseases, including HIV/AIDS;

[7] NOTING the Joint Declaration for a Socially Cohesive and Caring ASEAN adopted at the 33rd ASEAN Ministerial Meeting held in Bangkok in July 2000, to strengthen people-centered policies that will promote a positive environment for the disadvantaged, including those who are in ill health;

[8] COMMITTED to realizing a drug-free ASEAN, as called for by the Joint Declaration for a Drug-Free ASEAN adopted by the 33rd ASEAN Ministerial Meeting held in July 2000 and the Bangkok Political Declaration in pursuit of a Drug-Free ASEAN 2015 adopted by the International Congress “In Pursuit of a Drug Free ASEAN” held in October 2000;
[9] ENCOURAGED by the notable progress of the ASEAN Task Force on AIDS in responding to the call by the Fourth ASEAN Summit held in Singapore in February 1992, to implement regional activities on health and HIV/AIDS aimed at curbing and monitoring the spread of HIV by exchanging information on HIV/AIDS, particularly in the formulation and implementation of joint policies and programs against the deadly disease;

[10] REALISING that prevention is the mainstay of the response to HIV infection and that there are opportunities for the ASEAN region to prevent the wide-scale spread of HIV/AIDS by learning from the experiences of some ASEAN Member Countries, which have invested in prevention programs that have reduced HIV prevalence or maintained a low prevalence;

[11] ACKNOWLEDGING that prevention, treatment, care and support for those infected and affected by HIV/AIDS are mutually reinforcing elements that must be integrated in a comprehensive approach to combat the epidemic;

[12] STRESSING that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS, and that youth are especially vulnerable to the spread of the pandemic and account for over fifty percent of new infections;

[13] AFFIRMING that a multisectoral response has resulted in a number of effective actions for HIV prevention, treatment, care and support and minimization of the impact of HIV/AIDS;

[14] AWARE that resources commensurate with the extent of the problem have to be allocated for prevention, treatment, care and support;

[15] EMPHASISING that the epidemic can be prevented, halted and reversed with strong leadership, political commitment, multi-sectoral collaboration and partnerships at the national and regional levels;
Hereby DECLARE TO:

LEADERSHIP

[16] LEAD AND GUIDE the national responses to the HIV/AIDS epidemic as a national priority to prevent the spread of HIV infection and reduce the impact of the epidemic by integrating HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of national development planning, including poverty eradication strategies and sectoral development plans;

[17] PROMOTE the creation of a positive environment in confronting stigma, silence and denial; elimination of discrimination; addressing the prevention, treatment, care and support needs of those in vulnerable groups and people at risk, particularly young people and women; and strengthening the capacity of the health, education and legal systems;

[18] INTENSIFY and STRENGTHEN multisectoral collaboration involving all development ministries and mobilising for full and active participation a wide range of non governmental organisations, the business sector, media, community based organisations, religious leaders, families, citizens as well as people infected and affected by HIV/AIDS in the planning, implementation and evaluation of national responses to HIV/AIDS including efforts to promote mutual self help;

[19] INTENSIFY inter-ministerial collaboration at the national and international levels to implement HIV/AIDS programmes;

[20] SUPPORT strongly the mobilization of technical, financial and human resources to adequately advocate for and implement national and regional programs and policies to combat HIV/AIDS, including efforts to promote mutual self-help;

REGIONAL ACTIVITIES IN SUPPORT OF NATIONAL PROGRAMMES

[21] CONTINUE collaboration in regional activities that support national programs particularly in the area of education and life skills training for youths; effective prevention of sexual transmission of HIV; monitoring HIV, STDs and risk behaviors; treatment, care and support for people living with and affected by HIV; prevention of mother to child transmission; creating a positive environment for prevention, treatment, care and support; HIV prevention and care for drug users and strengthening regional coordination among agencies working with youths;
JOINT REGIONAL ACTIONS

[22] STRENGTHEN regional mechanisms and INCREASE and OPTIMISE the utilisation of resources to support joint regional actions to increase access to affordable drugs and testing re-agents; reduce the vulnerability of mobile populations to HIV infection and provide access to information, care and treatment; adopt and promote innovative inter-sectoral collaboration to effectively reduce socioeconomic vulnerability and impact, expand prevention strategies and provide care, treatment and support;

[23] MONITOR and EVALUATE the activities at all levels and systematically conduct periodic reviews and information sharing with the full and active participation of non-governmental organisations, community-based organisations, people living with HIV/AIDS, vulnerable groups and caregivers;

INTERNATIONAL COLLABORATION

[24] URGE ASEAN Dialogue Partners, the UN system organisations, donor agencies and other international organisations to support greater action and coordination, including their full participation in the development and implementation of the actions contained in this Declaration, and also to support the establishment of the Global HIV/AIDS and health fund to ensure that countries in the region would have equal opportunity to access the fund;

ASEAN WORK PROGRAMME ON HIV/AIDS

[25] ADOPT the ASEAN Work Programme on HIV/AIDS and work together towards accomplishing the regional activities in support of national programs and joint regional actions.

ADOPTED on this Fifth Day of November 2001 in Bandar Seri Begawan, Brunei Darussalam.
ASEAN Commitments on HIV / AIDS
12th ASEAN Summit, Cebu, Philippines, 13 January 2007

WE, the Heads of State and Government of the Association of South East Asian Nations (hereinafter referred to as ASEAN), gathered in Cebu, Philippines on 13 January 2007, devoting a Special Session during the 12th ASEAN Summit, to review and renew our commitments on HIV and AIDS;

RECOGNISING that the HIV epidemic brought about by factors such as poverty, gender inequality and inequity, illiteracy, stigma and discrimination, conflicts and disasters, affects groups most at risk like sex workers, men having sex with men, transgenders, and drug users including injecting drug users; and vulnerable groups such as migrants and mobile populations, women and girls, children and youth, people in correctional institutions, uniformed services, communities of populations in conflict and disaster-affected areas;

REAFFIRMING our earlier commitments to effectively respond to HIV in the ASEAN region, made at our first Special Session held in conjunction with the 7th ASEAN Summit in November 2001 in Bandar Seri Begawan, and reiterated at the 9th ASEAN Summit in October 2003 in Bali, the 2nd ASEAN-United Nations Summit in September 2005 in New York and the 11th ASEAN Summit in December 2005 in Kuala Lumpur;

RECALLING the commitment to achieve the Millennium Development Goals, in particular Goal No. 6 which specifically refers to halting the spread of HIV/AIDS, malaria and other diseases;

SUPPORTING the 2005 World Summit’s call and the Political Declaration made by the United Nations General Assembly at the High Level Meeting on AIDS held on 2 June 2006, to scale up significantly towards universal access to comprehensive prevention, treatment, care and support by 2010 for all those in need, and the reduction of vulnerability of persons living with HIV, especially orphans, vulnerable children and older persons;

REITERATING that the Declaration on the Elimination of Violence against Women in the ASEAN Region promotes and protects women’s rights by reducing their vulnerability to HIV and eliminating gender inequalities and gender-based violence by creating an enabling environment for the empowerment of women and strengthening their economic independence;

RECALLING ALSO the Beijing Plus Five process that aimed to undertake further actions and initiatives to implement the Beijing Declaration and Platform for Action, especially in promoting women’s health, including the fight against the HIV and AIDS pandemic, and also to further undertake gender-mainstreaming initiatives that address HIV and AIDS and other diseases;

NOTING the Hanoi Call to Action for Children and HIV/AIDS in East Asia and the Pacific Region of 24 March 2006, which highlights nine urgent actions to scale up response to children who are vulnerable to, infected and affected by HIV and AIDS.
GUIDED by ASEAN’s Vision 2020 as a concert of Southeast Asian nations, outward looking, living in peace, stability and prosperity, bonded together in partnership in dynamic development and in a community of caring societies; which reaffirms the social responsibility of all Member Countries to act together in resolving transboundary issues;

GRAVELY CONCERNED that the HIV epidemic continues to threaten our vision, and the lives and future of our peoples, especially the vulnerable populations throughout the region, with socio-economic consequences that pose a formidable challenge to ASEAN Community-building;

SADDENED that whereas HIV once primarily affected men, women now represent half of all people living with HIV and that as youth behaviour changes, rates of HIV among youth are rising at an alarming rate, with young people between 15 to 24, accounting for over fifty percent of new infections in some of our Member Countries;

REALISING that an effective response to HIV requires relentless efforts and continued commitment by all concerned in implementing comprehensive responses to reduce the number of new infections, and to provide treatment, care and support to adults and children living with HIV and AIDS;

AWARE that stigma and discrimination are barriers to HIV prevention, treatment, care and support, as well as serious threats to the quality of life and livelihood of people living with and affected by HIV;

ACKNOWLEDGING that we can achieve an effective response to HIV through strong leadership, country ownership, political foresight and commitment to sustainable financing, multi-sectoral coordination and partnerships with civil society including private sector, particularly people living with HIV, and communities vulnerable and most at risk to HIV, through region-wide and global policies that respect, protect and promote the rights of people living with HIV and groups vulnerable and most at risk to HIV;

EMPHASIZING that ASEAN’s Vientiane Action Programme (VAP) highlights the importance of addressing the core issues of poverty reduction, equity and health, and creating an enabling environment for preventing the spread of HIV and for the comprehensive treatment, care and support for people living with HIV in the region;

COMMENDING the untiring efforts of the ASEAN Health Ministers and their Senior Officials, especially the ASEAN Task Force on AIDS, to prevent further transmission of HIV and mitigate its impact through joint actions and policies for improved regional responses, especially recent efforts for more people-centred initiatives;

AFFIRMING that responses to HIV and AIDS require meaningful civil society participation, including greater involvement of people living with HIV; and that in ASEAN, civil society organisations have been actively involved in effective actions for HIV prevention, treatment, care and support and in mitigating its impact;
ENCOURAGED by the ongoing cooperation between ASEAN and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Secretariat and its co-sponsors, and other key partners in the response to HIV and AIDS;

RECOGNISING that although resources allocated for responding to the HIV epidemic have increased substantially in many Member Countries since our first Special Session in 2001, scaling up access to protection, HIV prevention, treatment and care for majority of the affected population and high-risk communities requires still larger shares of the national budgets towards universal access by 2010, greater assistance from international partners as well as mobilisation of the business and private sector if we are to ensure that our programmes and activities have wide coverage, adequate and sustainable support; 

ASSERTING that halting the spread of HIV requires the sustained cooperation and commitment of government at the highest levels, involvement of mass organisations, civil society, and strategic partners in HIV programme planning, implementation and monitoring and evaluation, so that vulnerable and most at-risk communities, especially children, are protected from the impact of AIDS;

Do commit ourselves, as we progress towards a caring and sharing ASEAN Community, to:

1. Prioritise and lead the mainstreaming and alignment of HIV policies and programmes with our national development and poverty reduction plans and strategies to involve multi-sectoral responses in harmonised approaches, address the gender dimension of the epidemic, and ensure that all stakeholders at national and local levels are actively and effectively involved; 

2. Harmonise programmes, activities, target population on HIV and AIDS, monitoring and evaluation systems from different sources of funding, consistent with the national program priorities, especially in the face of scaling up ART; efforts shall be given to fostering prevention and reduction of new cases and improve the performance of ART program to ensure highest adherence to drug regimens.

3. Ensure that our policies and programmes give ample emphasis to containing the epidemic in vulnerable populations; sharing of lessons, best practices and evidence-informed prevention policies; and moving prevention and education efforts, including public information campaigns, beyond the health sector, and especially address aspirations of children and young people, women, couples and other vulnerable groups to protect themselves against the disease;

4. Undertake to halt the spread of HIV, through not only the setting of ambitious national targets as committed in the 2006 UN General Assembly Political Declaration on HIV/AIDS but also through youth- and women-friendly sexual and reproductive health services, and specific HIV information, education, and communication;
5. Put into place necessary legislation and regulations (including workplace policies and programmes) to ensure that persons living with HIV and affected groups are protected and are not subjected to stigma and discrimination, have equal access to health, social welfare and education services, including continued food security and education for children;

6. Act to remove obstacles in access to quality HIV and AIDS prevention products, medicines, and treatment commodities;

7. Strengthen and facilitate the work of our AIDS coordinating authorities by endeavouring to chair and participate in their activities; expanding their membership to include all relevant key stakeholders involved in responses to HIV; allocating regular funds for their activities; and ensuring their accountability;

8. Strongly support the mobilisation and allocation of technical, financial and human resources to adequately implement, programmes and policies to respond to HIV;

9. Involve persons living with HIV, civil society organisations and the private sector, as equal partners in responses to the HIV epidemic, and ensure that the civil society has sustainable financial means and support to participate actively and meaningfully in our efforts against HIV and AIDS, including at policy and decision-making levels;

10. Strengthen the role of the ASEAN Task Force on AIDS to effectively implement regional responses to HIV, with multi-sector engagement, including that of the private sector; and ensure the meaningful participation of all relevant key stakeholders in efforts consistent with our regional and international commitments;

11. Guide the implementation of the operational work plan of the Third ASEAN Work Programme on HIV (AWPIII) for 2006-2010, which we adopt, and assign the ASEAN Task Force on AIDS to regularly report progress; and

12. Continue working with our Dialogue Partners, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Secretariat and its co-sponsors, other UN organisations, international partners, civil society organisations and the private sector in realising our commitment to scale up effective responses to HIV and AIDS.

ADOPTED in Cebu, the Philippines this Thirteenth Day of January in the Year Two Thousand and Seven.
B3. ENHANCING FOOD SECURITY AND SAFETY

STRATEGIC OBJECTIVE: To ensure adequate access to food at all times for all ASEAN peoples and ensure food safety in ASEAN Member States.

EXPECTED OUTCOME: Ensured adequate access to food at all times for all ASEAN peoples and ensured food safety

### FOCUS AREA: I. REGIONAL STANDARD AND PROCEDURES

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<td>B.3.iii Promote production of safe and healthy food by producers at all level;</td>
<td></td>
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<tr>
<td>B.3.xiv Enhance advocacy to promote production of safe and healthy food by producers and education and communication to communities for empowerment in food safety;</td>
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<tr>
<td>B.3.vii Enhance consumer participation and empowerment in food safety;</td>
<td></td>
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<tr>
<td>1.1.1 Development of legislative framework for food security from farm to table in ASEAN Member States</td>
<td>Legislative Framework for Food Security and Safety developed and adopted by AMS</td>
<td></td>
<td>AEGFS Lead country: Philippines</td>
</tr>
<tr>
<td>1.1.2 Development of Guidelines on food safety and food security</td>
<td>ASEAN Guidelines on food Inspection and food certification developed and adopted</td>
<td></td>
<td>AEGFS Lead country: Malaysia</td>
</tr>
<tr>
<td>1.1.3 Development of guidelines on Food Laboratories</td>
<td>Development of Guidelines on food laboratories developed and adopted</td>
<td></td>
<td>AEGFS Lead country: Malaysia</td>
</tr>
<tr>
<td>1.2.1 Development of Advocacy Template materials</td>
<td>ASEAN advocacy template materials for consumer education developed</td>
<td></td>
<td>AEGFS Lead country: Indonesia</td>
</tr>
<tr>
<td>1.2.2 Development of ASEAN Good Hygiene Practice</td>
<td>Publication of ASEAN Good Hygiene Practice developed and disseminated</td>
<td></td>
<td>Lead country: Thailand</td>
</tr>
<tr>
<td>Increase competency and specialization of ASEAN food laboratories</td>
<td>2.1.1 Regional Capacity Building of Food Laboratories on Laboratory Methodology</td>
<td>Training module harmonized</td>
<td>AEGFS Lead country: Singapore</td>
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<td>AMS Training centers identified</td>
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<td>Training of focal points conducted</td>
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<td></td>
<td>2.1.2 Training the Trainers Programme for food Inspection</td>
<td>Food inspector training manual developed</td>
<td>AEGFS</td>
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<tr>
<td></td>
<td></td>
<td>Training the trainers conducted</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Capacity Building on Risk Assessment</th>
<th>3.1.1 Development of inventory of regional competent Risk Assessors</th>
<th>list of competent risk assessors/experts in ASEAN generated</th>
<th>AEGFS Lead Country: Thailand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>ASEAN Risk Assessment Protocol developed and adopted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1.2 Study on food consumption and dietary intake</td>
<td>Study conducted</td>
<td>AEGFS</td>
</tr>
<tr>
<td></td>
<td>3.1.3 Inventory of risk assessment studies applicable to ASEAN</td>
<td>List of Risk assessment studies shared with AMS</td>
<td>AEGFS Lead Country: Malaysia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improvement of national emergency response systems to foodborne diseases and food outbreak</th>
<th>4.1.1 Information Sharing System under AFSN (INFOSAN)</th>
<th>ASEAN Information Network under AFSN utilized by AMS</th>
<th>AEGFS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Directory of emergency contact points (regional/national) developed and utilized</td>
<td>AEGFS</td>
</tr>
<tr>
<td></td>
<td>4.1.2 Training of AMS on National Response to Emergencies</td>
<td>AMS trained</td>
<td>AEGFS</td>
</tr>
<tr>
<td></td>
<td>4.1.3 Development of framework for food recall</td>
<td>Framework for food recall developed and implemented</td>
<td>AEGFS</td>
</tr>
<tr>
<td>Activity</td>
<td>Description</td>
<td>Status</td>
<td>Implementing Bodies</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>B.3.ii  Strengthen the work of ASEAN Coordinating Committee on Food Safety to better coordinate all ASEAN Food bodies/subsidiaries, and the implementation of their work programmes</td>
<td></td>
<td>AFSIP II developed and implemented</td>
<td>AEGFS Lead country :Malaysia</td>
</tr>
<tr>
<td>B.3.xv Provide opportunities such as forums, meetings to facilitate coordinated actions among stakeholders geared for promotion of food security and safety</td>
<td></td>
<td>Identified and implemented joint activities</td>
<td>AEGFS and ASEAN Secretariat</td>
</tr>
<tr>
<td>B.3.xvi Integrate these actions into a comprehensive plan of action with the ultimate goal of improving health outcomes</td>
<td></td>
<td>Identified collaborative activities with synergistic work</td>
<td>AEGFS and ASEAN Secretariat</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Description</th>
<th>Status</th>
<th>Implementing Bodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.3.ii  Strengthen the work of ASEAN Coordinating Committee on Food Safety to better coordinate all ASEAN Food bodies/subsidiaries, and the implementation of their work programmes</td>
<td></td>
<td>Monitoring template developed and adopted</td>
<td>AEGFS</td>
</tr>
<tr>
<td>5.2.1 Development of Monitoring template for food safety activities</td>
<td>Monitoring template developed and adopted</td>
<td>Monitoring template developed and adopted</td>
<td>AEGFS</td>
</tr>
<tr>
<td>5.2.2 Conduct of Annual AEGFS meetings</td>
<td>Progress Report on Implementation of Plans</td>
<td>Monitoring template developed and adopted</td>
<td>AEGFS</td>
</tr>
</tbody>
</table>
### KEY REGIONAL STRATEGIES
(Reference in ASCC Blueprint Section)

<table>
<thead>
<tr>
<th>B4. ACCESS TO HEALTHCARE AND PROMOTION OF HEALTHY LIFESTYLES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STRATEGIC OBJECTIVE:</strong> To ensure access to adequate and affordable healthcare, medical services and medicine, and promote healthy lifestyles for the peoples of ASEAN.</td>
</tr>
<tr>
<td><strong>EXPECTED OUTCOMES:</strong> Ensured accessibility to adequate and affordable healthcare, medical services and medicine, and promote healthy lifestyles for the peoples of ASEAN.</td>
</tr>
</tbody>
</table>

### FOCUS AREA: I. MATERNAL AND CHILD HEALTH (MDG 4 and MDG 5)

**Lead countries:** Myanmar, Philippines, Thailand, and Viet Nam

| Development of regional framework on Maternal and Child Health in accelerating achievements of Millennium Development Goals (MDGs) 4 and 5 |
|__________________________________________________________________________________________________________________________|
| B.4.i. Promote investment in primary health care infrastructure, in a rational manner and likewise ensure adequate financing and social protection for the poor and marginalised populations for better access to services and achievement of health-related Millennium Development Goals (MDGs); |
| 1.1.1 Conducting of a consultative workshop to develop framework |
| 1.1.2 Facilitating and monitoring the implementation of the framework in AMS |
| 1.1.3 Collaboration with partner organizations such as WHO, UNFPA & UNICEF |
| Regional framework on Maternal and Child Health developed and implemented |
| MDG 4, 5 monitored and reported at SOMHD |
| Identified/implemented joint activities |
| Lead country: Thailand |
| SOMHD to designate an ASEAN task force |
| SOMHD to designate an ASEAN task force |

| Information Sharing and Evidence-based advocacy |
|__________________________________________________________________________________________________________________________|
| B.4.xiii Encourage exchange of experts in the field of public health, medicine, physical and health education, to promote sharing of knowledge and experience; |
| 1.2.1 Development of Advocacy tools using ASEAN Platforms (AHMM) |
| 1.2.2 Sharing of best Models on MCH |
| 1.2.3 Exchange programmes in the field of maternal and child health |
| Advocacy tools on Maternal and child health advocated at ASEAN Health Minister Meeting 2012 |
| Workshops/seminars/exchange and attachment visit conducted |
| Inventory of MCH experts and inventory of TA providers to and from ASEAN |
| SOMHD |
| lead country: Thailand |
| Lead country: Thailand |

| B.4.xxiv Promote the exchange of experiences among ASEAN Member States on public health policy formulation and |
|__________________________________________________________________________________________________________________________|
| Information Sharing and Evidence-based advocacy |
| B.4.xiii Encourage exchange of experts in the field of public health, medicine, physical and health education, to promote sharing of knowledge and experience; |
| 1.2.1 Development of Advocacy tools using ASEAN Platforms (AHMM) |
| 1.2.2 Sharing of best Models on MCH |
| 1.2.3 Exchange programmes in the field of maternal and child health |
| Advocacy tools on Maternal and child health advocated at ASEAN Health Minister Meeting 2012 |
| Workshops/seminars/exchange and attachment visit conducted |
| Inventory of MCH experts and inventory of TA providers to and from ASEAN |
| SOMHD |
| lead country: Thailand |
| Lead country: Thailand |

<p>| B.4.xxiv Promote the exchange of experiences among ASEAN Member States on public health policy formulation and |
|__________________________________________________________________________________________________________________________|
| Information Sharing and Evidence-based advocacy |
| B.4.xiii Encourage exchange of experts in the field of public health, medicine, physical and health education, to promote sharing of knowledge and experience; |
| 1.2.1 Development of Advocacy tools using ASEAN Platforms (AHMM) |
| 1.2.2 Sharing of best Models on MCH |
| 1.2.3 Exchange programmes in the field of maternal and child health |
| Advocacy tools on Maternal and child health advocated at ASEAN Health Minister Meeting 2012 |
| Workshops/seminars/exchange and attachment visit conducted |
| Inventory of MCH experts and inventory of TA providers to and from ASEAN |
| SOMHD |
| lead country: Thailand |
| Lead country: Thailand |</p>
<table>
<thead>
<tr>
<th>FOCUS AREA II. INCREASE ACCESS TO HEALTH SERVICES FOR ASEAN PEOPLE</th>
<th>Lead countries: Indonesia, Thailand, and Viet Nam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing access to primary health care for ASEAN citizen including migrants in achievement of health-related Millennium Development Goals (MDGs)</td>
<td></td>
</tr>
<tr>
<td><strong>B.4.i</strong> Promote investment in primary health care infrastructure, in a rational manner and likewise ensure adequate financing and social protection for the poor and marginalised populations for better access to services and achievement of health-related Millennium Development Goals (MDGs);</td>
<td>2.1.1 Collaboration with WHO</td>
</tr>
<tr>
<td><strong>B.4.xxi</strong> Strengthen existing health networking in ASEAN Member States in order to push forward an active implementation on health services access and promotion of healthy lifestyles, as well as continually exchange of knowledge, technology and innovation for sustainable cooperation and development;</td>
<td>2.1.2 Development of regional strategy on health care services and Primary Health Care</td>
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<tr>
<td></td>
<td>2.1.3 Development of advocated evidence – based on health care services</td>
</tr>
<tr>
<td>Sharing of best practices in improving the access to primary health care by people at risk/vulnerable groups</td>
<td>2.2.1 Promoting of sharing best practice on primary health care among at-risk and vulnerable people among AMS using appropriate means (workshop/seminars/exchange and attachment visit/websites)</td>
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<tr>
<td>B.4.xiii Encourage exchange of experts in the field of public health, medicine, physical and health education, to promote sharing of knowledge and experience;</td>
<td>2.2.2 Joint activities with WHO on Human Resource Development</td>
</tr>
<tr>
<td>B.4.xvii Promote the sharing of best practises in improving the access to primary health care by people at risk/vulnerable groups, with special attention to diabetes mellitus, cardiovascular diseases, cancers and disabilities through regional workshops, seminars, and exchange visits among the ASEAN Member States;</td>
<td>2.2.3 Inventory of experts on primary health care</td>
</tr>
<tr>
<td>B.4.xxi Strengthen existing health networking in ASEAN Member States in order to push forward an active implementation on health services access and promotion of healthy lifestyles, as well as continually exchange of knowledge, technology and innovation for sustainable cooperation and development;</td>
<td>2.2.4 Promotion utilization of experts in providing technical assistance to AMS or resource person in regional initiatives</td>
</tr>
<tr>
<td>B.4.xxv Promote the exchange of experiences among ASEAN Member States on public health policy formulation and management.</td>
<td></td>
</tr>
<tr>
<td>Increasing access to primary health care for migrants</td>
<td>B.4.i  Promote investment in primary health care infrastructure, in a rational manner and likewise ensure adequate financing and social protection for the poor and marginalised populations for better access to services and achievement of health-related Millennium Development Goals (MDGs);</td>
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<tr>
<td>3.1.1 Development of regional cooperation framework on migrants health</td>
<td>Regional cooperation framework in ensuring health care for migrants developed and implemented</td>
</tr>
<tr>
<td>3.1.2 Collaboration with relevant partners including IOM, WHO, UNFPA, UNDP on migrants health</td>
<td>Identified and implemented joint activities</td>
</tr>
<tr>
<td>3.2.1 Development of advocacy tool on migrant health</td>
<td>Evidence –based advocacy tool developed and advocated at the 11th AHMM, 2012</td>
</tr>
<tr>
<td>3.3.1 Promotion of sharing best practices among AMS through appropriate means including workshops/seminars/ exchange and attachment visit/existing websites</td>
<td>Best practices in improving the access to services for migrants documented shared.</td>
</tr>
<tr>
<td>Implementation of ASEAN Healthy Lifestyle, 2002 B.4.x Promote collaboration in Research and Development on health promotion, health lifestyles and risk factors of non-communicable diseases in ASEAN Member States; B.4.xi Promote the sharing of best practices in improved access to health products including medicines for people in ASEAN</td>
<td>4.1.1 Revitalisation of ASEAN Healthy Lifestyle, 2002 4.1.2 Development and implementation of ASEAN Regional Strategy on selected NCD 4.1.3 Collaborate with WHO for technical</td>
</tr>
<tr>
<td>Facilitating enabling environment for ensuring promotion of healthy lifestyle for the people of ASEAN</td>
<td>4.2.1 Coordination with existing training/academic institutions to establish a Center for Excellence on Non Communicable Diseases</td>
</tr>
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</tr>
<tr>
<td><strong>B.4.x</strong> Promote collaboration in Research and Development on health promotion, health lifestyles and risk factors of non-communicable diseases in ASEAN Member States;</td>
<td>- Development an inventory of experts on NCDs from AMS developed</td>
</tr>
<tr>
<td><strong>B.4.xi</strong> Promote the sharing of best practices in improved access to health products including medicines for people in ASEAN</td>
<td>4.2.2 Workshop to identify key indicators on Healthy Lifestyle especially on NCDs</td>
</tr>
<tr>
<td><strong>B.4.xxi</strong> Strengthen existing health networking in ASEAN Member States in order to push forward an active implementation on health services access and promotion of healthy lifestyles, as well as continually exchange of knowledge, technology and innovation for sustainable cooperation and development;</td>
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<thead>
<tr>
<th>Development and implementation of ASEAN Work Plan on tobacco control</th>
<th>4.3.1 Facilitating ASEAN Work Plan on Tobacco Control</th>
<th>ASEAN regional strategy and Work Plan on Tobacco Control developed and implemented</th>
<th>Lead country: Thailand</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B.4.iv</strong> Develop and adopt a framework for unhealthy food and beverages including alcohol similar to the Framework Convention on Tobacco Control (FCTC);</td>
<td>4.3.2 Collaboration with WHO</td>
<td></td>
<td>ASEAN Technical Working Group on Tobacco Control</td>
</tr>
<tr>
<td><strong>B.4.v</strong> Enhance awareness on the impact of regional/global trade policies and economic integration on health and develop possible strategies to mitigate their negative impacts through regional workshops and seminars, advocacy, sharing of studies and technical documents;</td>
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<tr>
<td>5.1.1</td>
<td>Conducting a workshop to assess status of Traditional Medicine/Complementary and Alternative Medicine focus on herbal medicine in the AMS</td>
<td>Regional roadmap as a reference towards integration of TM/CAM focus on herbal medicine into health services system among ASEAN Member States developed and implemented</td>
<td>Lead countries: Indonesia, Philippines, AWGPD</td>
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<tr>
<td>5.1.2</td>
<td>Preparation of model monograph on use of herbs in PHC for all ASEAN Member States (WHO-ASEAN joint activity)</td>
<td>Harmonized standard of TM/CAM: under which the sub output (ASEAN Monograph on Herbal Medicines)</td>
<td>Lead countries: Indonesia, Philippines, Thailand</td>
</tr>
<tr>
<td>5.1.3</td>
<td>Workshop for finalization of model monograph for AMS to develop their own national monograph on use of herbs medicine in PHC (WHO-ASEAN joint activity)</td>
<td>ASEAN Monograph on Herbal Medicines</td>
<td>Lead countries: Indonesia, Philippines, Thailand</td>
</tr>
<tr>
<td>5.1.4</td>
<td>ASEAN Regional Capacity building and training in the inclusion of Traditional Medicine (herbal medicines) in healthcare system based on lessons learnt from China</td>
<td>Methodologies on how to include TM/CAM in the health care system established</td>
<td>Lead countries: Indonesia, Philippines, Thailand</td>
</tr>
<tr>
<td>Facilitation of exchange of information on research results in safety, efficacy and quality of herbal and traditional medicine among AMS</td>
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<td><strong>B.4.xviii</strong></td>
<td><strong>Empower consumers to become active participants in health care and to make informed choices to maximise the benefits and minimise the risks of use of Traditional Medicine/Complementary and Alternative Medicine (TM/CAM);</strong></td>
<td></td>
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<tr>
<td><strong>5.2.1 Workshop on sharing available information on research in safety, efficacy and quality of herb and traditional medicine among ASEAN Member States</strong></td>
<td><strong>Compilation (compendium) of research results</strong></td>
<td><strong>Recommendations and strategies to better utilize traditional medicine as alternative health care</strong></td>
<td><strong>Lead countries:</strong> Indonesia, Philippines, Thailand</td>
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<tr>
<th>Strengthen capacity and competitiveness in health related products and services</th>
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<td><strong>B.4.vi</strong></td>
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<tr>
<td><strong>B.4.xv</strong></td>
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<tr>
<td><strong>6.1.1 Develop programme to strengthen quality assurance &amp; non-pharmacopeial;</strong></td>
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<tr>
<th>Promotion of rational use of drug, especially on prescription of antibiotics</th>
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<tr>
<td><strong>B.4.xi</strong></td>
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<tr>
<td><strong>B.4.xxii</strong></td>
</tr>
<tr>
<td><strong>6.2.1 Implement WHO – ASEAN joint activities:</strong></td>
</tr>
</tbody>
</table>

| **Strategies, Methodologies and mechanisms to combat counterfeit drugs developed and implemented** | **Programme to develop ASEAN Pharmacovigilance System developed.** | **Suggested lead countries:** Brunei & Singapore |

| **Compilation (compendium) of research results** | **Recommendations and strategies to better utilize traditional medicine as alternative health care** | **Lead countries:** Indonesia, Philippines, Thailand |

| **Promotion of rational use of drug, especially on prescription of antibiotic;** | **Strategies, Methodologies and mechanisms to combat counterfeit drugs developed and implemented** | **Programme to develop ASEAN Pharmacovigilance System developed.** | **Suggested lead countries:** Brunei & Singapore |
### 6.2.2 Workshop to assess the level of the rational use of drugs in AMS

- **Regional programme on rational use of drugs with focus on prescription of antibiotics, antibiotic surveillance, and risk management.**
- **Lead countries:** Indonesia, Brunei, Singapore

### 6.2.3 Collaboration with WHO for technical assistance in developing training modules, training materials and organizing regional training of trainers and/or training materials.

- **Training modules and materials produced**
- **Training the trainers conducted**

### 6.3.1 Established networking/channel to exchange of information and experience on drug price control to access essential drug for all ASEAN Member States;

- **Channels developed among AMS (email, etc) on drug prices**
- **Experiences and information shared among AMS on drug price to improve access to essential drugs**

### 6.3.2 Regional Sharing information, best practices

<table>
<thead>
<tr>
<th>B.4.xxiii</th>
<th>Exchange of information and experience on drug price control to access essential drug in all ASEAN Member States;</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.4.xxiv</td>
<td>Promote the exchange of experiences among ASEAN Member States on public health policy formulation and management.</td>
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</table>
### B5. Improving Capability to Control Communicable Diseases

**Strategic Objective:** To enhance regional preparedness and capacity through integrated approaches to prevention, surveillance and timely response to communicable and emerging infectious diseases

<table>
<thead>
<tr>
<th><strong>FOCUS AREA:</strong></th>
<th><strong>PROJECTS/ACTIVITIES</strong></th>
<th><strong>SPECIFIC OUTPUTS</strong></th>
<th><strong>RESPONSIBLE BODIES</strong></th>
</tr>
</thead>
</table>
| **B.5. IMPROVING CAPABILITY TO CONTROL COMMUNICABLE DISEASES** | Regional cooperative arrangements through multisectoral and integrated approaches in the prevention, control, preparedness for emerging infectious diseases in line with International Health Regulations 2005 and the Asia Pacific Strategy for Emerging Diseases (APSED); | 1.1.1 Development of ASEAN Medium Term Plan on EID (2011-2015) with the following proposed thrusts; 
   a) Building ASEAN EID Mechanism for surveillance, prevention, preparedness and responses to EIDs including the following components; laboratory, risk communication, animal health and human health 
   b) Addressing specific diseases (Rabies, Dengue Fever, Malaria, Tuberculosis) 
   c) Multi-pandemic preparedness and responses | ASEAN Mechanism for surveillance, prevention, preparedness and response to EIDs established, implemented, tested, monitored and evaluated |
| | Establish/strengthen/maintain regional support system and network to narrow the gap among ASEAN Member States in addressing emerging infectious diseases and other communicable diseases; | 1.1.2 Implementation of ASEAN Medium Term Plan (2011-2015) | AEGCD |
| | To tackle the issues of clean water, hygiene, sanitation and waste management that have implications on infectious diseases; | 1.1.3 Implementation of Animal Health Project with WHO-EC Project WHO-EC Project on Strengthening Surveillance and Response Capacity for Highly Pathogenic and Emerging and Re-emerging Diseases (HPED) | Project on animal health and human health implemented effectively |
| | Strengthen cooperation among ASEAN Member States in contact tracing and health quarantine; | | AEGCD |
| | Strengthen and maintain surveillance system for infectious diseases including HIV and AIDS, malaria, dengue fever, and tuberculosis; | | |
| 1.2.1 | Development of SOPs for mobilisation and utilisation of regional stockpile of antivirals | SOPs for mobilisation and utilisation of regional stockpile of antivirals developed and used. | AEGC D JICS Singapore |
| 1.2.2 | Consultative Meetings with AMS on regional sharing/stockpiling of essential and critical supplies needed and possible sources/mobilization processes | Challenges in the mobilization of stockpile refined SOP revised accordingly | AEGC JICS Singapore WHO |
| 1.2.3 | Management of stockpiling | | |
| 1.2.4 | Explore possibility of regional procurement of drugs, reagents, and other products critical to respond to EIDs, as agreed by AMS | ASEAN regional mechanism on procurement of drugs identified and agreed by AMS | |
| 1.2.5 | Strengthen cooperation among ASEAN Member States in contact tracing and health quarantine | Harmonized contact tracing and health quarantine identified and agreed | AEGC JICS |
| 1.2.6 | National SOPs tested among AMS on regular basis through table top exercises | Scheduled Table Top Exercises agreed to carried out regularly and hosted by Member States or a rotation basis | AEGC AWGPPR |

Ensuring availability of regional stockpile of antivirals and Personal Protective Equipment (PPE) for all Member States and for rapid response and rapid containment of potential pandemic influenza;

B.5.iii Ensure that stockpile of antivirals and Personal Protective Equipment (PPE) is maintained at regional level for all member states and for rapid response and rapid containment of potential pandemic influenza;
## FOCUS AREA II. ENHANCING REGIONAL SUPPORTIVE ENVIRONMENT

<table>
<thead>
<tr>
<th>Establishment and maintenance of regional support system and network in addressing emerging infectious diseases and other communicable diseases</th>
<th>2.1.1 Implementation of ASEAN Risk Communication Center under ASEAN Medium Term Plan (2011-2015)</th>
<th>ASEAN Risk Communication Center (ARCC) established and operated</th>
<th>AEGCD Lead country: Malaysia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B.5.ii</strong> Establish/strengthen/maintain regional support system and network to narrow the gap among ASEAN Member States in addressing emerging infectious diseases and other communicable diseases;</td>
<td>2.1.2 Implementation of APL Work Plan under ASEAN Medium Term Plan (2011-2015)</td>
<td>ASEAN Plus Three Partnership Laboratories (APL) operational based on TOR, through sharing of laboratory-based surveillance data and capacity building</td>
<td>AEGCD APL Malaysia</td>
</tr>
<tr>
<td><strong>B.5.vii</strong> Promote the sharing of best practices in improving the access to primary health care by people at risk/vulnerable groups, with special attention to HIV and AIDS, malaria, dengue fever, tuberculosis, and emerging infectious diseases through regional workshops, seminars, and exchange visits among the ASEAN Member States;</td>
<td>2.1.3 Regular meetings for updating</td>
<td>Focal Points such as ASEAN Expert Group on Communicable Diseases, Communication, National Laboratory Contact Points continued to be functional</td>
<td>AEGCD</td>
</tr>
<tr>
<td><strong>B.5.viii</strong> Strengthen regional clinical expertise through professional organisations networks, regional research institution, exchange of expertise and information sharing;</td>
<td>2.1.3 Regular uploading of information (website)</td>
<td></td>
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<tr>
<td><strong>B.5.ix</strong> Strengthen cooperation through sharing of information and experiences to prevent and control infectious diseases related to global warming, climate change, natural and man-made disasters;</td>
<td></td>
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</table>

### 2.1.3 Regular meetings for updating

Focal Points such as ASEAN Expert Group on Communicable Diseases, Communication, National Laboratory Contact Points continued to be functional.

### 2.1.3 Regular uploading of information (website)
<table>
<thead>
<tr>
<th>Annex 3</th>
<th>Reduction of the impact of HIV transmission and the impact of HIV epidemic and improve better access to affordable antiretroviral treatment and opportunistic disease treatment as well as diagnostic reagents.</th>
<th>1.1.1 Completion of the third ASEAN Work Programme on HIV and AIDS (AWPIII)</th>
<th>Activities under AWP3 – Year 2010 implemented</th>
<th>ATFOA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B.5.iv. Reduce the impact of HIV transmission and the impact of HIV epidemic, consist with the Millennium Development Goals (MDGs), the UNGASS declarations on HIV and AIDS, ASEAN Commitments on HIV and AIDS, and Third ASEAN Work Programme on HIV and AIDS;</td>
<td>1.1.2 Development of AWP 4 (2011-2015), with the following proposed thrust:</td>
<td>ASEAN Work Programme on HIV and AIDS developed and implemented (2011-2015)</td>
<td>ATFOA</td>
</tr>
<tr>
<td></td>
<td>B.5.v. Improve better access to affordable antiretroviral treatment and opportunistic disease treatment as well as diagnostic reagents;</td>
<td>A. HIV in the World of Work (A.3.iv – Implement Plan of Action to promote Decent Work)</td>
<td></td>
<td>Lead countries: Thailand and Indonesia</td>
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<td></td>
<td></td>
<td>B. HIV among migrants</td>
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<td></td>
<td></td>
<td>C. Support in the development of comprehensive prevention intervention</td>
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<td></td>
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<td>D. Improve Access to affordable ARV, OI drugs and diagnostics</td>
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<td></td>
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<td>E. Greater Involvement and Empowerment of PLHIV</td>
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<td></td>
<td></td>
<td>F. Regional initiatives to strengthen governance of country response</td>
<td></td>
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<tr>
<td>REGIONAL STRATEGIES</td>
<td>PROJECTS/ACTIVITIES</td>
<td>EXPECTED OUTPUTS</td>
<td>RESPONSIBLE BODIES</td>
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<tr>
<td>Promoting of multi-sectoral coordination and planning on Pandemic Preparedness and Response at the regional level including development of a regional Multi-Sectoral Pandemic Preparedness and Response Plan.</td>
<td>1.1.1 Conducting multi-sectoral assessment in AMSs</td>
<td>Report on Status of Multisectoral pandemic preparedness based on in-country assessment Report disseminated</td>
<td>AEGCD ATWGPPR</td>
<td></td>
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<tr>
<td></td>
<td>1.1.2 Development of advocacy material for pandemic preparedness to non-health sectors</td>
<td>Adopted strategies material to strengthen national capacity in conducting advocacy for pandemic preparedness to non-health sectors</td>
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<td></td>
<td>Convening Incidental Command System (ICS) Workshop</td>
<td>Adopted the on-scene command and response system in pandemics through the use of Incident Command System (ICS)</td>
<td>ATWGPPR</td>
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<td></td>
<td>Conducting Southeast Asia Regional Multi-sectoral Pandemic Preparedness and Response Table Top Exercise: Managing the Impact of Pandemics on Societies, Governments and Organizations</td>
<td>Workshop conducted A set of recommendations to improve regional cooperation and facilitate a “whole of society” approach to preparation and response to a pandemic</td>
<td>ATWGPPR</td>
<td></td>
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<td></td>
<td>Development and implementation of PPR Work Plan for 2011 - 2015</td>
<td>PPR Work Plan developed and implemented</td>
<td>ATWGPPR</td>
<td></td>
</tr>
<tr>
<td>Projects &amp; activities</td>
<td>Output/ Deliverable</td>
<td>Lead Country/ies</td>
<td>Possible Partners &amp; Collaborators</td>
<td>Rank (w/in thrust)</td>
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<tr>
<td>1. To promote ASEAN’s collective agenda at international and regional platforms utilising evidence-based epidemiological data and research findings towards achieving its goal;</td>
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</tbody>
</table>
| 1.1. ATFOA Workshop on ASEAN Priority Advocacy Agenda Back-to-back: AWP4 Resource Mobilization Meeting | • List of Accomplishments of ASEAN in HIV & AIDS  
• Regional policy advocacy issues identified  
• AWP4 fully funded | ASEAN Secretariat  
UNAIDS | Part of planning | February – March 2011  
Proposed: 5-6 April 2011 |                               |
| 1.2. ASEAN Participation at Universal Access Round Table  
• UA Regional Consultation to take stock of region’s progress | • ASEAN progress discussed  
• ASEAN Work on HIV & AIDS showcased and promoted in UA RTD | Philippines;  
ASEAN Secretariat | UNAIDS | 2 | March 2011 |
| 1.3. ATFOA Inter-sectoral collaboration with labour and foreign ministry  
• Second ASEAN High Level Multi-Stakeholders Meeting on HIV Prevention, Treatment, Care and Support for Migrant Workers | • Support the implementation of the ASEAN Declaration on Migrant Workers | Philippines;  
(ASEAN Sec) | UNDP |                           | February 2011  
March 1-2, 2011 |
| 1.4. ASEAN Participation in High Level meeting on UNGASS review in New York, 2011 – (ASEAN presentation) or Sideline Meeting – to bring issues (under 1.2) in the global forum | • ASEAN Work on HIV & AIDS showcased and promoted | Concurrent Chairs (Brunei 2011);  
Cambodia (as Vice Chair) | UNAIDS | 3 | 2011 |
| 1.5. ATFOA Participation at 10th ICAAP - Busan, 2011, which may include the following:  
• Organize Leadership Forum  
• Propose forum to Busan conference local organizing committee (LoC) and  
• Conduct Leadership Forum  
• Set-up ASEAN exhibition booth  
• Confirm and organize logistics and resource materials for distribution  
• Display booth at conference  
• Co-sponsor other Symposia during the Conference | • ASEAN Work on HIV & AIDS showcased and promoted  
• Leadership in AMS strengthened  
• Advocacy on critical regional issues supported by ASEAN | Indonesia;  
ASEAN Secretariat | UNAIDS | 4 | 2011 |
| 1.6. ASEAN Summit on AIDS to Commemorate the 10th Anniversary of the ASEAN Declaration on HIV/AIDS | ASEAN Summit Declaration Statement | Indonesia (1) Lao PDR (2) | UNAIDS + | 1 | 2011 |
| 1.7. ASEAN Participation at 2012 ESCAP inter-governmental meeting of health ministers and ministers responsible for public security in supporting the agenda for high impact intervention for key affected populations | Joint (Sideline) Meeting between Health and Public Security Minister | Thailand; UNDP/UNAIDS | 5 | 2012 |
| 1.8. AFTOFA Participation in the 11th ASEAN Health Ministers Meeting in Bangkok | AHMM endorsed ASEAN vision on HIV and AIDS (new) | Thailand | UNAIDS + | 6 | 2012 |
| 1.9. Development of ASEAN WAD Messages to promote collective ASEAN advocacies | Annual ASEAN Message for World AIDS Day (WAD) | Concurrent AFTOFA Chair | Regular Activity | 2011 |

<table>
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<tr>
<th>Projects &amp; activities</th>
<th>Output/ Deliverable</th>
<th>Lead Country/ies</th>
<th>Possible Partners &amp; Collaborators</th>
<th>Rank (w/in thrust)</th>
<th>Timeline</th>
</tr>
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<tbody>
<tr>
<td>2. To strengthen capacity to plan, implement and monitor and evaluate in both prevention and treatment through knowledge sharing among ASEAN Member States</td>
<td></td>
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<tr>
<td>2.1. Document best practices of ASEAN regional initiatives to promote South to South learning and capacity development</td>
<td>Best Practices identified in the ASEAN</td>
<td>Malaysia</td>
<td></td>
<td>1</td>
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<tr>
<td>2.2. Utilising the South to South Collaboration to advocate and develop prevention interventions (e.g. review of national strategic plans, obtaining and utilising evidence based on Asian Epidemic Modelling, Modes of Transmission tool and costing projection)</td>
<td>List of regional challenges, proposed interventions and possible funding support identified</td>
<td>Thailand</td>
<td>UNDP</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2.3. Develop a regional initiative on capacity building for health ministry staff + other relevant ministries on developing and using evidence based resources to plan programmes to achieve ASEAN’s long-term goals.</td>
<td>Capacity for evidence based programming developed</td>
<td>Singapore</td>
<td></td>
<td></td>
<td>2012</td>
</tr>
</tbody>
</table>
2.4. ATFOA collaboration with ASEAN University Network - to promote Network as a resource on HIV and AIDS, and to build expertise on HIV and AIDS in the region’s academic sector  

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Timeframe</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>Link with Schools of Public Health established (with ASEAN education sector)</td>
<td></td>
<td>TBI</td>
<td>3</td>
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<tr>
<td>Moved to Phase 2 (2014)</td>
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3. To leverage for increased access to affordable HIV-related care and treatment

3.1 Addressing the 2010 WHO 

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Country</th>
<th>Agency</th>
<th>Timeframe</th>
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</thead>
<tbody>
<tr>
<td>AMS able to adapt to the new guidelines of WHO</td>
<td></td>
<td>Malaysia</td>
<td>WHO</td>
<td>3</td>
</tr>
</tbody>
</table>

3.2 Improve affordable access to ART through information sharing (as part of 2.2)  

3.3 Addressing Co-infection TB & HIV, (suggested directions)  

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Country</th>
<th>Agency</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATFOA able to provide venue for strategy development</td>
<td></td>
<td>Cambodia</td>
<td>WHO</td>
<td>1</td>
</tr>
</tbody>
</table>
References


3. ASEAN, ASEAN Socio-Cultural Community Blueprint. 2009, Association of South-East Asian Nations: Jakarta.


10. UNAIDS, Regional report on scaling up towards Universal Access to prevention, treatment, care and support., in Tackling HIV and AIDS challenges in the Asia and Pacific region. 2006, UNAIDS.


25. UNAIDS, HIV transmission in intimate partner relationships in Asia. 2009.


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60. HIV and AIDS Data Hub. 4 September 2010); Available from: www.aidsdatahub.org.


70. Indonesia, National AIDS Spending Assessment Preliminary 2009-2010.


ATFOA Focal Agencies

- Departement of Health Services, Ministry of Health, Brunei Darussalam
- National Center for HIV/AIDS Dermatology and STD, Ministry of Health, Cambodia
- Communicable Disease Control, Ministry of Health / National AIDS Commission, Indonesia
- Center for HIV/AIDS/STIs (CHAS), Ministry of Health, Lao PDR
- Disease Control Division, Ministry of Health, Malaysia
- National AIDS Programme, Ministry of Health, Myanmar
- Philippine National AIDS Council Secretariat, Department of Health, Philippines
- Communicable Disease Division, Ministry of Health, Singapore
- Bureau of AIDS, TB, and STIs, Department of Disease Control, Ministry of Public Health, Thailand
- Viet Nam Administration of HIV/AIDS Control, Ministry of Health, Viet Nam

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