

HIV IN THE ASEAN REGION



**Second Regional Report on HIV & AIDS
2011 - 2015**



one vision
one identity
one community



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Second Regional Report on HIV & AIDS
2011 - 2015**

The ASEAN Secretariat
Jakarta



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ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AEM	Asian Epidemic Model
AHMM	ASEAN Health Ministers' Meeting
AHRN	Asian Harm Reduction Network
AIDS	Acquired Immune Deficiency Syndrome
AMS	ASEAN Member States
APCOM	Asia Pacific Coalition on Male Sexual Health
APNSW	Asia Pacific Network of Sex Workers
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 programmes (on HIV and AIDS)
CHAS	Centre for HIV/AIDS and STI (Lao PDR)
CHCC	Community Health Care Centre
CBO	Community based organisation
CDC	Communicable Diseases Centre
CSO	Civil society organisation
CUP	100% Condom Use Programme
DOH	Department of Health
FSW	Female sex workers
GARPR	Global AIDS Response Progress Report
GFTAM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater involvement of people living with HIV and AIDS
HIV	Human immunodeficiency virus
HTC	HIV Testing and Counselling
HSS	HIV sentinel surveillance
IBBS	Integrated bio-behavioral survey
IHBSS	Integrated HIV behavioural surveillance survey
ICA	Investment case analysis
ICAAP	International Congress on AIDS in Asia and the Pacific

JKN	Jaminan Kesehatan Nasional (Indonesia health insurance scheme)
LGU	Local government units
KP	Key populations
LGBTI	Lesbian, gay, bisexual, transgender and intersex
LSIS	Lao Social Indicator Survey
MDG	Millennium development goals
MMT	Methadone maintenance therapy
MOH	Ministry of Health
MSM	Men who have sex with men
MTCT	Mother to child transmission
MTR	Mid-term review
NAC	National AIDS Committee/Council
NADA	National Anti Drug Agency
NASA	National AIDS spending assessment
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs (Cambodia)
NGO	Non government organisation
NSAP	National strategic action plan
NSEP	Needle and syringe exchange programmes
NSP	National strategic plans
OST	Opioid substitution therapy
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PNAC	Philippines National AIDS Council
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
RRTR	Reach, recruit, test, treat, retain
SHC	Social Hygiene Clinic
SOMHD	Senior Officials Meeting on Health Development
STI	Sexually transmitted infection
SW	Sex workers
TASP	Treatment as prevention
TG	Transgender
UNAIDS	Joint United Programme on AIDS
WHO	World Health Organization
WLHIV	Women Living with HIV Network

EXECUTIVE SUMMARY

Overview

Responding to the call by the Fourth ASEAN Summit in Singapore in 1992, the ASEAN Task Force on AIDS (ATFOA) was established to implement regional activities on health and HIV and AIDS. ATFOA aims to curb and monitor the spread of HIV, and its work has been guided by global commitments on HIV and a series of work plans. HIV in the ASEAN Region is the second ASEAN Regional Report on HIV and AIDS and reports on the achievements of ASEAN Member States (AMS) in implementing the 4th ATFOA work plan for the period 2011 – 2015. In this period, AMS have been working towards the achievement of ambitious country-set targets under the umbrella of the UNAIDS 2011-2015 strategy, Getting to Zero and guided by the goals enshrined in the 2011 ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths (Annex One).

The HIV Epidemic in Southeast Asia

There are approximately 1.7 million people living with HIV (PLHIV) in the ASEAN region of which close to a third are female. Of the total number of people living with HIV, at least 46% are adults who are eligible for antiretroviral therapy (ART) and of which just fewer than 60% are receiving ART. A number of AMS either fully fund or almost fully fund their HIV programmes from domestic sources and public funds.

Across Asia, HIV is largely concentrated among key populations (KP), especially, though not exclusively, in large cities and urban areas. The fastest growing epidemics in the region are among Men who have Sex with Men (MSM) and transgender. All AMS face varying challenges in ensuring that KP do not experience stigma and discrimination that impact on their access to prevention and treatment services. The steady decline in HIV prevalence among female sex workers (FSW) is one of the great success stories of the HIV response in the ASEAN region. However, the burden of HIV infection among sex workers is disproportionately high relative to the general population in AMS. People who inject drugs (PWID) continue to be at high risk of contracting HIV but the introduction of harm reduction programmes in a number of AMS, especially Indonesia and Malaysia, Viet Nam and Myanmar have significantly impacted on prevalence in this population.



Getting to Zero

The 2011 UN Political Declaration on HIV and AIDS called on member nations to intensify efforts to eliminate HIV and AIDS. This includes a better understanding of the key populations who need to be targeted for HIV prevention and the availability of new prevention tools. Increasingly, AMS have recognised that KP need to be the primary targets of prevention efforts and that ensuring access to prevention and treatment for KP is critical to achieving global targets. Getting to Zero (The Three Zeros) aimed to advance global progress in achieving ambitious country-set targets for universal access to HIV prevention, treatment, care and support, halting the spread of HIV and contributing to the achievement of Millennium Development Goals (MDG) by 2015, especially MDG Six which specifically targeted HIV.

The treatment cascade is a helpful model for measuring key indicators in the HIV Response. It is made up of five stages: HIV Testing and Diagnosis; Linkage and enrolment in care; ART; Retention; Viral Suppression. Achieving viral suppression for all people living with HIV on ART is the ultimate goal of the cascade. Across the ASEAN region, success has been mixed in facilitating access to HIV testing, treatment and maintaining people living with HIV in care. Most AMS report high levels of retention in care at 12 months, but limited data is available on levels of viral suppression. In the critical area of prevention of mother to child transmission (PMTCT), the record is also mixed – some members report almost 100% coverage in this area, while others are much lower. The regional coverage rate is 19% well below the global average of 62%.



Overall, there has been significant progress across ASEAN in reaching the global targets. This has included collaboration by eight AMS in the ASEAN Cities Getting to Zero Project. Nonetheless, there are on-going challenges in taking evidence-based programmes to scale, especially those programmes prioritising KP, and where changes to the legal framework, such as decriminalisation, are optimal. At the regional level, there is a good understanding of what is needed to end HIV by 2030. However, at the individual AMS level, the capacity to scale up programmes varies significantly. While this is partly to do with resource allocation, it is also, as identified by UNAIDS and others, about increasing levels of community engagement, facilitating community-based HIV Testing and Counselling (HTC), decentralising HIV treatment and care, and focussing efforts where they are most needed.

Towards the End of HIV – Beyond 2015

Globally, there is new narrative on HIV treatment and new, final, ambitious, but achievable targets, and AMS are now exploring how to achieve these targets:

- by 2020, 90% of all people living with HIV will know their HIV status
- by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy
- by 2020, 90% of all people receiving antiretroviral therapy will have viral suppression

Critical to achieving the global targets are well resourced and targeted HIV responses. To this end, AMS have been encouraged to develop investment cases which examine how countries can resource and finance their HIV responses, especially as international funding is reduced, and where best to target resources for the most impact. To date, five AMS have developed investment cases – Viet Nam, Indonesia, Myanmar, Philippines and Thailand.

Post-2015 offers further opportunities for ATFOA to demonstrate its commitment to south-south collaboration and peer support in achieving global targets for ending HIV. A number of opportunities exist to build on the achievements of the fourth ATFOA Work Plan and support the achievement of targets for 2020 and the vision for 2030 of Zero New HIV Infections, Zero Discrimination and Zero AIDS-related deaths. There are common themes and issues in the reporting by AMS on their HIV responses, particularly around ART coverage, prevention for KP and financing the response. It is important that AMS take the opportunity to shape the regional programme so that in reflecting the new global targets, it does so in ways which best support and enable AMS to expand and consolidate their HIV responses. As such, there is a range of options and possibilities.

- 1 Leverage the good will and cooperation within ATFOA, and the advantages provided through the consolidation of the ASEAN Economic Community, to encourage AMS to commit more domestic funding for HIV programmes, including targeted prevention for KP and strategic and economic support for those AMS who are currently more reliant on international development assistance.
- 2 Embed the political capital for the ASEAN HIV response at regional, national and local levels. Use this capital to address ongoing issues and challenges around decriminalisation of sex work and male-to-male sex and managing epidemics in PWID.
- 3 Address programmatic gaps, as identified in the Phase II Regional Assessment of the Getting to Zero Cities Project, for example, barriers to KP accessing prevention and treatment programmes.
- 4 Undertake joint programmes with regional KP networks such as Asia Pacific Coalition on Male Sexual Health (APCOM), Asian Harm Reduction Network (AHRN) and Asia Pacific Network of Sex Workers (APNSW) in collaboration with UNAIDS, and where relevant, the Global Fund.
- 5 Advocate through regional institutions and associations including the ASEAN Economic Community for affordable access to Antiretrovirals Therapy (ART) for all AMS, especially those with the greatest HIV burden. For example, the establishment of a common fund for the bulk purchase of Antiretroviral (ARV) to obtain the best price possible and to encourage

increased domestic production. of ARV and Opioid Substitution Therapy (OST) by countries such as Thailand.

- 6 Focus the implementation of Treatment as Prevention (TASP) on specific populations in whom the prevention impact is expected to be greatest (e.g. sero-discordant couples, pregnant women, key populations).
- 7 Strengthen monitoring and evaluation of ASEAN-wide HIV programmes.

Introduction



1.1 Overview of ASEAN and Its Commitments on HIV and AIDS



The Association of Southeast Asian Nations or ASEAN was established in 1967 with the ultimate goal of establishing one community built on the foundations of economic and political stability and socio cultural relationships. It was not until the signing of the ASEAN charter and its eventual introduction in December 2008 that ASEAN was transformed from a loosely governed coalition to one with a legal standing and a rules-based approach. ASEAN comprises ten member states: Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam. It comprises 8.8% of the world's population, approximately 625 million people. The ASEAN region is made up of diverse ethnicities, cultures, customs, religions, language and dialects, modes of government and levels of development. Collectively, it has the third largest labour force in the world behind China and India¹.

Responding to the call by the Fourth ASEAN Summit in Singapore in 1992, the ASEAN Task Force on AIDS (ATFOA) was established to implement regional activities on health and HIV and AIDS. ATFOA aims to curb and monitor the spread of HIV by exchanging information and the formulation of joint policies and programs to promote HIV prevention, care and treatment. Since its formation, ATFOA has developed and implemented three multi-year ASEAN Work Programmes on AIDS (AWP).

ASEAN cooperation on HIV and AIDS is coordinated under ASEAN Health Ministers Meeting (AHMM) and ASEAN Senior Officials Meeting on Health Development (SOMHD). The 10th AHMM in Singapore endorsed the ASEAN Strategic Framework on Health Development (2010-2015), which included HIV and AIDS. ASEAN has subsequently developed guiding principles for the mechanism of the ASEAN post-2015 health development agenda. While respecting the national laws and regulations in ASEAN Member States (AMS), the guiding principles of the new

mechanism aim to strengthen the effectiveness and timeliness of ASEAN Health Cooperation for the benefit of the health of individuals and communities in the ASEAN region post-2015 through:

- Accountability - using evidence-based approaches in setting health priorities and agreed upon common goals and targets which must be measurable, with the commitment in implementation by all parties, including strengthening health information system
- Leadership - pro-active delivery of AHMM policy leadership supported by a responsive SOMHD Mechanism
- Operational and resource efficiency - effective use of scarce health resources, flexibility, transparency, good governance, maximising synergies, partnerships, and participation, and avoiding duplication with other relevant organizations and stakeholders
- Capacity building - enhancing active engagement in ASEAN Health Cooperation by the application of the principle of shared responsibility
- Positioning ASEAN in Global Health - strengthening ASEAN's role and image through active contributions to global health in various platforms and strengthening collaboration with other countries and development partners².

The guiding principles contained within the post-2015 mechanism will help to inform the development of an ASEAN-centred response covering the period 2016-2020 and support AMS to consolidate and expand their response to HIV through individual and collaborative action. Post-2015 there is an opportunity for AMS to further collaborate in sharing lessons on how to advance policy change and successfully manage the tensions and contradictions which may emerge in promoting inclusive responses to HIV. Opportunities exist for expanding collaboration with diverse stakeholders such as key populations (KP), religious leaders, political leaders, policy makers and the private sector.

1.2 Revisiting a regional approach to HIV and AIDS

Since its creation, one of ATFOA's major publications has been Addressing AIDS in ASEAN Region: First Regional Report on HIV & AIDS . This report was endorsed by ATFOA and by the SOMHD in 2012 and was officially launched, along with other ASEAN Health publications, during the 11th AHMM in June 2012 in Phuket, Thailand. The report identified not only the achievements and challenges with ASEAN in the response to HIV, but also the lessons learned by each AMS, making it an essential learning tool for all AMS and other regions.

At the 21st Meeting of the ATFOA in Melaka, Malaysia in September 2013, which was attended by delegates from Brunei Darussalam, Indonesia, Lao PDR, Malaysia, Republic of the Union of Myanmar, Philippines, Singapore, Thailand, Viet Nam, the ASEAN Secretariat and other stakeholders, the idea was put forward for the development of the 2015 Regional ASEAN Report on HIV and AIDS. This idea was accepted and led to the development of this document, the 2nd ASEAN Regional Report on HIV and AIDS. The task of leading the development of this report was allocated to the Philippines. During the 22nd ATFOA Meeting held on 24-27 June 2014 in Mandalay, Myanmar, the Philippines presented the proposed contents, timeline and mechanism for the report. ATFOA suggested that this report include information on the implementation of the ASEAN Declaration of Commitments on HIV and the inclusion of the documentation of Good Practices of the Getting to Zeros Project. The data in this report is drawn from a range of sources, including Global AIDS Response Progress Reports (GARPR) and the AIDS Data Hub (www.aidsdatahub.org).

Since its inception, the work of ATFOA has been guided by successive AWP. From 2011 through to 2015, AMS have worked towards the implementation of the fourth AWP. A key aspect of AWP IV has been to operationalise the ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths. This was agreed on by AMS at the 19th ASEAN Summit in Bali, Indonesia in 2011. The Declaration reaffirmed the commitment of AMS to accelerate progress in achieving the Millennium Development Goal 6 (MDG 6), which specifically refers to halting and reversing the spread of HIV and AIDS, and other related MDGs by 2015 through:

- Reducing sexual transmission of HIV by 50 % by 2015
- Reducing transmission of HIV among people who inject drugs by 50% by 2015
- Scaling up antiretroviral treatment, care and support to achieve 80% coverage for people living with HIV who are eligible for treatment, based on WHO HIV treatment guidelines
- Eliminating new HIV infections among children and substantially reducing AIDS-related maternal deaths by 2015
- Reducing by 50% tuberculosis deaths among people living with HIV.

In order to reflect the progress of ASEAN in achieving the Three Zeros, the objectives of the 2nd ASEAN Regional Report on HIV and AIDS are to:

- Provide an update on the HIV and AIDS Status of the ASEAN Region
- Provide an update on the HIV and AIDS Status of each AMS

- Assess the progress made in operationalizing the 2011 ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Death particularly on the five targets articulated in the ASEAN Declaration of Commitment
- Document collaborative efforts of the AMS (highlighting the ATFOA activities) in operationalizing the 2011 ASEAN Declaration of Commitment
- Document lessons learned and good practices experienced from the implementation of 2011 ASEAN Declaration of commitment on getting to The Three Zeros (see Figure 5)
- Document overall progress, strategic opportunities and challenges in responding to the HIV epidemic in the ASEAN context.

1.3 Asian Epidemic Modelling

Asian Epidemic Modelling (AEM) was initially presented in the 2008 in the Asia Commission on AIDS. It is a semi-empirical model that is closely tied to real-world epidemiological and behavioural data that should normally be collected during national response planning, monitoring, and evaluation (See Figure 1). It has been used extensively by a number of AMS to estimate current and future epidemic.

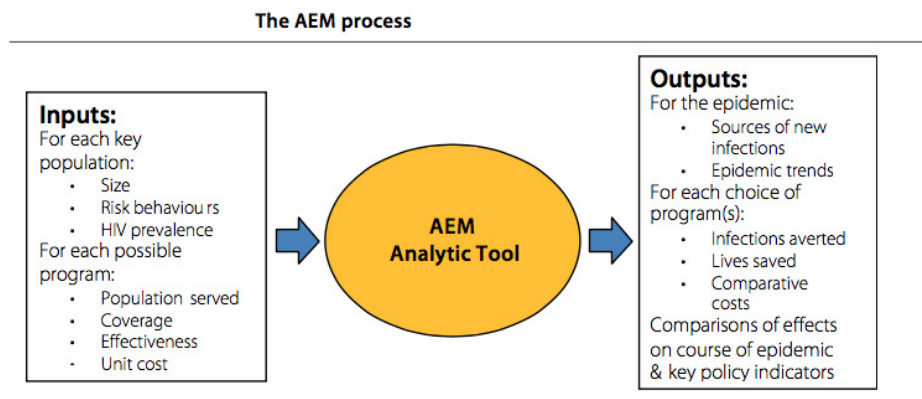


Figure 1: Simplified AEM Model (*Optimizing Viet Nam's HIV Response: An Investment Case 2014*)

Overview of HIV Epidemic in Southeast Asia



2.1 HIV Epidemic in the ASEAN Region

There are approximately 1.7 million people living with HIV in the ASEAN region of which close to a third are female. Of the total number of people living with HIV (PLHIV), at least 46% are adults who are eligible for antiretroviral therapy (ART) and of which just under 60% are receiving ART⁶. A number of AMS either fully fund or almost fully fund their HIV programmes from domestic sources, and are able to cover the cost of ART purchases, at least at the present level of coverage.

Across Asia there has been a 26% reduction in new infections since 2001 and no AMS is experiencing, or facing, a generalised epidemic. However, a number of AMS are experiencing emerging epidemics, for example, between 2001 and 2012 new infections increased 2.6 times in Indonesia and doubled in the Philippines⁷. It is significant that even in those AMS where overall incidence has been successfully reduced, this success belies the size of concentrated epidemics (more than 5% prevalence), in both specific geographical locations and among specific KP who are at higher HIV risk.

Most AMS have moved beyond the initial phases of injecting-driven epidemics, although prevalence among people who inject drugs (PWID) in member states with medium to large injecting populations (Indonesia, Myanmar, Thailand Viet Nam and Malaysia), remains high. Many PWID were infected with prior to the introduction of needle and syringe exchange programmes (NSEP). Further, to achieve zero new infections in PWID, NSEP and related programmes need to be scaled up. However, the role of sexual transmission in AMS epidemics has increased, presenting greater and different challenges for halting and reversing the spread of infection.

HIV epidemics in Cambodia, Myanmar and Thailand dominated the first decade of the pandemic in the ASEAN region. In these three countries, epidemics were brought under control through programmes such as the 100% Condom Use Programme (CUP), pioneered in Thailand and adapted by a number of AMS to address HIV transmission among sex workers. As a result, HIV incidence has declined among this population group. The combined effect of measures to combat risks in the sex industry has resulted in a slowdown in the rate of growth of the regional epidemic, starting in the early-2000s⁸. Similarly, harm reduction programmes in Malaysia and Indonesia in particular have had a dramatic impact on HIV among PWID. New infections among children in the ASEAN region have declined 28% to 23,000 in 2013 since 2001, largely due to the introduction prevention of mother to child transmission (PMTCT) programmes⁷.

Despite those achievements, there are growing epidemics in some geographic areas and within key populations at higher risk of HIV, notably, men who have sex with men (MSM) and PWID. Not enough people from these populations know their HIV status, inhibiting opportunities for them to access early treatment. Low

coverage of HIV interventions has meant that infections are not being prevented as effectively in these populations, as well as in the partners of PWID and female partners of sex worker clients. Consequently, their relative contribution to the total number of new infections is increasing, even as the overall numbers decline. Further, the rate of decline is also slowing and potentially coming to an end. Without further prevention expansion, innovation and success, it is likely that new HIV infections will rise again as the number of sex work clients increases, including transmission to their intimate partners, transmission related to injecting drug use continues and the epidemic among MSM continues to grow⁷.

Domestic financing in most AMS has increased considerably in the 2011-2015 period, although HIV expenditure still remains insufficient. International funding is shrinking and those AMS most affected by donor withdrawal need to develop to investment cases to explore new ways to resource programmes. Despite progress and legislative change in some countries, all AMS continue to have laws, policies and practices that are linked to driving stigma and discrimination and inhibiting access to HIV services.

2.2 HIV and Key Populations

Across Asia, HIV is largely concentrated among KP, especially, though not exclusively, in large cities and urban areas. The fastest growing epidemics in the region are among MSM. All AMS face varying challenges in ensuring that KP do not experience stigma and discrimination that impact on their access to prevention and treatment services⁷. National Strategic Plans for HIV and AIDS (NSP) are now more likely to reflect the need for prevention efforts to focus on KP, and donor-funded programs have undertaken a process of reorienting funds towards programmes for KP. The Global Fund to Fight AIDS, TB and Malaria (The Global Fund) has developed a new funding model, designed to invest as effectively as possible, so that partners can reach people affected by the diseases⁹. One of the pre-requisites for funding under the new model is robust epidemiological data, in particular on KP. The foundation of a country's funding application is now their UNAIDS investment case, with an expectation that they be developed through an inclusive country dialogue process that includes all stakeholders but especially KP. UNAIDS has developed four steps to assist countries to tailor an investment case to national contexts - the steps are Understand, Design, Deliver, Sustain¹⁰.

Men who Have Sex with Men and Transgender

Men who Have Sex with Men

National HIV prevalence in MSM is estimated to be more than 5% in at least five AMS -Indonesia, Malaysia, Myanmar, Thailand and Viet Nam. Prevalence

is particularly high - 15% to nearly 31%, in at least three large urban areas - Bangkok, Ha Noi and Jakarta⁷. In the Philippines, the number of reported HIV cases has jumped from one per day in 2007 to thirteen per day by August 2013, with MSM accounting for ten of those thirteen cases¹¹. While progress is being made, across the ASEAN region the trend is an increase in HIV prevalence among MSM as shown in Figure One. As noted by Thailand in their 2015 Global AIDS Response Progress Report (GARPR)¹², scale and coverage of prevention programmes are not enough to reach targets for both MSM and transgender (TG). In Indonesia, consistent with 2012 projections, MSM remain the primary driver of the epidemic¹³. Many MSM avoid seeking health and HIV services for fear of legal and social repercussions, discrimination and even violence presenting a serious barrier to delivering HIV prevention and treatment services. There is extensive documentation from across Southeast Asia of health workers who discriminate against MSM¹⁴.

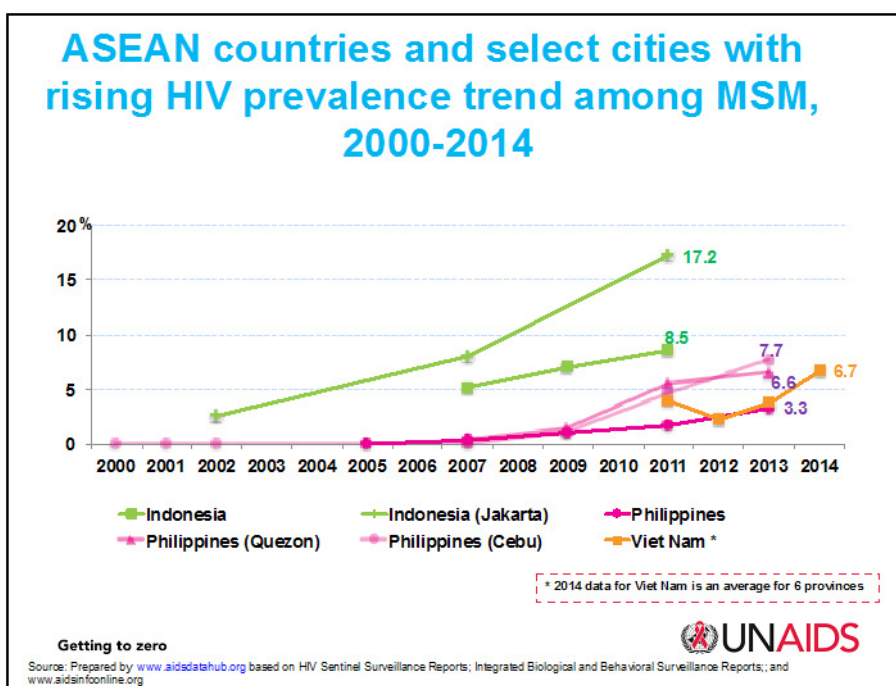


Figure 2: MSM Prevalence in five AMS 2000 - 2014

Historically, there is a lack of research on male-to-male sex in the ASEAN region, and Asia more generally, and this has been reflected in the lack of targeted prevention programmes. As surveillance systems have strengthened and behavioural research initiated, there has been an increase in the availability of strategic information on MSM leading to a better understanding of their vulnerability to HIV infection. This information has contributed to changed funding

priorities, especially among donors and also, to varying degrees, among AMS governments. Increasingly, it is understood by AMS that the HIV response for MSM needs to be positioned within the broader context of lesbian, gay, bisexual, transgender and intersex (LGBTI) rights, and that focussing on sexual orientation and gender identity (SOGI) issues to address stigma, discrimination and violence is very much part of an effective and holistic response to HIV for both MSM and TG¹⁵.

Some countries are beginning to explore models for legal recognition of same-sex relationships. The governments of Thailand and Viet Nam have discussed proposals for law reform in the areas of civil unions and registration of partnerships. Viet Nam has removed penalties for conducting same-sex marriage ceremonies, although it has not taken the further step of legal recognition of same-sex marriage. Proposals have been developed in Thailand for inclusion of sexual orientation in the non-discrimination clause of the Constitution¹³.

Transgender

For surveillance and programming purposes, TG are often included in MSM category. However, HIV prevalence can vary significantly between MSM and TG, as do their sexual identities. In Thailand, the median HIV prevalence among TG in 2014 in Bangkok, Chonburi, Chiang Mai and Phuket was 12.7%, higher than the national average for MSM at 9.2%¹³. In Indonesia, TG prevalence appears to have stabilised, but in some sites is significantly higher than for MSM¹⁴. In Malaysia, prevalence among TG is less than for MSM, but surveillance indicates an increase of from 4.8% in 2012 to 5.6% in 2014 (see Figure 3). In other AMS, prevalence in TG is not disaggregated from MSM. In the study *Lost in Transition: Transgender People, Rights and HIV Vulnerability in the Asia-Pacific Region*, TG are identified as among the most socially ostracised KP in the region and are lacking in fundamental rights, including access to basic health care and social protection schemes¹⁵. There is a need for concerted action by governments, civil society, development partners and the transgender community itself to design and conduct further research to address the lack of information on TG¹⁷.

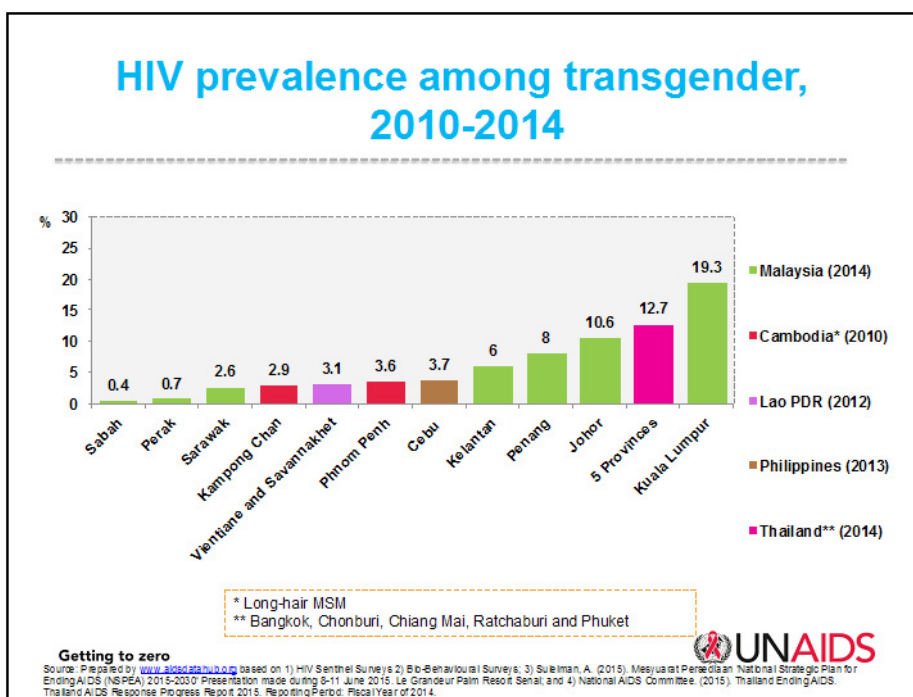


Figure 3: HIV Prevalence in Transgender in five AMS

People Who Inject Drugs

In 2012, HIV prevalence among PWID in Indonesia was 36.4% and in Cebu, the Philippines 53.8%⁷. In Malaysia, Myanmar, Thailand and Viet Nam, harm reduction programmes have successfully contributed to declines in prevalence. However, these programmes do not have full coverage, and in some AMS there continues to be significant political and social resistance to their wider implementation. In Thailand in 2014 there were just 42 sites distributing needles and syringes at no cost, with an average of just 14 distributed per person, well short of the country target of 88¹³. In Viet Nam, at the end of 2013, 97.3% of PWID surveyed reported using sterile equipment for last injection. Needle and syringe exchange programme coverage was only 29% and Methadone Maintenance Therapy (MMT) coverage was 15%¹⁶. National trends sometimes mask significant geographical variations in HIV prevalence among PWID. In the province of Thai Nguyen in Viet Nam, the prevalence among PWID was reported to be 38.8% in 2012, compared with the national prevalence of 11.6%. Regional 2012 data shows that the median distribution of needles and syringes was around 100 syringes per person who injects drugs per year – half the recommended level⁸. In Myanmar, the number of needles and syringes distributed was 168 per person in 2014 compared to 147 in 2013. However, Integrated Behavioural Surveillance Survey (IBBS) data from 2014 suggests seven times as many are

needed each year than are currently distributed. According to the IBSS of the previous year (2013), only 30.7% of PWID used sterile equipment the last time they injected¹⁷. Opioid substitution therapy (OST) including MMT is being rolled out to complement NSEP in countries with harm reduction programmes. Despite overwhelming evidence that harm reduction measures decrease new infections among PWID, access to these services is still inadequate. In 2011, one major resolution of the Philippines National AIDS Council (PNAC) was the approval of operation research for harm reduction in Cebu. This research project on harm reduction was intended to open possibilities for a future implementation of evidence-based HIV programs targeting PWID in selected sites.

Sex Workers

The steady decline in HIV prevalence among female sex workers (FSW) is one of the great success stories of the HIV response in the ASEAN region. However, the burden of HIV infection among sex workers is disproportionately high relative to the general population in AMS – 7.4% in Indonesia 2014, 6.3% in Myanmar 2014, and 10% in Cambodia 2010 (see Figure 4). The decline in HIV prevalence is generally attributed to rigorous health promotion campaigns that have included peer education, free condoms, education materials, free STI and HIV screening and sex worker-friendly clinics.

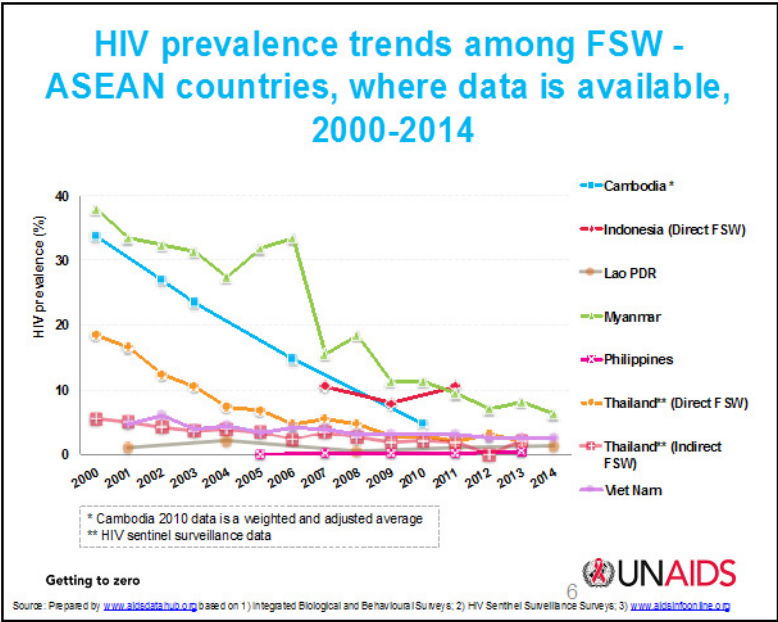


Figure 4: HIV trends among female sex workers in AMS

As observed in other KP, there are geographical areas with higher HIV prevalence (see Figure 4), for example, Ha Noi, where prevalence among female sex workers was 22.5% in 2012 or Jayawijaya, Indonesia, with 25% prevalence in 2012. In Myanmar, there are specific high-prevalence areas - 15% surveyed in Patheingyi, Myanmar, were living with HIV¹⁸.

2.3 Legal Policy Framework and Key Populations

There is increasing recognition in ASEAN of the need to better align the legal framework with policy frameworks. In Myanmar a comprehensive national legal review was carried out for the first time in 2014 at national and sub-national levels. The results of this review were presented in a report recommending steps to reform out-dated laws and policies hampering implementation of HIV prevention and treatment efforts¹⁸. In Thailand, the draft Gender Equality Law was submitted to the National Assembly in December 2014, and subsequently approved by the National Assembly in January 2015. This law includes the statement that sexual expression that is different from one's sex at birth as a basis for gender discrimination is prohibited¹³. In Cambodia, efforts to reduce HIV transmission amongst PWID have been hampered by the current legal and policy environment, i.e. the Law on Human Trafficking and Sexual Exploitation, the Village Commune Safety Policy, and most recently, the new law on drug control. The effect of these laws has been to drive PWID underground and disrupt the operation of the NSEP¹⁹. In the Philippines, the need for reform is urgent, with the situation requiring an enabling environment that promotes health-seeking behaviours and is supported by national laws or local ordinances that will allow the implementation of a harm reduction programmes.

It is recognised within the HIV sector, globally and regionally, that harm reduction is strategically important in preventing transmission between PWID, and between PWID and their intimate partners, the majority of whom do not inject drugs. In Malaysia, in a context of considerable social, religious and legal constraint it has nevertheless been possible to implement harm reduction programmes for PWID. At the centre of this approach has been the reframing of injecting drug use as a

public health issue rather than just a criminal issue. An example of this reframing has been the move toward rehabilitation rather than detention (see Box 1).

Alternative action to compulsory detention: Malaysia's innovative 'Cure and Care' clinics

When a progress report suggested that Malaysia was lagging behind on Millennium Development Goal 6 — to halt and reverse the spread of HIV, the Government took decisive action. In November 2005, after reviewing its policy of using compulsory detention as the main response to injecting drug use, the cabinet introduced harm reduction and voluntary treatment.

Compulsory detention of people who use drugs is associated with high rates of relapse 103 and in 2010 the Malaysian Government began to gradually introduce a number of voluntary and community-based treatment services. Although some compulsory drug detention centres still exist in Malaysia, the National Anti-Drug Agency has already transformed eight such facilities into 'Cure and Care' clinics.

These voluntary outpatient treatment facilities provide a range of services based on an individual clinical assessment, including provision of food, a place to rest and bathing facilities, medical check-ups, methadone maintenance therapy, counselling, support for re-integration and access to HIV services.

Box 1: Malaysia's voluntary rehabilitation 'Cure and Care' clinics

2.4 Other Vulnerable Populations

Migrants and Mobile Populations

The structure of ASEAN as an economic and socio-cultural community has led to expansion of cross border migration within ASEAN. Being a migrant or a member of a mobile population is not a risk factor for HIV in itself. However, migrants often lack access to mainstream health care, education and social services. Migrants may be more vulnerable to exploitation and abuse because of poverty, lack of education and legal status. For a variety of reasons, data collection on migrant and mobile populations has lagged behind that of other vulnerable and key populations. The very nature of migration makes accessing individuals and compiling population-level data challenging. From the data that is available, highly mobile populations such as truck drivers, fisherman and itinerant labourers, have the highest prevalence of HIV among migrants²³.

At Risk Youth

As noted in first regional report, *Addressing AIDS in ASEAN Region*, youth from key populations are another vulnerable group⁴ and this continues to be the case.

Young people under the age of 25 cross-over with other key populations including MSM, sex workers and PWID. However, there is limited data available on youth in the 15 to 24 age group or where it is available, sample sizes are small. Research from Viet Nam suggests that there might be a new risk for HIV transmission among youth, particularly MSM and FSW who use amphetamines²⁰. Thailand recognises young MSM as needing particular prevention programs and strategies and since 2012 adolescents are allowed to test for HIV without parental approval¹³.

Intimate Partners of People Living with HIV and Other Key Populations

Specific ASEAN data is not available on the percentage of new infections attributable to women. However, there has been an increase across Asia more broadly where the number of new infections among women has increased from 21% in 1990 to 38% in 2013²¹. A number of AMS have identified that the intimate partners of PLHIV and other KP, as vulnerable to HIV infection, in particular, female partners of PWID, MSM and clients of sex. The Myanmar 2015 GARPR notes that the high proportion of FSW infected in the 1990s has produced a 'knock-on effect' of increasing the proportion of women being infected by their male partners¹⁸. Further, in Myanmar a considerable number of new infections occur in low risk women indicating an increase in transmission between intimate partners.

In Malaysia, new HIV cases have declined since 2003 but the proportion of female/male has shifted, with increasing infections among females²². The Ministry of Health (MOH) profile of female HIV cases in 2014 indicated that 92% had acquired HIV through heterosexual transmission and 40% were 'housewives'²⁵. In Viet Nam, 28% of new infections occurred among women who were in long-term sexual relationships with a PHIV, particularly men who have injected drugs, but also MSM and/or are clients of sex workers²³. Further, nearly three-quarters of new infections occurred between PWID who share needles and other injecting equipment, and from PWID to their regular sexual partners²⁶. Intimate partner transmission has received limited attention and investment in prevention efforts to date.

Getting to Zero



The 2011 UN Political Declaration on HIV and AIDS called on member nations to intensify efforts to eliminate HIV and AIDS, reaffirming the 2001 and 2006 declarations and the urgent need to significantly scale up efforts towards the goal of universal access to comprehensive prevention treatment, care and support²⁴. The UNAIDS Strategy 2011-2015, Getting to Zero (The Three Zeros) as shown in Figure 3. The Three Zeros aimed to advance global progress in achieving ambitious country-set targets for universal access to HIV prevention, treatment, care and support, halting the spread of HIV and contributing to the achievement of Millennium Development Goals by 2015. In 2012, the ASEAN Member States made a unanimous commitment to accelerate progress in achieving MDG 6.

3.1 HIV Prevention Programmes

Prevention remains the cornerstone of the response to the HIV epidemic but there have been significant shifts in our understanding of HIV prevention. This includes a better understanding of the KP who need to be targeted for HIV prevention and the availability of new prevention tools. Increasingly, AMS have recognised that the primary targets of prevention need to be KP. Ensuring access to these populations is critical in achieving global targets. In recent years, prevention efforts for KP such as MSM, sex workers and PWID across the ASEAN region have been stepped up. There has also been increased research into the factors which make KP more vulnerable to HIV infection, and a greater focus on the large urban centres in the region where epidemics among KP are concentrated.

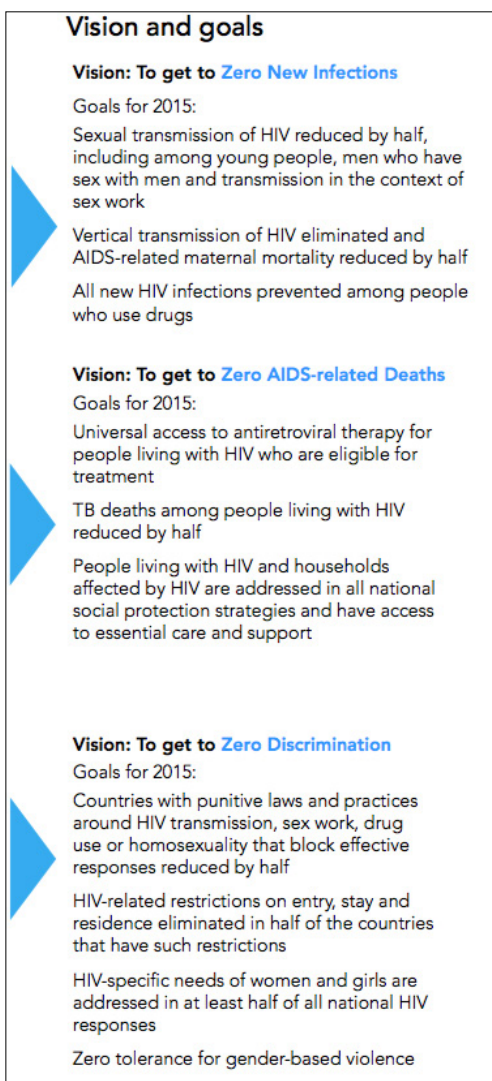


Figure 5: Vision of Getting to Zero

The model universally advocated for reaching KP emphasises the importance of community engagement and involving affected communities and networks at all stages of the HIV response. The Three Zeros strategy has encouraged AMS to revisit their prevention programmes and reinvigorate them. New developments and innovations around testing, delivery of information, harm reduction and treatment as prevention (TASP) have been incorporated into NSP. In Viet Nam, the government has acknowledged that investment in HIV prevention has not been sufficiently targeted. According to the most recent expenditure analysis, 19.8% of HIV prevention expenditure in 2011 and 2012 went to programmes targeting PWID, 10.5% of expenditure was targeted at FSW and just 1.4% targeted MSM, although these population groups accounted for an estimated 54% of new infections in 2013. Similarly in Myanmar, according to the 2012-2013 National AIDS Spending Assessment (NASA), care and treatment comprised almost half of overall HIV-related spending in the country (49%), and prevention only accounted for 21%²⁵.

3.2 The HIV Treatment Cascade

The HIV treatment cascade, also known as the HIV care continuum, is a system to monitor the number of PLHIV who are receiving medical care, and in particular, have access to ART. The system recognises the new science of viral suppression, which states that when people are engaged in care and taking ART to reduce the amount of virus in their body, it makes them less likely to transmit HIV to others. The HIV treatment cascade is a framework for improving the delivery of services across the continuum of care. In the quest to optimize HIV treatment, the HIV treatment cascade has emerged as an important tool that illustrates key transitions in the HIV service continuum²⁶. The treatment cascade can be used to identify issues and opportunities to improve service delivery for PLHIV across the entire continuum of care from diagnosis of HIV infection to initiation of ART, retention, and eventual viral suppression. For example, in Viet Nam, recent analysis confirms that many individuals are lost at various stages of the HIV cascade, reducing the proportion of PLHIV who achieve viral load suppression and other treatment benefits²⁴. Loss to follow up is also an issue in other AMS. In Indonesia, the cascade model has been adapted for the district level and is known as the LKB – Integrated, Decentralized Continuum of Care Services. It is a key strategy in targeting HIV testing and treatment services in the areas with the highest burden. In other AMS, plans are in process to ensure that there are linkages between prevention, care and treatment, for example, in Myanmar the new NSP (2016-2020) emphasises the importance of a service delivery model that ensures an escalation in efforts on prevention while also continuing to expand access to treatment²⁷.

The Stages of the HIV Treatment Cascade

1. HIV Testing and Diagnosis
2. Linkage and enrolment in care
3. ART
4. Retention
5. Viral Suppression

Many potential opportunities for delayed diagnosis and patient attrition exist along the cascade of services and contribute to morbidity and mortality and continued HIV transmission. Initial diagnosis often occurs at late stages of disease progression due to delays in testing, lack of access to testing and the time taken to deliver results. The limited available data on retention from the time of diagnosis to initiation of ART indicates that a high proportion of PLHIV are lost in the transitions from testing to pre-ART care and from pre-ART care to ART⁷.

HIV Testing and Diagnosis

In all AMS, HIV screening is provided free of charge in government health facilities, but making testing easier, especially for KP, is essential. A systematic review and meta-analysis of community-based approaches has shown that community-based testing and counselling achieve high rates of uptake and reach people with high CD4 counts²⁸. There has been scale up of testing programmes in period 2011-2015 with innovations such as community-based testing, including finger-prick and saliva tests in some AMS. However, data on testing rates show that rates of diagnosis are still relatively low. Regional data and projections show that most PLHIV in the region do not know their status and many find out their HIV status when their CD4 cell count is fewer than 100⁷. For example, in Cambodia community-based finger prick testing for HIV has been conducted among KP since 2013. However, community based testing in this context has returned low rates of positivity, suggesting it is not reaching those at highest risk²².

In Myanmar, a community-based HIV testing and counselling (HTC) policy that allows NGO to provide rapid testing, and is endorsed by the Ministry of Health (MOH), has been in place since 2014¹⁸. In Malaysia, legislation determines that rapid testing must be accompanied by confirmatory testing requiring a blood draw which can be a barrier to the implementation of testing by NGO²³. Currently, there are only a few community based-organisations (CBO) in Malaysia with the capacity to provide HIV testing and counselling and with linkages to follow-up care and preventive services. One of those CBO is PT Foundation, which operates the Community Health Care Centre (CHCC) in Kuala Lumpur providing anonymous and confidential HIV screening where results are provided within the hour²⁹.

In Thailand, increasing access to testing for young people has partly been addressed by removing the legal barrier requiring parental consent for young people to access HIV testing and among FSW, HTC rates are largely on

target¹³. Some of the obstacles identified by KP that contribute to not testing for HIV include - inconvenience of getting to test site, time required and fear of knowing results (30% did not return for results 2014)¹³. Thailand has reinforced implementation of same-day HIV results at public health facilities throughout the country and introduced national guidelines for rapid testing. These efforts are making community-based HTC services possible and popular¹³. In Lao PDR, the number of HIV tests conducted has increased to nearly 60,000 in 2014 from a low of 39,000 in 2013, a year in which there was well-documented shortage of test kits. However, only 20% of KP had undergone an HIV test and knew their results, well below the target of 80% indicating that while testing has increased it is not well targeted³⁰. In Indonesia, the number of PWID who had received an HIV test and know the result has increased from 44.7% in 2007 to 90.6% in 2011. However, of the estimated 590,000 PLHIV, only 31.9% knew their status¹⁴. In Viet Nam, testing rates are low and appear to be declining. For example, among FSW rates of testing declined from 43.8% in 2011 to 31.5% in 2012. Similarly for MSM, the rate declined from 30.2% in 2011 to 28.9% to 2013 and among PWID from 29.1% in 2011 to 23.6% in 2013.

Linkage to Care

Once a person is diagnosed with HIV, they need to be connected to an HIV healthcare provider where there is access to treatment, counselling and prevention education. Across AMS, there are mixed results in linking PLHIV to care and the data is not always available to indicate how many PLHIV either do not return for their results, or having received their results, are not then linked into care. For example, in Thailand, 40% of the pregnant women diagnosed with HIV do not return to the delivering facility for on-going care post-partum¹³.

Antiretroviral Therapy (ART)

The World Health Organization (WHO) recommends that ART should be initiated in all individuals with HIV regardless of WHO clinical stage and at any CD4 count, and as a priority, ART should be initiated among all adults with severe or advanced HIV clinical disease and adults with CD4 count ≤ 350 cell/mm. HIV positive people in serodiscordant couples should be offered ART to reduce HIV transmission to uninfected partners. ART coverage in AMS has significantly increased across the ASEAN region in the last five years, but there are still gaps in coverage (see Figure 6 for ASEAN ART coverage). In some cases, implementation of the new WHO guidelines will be a significant challenge and may not always be the most cost effective approach. For example, the recent investment case developed by Indonesia noted that concentrating ART initiation criteria on PLHIV with a CD4 = 350++ would avert more infections and would be more cost-effective than a criteria of CD4 = 500 or more ³¹.

Antiretroviral therapy coverage and treatment gap, ASEAN countries, 2014

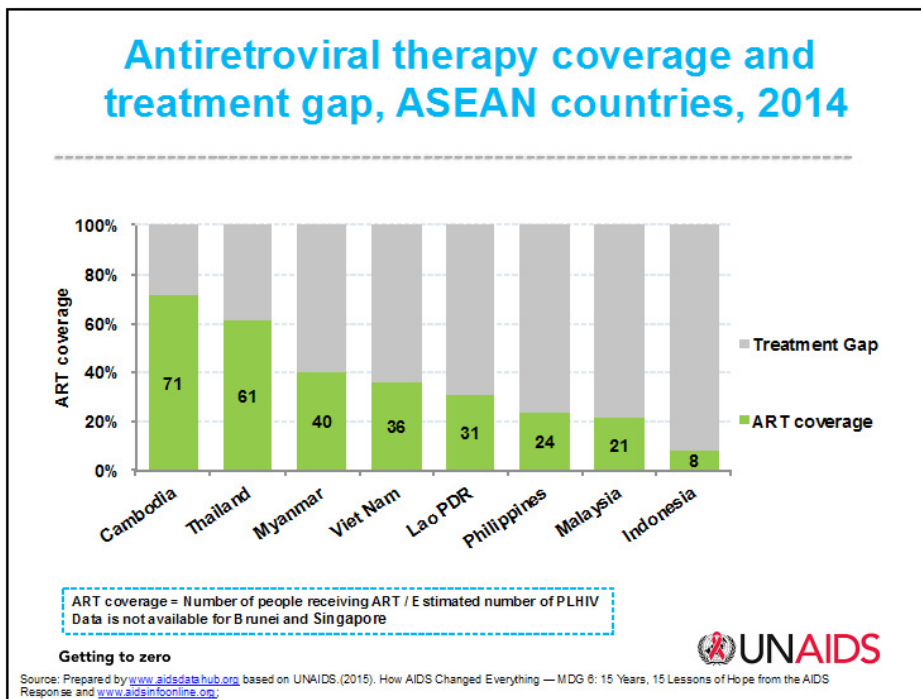


Figure 6: ART Coverage and Gaps in ASEAN Member States

In Malaysia, there are 88,093 PLHIV of which 21,654 people were receiving ART at the end of 2014, around half (47%) of the 42,408 (AEM) eligible for ART. However, the retention rate is strong with 95.1% still on treatment at 12 months. First line treatment is available at no cost, including to those in closed settings such as prisons and drug rehabilitation centres. There is also significant funding of second line treatment²⁵. As of June 2015, Myanmar had 95,509 adults and children receiving ART, representing 45% of all estimated PLHIV. The number of PLHIV on ART has more than doubled since 2010 as a result of the rapid scale-up of ART in public facilities, as well as the decentralisation of ART. From 2013, the number of health centres offering ART increased from 37 to 184 sites (74% of which are public facilities) in 2014. The number of PLHIV treated in public facilities compared to non government facilities reflects the shift in ART service provision, with 45% receiving ART in the public sector and 52% in the NGO sector. Continued scale-up and decentralisation of ART will ensure greater equity in geographic coverage of ART services nationwide. However, there are challenges to address, including late initiation of ART, this is despite, national guidelines supporting early access to treatment.

In Indonesia, one barrier to treatment access is the National Social Protection Scheme for Health (JKN) which does not support treatment related to self-inflicted

diseases, particularly those related to illegal drug use and alcoholism. This condition of access impairs treatment availability for PWID. As is noted in Indonesia investment case¹⁴ the annual number of new ART initiators continues to fall short of the estimated number of new infections. In Thailand, although ART coverage increased during 2010-2014, many PLHIV learn about their positive status and are initiated into ART at a late stage. This dramatically reduces the effectiveness of ART. In addition, coverage of screening of co-infections such as tuberculosis has not been increased significantly. As a result of these factors, a considerable proportion of PLHIV, as noted previously, die within the first six months after diagnosis, even though they have access to HIV services and treatment¹³. Thailand has adopted a programme of making ART available to all people irrespective of CD4 count; the effectiveness of this strategy will be improved with greater levels of early detection and treatment for KP and improved access for non-Thais. The approach of early treatment reflects support for evidence from HPTNO52, treatment as prevention (TASP). Prior to the changed eligibility, Thailand had achieved ART coverage of 80.3% in 2103. A total of 426,274 adults and children were enrolled in HIV care by 2104, of which 271,652 were receiving ART¹³.

Retention and Adherence

Strict adherence to ART and retention in care is essential to sustained HIV suppression, reduced risk of drug resistance, improved overall health, quality of life, and survival; poor adherence is the major cause of therapeutic failure. Improved drug regimens with a low pill burden, without a food requirement and few side effects are associated with higher levels of retention and adherence. The region appears to be showing high levels of retention, with those AMS able to provide data, achieving the WHO target of 80%. More widespread implementation of the 2013 WHO guidelines, which recommend that eligible patients receive a simplified daily single-pill regimen where possible, should help to maintain high levels of adherence. In Lao PDR, the 12 month retention rate at the end of 2014 was 85% and Myanmar 82.1%. In Cambodia, ART retention at 12 months decreased slightly from 84.5% in 2014 to 75.9% in 2015, while in Viet Nam it has remained stable over the past years at over 80%.

In Thailand, retention in treatment at the end of 12 months was 83.0% in 2014. To address retention rates a unique identifier system is being introduced to assist in tracking patients through the health system and therefore reduce loss to follow-up. Furthermore, the retention rate at 60 months was 75% in both 2014 and 2015. Currently, six provinces have been equipped and trained on a unique identifier system. Treatment retention rates in Singapore are generally high 92.7% at 12 months 2012, 94% 2013, and 97.5% 2014³⁴.

Viral Suppression

Viral load tests are currently too expensive to be available in most AMS or are beyond the cost of most PLHIV. In Thailand, 96.1% of ART patients who tested

for viral load during 2014 had achieved viral suppression. The cost of viral load testing ranges from 2000 to 5000 THB and is available at both public and private facilities. In Singapore, viral load testing is part of the routine standard of care for HIV patients. The percentage of people on ART tested for viral load who were virally suppressed was 92.5% in 2013 and 95.9% in 2014³⁴. In other AMS, data is not available on viral suppression and there is limited information on availability of, or access to, viral load testing.

3.3 Prevention of Mother-Child Transmission

All countries in the ASEAN region have prioritised programmes to stop new HIV infections among children through PMTCT and have included them in their national strategic plans. A number of AMS have achieved relatively high coverage levels for PMTCT — notably Cambodia, Malaysia, Myanmar and Thailand, where coverage rates are above 50%, and Malaysia at nearly 100%. Singapore has seen very few cases of mother-to-child HIV transmission over the years, since antenatal HIV screening was made part of the standard of care over 10 years ago. There were no cases in 2014, and 87.5% of HIV positive pregnant women received ART to reduce the risk of MTC transmission³⁴. The regional coverage rate of 19% is well below the 62% global average. Early infant diagnosis of HIV varies widely across the ASEAN region, from single digit figures in some countries (Lao PDR, Myanmar and, the Philippines) to 100% in Malaysia⁷.

3.4 Essential Elements for an Effective Response

The UNAIDS 2011-2015 Strategy, Getting to Zero, identified five key challenges for global HIV:

- HIV as a pathfinder and investment opportunity – countering the myth that the HIV response undermines progress on other global priorities
- Priority setting, alignment and harmonization – greater efforts to focus finite resources where they deliver the greatest returns
- Access to affordable medicines and commodities – addressing the gaps in access to HIV treatment within and between countries
- Strengthening systems – 30 years into the epidemic, national programmes and global partners are just beginning to actively support, deepen and strengthen community engagement³⁵.

It is appropriate to review the ASEAN response to HIV, both regionally and at the country-level, not just in terms of progress towards achieving global, but also in relation to its success in responding to the key challenges to an effective

response. These are not new challenges, indeed they were highlighted in the 2008 Report of the Commission of AIDS in Asia⁵, but they have come into sharper relief in the last decade, especially in AMS where donor funding has outweighed domestic funding for HIV programmes. Critically, these challenges demand that countries have full ownership of their HIV responses. 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
- One agreed country-level Monitoring and Evaluation system.

Subsequent targets, including Universal Access and Getting to Zero, were envisioned through the prism of The Three Ones, the recommended foundation infrastructure for country responses. The UNAIDS 2016 – 2021 Strategy continues the direction set by previous strategies while incorporating expanded targets (see Chapter Five) and results linked to the Sustainable Development Goals³⁶.

National Coordinating Mechanisms and Strategic Plans

The regular development and implementation of NSP is widespread across AMS. NSP have contributed to AMS refining and better targeting their HIV responses. They have also been a requirement of donor funding, as have national coordinating mechanisms such as national AIDS councils, committees and commissions. Mid-term reviews (MTR) of NSP have provided valuable feedback to national coordinating bodies and international partners on the implementation of NSPs, the extent to which the 2011 targets have been achieved or are on track to be achieved, as well as unresolved challenges. The MTR for the Lao PDR NSP 2011-2015³⁷ found, in keeping with the findings from reviews of other AMS, that there has been significant progress including increased political commitment and stronger civil society engagement but there are outstanding challenges including increasing the capacity to monitor and evaluate the current response and generate and act effectively on strategic information³³. The MTR of the 2011-2016 Philippine Strategic Plan on HIV and AIDS provides a comprehensive list of recommendations with a highly detailed review of all programmes, raising concerns about how much can be implemented or rectified in the short term given the extent of the gaps identified³⁸. The 2013 MTR of the Myanmar NSP on HIV and AIDS (2011-2016) assessed the relevance, effectiveness, efficiency and sustainability of strategies and activities against progress made since the beginning of the plan as well as assessing available resources, opportunities and

challenges ahead, resulting in strengthening emphasis in 2014 in eight key areas in order to achieve the global targets set in 2011¹⁸.

Generating Strategic Information

The principle roles of HIV strategic information are to:

- Understand the epidemic and the extent of change resulting from interventions
- Track and gauge the health sector's response to HIV, particularly the health system inputs, intervention coverage, quality of services and outcomes and impact
- Inform programme improvement, assuring quality and maximum return on resources³⁹.

The value of up to date, reliable and relevant behavioural and epidemiological surveillance data is recognised as critical in developing and implementing HIV programmes. In the ASEAN region, all AMS have access to some form of surveillance data, but the capacity to generate and analyse behavioural and epidemiological data varies across AMS. The development of investment cases has provided an opportunity to use a range of existing data to model scenarios and generate strategic information in order to estimate the investments and timeframes required to respond to HIV in a cost-effective and optimal manner. For example, Indonesia has a large population and multiple epidemics over a large geographic area, and while it has developed some effective responses, these need to be significantly scaled up. The Indonesian response is also hindered by the uneven availability of data across provinces, including behavioural and epidemiological data. The main source of behavioural and epidemiological data is generally through an Integrated Bio-Behavioural Survey (IBBS), but such activities are expensive and usually only conducted in large cities or district. A strategic approach needs to be taken to extrapolate city or district data to apply to the province as a whole. In those provinces where no IBBS has been conducted or is likely to be conducted in the near future, IBBS from similar provinces and national-level data can be used for size estimation (as discussed in Box 2).

Indonesia – Generating Strategic Information with finite resources

In view of the decentralized governmental system in Indonesia in which district funding play an important role in the financing of health and other social services, developing Investment Case Analysis (ICA) for individual provinces and districts is quite logical. Ideally, ICA would be available for all provinces and districts in Indonesia, or at minimum for the 141 HIV priority districts and their respective provinces. This would (1) provide a basis for a detailed understanding of the local HIV situation for local stakeholders and (2) provide useful materials for advocating for increased priority and funding for HIV.

The main constraint to accomplishing this will be the availability of data specific to a province and/or district of interest. All provinces and districts will have available (1) total population size estimates and (2) KP population size estimates (from mapping) and official Ministry of Health size estimation exercises. But to undertake a meaningful ICA, behavioural and epidemiologic data such as are provided by IBBS are needed. The use of software packages such as AEM is helpful in carrying out such analyses as AEM provides “default” values for key parameters in the event that local data are not available, but analyses based entirely upon default values are likely not to describe local situations very well. Using epidemiologic data from comparable provinces or districts in lieu of province- or district-specific data is a step in the right direction. It should be recognized, however, that due to data limitations undertaking ICAs at the provincial or district levels could produce results that are unstable and should be viewed as indicative as opposed to precise data/results.

With these constraints in mind, the basic recommended approach is as follows. For provincial ICA, the required epidemiologic parameters are taken from IBBS results for cities/districts in the reference province. The IBBS data are available for two or more cities/districts, the average of these could be used as a provincial estimate. If data is only available for one district, a decision will have to be made as to whether that district is sufficiently “representative” of the province. If not, then an informed judgment will have to be made as to how the values for the single district for which data are available should be adjusted to better represent the province. If there are no IBBS data for a province, the options are to (1) use epidemiologic data from another province that is thought to be similar or (2) use national-level data (i.e. national averages).

The Case for Increased and More Strategic Investment In HIV in Indonesia 2015

Box 2: Generating Strategic Information in Indonesia

Addressing AIDS in the ASEAN Region⁵ (2011), identified that civil society involvement in ASEAN countries had improved in previous years, with seven countries reporting in their 2010 UNGASS Project Reports that there was active consultation with CSO in the development of the reports but that there were limitations on the involvement of civil society in planning, particularly in the

formulation of the national budget for HIV and that there was a marked decline in average national HIV budget for CSO activity.

As a result, CSO in a number of AMS have been depended on international donor funding for their programmes and infrastructure. Redressing the balance is a challenging process and in some AMS there are a number of legal barriers to community engagement. The discourse around the engagement of CSO is framed as civil society delivering programs to KP rather than KP informing government policy and programmes. The Viet Nam investment case presents a comprehensive plan for how better collaboration between government and CSO can facilitate the delivery of services more efficiently, effectively and with cost savings. Consultation with KP has provided valuable information around the type of programmes which might be feasible and acceptable to KP including requirements around condoms, lubricant and injecting equipment. Myanmar, in its 2015 GARPR, puts forward some of the challenges faced, and successes achieved in its nascent programme of community engagement (see Box 3).

Strengthening Community Engagement - Myanmar

“Continued efforts are needed to strengthen the role of civil society in the national response to HIV. Civil society organizations (CSO) have growing expectations for their full participation in decisions concerning funding planning and coordination. CSOs are represented on all of the various TWGs and the Myanmar Health Sector Coordinating Committee. The HIV Technical and Strategy Group (TSG) is also open to all interested parties to attend and welcomes participation from civil society organizations and KP. PLHIV are also represented on a Joint Parliamentary and Community Network Consortium Committee on HIV and Human Rights.

A greater number of NGOs have come forward to help in delivering services to address HIV among PWID and implement harm reduction activities, including in areas that have so far been underserved. There is still a need to simplify and streamline procedures of negotiating a Memorandum of Understanding (MOU) with the counterpart government authorities.

There are also issues related to the perceived sensitivities around HIV prevention activities among MSM, FSW and PWID, which result in police crackdowns on needle and syringe programs and resistance from some ethnic and faith-based communities. Further efforts are necessary to improve coordination among implementing partners and stakeholders including the police, community leaders and members. Also, the willingness and openness of stakeholders to address local level issues needs to be more deliberate.”

Myanmar – Global AIDS Response Progress Report - 2015

Box 3: Strengthening Community Engagement in Myanmar

Investment and sustainability

Domestic funding for HIV programmes varies significantly across AMS. Singapore's HIV programme is entirely self-funded and the Malaysian programme is also largely supported by public funds, though it is in receipt of a grant through Round 10 of the Global Fund, to support the scale up of services for PWID and sex workers. In both Thailand and the Philippines external funding accounts for less than 5% of the overall HIV budgets. Donor funding in Southeast Asia, has tended to cover not only the costs of specific program interventions but also much of the programme architecture and management costs⁴². Thailand has made a serious political investment in their HIV response and has the financial resources to support this. It could be argued that that both Indonesia and Viet Nam could largely fund their HIV responses from public funds. This is changing, at least to some extent, and in Indonesia in 2012 the total expenditure on HIV was US\$87.5 million, of which nearly US\$37 million was domestic funding. In Viet Nam, domestic funding has increased from US\$26 million (26.1%) in 2011 to US\$30 million (31.8%) in 2012²⁶. The Government of Viet Nam has initiated the *Project on Sustainable Financing for HIV/AIDS Prevention and Control Activities in 2013-2020 Period*, which has been endorsed by the Prime Minister. Among the project's objectives is to use domestic resources for 50% of total spending prevention and treatment by 2015 and for 75% of total spending by 2020²⁶.

Although external funding currently remains integral to the national response, Myanmar is intensifying efforts to increase country-owned financing and contributed to 8% (US\$4.1 million) of total HIV spending in 2013, a five-fold increase from 2012. The Ministry of Health allocated additional funding of US\$1 million for MMT in 2014 and US\$5 million for ART in 2015. With the support of the World Bank and UNAIDS, the Government of Myanmar will develop a financial transition plan in 2015-2016 to continue to strategically expand domestic funding²⁸.

Enabling environment – Addressing stigma and discrimination

ASEAN has committed to achieving zero discrimination of PLHIV in the region. Global AIDS Response Progress Reports from member states document a range of processes intended to promote the human rights of PLHIV and provide protection from stigma and discrimination. At present, just four AMS have protective laws and regulations at the national level for PLHIV, which is unchanged since the 2011 *Addressing AIDS in ASEAN Region*. There are limited mechanisms for monitoring and enforcing protective mechanisms although reducing stigma and discrimination is consistently included as an objective of HIV programmes. Malaysia reports that the promotion of an enabling environment, including eliminating stigma and discrimination, continues to be a priority, noting that activities have included training of health care workers on how to provide MSM and transgender friendly sexual health services²⁵.

In the ASEAN region, HIV infection has disproportionately affected KP - PWID, sex workers, MSM and transgender, who may already be marginalised and vulnerable to discrimination and violence. Behaviours that sit outside of the mainstream are frequently described as taboo and therefore not openly discussed, resulting in policy and legislation gaps. This impacts on the ability to implement effective HIV programmes, and this is particularly so in the area of injecting drug use where the tension between illegal drug use and providing sterile injecting equipment for PWID often sits uneasily with governments and society at large. However, Indonesia and Malaysia in particular, have demonstrated that when there is political will and engagement with key stakeholders such as faith-based organisations and the police, harm reduction programmes can be implemented successfully. Addressing the broader issue of stigma and discrimination against PLHIV is perhaps more challenging and there is limited data available measuring levels of discrimination within AMS, though in all sites where data is collected, large numbers of PLHIV still report some level of discrimination. Malaysia suggests that there is a need to define better outcome indicators that allow programmes to measure progress on stemming stigma and discrimination in the work place and in the community. Currently, this kind of information is not available and as a result it is difficult to know whether existing programmes to address stigma and discrimination have any lasting value or impact.

ASEAN Regional HIV and AIDS Commitment



4.1 Introduction

In the 2011 Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS, the United Nations members committed to redouble efforts to achieve by 2015 universal access to HIV prevention, care, treatment and support as a critical step towards ending the global HIV epidemic and achieving the goals of MDG 6, in particular to halt and begin to reverse, by 2015, the spread of HIV²⁷. In 2011, ASEAN acted on this call with its own Declaration of Commitment, Getting to Zero New Infections, Zero Discrimination, Zero AIDS-Related Deaths⁴². The commitments enshrined in the five goals of the Declaration reflected the strategic vision of the 2011-2015 UNAIDS Strategy and committed AMS to work towards an ASEAN with Zero New HIV Infections, Zero Discrimination and Zero HIV Related Deaths by:

- Reducing sexual transmission of HIV by 50 % by 2015
- Reducing transmission of HIV among people who inject drugs by 50 % by 2015
- Scaling up antiretroviral treatment, care and support to achieve 80 % coverage for people living with HIV who are eligible for treatment, based on WHO HIV treatment guidelines
- Eliminating new HIV infections among children and substantially reducing AIDS-related maternal deaths by 2015
- Reducing by 50 % tuberculosis deaths among people living with HIV.

4.2 Regional Platform

The 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 civil society organizations. The updated scope of work as endorsed by 18th ATFOA and the 6th SOMHD Meetings includes:

- Implement relevant directives emanating from the SOMHD
- 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
- Formulate, adopted and review policies, strategies and programmes for regional cooperation on HIV and AIDS
- Identify and explore priority areas of current interests for regional cooperation

- Develop, implement, monitor and evaluate ASEAN work programmes on HIV and AIDS
- Share information, lessons learned and best practices on HIV and AIDS
- Strengthen and expand mutually beneficial cooperation with partner organisations and other stakeholders.

4.3 Review of ASEAN Work Programmes

1st Medium Term Work Programme (AWP I) to Operationalise the Regional Programme on HIV and AIDS Prevention (1995-2000)

Under the 1st Work Programme on HIV and AIDS, nine activities were implemented between 2005 – 2010 using a cost sharing model between the hosts and participating countries. This initial endeavour of taking a regional approach to tackle the HIV epidemic produced useful lessons for the planning of future work programmes. Lessons from AWP I include:

- Instead of focusing on country level projects, regional level programmes should generate “value added” responses to the epidemic
- Avoiding projects that are one-off events
- The need to build capacity for implementers, ASEAN Secretariat and complementation of staff to effectively complete the projects.

2nd ASEAN Work Programme on HIV and AIDS (2002-2005)

The main objective of AWP II was to decrease HIV transmission and mitigate the social and economic impact of the disease in the ASEAN Member States. The AWP II included three major components comprised of:

- Joint action programmes
- Regional activities in support of country programme strategies
- A non-programme strategy.

Thirteen projects were implemented under these three components. Joint actions by Member States made several contributions towards country and regional responses. These included:

- Assisting Member States to improve the enabling environment for effective responses to the HIV epidemic
- Enhancing the involvement of civil society in all AMS
- Increasing the involvement of PLHIV in national and regional responses to the HIV epidemic

- Improving leadership in the response to the HIV epidemic, through collaboration with the Asia Pacific Leadership Forum on HIV and AIDS and the Development (APLF)
- 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, 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.

3rd ASEAN Work Programme on HIV and AIDS (2006-2010): “Stopping AIDS, Working Together”

The AWP III was designed to tackle issues that could primarily be addressed through regional action, to use existing mechanisms to facilitate AMS 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, CSO and the private sector, along with strengthening knowledge management and information sharing at country and regional levels. The overall objective of the AWP III was to prevent the further transmission of HIV, and mitigate the impact of HIV and AIDS by improving regional responses and enhancing AMS development of people-centred initiatives. In addition, four specific objectives were defined and operationalized through several projects. An Operational Plan (2007-2008) for the first phase focused on completing the activities undertaken and planning for AWP IV.

The AWP III highlighted the challenges of undertaking a multiplicity of activities within the context of inadequate capacity and resources e.g. financial, human and technical at country level offices and at the ASEAN Secretariat. However, despite these limitations, most activities were implemented. Success is highlighted in the fulfilment 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
- Strengthening and creating cross sectoral collaboration with other ASEAN entities and external agencies and organisations
- Promoting South to South cooperation in learning and sharing knowledge
- Engaging in evidence-based policy advocacy.

Implementation of AWP III was facilitated by:

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

The AWP III identified the following challenges:

- Resource constraints including funding constraints and the lack of human resources at the ASEAN Secretariat
- Strengthening follow through and structure monitoring framework taking into account existing, annual ATFOA meeting process
- The need for strategic partnerships and collaboration with other sectors.

4th ASEAN Work Programme on HIV And AIDS (2011 – 2015)

The AWP IV was developed by the ATFOA as its last activity under AWP III. The AWP IV was underpinned by three strategic thrusts:

- Policy advocacy at regional and global level
- Strengthening capacity and knowledge sharing among AMS
- Strengthening regional mechanisms to take advantage of available opportunities.

The AWP IV included four strategic outcomes:

- ASEAN highly regarded as a well-coordinated regional policy and advocacy body
- An intra-ASEAN and South-South Collaboration sharing and learning mechanism established by AMS
- ASEAN-generated regular regional overviews of the epidemic
- 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 were to be operationalized through the following objectives:

- Promote ASEAN's collective agenda at international and regional platforms utilising evidence-based epidemiological data and research findings
- Strengthen the capacity of national ministries and agencies to plan, implement and monitor and evaluate prevention and treatment programmes through knowledge sharing among AMS Leverage access to affordable HIV related care and treatment.

The Operation Plan for 2011-2012 was agreed on using the prioritization criteria developed by ATFOA at its 18th Meeting. The strategic framework and the operation plan were approved by the SOMHD through a referendum on 25 March 2011 and during the 6th SOMHD. A key component of AWP IV was the ASEAN Cities Getting to Zeros Project conducted from 2011-2014.

ASEAN Cities Getting To Zeros Project 2011 – 2014

In November 2011, back-to-back with the 19th meeting of ATFOA, and facilitated by the ASEAN Secretariat and hosted by Indonesia, an International Symposium, with the theme 'Getting to Zero New HIV Infection, Zero Discrimination, and Zero AIDS Related-Deaths' was convened. The symposium was also organized as a follow-up to the adoption of the ASEAN Declaration on Getting to Zero New HIV Infections, Zero Discrimination and Zero AIDS Related-Deaths, during the 19th ASEAN Summit, in Bali, Indonesia. The 19th ATFOA Meeting noted Indonesia's proposal in developing a regional project to implement comprehensive interventions in 'Getting to Three Zeros' by establishing partnerships among highly prioritized (selected) cities across AMS and under the ASEAN Work Programme IV (2011 – 2015).

Eight AMS agreed to participate in the scheme - Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand and Viet Nam. Indonesia was the lead country and submitted a concept note to ASEAN Secretariat which was later on noted by leaders during the 11th AHMM in Phuket, 2012.

Implementation Milestones of the ASEAN Cities Getting to Zeros 2011-2014

2011

- ASEAN leaders during the 19th ASEAN Summit adopted the ASEAN Declaration of Commitment towards an ASEAN with Zero new HIV infection, Zero Discrimination and Zero AIDS-related Deaths on 27 November 2011 in Bali, Indonesia. *"We underline the importance of effective and comprehensive response to prevent and reduce the number of new infections and provide appropriate treatment, care and support to key affected populations and other vulnerable groups."* (President of Indonesia and Chair of the 19th ASEAN Summit, Susilo Bambang Yudhoyono)

2012

- Cities Partnership Meeting on ASEAN Getting to Zero New HIV Infection, Zero AIDS Discrimination and Zero AIDS-related deaths, 3 July 2012, Phuket, Thailand; as side line Meeting of 11th ASEAN Health Ministers Meeting (AHMM). Output of the meeting included the “Recommendation of the Cities Partnership Meeting on ASEAN Cities Getting to Zero: Community Leads, Community Involvement”.
- Participating cities commenced initiating ASEAN Cities Getting to Zero in various sites.
- Operationalization of the ASEAN Cities Getting to Zero was also acknowledged at the AHMM meeting. This document was also shared at the ATFOA Meeting in Luang Prabang, Lao PDR in September 2013.

2013

- Phase I - ASEAN Cities Getting to Zeros Orientation Workshop Rapid Assessment and Planning Tools, 5- 7 February 2013, Jakarta, Indonesia.
- Phase II – Technical Support to the Implementation of the ASEAN Cities Getting to Zero Report: Consolidated Findings, Analysis and Recommendations. *Based on the findings of the Phase II, the consultant recommended a common Monitoring and Evaluation (M&E) Framework.*
- In support of ASEAN Cities Getting to Zero Project, the Melaka Historic City launched its Getting to Zero Project on 5 September 2013, Melaka.
- At the 11th International Congress on AIDS in Asia and the Pacific (ICAAP) in Bangkok, Thailand, a satellite session facilitated by the ASEAN Secretariat, included as speakers the Coordinating Minister of Social Welfare, the Chair of the National AIDS Commission of Indonesia and the Mayor of Melaka, Malaysia discussing the operationalization of the ASEAN Cities Getting to Zero initiative.

2014

- The ASEAN Cities Getting to Zero Progress was presented at the 22nd ATFOA Meeting, 24-26 June 2014, Mandalay, Myanmar. Participating AMS reported on operationalizing ASEAN Cities Getting to Zero and that from the participating eight countries and original thirteen cities, expansion to other sites had taken place in Malaysia, Philippines and Indonesia.
- Also at the 22nd ATFOA Meeting it was noted that there had been some also been site changes some of the participating countries, and some AMS were facing challenges in the operationalization of this initiative. The meeting therefore noted that a consolidated follow up was needed to capture the results from the participating cities and other developments, and to strengthen the monitoring and evaluation aspect of this initiative.

Since the commencement of the ASEAN Cities Getting to Zero initiative, there have been significant advancements at the global level in the response

to HIV which has led to the expectation that the HIV pandemic can be ended by 2030. What commenced with the Getting to Zero approach, has now been operationalized to the 90-90-90 approach, which is in line with the cities-based approach that ASEAN has taken.

Global initiatives on Fast Track Cities to end the AIDS Epidemic: Cities Achieving 90-90-90 Targets by 2020

2014

- Meeting of Mayors, Senior City Officials and Partners, Cities at The Centre, Mobilising city-led responses for ending the global AIDS epidemic, 19-20 July 2014, Melbourne, Australia as side line meeting of 20th International AIDS Conference. The ASEAN Cities Getting to Zero: Localizing The Three Zeros was presented in this meeting.
- Paris Declaration, 1 December 2014 on Fast Track Cities: Ending the AIDS Epidemic, Cities Achieving 90-90-90 Targets by 2020.

Recommendation: Follow Up Workshop of ASEAN Cities Getting to Zero Initiative, with the Fast-track Cities: Cities Achieving 90-90-90 Targets by 2020 approach

The purpose of the workshop is to bring together key municipal and civil society representatives from ASEAN Cities Getting to Zero Participating Cities and AMS to share experiences, challenges and solutions, develop fast-track action plans and tools to achieve the fast-track targets, including 90-90-90, by 2020 and define mechanisms for effective south-south collaboration.

The objectives of the follow-up workshop will be to:

- Provide an opportunity for priority cities share experiences, challenges and solutions
- Develop a Fast-Track Road Map
- Strengthen mechanisms for effective South-South collaboration.

ASEAN Cities Getting to Zero – A best practice example from the Philippines

Klinika Bernardo (Male Sundown Clinic): Bringing HIV Services Closer to the Community Quezon City, Philippines

Purpose: HIV prevalence has increased from less than 1% from 1993-2007 to 6.6% in 2013 based on the integrated HIV Behavioural Surveillance and Serological Surveillance. There has been a shift in new HIV cases from FSW to MSM with unprotected anal intercourse now the most common form of HIV transmission. To respond to the increases in MSM infections, the Quezon City Health Department responded with a range of MSM-focussed initiatives. The Klinika Bernard (KB), an existing social hygiene clinic (SHC), was identified as a strategic location for MSM clinic and the following steps were implemented at the clinic to increase MSM access:

- hiring and training of 25 peer educators for the SHC
- changing of opening hours
- hiring of a physician
- reallocation of budget and improved logistics
- establishment of a case management approach
- strategic planning and development of vision and mission
- procurement of a CD4 machine
- monitoring and evaluation.

Klinika Bernard is now open from 3pm to 11 pm, whereas previously it had operated standard 8am to 5pm business hours. This strategic decision ensured that working MSM could more easily access services. HIV testing and counselling, treatment and care, using a case management approach, is provided. Testing rates have increased significantly since 2012 when the clinic opened as an MSM-friendly service, and in two consecutive years, KB has had the highest HIV positivity rate among all social hygiene clinics in Quezon City.

The operation of KB has been sustained over time due to the commitment of the Quezon City Government, KB staff and peer educators. Policies in support of HIV prevention, diagnosis, treatment and care in Quezon City include: I) Ordinance creating the local AIDS Council; (II) Draft policy on HIV prevention control program; (III) Resolution naming Klinika Bernardo Sundown Clinic (IV) Antidiscrimination; and (V) Lesbian, Gay, Bisexual and Transgender (LGBT) ordinance. Local Governments in the Philippines could replicate the services provided through KB. Local executives need to prioritise HIV and health care providers need to be innovated in their approach to dealing with MSM.

Box 4: ASEAN Cities Getting to Zero – A best practice example in the Philippines

Towards the End of HIV – 2015 Onwards



5.1 New Global Targets

As the world contemplates the way forward following the 2015 deadline for the targets and commitments in the 2011 Political Declaration on HIV and AIDS, a final target is needed to drive progress towards the concluding chapter of the AIDS epidemic, promote accountability and unite diverse stakeholders in a common effort. This applies as much for the ASEAN region as it does elsewhere in the world. Whereas previous targets sought to achieve incremental progress in the response, the aim of the post 2015 era is to end the AIDS pandemic by 2030⁴³.

Globally, there is new narrative on HIV treatment and a new, final, ambitious, but achievable targets, and AMS are now exploring how to achieve these targets within the region:

- By 2020, 90% of all people living with HIV will know their HIV status
- By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy
- By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression⁴³.

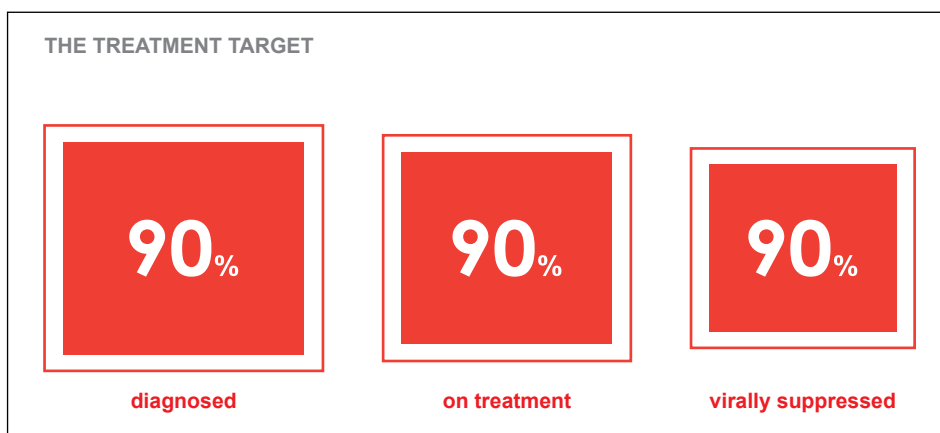


Figure 7: The Global Treatment Target for 2020 (UNAIDS)

Modelling suggests that achieving these targets by 2020 will enable the world to end the AIDS epidemic by 2030, which in turn will generate profound health and economic benefits⁴³. HIV treatment is a critical tool towards ending the AIDS epidemic, but it is not the only one. While taking action to maximize the prevention effects of HIV treatment, urgent efforts are similarly needed to scale up other core prevention strategies, including elimination of MTCT, condom programming, pre-exposure prophylaxis (PrEP), harm reduction services for people who inject drugs and focused prevention programming for other KP. To put in place a

comprehensive response to end the epidemic, concerted efforts will be needed to eliminate stigma, discrimination and social exclusion⁴³.

Ending AIDS will require uninterrupted access to lifelong treatment for tens of millions of people, necessitating strong, flexible health and community systems, protection and promotion of human rights, and self-replenishing financing mechanisms capable of supporting treatment programmes across the lifespan of people living with HIV. As new technologies arise – including simpler, more affordable diagnostics; simpler, better tolerated ART; and ultimately longer-lasting and more affordable ART that overcome the need for daily dosing – political will, system preparedness and timely adoption and implementation of global normative guidance will be needed to bring these new tools to scale.

Reaching the internationally-agreed AIDS targets, towards the vision of Asia and the Pacific with zero new HIV infections, zero discrimination and zero AIDS deaths, requires:

- Strengthening political leadership and national ownership, as well as fully involving people living with HIV and key populations at all stages of the AIDS response
- Enhancing HIV prevention efforts, with particular focus on key populations at highest risk and geographical hotspots within countries
- Speeding up, expanding and sustaining HIV testing and counselling and access to antiretroviral treatment, including community-based HIV testing
- Continuing and augmenting efforts to procure affordable medicines, diagnostics and prevention commodities for the region and beyond
- Involving affected communities and networks at all stages of the AIDS response - from planning to delivery and monitoring
- Advancing human rights and gender equality through the removal of laws, policies and practices that fuel stigma and discrimination, violate rights and hamper the AIDS response
- Increasing and sustaining domestic resources for HIV and ensuring funding is directed to where it will have the greatest impact⁷.

ASEAN Post-2015 Health Development Agenda

The ASEAN Post 2015 Development Agenda specifically prioritises issues which directly relate to the HIV response, including promotion of mental health, prevention of communicable diseases, strengthening laboratory capacity, and universal health coverage. The Agenda acknowledges that there is a continuing need to achieve the unfinished health-related MDG including MDG 6 which targeted HIV and AIDS, Malaria and other diseases.

5.2 Regional Cooperation to Achieve Universal Access to HIV Prevention, Treatment, Care and Support in Asia and the Pacific Beyond 2015

The Asia-Pacific Intergovernmental Meeting on HIV and AIDS met in Bangkok, 28-30 January 2015¹ and endorsed the Regional Framework for Action on HIV and AIDS beyond 2015. The proposed framework is focused on several thematic areas to advance the implementation of commitments made at the regional and global levels. These include the following:

(a) **Accelerating the removal of legal and policy barriers to achieve universal access**, building on the achievements in recent years in identifying the legal and policy barriers that hamper the effectiveness of AIDS responses in the Asia-Pacific region through national reviews and multi-stakeholder consultations and programmatic efforts aimed at eliminating stigma, discrimination and violence against people living with and affected by HIV, as well as key populations.

(b) **Effectively engaging communities in the AIDS response for programme delivery**, through local financing and task shifting for community-led implementation of HIV programmes that address structural, cultural and social barriers to effective AIDS responses within local communities; in addition, addressing the needs and concerns of youth should be an integral part of national reviews and multi sectoral consultations in line with the commitment made in the 2011 Political Declaration.

(c) **Enhancing financial sustainability, national ownership and capacity**, as well as committing a greater proportion of national resources using the evidence of national HIV investment cases and sustainability plans to improve the programmatic effectiveness, targeting and quality of responses to HIV, including innovative domestic financing approaches and strategies.

(d) **Continuing regional mechanisms to sustain momentum and reporting on progress made in fulfilling regional and global commitments on HIV and AIDS**, through the implementation of a regional framework for action on HIV and AIDS beyond 2015, comprising a set of proposed activities that could feed

¹ The Regional Framework for Action on HIV and AIDS beyond 2015 is for ASEAN's reference only.

into national efforts already under way to meet commitments made in the 2011 Declaration and Commission resolutions 66/10 and 67/9 (see Figure 7).

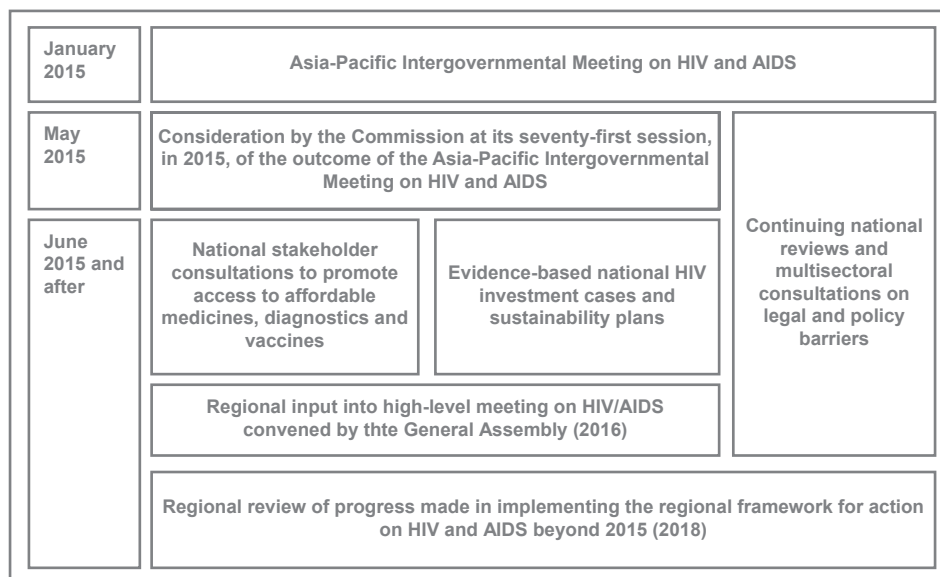


Figure 8: Regional Framework for Action on HIV and AIDS Beyond 2015

5.3 Investment Cases

A cross-cutting issue in all thematic areas is the question of how AMS can continue to resource the scale up of the response to HIV. Donor funds are shrinking; a number of donors have scaled back their support or have withdrawn completely. The Global Fund, which continues to make funding available to a number of AMS, is now implementing its new funding model (2012 - 2016). In the new model, the foundation of the funding application is the country's UNAIDS investment case which must be developed through an inclusive 'country dialogue' process that includes all stakeholders, but especially KP⁴³. The development of an investment case provides the opportunity for countries to map possible future trajectories of epidemics and the resources needed for different combinations of interventions and scale¹².

As argued in *Optimizing Viet Nam's HIV Response: An Investment Case*²⁶, if bold decisions are not made soon to increase domestic funding, Viet Nam will face a resurgence of HIV infections and AIDS deaths and very high future resource needs²⁶. This argument is relevant to all AMS where donor funds are principle source of funds for HIV programmes and which have supported programmes for PWID, MSM, sex workers and MSM. In the past, these programmes often

been politically sensitive, and donor funding has enable governments to be one step removed from potentially controversial programmes. To date, five AMS have developed investment cases – Viet Nam, Indonesia, Myanmar, Philippines and Thailand.

There has been progress across ASEAN in reaching the global targets. Nonetheless, there are ongoing challenges in taking evidence-based programmes to scale, especially those programmes prioritising KP, and where changes to the legal framework, such as decriminalisation, are optimal. At the regional level, as indicated in ASEAN declarations and ATFOA work plans, there is a good understanding of what is needed to end HIV by 2030. However, at the individual AMS level, the capacity to scale up programmes varies. There has been progress across ASEAN in reaching the global targets. Nonetheless, there are ongoing challenges in taking evidence-based programmes to scale, especially those programmes prioritising KP, and where changes to the legal framework, such as decriminalisation, are optimal. While this is partly to do with resource allocation, it is also, as identified by UNAIDS⁷ and others, about increasing levels of community engagement, facilitating community-based HTC, decentralising HIV treatment and care, and focussing efforts where they are most needed.

The ATFOA serves as a peer support mechanism. While it may be difficult to quantify ATFOA's impact, this is often the case within ASEAN, where support is directed towards achieving consensus and is consciously, non-confrontational. Given the outstanding challenges faced by the majority of AMS in achieving an end to HIV, a dedicated HIV-focussed task force continues to be an essential component for promoting for effective governance and keeping HIV high on the agenda at the regional and country levels. Mainstreaming HIV within a broader health programming framework holds a strong risk that the momentum generated through ATFOA will be lost including the invaluable knowledge sharing, policy development and advocacy work.

5.4 Possible Options for Considerations as Part of Regional Approach to HIV under the ASEAN Post-2015 Mechanism

Post-2015 offers further opportunities for ATFOA to demonstrate its commitment to south-south collaboration and peer support in achieving global targets for ending HIV. A number of opportunities exist to build on the achievements of AWP IV and support the achievement of targets for 2020 and the vision for 2030 of Zero New HIV Infections, Zero Discrimination and Zero AIDS-related deaths. There are common themes and issues by AMS on their HIV responses, particularly around ART coverage, prevention for KP and financing the response. It is important that AMS take the opportunity to shape the regional programme so that in reflecting the new global targets, it does so in ways which best support and enable AMS to

expand and consolidate their HIV responses. As such, there is a range of options and possibilities.

- 1 Leverage the good will and cooperation within ATFOA, and the advantages provided through the consolidation of the ASEAN Economic Community, to encourage AMS to commit more domestic funding for HIV programmes, including targeted prevention for KP and strategic and economic support for those AMS who are currently more reliant on international development assistance.
- 2 Embed the political capital for the ASEAN HIV response at regional, national and local levels. Use this capital to address ongoing issues and challenges around decriminalisation of sex work and male-to-male sex and managing epidemics in PWID.
- 3 Address programmatic gaps, as identified in the Phase II Regional Assessment of the Getting to Zero Cities Project, for example, barriers to KP accessing prevention and treatment programmes. ATFOA has committed to conducting a workshop with key stakeholders from the cities participant in the Getting to Zero project including government and community representatives to forge a network for current and future collaboration. To complement this active engagement of KP, there is a need to create a platform by which KP can report on progress of government programmes and the quality of the partnerships between government and community through biannual report card. This can be applied at the regional and country level, for example, working with and through national and regional networks of KP.
- 4 Undertake joint programmes with regional KP networks such as Asia Pacific Coalition on Male Sexual Health (APCOM), Asian Harm Reduction Network (AHRN) and Asia Pacific Network of Sex Workers (APNSW) in collaboration with UNAIDS, and where relevant, the Global Fund.
- 5 Advocate through regional institutions and associations including the ASEAN Economic Community for affordable access to ART for all AMS, especially those with the greatest HIV burden. For example, the establishment of a common fund for the bulk purchase of ARV to obtain the best price possible and to encourage increased domestic production of ARV and OST by countries such as Thailand.
- 6 Focus the implementation of Treatment as Prevention (TASP) on specific populations in whom the prevention impact is expected to be greatest (e.g. sero-discordant couples, pregnant women, key populations).
- 7 Strengthen monitoring and evaluation of ASEAN-wide HIV programmes.

Ensuring the supply of ART, methadone, reagents and other commodities for the HIV response in Viet Nam

Currently, only 5% of ARVs are purchased using domestic resources and procurement processes; donors using international procurement mechanisms procure the other 95%. Donors also import the majority of the methadone used for the MMT programme. To ensure increased coverage of ART and MMT as donors withdraw, Viet Nam will need to scale-up the efficient procurement of ARV, methadone, reagents and other commodities using domestic funds and study the possibility of domestic production. Local production of methadone is expected to be considerably cheaper than importing methadone. Increasing domestic production will help to meet the growing needs of the MMT programme. In 2013, the Ministry of Health granted permission to five domestic companies that meet requirements to produce methadone; one company is already producing methadone for domestic consumption. Analyses of ARV procurement data in Viet Nam, suggests that the unit costs for domestically procured ARV drugs are much greater than the unit costs of the same medicines procured through international donor programmes, mainly due to the domestic procurement of small quantities. International experience also suggests that the careful review and revision of national procurement arrangements (centralized procurement) can lead to immediate and dramatic savings. In the longer term, Viet Nam will need to explore building local capacity to ensure the sustainable supply of affordable ARV drugs.

Optimizing Viet Nam's HIV Response: An Investment Case (2014)

Box 5: Strategies for procurement in Viet Nam

Country Profiles





BRUNEI DARUSSALAM

The prevalence of HIV in Brunei Darussalam is very low, with just 93 reported cases from 1986 to the end of 2013. Between 2011 and 2014, 45 new cases of HIV were recorded, a significant number relative to the total number of reported cases. In 2014, there were 15 HIV confirmed cases. Thirteen out of 15 were transmitted through sexual contact; two cases were recorded where mode of transmission was unknown. Only one out of 15 cases was female. Out of the 14 males, six cases were reported in MSM, indicating that they are a key population. There is no known transmission through sharing of injecting equipment and only one case of mother-to-child transmission recorded since 1995, which was in 2011. A total of nine other children have been born to five HIV positive women in the past seven years. Despite the low HIV prevalence, an increase in STI has occurred over the past decade.

Getting to Zero – The National Response

Brunei Darussalam is fully committed to ensuring universal and equitable access for comprehensive health care services. Free and comprehensive health care is available to all citizens and permanent residents of Brunei Darussalam. This includes HIV prevention, care, treatment and support, although there is no separate budget for HIV services or national HIV Strategy. First-line ARV are available to citizens and permanent residents. Provision of second and third-line ARV are subject to internal regulations. All eligible PLHIV have access to ART and care is provided through a specialist clinic under a consultant physician in infectious diseases. HIV is a notifiable disease under the Infectious Disease Act (2010) and it is compulsory for all clinicians to report any positive cases to the Department of Health Services. HIV surveillance is conducted through routine screening including - antenatal patients, blood donors, tuberculosis patients, workers during routine pre-employment medical check-ups, foreign workers, prisoners and those in drug rehabilitation.

Gaps and Challenges

There is no behavioural or prevalence data available in relation to general population or key populations such as MSM, FSW, PWID or TG. There is a lack of prevention and treatment services targeting KP, particularly MSM, who appear to be the population predominantly affected by HIV in Brunei Darussalam. There are no specific prevention or outreach programs for MSM and TG. Current laws prohibiting homosexual acts and cross-dressing make these groups difficult to target and are a barrier to the formation of peer support networks or associations.

Towards 2030 – Strengths and Opportunities

Although there is a gradual increase over time in the number of new diagnosis each year, the availability of ART for PLHIV can significantly contribute to viral suppression, especially if the country adopts the most recent WHO guidelines on ART provision and continues to provide a high level of care for PLHIV.

Financing the Response

Brunei Darussalam's HIV response is fully funded through domestic sources.

Data is drawn from the Global AIDS Progress Reporting 2014 in Brunei Darussalam



CAMBODIA

In 2014, using AEM, there were an estimated 694 new adult infections and 156 children (0-14yrs). Sexual transmission is the primary mode of transmission, with around 48% of all new infections resulting from spousal transmission, 25% through sex work, and a further 11% from 'casual sex' in 2014. Sexual transmission among MSM is estimated to account for 3% of new infections in 2014 and injecting 13%. HIV prevalence among the general population, 15-49 years, has been steadily declining over the past decade from 2.0% in 1998 to 0.7% in 2013. The 2015 GARPR notes the high HIV prevalence 24.4% among PWID could allow this proportion to increase rapidly if unchecked.

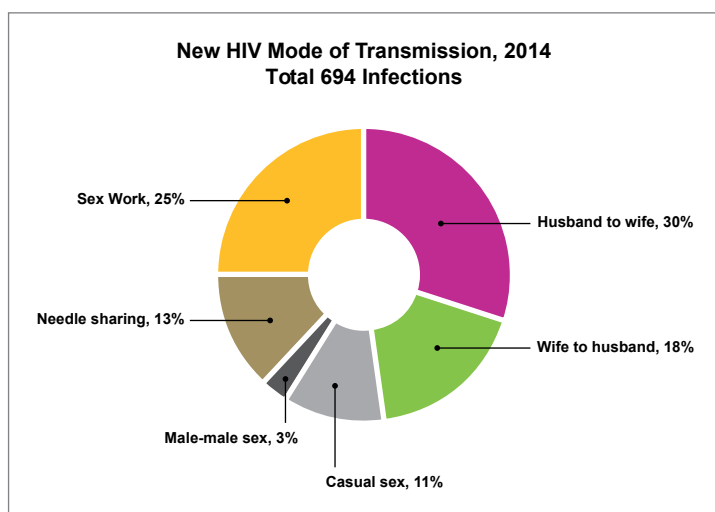


Figure 9: New Infections by modes of transmission in Cambodia 2014

Getting to Zero - The National Response

The NSP aims to provide a 'synergistic and comprehensive approach' to KP prevention and care through 'Boosted Continuum of Prevention to Care and Treatment'. This approach aims to identify newly diagnosed PLHIV to ensure they are brought into, and retained in treatment, through targeting areas where new infections are occurring among KP. A National Harm Reduction Strategy has been developed, but not yet formally launched. The strategy has five objectives: to expand NSP to more PWID; MMT scale up and scale up access to and provision of other key health interventions for PWID; strengthen strategic information base; and ensuring an effective enabling environment in support of harm reduction for PWID.

Cambodia is completing the implementation of its 3rd NSP (2011-2015). During the life of the plan, there has been an increasing recognition of the importance of policy and innovation in building and maintaining an effective approach to the epidemic. In 2014, the Chief of Technical Bureau, National Center for HIV/AIDS, Dermatology and STDs (NCHADS) undertook a process of capacity building with national leaders, policy makers, programmers, civil society and key populations to increase collaboration and better utilise the resources of all stakeholders in the response. This process has taken into account the global context in which international funding has been reduced and the need to both increase domestic funding and build local ownership of the response.

Gaps and Challenges

Cambodia faces a number of challenges over the next five years in relation to securing funding and ensuring the effective and efficient use of resources. There is a need to increase domestic funding for HIV. However, at the national level HIV will potentially have to compete with other high prevalence diseases for national attention and resources. There is a need to increase the retention of PLHIV in care and treatment and to implement the harm reduction strategy. Among KP the level of HIV risk is variable, and currently many people in these populations at relatively low risk are reached and tested frequently, while others at higher risk may not be reached at all. For example, community-based finger prick testing for HIV among KP since 2013, has returned very low rates of HIV positivity, indicating that while overall coverage is high, those at highest risk are not being reached.

ART coverage has increased from 68.0% in 2013 to 78.9% in 2014 although 12 months retention in ART has declined from 84.5% in 2013 to 75.9% in 2014. All health facilities dispensing ART experienced a stock-out of at least one required ART in 2014. Drop out occurs at every point of the cascade of prevention, diagnosis, treatment and care and there is a lack of strategic information to assist in identifying both the number of people diagnosed and level of drop out at various points of the cascade. The percentage of referral cases for both TB and HIV has increased gradually from 40% in 2007, to over 80% in 2011-12. However, the proportion of HIV+ incident TB cases receiving treatment for both HIV and TB decreased significantly from 57.2% in 2014 to 23.6% in 2015.

Towards 2030 – Strengths and Opportunities

Cambodia is developing its NSP for the period 2015-2020 in the context of the vision of The Three Zeros. The three primary objectives are: to reduce the estimated HIV incidence among the population aged 15 years and older from 18/100,000 to 3/100,000 or less by 2020; reduce the HIV transmission rate from HIV positive mothers to their infants from 13% in 2010 to 5% or less by 2020; and maintain estimated current HIV/AIDS related mortality rate at or below 0.05/100,000. One of the strengths of the Cambodian response is the recognition of the need to target and adapt responses to the changing epidemic and resource





environment. For example, Cambodia is investigating how it can scale up programmes identifying those KP that are most at risk for HIV testing and other prevention services while scaling back home and community-based care, now that the need for the this care is diminishing due to the effectiveness of ART.

Data is drawn from 2015 Cambodia Country Progress Report

INDONESIA

Overall, HIV prevalence in Indonesia is low. However, as a large and diverse country made up of thousands of islands, it is not surprising that epidemics vary across the archipelago. Epidemics in Indonesia tend to be concentrated among KP, with transmission routes a mix of sexual and injecting. While the general population prevalence overall is low, the prevalence in West Papua is 2.4% and the primary mode is now sexual transmission.

There has been a shift in the proportion of inject versus sex as the primary mode of transmission. In 2007, 49.8% of infections were attributed to IDU and 41.8% to heterosexual transmission. By 2011, heterosexual transmission was 71% and PWID 18.7%. Asian epidemic modelling projects 541,700 people will be HIV+ by 2014 without accelerated prevention. New infections in PWID are projected to decrease from 40% in 2008 to 28% in 2014, while infection through sexual transmission will rise from 43% to 58%, and it is expected that this trend will continue. Increases in the number of newly diagnosed reflects, in part, improved access to testing, with 42,662 PLHIV identified during the preceding two years. The cumulative number of infections in Indonesia has risen sharply from 7,197 in 2006 to 76,879 by 2011.

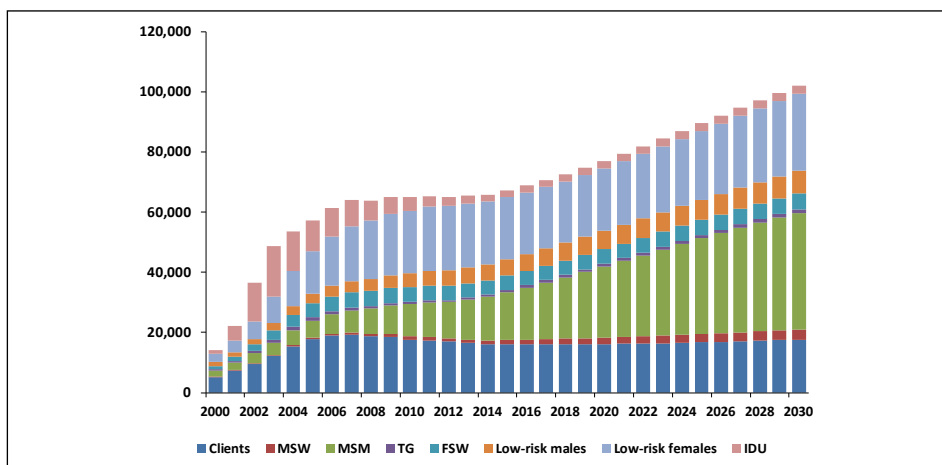


Figure 10: Estimated and projected number of annual new infections by population group in Indonesia 2013

Getting to Zero – The National Response

Recent data suggests HIV transmission may be slowing but continues to expand among some KP, particularly, MSM. IBBS data from 2013 suggests that some progress has been made in stabilising sub-epidemics in some KP and in the general population in West Papua. Some success has also been made in

increasing the number of eligible persons on ART, but continues to fall short of the annual number of new infections. There are also insufficient ART retention rates, and as a consequence the potential impact of ART on prevention and mortality is limited¹⁴. The Indonesia investment case (2015) shows that if the highest level of investment were to be adopted, the number of PLHIV would peak at 702,000 in 2019 and would fall to 509,000 in 2030. The annual number of new infections would fall from 66,000 in 2013 to 32,600 in 2020 and 17,400 by 2030. This indicates that even while Indonesia could achieve substantial impact on their epidemic through high-level investment, it cannot end HIV by 2030.

Gaps and Challenges

To implement the best case scenario described in the investment case, Indonesia will need to go from an investment of an estimated US\$108 million per year to US\$211 million per year between 2014 and 2020 and US\$330 million per year between 2021 and 2030, although it would begin to decline from 2027. Therefore, significant new funding needs to be secured.

Towards 2030 – Strengths and Opportunities

The scale up of the LKB – Integrated, Decentralized Continuum of Care Services, will potentially produce both cost savings and reduce HIV morbidity and mortality through targeting communities with the highest burden for ART.

Data is drawn from 'The Case for Increased and More Strategic Investment in HIV in Indonesia, 2015' and the 'Republic of Indonesia Country Report on the follow up to the Declaration of Commitment on HIV AIDS, 2012'

LAO PDR

Lao PDR has a very low prevalence of HIV among the general population at 0.29% but shows an increasing trend from 0.16% in 2003 to 0.29% in 2014. This trend may reflect a rise in cross border migration, especially given there is higher HIV prevalence in nearby countries. The establishment of the ASEAN Economic Community has improved transport and communication and provided more employment opportunities, which facilitate ease of migration. It is estimated that there are approximately 200,000 migrant workers in the Lao PDR, primarily in the construction industry. Sex is the primary mode of transmission and heterosexual contact accounted for the majority, 88%, of transmissions between 1990-2014. The second most common mode of transmission is mother to child, 4.9%, although it is noted that there is limited data on MTCT. The highest prevalence of HIV is found in KP, primarily MSM 1.6%, injecting drug users 1.5%, and sex workers 1.4%.

Getting to Zero - The National Response

The National Strategic and Action Plan (NSAP) 2011-2015, outlines a goal to maintain the present low level of GP prevalence below 1% and ensure seroprevalence among KP is below 5% by 2015, a goal that has already been achieved. For the next NSAP, the aim is to reduce KP prevalence to below 3%. To achieve a decrease in HIV prevalence in KP, a number of strategies have been implemented including a condom social marketing campaign, with an average of four million condoms sold over the past 3.5 years, representing 115% above target. A pilot harm reduction project, 'Greater Mekong Sub-region Capacity Building for HIV and AIDS Prevention Project' was implemented in two provinces supported by Australian AID and the Asian Development Bank (ADB). The pilot project concluded in 2014 and the government is currently negotiating for continuation of the project. Lao PDR is committed to reducing MTCT and counselling is currently offered at ANC across four provinces for all pregnant women and their partners, and testing rates have improved significantly from 4% in 2008 to 55% in 2013. There is an intention to scale-up counselling and testing services at ANC to cover all provinces by 2020.

ART coverage was 57.7% in 2014, a slight reduction from 2013 figure of 58.26%. Lao PDR appears to be achieving a relatively high ART retention rate of 85.2% at 12 months. HIV testing has expanded over the past six years to 172 sites in 2014. There is also a significant investment in new testing approaches such as mobile point of care testing and the use of rapid HIV tests for KP.

The Management of HIV and tuberculosis has seen improvements in testing and treatment. In 2013, 56% of TB patients had received an HIV test result and this increased to 70% in 2014. WHO guidelines relating to prevention of TB have been

implemented and 79% of TB-HIV patients received Cotrimoxazole preventive therapy in 2013. Isoniazid preventive therapy has been initiated in nine sites, with 100% of people enrolled in HIV care having their TB status assessed over 12 months. The proportion of TB-HIV patients on ART is not systematically reported but the intention remains to improve collaboration and reporting.

Significant progress has been made on stigma and discrimination including the introduction of the HIV/AIDS Control and Prevention Law 2010 that addresses the rights of KP, although sex work remains illegal. The Lao Social Indicator Survey (LSIS) conducted in 2012 found high levels of stigma and discrimination against HIV among the general population. Government support for the development of NSAP 2016-2020 and the passing of the 2010 law on HIV control and prevention with its emphasis on addressing stigma and discrimination and promoting equality are put forward as examples of best practice.

Gaps and Challenges

The national HIV programme still falls short on several of its targets, with concerns that in the care and treatment cascade there is a significant loss to follow up (see Figure 11) . Testing rates for KPs need to be increased. It has been identified that there is a need to streamline and make services more accessible, improve technical and organisational capacity, create demand for testing among KP and promote ART adherence. At present, only 57% of the estimated number of PLHIV are diagnosed and of these 83% are enrolled in care. Coverage for ART for 3,040 PLHIV is below the target of 5,283. Inadequate procurement and stock systems have long been identified as a problem though there have been some recent improvements achieved with the support of funding from the Clinton Health Access Initiative.

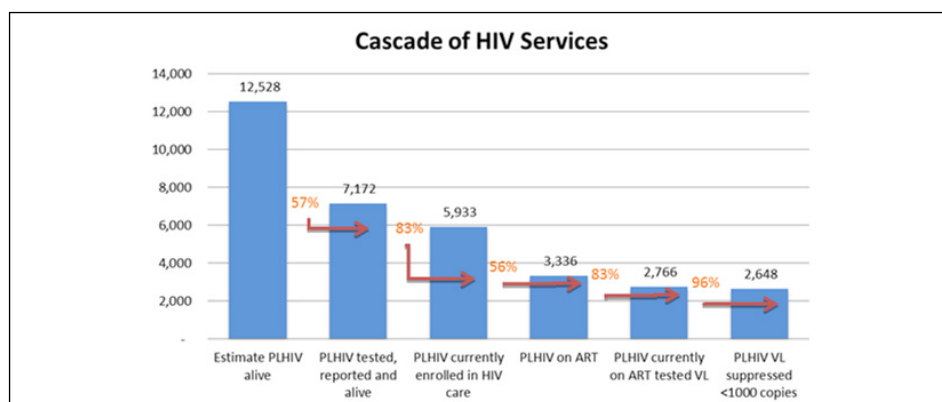


Figure 11: Treatment Cascade in Lao PDR 2014

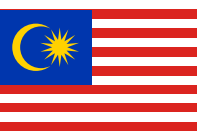
Towards 2030 – Strengths and Opportunities

The shift in the economy to lower middle-income country opens up the capacity for Lao PDR to draw on more domestic funding to maintain some of the achievements around reducing prevalence in KP. The Centre for HIV/AIDS and STI (CHAS) is seeking to manage the contradictions between existing laws in sex work is illegal and best practice in prevention.

Financing the Response

Funding for the HIV response in Lao PDR is 80% from international sources and 20% from public sources.

Data is drawn from the Lao PDR Global AIDS Response Progress Report, 2015



MALAYSIA

There are an estimated 91,848 PLHIV nationwide in 2014, about 0.44% of the total population. There has been a shift in transmission route trend overtime from injecting to sexual transmission. In 1990, only 5.3% of transmission was attributed to sexual transmission, increasing to 18.9% in 2000, 48.5% in 2010 and 78.3% in 2014.

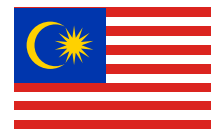
Among men, 21.5% acquired HIV via injecting drug use and 73.6% through sex while most new HIV infections amongst women have occurred through heterosexual transmission. The MOH profile of female HIV cases in 2014 indicated that almost 20% were below 25 years, 92% had acquired HIV through sexual transmission and 40% were women who were infected via their HIV+ spouse. Overall, the epidemic is concentrated among key populations: PWID, sex workers, transgender and MSM. The most recent IBBS indicated that the prevalence of HIV in sex workers in 2012 is 4.2% and 7.3% in 2014, MSM 7.1% in 2012 and 8.8% in 2014, PWID 18.9% in 2012 and 16.6% in 2014, and TG 5.7% in 2012 and 5.6% in 2014. With the exception of MSM, prevalence appears to be declining among KP (see Figure 12).

Risk Factor	1990	2000	2010	2030
Injecting drug use	470 (60.4%)	3,815 (74.7%)	1,737 (47.6%)	680 (19.3%)
Sexual Transmission	41. (5.3%)	964 (18.9%)	1,773 (48.5%)	2,572 (73.8%)
Heterosexual	38 (4.9%)	902 (17.7%)	1,472 (40.3%)	1,768 (50.3%)
Homosexual	3 (0.4%)	62 (1.2%)	301 (8.2%)	985 (28%)

Figure 12: Percentage of new HIV cases by risk factor in Malaysia 2104 (MOH 2014)

Getting to Zero – The National Response

In 2013, ART coverage was 17,369 or 47% of the 37,274 who were eligible. Although there is a significant gap in coverage, the retention rate at 12 months is strong at 95.1%. First line ART is available at no cost, including for those in 'closed settings' i.e. prisons and drug rehabilitation. Second line treatment is also available and funded through the Ministry of Health. It is expected that from 2014, new HIV infections will decline for most KP, with the exception of 'low risk' male and female sex workers. Asian epidemic modelling indicates that HIV prevalence among PWID will stabilise at 14%, MSM 9%, FSW 3% and transgender 6%.



Needle and syringe programmes and MMT are the cornerstone of the prevention programme for PWID and have been undertaken in collaboration with NGO, generating worldwide attention and praise. MMT is available through the National Anti Drug Agency (NADA) services and prisons, and there has been a significant shift in treatment for drug dependence from mandatory to voluntary rehabilitation centres. MMT is available in 18 prisons and approximately 160,509 (94%) of estimated total of 170,000 PWID have been reached through the harm reduction programme. The first harm reduction programme was piloted in 2005 and implemented nationwide in 2006. In addition to the NSEP, OST and MMT, the harm reduction programme offers other services such HIV counselling and testing, job placements and drug rehabilitation. Harm reduction is now included in police training and the in the training manual for religious leaders. There is an MMT programme operating out of a mosque at the University of Malaya, indicating the extent to which harm reduction has been mainstreamed.

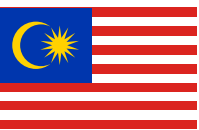
HIV spending has increased every year, and in 2013 total expenditure was calculated at around RM 181 million (USD 56.5 million), an increase of 2.6% on the previous year. Of Malaysia's expenditure on HIV, 95% was through government funding. The majority of expenditure (66%) was spent on care and treatment, reflecting the aim to scale up ART coverage.

Gaps and Challenges

Malaysia has identified a number of on going challenges. These include addressing low knowledge levels among young people, and the need for an increased health workforce if scale up of testing and treatment is to succeed and 100% PWID eligible are to receive OST. Greater investment will be required in the health system, including primary care to improve coverage and integration of HTC, PMTCT, ART, TB and sexual and reproductive health. Currently, the gap in early TB screening of PLHIV contributes to late diagnosis and high mortality rates. There is also a pronounced need to involve private health providers in PMTCT. Better outcome indicators are also required for stigma and discrimination and gender based violence, including the development of an operational plan to address these issues.

The Malaysian response to HIV with its increasing focus on harm reduction has underwritten the paradigm shift from punishment and law enforcement to public health – criminal to patient. Despite some limitations in the respective laws, Malaysia embarked on public health approach in addressing the issues. For example, as informed by the surveillance data, the harm reduction programme using a public health approach has seen new cases decline more than 70% in PWID.

Towards the elimination of HIV vertical transmission by 2015, the PMTCT program was rolled out nationwide in 1998 and is available at all government health clinics



and hospitals. These programmes focus on detection of HIV infection during pregnancy, safer delivery, ARV prophylaxis for infants and safer infant feeding practices. Coverage of HIV positive mothers through public facilities improved from 49.7% in 1998 to almost 100% in 2013.

Despite these positives, civil society organisations often struggle to achieve financial sustainability, limiting their capacity to develop effective and meaningful engagement with KP. There are a lack of HIV prevention programmes and implementing partners to address sexual transmission in the MSM population. Because of social barriers and self-stigma, MSM populations have indicated that they prefer HTC in the community rather than through government services.

Towards 2030 – Strengths and Opportunities

Declining rates of HIV in PWID indicate the success of harm reduction programmes. Consultations with CBO and key-affected representatives were conducted to ensure their inputs and concerns were reflected into the NSP and civil society also contributed to the Mid-Term review of the NSP. Malaysia is well placed to continue to strengthen the relationship between government and civil society over the life of the next NSP and mobilise the same energy, policy shift, involvement of religious and political leaders that has occurred in relation to PWID to other KP and issues of sex and sexuality.

Financing the Response

The total expenditure on HIV has increased almost every year since the early years of the epidemic. In 2013, total expenditure was calculated at around RM 181 million (US\$56.5 million), an increase of 2.6% on the previous year. Of the country's expenditure, 95% was through public funding.

Data is drawn from the Malaysia Global AIDS Response Progress Reports for 2014 and 2015

MYANMAR



The response to HIV in Myanmar is dynamic with significant shifts in policy and programming in recent years, including a move towards decentralised services. HIV is concentrated among MSM, PWID and FSW, with a general population prevalence of 0.54% in 2014. The highest number of HIV infections are found in urban areas and the north eastern and northern parts of the country where injecting is widespread. In 2014, 9000 new infections were identified, with the highest numbers in Kachin, Yangon, Shan, Sagaing and Mandalay. Unsafe injecting practices remain the primary mode of transmission, but there is also significant number of infections through heterosexual and MSM (see Figure 13). Low risk women make up a high proportion of new infections through heterosexual sex, as a result of sex with husbands and regular partners where condom use is low.

General population prevalence is trending down and is estimated to continue to decline to around 0.44% by 2021. While the prevalence among KP is high, HIV sentinel surveillance (HSS) indicates a decline from 2012-2014 among KP with the exception of PWID. HIV prevalence in PWID is 28.3% (IBBS 2014) 23.1% (HSS 2014); FSW: 7,1% (2012) & 6.3% (2014), MSM: 8,9% (2012) & 6,6% (2014). For MSM, prevalence is significantly higher - 25% among those aged 35-39 years. Epidemiological modelling estimates 212,000 people are living with HIV of which 34% are female. In 2014, there were 11,000 AIDS related deaths, a decline from 15,000 in 2011.

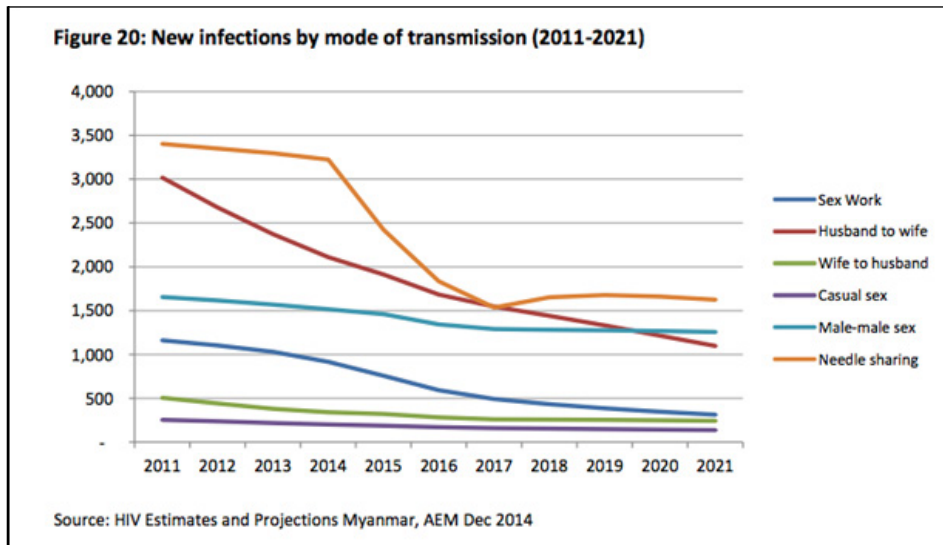


Figure13: New Infections by modes of transmission Myanmar in 2014



Getting to Zero – The National Response

HIV is priority disease in the current National Health Plan (2011-2015). Efforts to reduce stigma and discrimination have included a review of the legal framework and a plan to operationalize a series of recommendations related to existing, restrictive laws. There are challenges around community resistance to NSEP with people unwilling to host them in their neighbourhoods, and the need to educate the public and promote the public health benefits of NSEP. In addition, in future, NSEP need to become entry points for drug use treatment. Another issue is that carrying injecting equipment remains illegal and is used as evidence of injecting by the police.

In 2014, an additional US\$1 million in domestic contributions was provided for methadone maintenance treatment, and an additional US\$5 million in domestic contributions was allocated for ART in 2015. Decentralisation of treatment services is allowing people to access interventions closer to where they live, reducing costs to the patient and promoting the normalisation of HIV disease. Further, in 2014 the testing policy was reviewed to allow community based rapid testing by NGO. Much emphasis is placed on promoting early HIV testing and enrolment in care to improve patients and community outcomes. The shift to decentralise HTC and treatment will increase reach and take the pressure off the main ART centres, allowing them to focus on more difficult cases. In many cases, once PLHIV are stabilised on ART, they will no longer need to attend a major ART centre. Routine monitoring indicates that more MSM were reached in 2013 than 2012. The NSP was extended by one year from 2011-2015 to 2016 to align with the end of the Global Fund grant, and development of a new NSP (2016-2020) is underway.

Coverage of interventions to reduce sexual transmission increased in the period 2012 to 2013, facilitated by increases in spending. There was an 11% increase for FSW programmes in 2013 and the number of FSW reached increased by 25%. However, funding for MSM programmes decreased by 15%, although this does not appear to have negatively impacted on the reach of interventions among this population. With the exception of 2012, when the funding flow for HIV related interventions slowed, the distribution of injecting equipment has increased. There is also a significant scaling up of MMT, and the number of sites providing MMT increased from 28 in 2013 to 41 in 2015 with 9080 people received MMT by June 2015.

Overall, ART services have expanded and the number of sites providing ART has increased by 37 in 2014. Of these, 108 compared to 100 in 2013, are offering paediatric specialist ART services. ART retention at 60 months was 75.1% indicating a need to improve treatment retention over time. Myanmar introduced eligibility for ART at 500 CD4 in early 2015 and using domestic funding from the MOH budget and Global Fund resources aims to increase treatment coverage

to 90% of PLHIV by 2020. By June 2015, ART coverage based on all PLHIV is 45% and coverage among those eligible for ART with CD4 less than 500 is 59%.

Following the reform process and national elections, the government has begun a process to review many of its laws and enact new legislation. The government initiated a consultative process with relevant government ministries, United Nations agencies, and local and international non-governmental organisations to discuss a draft proposal that resulted in proposed amendments to the 1993 Narcotics Drugs and Psychotropic Substance Law submitted to the President's Office. The focus of the discussions has been on providing adequate and relevant treatment for drug users rather than imprisonment, reducing sentences to make them more proportional to the crime, and creating a legal framework to support harm reduction. Advocacy efforts have also been undertaken to revise the Burma Excise Act 1917 and other legislation such as the Suppression of Prostitution Act 1949.

Gaps and Challenges

Prevention needs to strengthen its focus on clients of sex workers and increase coverage for MSM and PWID. Stronger political commitment will be required to achieve legal reform. Stigma and discrimination is high and is therefore a priority. For example there is evidence that orphans and children with HIV experience discrimination in relation to education and from extended family. Identified priority areas include scaling-up prevention services, early HIV testing and enrolment in ART to improve treatment as prevention result. There is still a need to make services more user-friendly, particularly KP such as MSM. Myanmar is on track for zero new infections among children, although due to gaps in the data it is not clear for example what percentage of infants born to an HIV positive mother received a virological test for HIV within two months of birth. As well, strategies to promote recruitment and retention of staff need to be explored, as well as further opportunities for task shifting.

There is also a need to strengthen the role of CSO in the HIV response particularly in relation to addressing issues of stigma and discrimination. Additionally, the processes around the negotiation of memorandum of understandings need to be improved to facilitate CSO coming forward to provide services particularly for PWID (GARPR 2015). There is a continuing need to address laws in relation to control of communicable diseases, sex work and drug use so that they do not negatively impact on HIV interventions. There is resistance among some ethnic and faith-based communities, and an on-going need for community education. One recent positive development in terms of community education has been to engage well-known Football players to serve as advocates to mobilise support KPs and PLHIV. Gaps in the monitoring and the evaluation system were identified in the MTR, such as poor telecommunication and insufficient human and financial resources. Strategies to address gaps will be included in the next NSP.





Towards 2030 – Strengths and Opportunities

Myanmar's response to the HIV epidemic demonstrates the Government's commitment to creating a supportive, enabling environment. The results of the mid-term review of the NSP have been used to design the new NSP. Proposed changes to the new NSP were discussed and agreed upon by a large number of representatives from government, civil society, the UN and donor agencies. This process has generated further good will and collaboration among partners. There is an increasing level of involvement of civil society, including PLHIV groups, with representation on key working groups and the Myanmar Health Sector Coordination Committee. The Parliamentary Committee on Population and Social Development, Rule of Law and Human Rights has been encouraged to allow civil society a more meaningful participation in HIV-related policy reforms. It is recognised that continued efforts are needed to strengthen the role of civil society in the HIV response.

There is a clear recognition of the importance of strategic information, and in 2013 Myanmar set 15 priority actions to be taken in the years ahead to strengthen monitoring and evaluation systems. Surveillance systems are in place and bio-behavioural surveys among KP have been conducted. Governmental and legal reforms currently under discussion are anticipated to facilitate the growth of a favourable environment for HIV prevention interventions for key populations and strengthen support for PLHIV. The new NSP (2016-2020) aims to build on the progress achieved to-date, with a focus on fast-tracking the national HIV response. By implementing and reinforcing a continuum of HIV prevention, care and treatment and continuing to strengthen strategic information and community systems, Myanmar aims to end HIV as a public health threat by 2030.

Financing the Response

Funding for the current HIV prevention and control activities are mainly from international sources. The public sector contribution increased from 2% in 2012 to 8% in 2013 of total HIV spending. The Ministry of Health made an additional US\$6 million in domestic contributions to the national response and has committed to increase domestic financing. The Government of Myanmar will develop a financial transition plan in 2015-2016 to ensure a sustainable national HIV response.

Data is drawn from the Myanmar Global AIDS Response Progress Report 2015 and Investing for Impact, From Resources to Results: Getting to Zero in Myanmar 2013

PHILIPPINES



The Philippines has a concentrated and rapidly growing epidemic among MSM and PWID, particularly in urban areas. General population prevalence is low and estimated to be 0.051%. The rapid spread of HIV infections among key populations is primarily due to the sharing of needles and syringes in PWID and unprotected sex in MSM. An explosive HIV epidemic among PWID exists in Cebu City: in 2008, HIV transmission in Cebu was primarily due to sexual contact (90%), but by 2012 it was primarily the result of injecting drug use (77%). Biological and behavioural surveillance data collected in Cebu City reported HIV prevalence in PWID at 54%, with Hepatitis C prevalence reaching 94%. The same study found that 15% of freelance female sex workers had injected drugs, and among male injectors, 24% reported same sex behaviours. There are an estimated 6000 PWID in metro Cebu, of which the majority share their injecting equipment. Low levels of condom use are reported between PWID and their partners. With regards to MSM, the other, critical KP, data from sentinel sites monitored since 2005 shows an upward trend nationally (see Figure 10).

Key Population	2007	2009	2011	2013	2015
Female sex workers in Registered Entertainment Establishments (RFSW)	0.0%	0.23%	0.13%	0.07%	n/a
Freelance female sex workers (FFSW)	0.05%	0.54%	0.68%	1.03%	n/a
Males who have sex with males (MSM)	0.30%	1.05%	2.12%	3.50%	4.9%
People who inject drugs (PWID) in Cebu	0.40%	0.59%	53.8%	52.30%	5.3%

Figure 14: HIV Prevalence in key populations in the Philippines

There is low HIV knowledge among young people, with only 20% being able to accurately identify ways to prevent HIV infection and recognise misconceptions about how HIV is transmitted. In 2013, the number of SW reached with HIV prevention programmes was 48% (IHBSS, 2013), condom use with most recent client was 47.4%, and 12.6% of sex workers had received an HIV test in the past twelve months and knew the result. Data from the 2013 IHBSS indicates that only 22.6% of MSM were reached by prevention programmes, 40.7% used a condom for last anal sex and 9.3% had received an HIV test and knew the result.

Getting to Zero – The National Response

While ART coverage is improving - from 19.8% (2012) to 43.1% (Aug 2015), it remains low. The total number of adults and children receiving ART is 11411, with 26,440 PLHIV estimated to be eligible for ART. Retention at 12 months is 86.0%.



National AIDS/STI Prevention and Control data on PLHIV who have started on TB treatment in 2013 is 525 and the number enrolled in care with co-infection is 796, a coverage level of 65.95%. The percentage of pregnant women who received ART to reduce MTC was 7.59% and there is no data on the number of women who were provided with ART during the breast feeding period and on whether babies born to an HIV positive women received a virological test for HIV within two months of birth. Based on modelling in 2012, the number of children 0-12 who will be newly infected with HIV will be 110 or 30.22%.

The ASEAN Getting to Zero Project has been rolled out in 33 sites in the Philippines. The key achievements of the project have been to get Local Government Units (LGU) to assess their existing response to HIV and AIDS, and in some cases, reactivate non-functional local AIDS coordinating councils. The project has also provided an opportunity to collect information about local government-level responses to HIV and AIDS which, in addition to data from the IHBSS, has allowed the Philippines to get a better overall picture of the HIV situation. The project also offered an opportunity for the LGU to recognise the weaknesses and strengths of their HIV and AIDS services and provided an evidence base for planning and opportunities for the sharing of good practices among LGU.

Gaps and Challenges

The upward trend in PWID and MSM threatens the Philippines capacity to achieve The Three Zeros. There are challenges around the scale up of PMTCT; it is 'institutionalised' in the health system but only in high burden sites of Manila and Cebu. There are also likely to be challenges around implementing the new WHO guidelines for ART initiation given the low testing rates and late diagnosis. There are continuing challenges around prevention among KP particularly PWID and MSM. Data on PWID in the Philippines is only available for Metro Cebu. The Philippines has no NSEP or OST programmes at present for PWID.

Towards 2030 – Strengths and Opportunities

The Philippines National AIDS Council (PNAC) is proactive in many areas. It has created an executive committee to streamline decision-making. All regional health offices have been instructed to prioritise HIV. The opportunities: Global Fund, funding model and new project focuses on key populations – PWID and MSM, with the new project set to start in the last quarter of 2015. Funding for project totals US\$13.9 million and will focus primarily on prevention. The Department of Health (DOH) is moving toward fully covering the cost of ART, with 90% of ART costs covered by DOH since 2014 and PHP 30000 provided through the National Health Insurance Program for every PLHIV.

Financing the Response

In 2013, 468 million PHP or \$US10.8 million was spent on the HIV response. While this is a decrease from 2011 (US\$12.6 million) it is an increase from 2012 spending (US\$9.6 million). In 2013, public funding was 191,974,886 PHP, international funding 245,287,143 PHP and private funding 756,131 PHP. Funding levels seem to fluctuate, for example, spending on prevention increased in 2012 from 155,385,039 in 2011 to 247,554,335 PHP but declined again in 2013 194,682,933. Spending for treatment and care has increased over the last three years. The Global Fund is the biggest external contributor but there is an acknowledged need to increase the domestic budget for HIV.

Data is drawn from the Philippine Strategic Plan on HIV and AIDS, Mid-term Review 2014 ; The 2014 Global AIDS Response Progress Report, Investment Opportunities for Ending AIDS in the Philippines by 2022; and, the HIV/AIDS and ART Registry the Philippines March 2015





SINGAPORE

Singapore continues to have a low level epidemic. New diagnosis have been stable across the three year period between 2012 – 2014, with 469 new diagnosis in 2012, 454 in 2013 and 456 in 2014. Prevalence among the general population in 2014 was 0.15% (see Figure 15). The primary mode of transmission is sexual contact with 59% of the 6685 cumulative cases attributed to heterosexual transmission and 35% through homosexual and bisexual transmission. As a result of strict drug laws, intravenous drug abuse accounted for only 2% of all HIV cases at end 2014. In 2013 four new diagnoses were attributed to PWID and in 2014 only one case was attributed to PWID. The epidemic in Singapore is predominantly male, and as of December 2014 there were 6076 male cases and 609 female cases sex, a ratio of almost ten males to one female. HIV prevalence in MSM was 3.14% in 2013 and 3% in 2014. Prevalence in sex workers is very low at 0.04% in 2013 and 0% in 2014.

	2012	2013	2014
Number of newly diagnosed HIV cases	469	454	456
Number of PLHIV	4193	4558	4948
Known HIV Prevalence in resident population aged 15 and above	0.13%	0.14%	0.15%
HIV Prevalence among MSM	NA	3.14	NA
HIV Prevalence among sex workers	0%	0.04%	0%

Figure 15: Summary of HIV Status in Singapore

Getting to Zero – The National Response

HIV prevention and education is the core strategy of the national HIV/AIDS control programme in Singapore. The programme adopts a multi-sectoral approach which comprises public education and education of KP, HIV testing and counselling, protection of the blood supply, management of PLHIV, their contacts and others who have been exposed to the infection, surveillance of the disease and supporting legislation. The National HIV Policy Committee is a high level ministerial-chaired platform which sets the general direction for HIV management in Singapore. The National AIDS Control Programme is under the MOH and there is active involvement from other government agencies and the community and private sectors. The National Public Health Unit maintains the HIV registry and manages contact tracing.

Education and prevention is targeted at the general population and at key populations. Information on HIV testing and prevention is available from a wide variety of sources. Structured educational programmes targeted at youths, workplaces and at-risk groups (e.g. sex workers and MSM) are available through



the Health Promotion Board and Department of Sexually Transmitted Infections (STI) Control Clinic (DSC). For example, HIV prevention programmes for youths are largely focused on empowerment and education. An STI and HIV education programme entitled “Empowered Teenagers” (eTeens) has been implemented for youths aged 15-17, while initiatives such as the Guidelines on managing HIV and AIDS in the Workplace have been developed to help companies progressively achieve workplace education as well as enabling environments for employees with HIV. The DSC Clinic maintains a hotline for members of the public to provide advice on HIV testing.

Anonymous testing is available at ten sites. A total of 41,000 anonymous tests were carried out from 2012 to 2014, of which 1.45% were HIV positive. Voluntary opt-out testing is also done in healthcare settings, with 0.19% positive cases per 100,000 tests from 2012 to 2014. The majority of HIV cases are managed by the Communicable Disease Centre (CDC) and the Medisave scheme allows SGD\$550 a month to be used for ART. Medifund assistance was extended to ART from February 2010, and further subsidies were made available to eligible patients at public hospitals from September 2014. The overall aim of the Singapore HIV prevention and control strategy is to detect cases and prevent new transmission, i.e. getting to zero. Although this slogan is not used explicitly, the programme is aligned to this objective in policies and control measures.

Gaps and Challenges

Ongoing efforts are being made to address HIV-related stigma in the workplace through workplace programmes, experiential roving exhibitions and the broadcast of a television drama series. There is strong focus on reducing the proportion of late stage diagnosis by continuing to promote testing especially among high risk heterosexual men and MSM.

Towards 2030 – Strengths and Opportunities

The well-established and well-resourced health system in Singapore facilitates comprehensive testing, care and treatment, thereby maximising the prevention opportunities offered by Treatment as Prevention (TASP). Mature biological and behavioural HIV surveillance systems mean that there is solid data available for planning purposes. There is an opportunity to build on the monitoring and evaluation data to better understand the behaviours and needs of KP.

Financing the Response

The Singapore response is fully funded from domestic sources.

Data is drawn from the Singapore Global AIDS Response Progress Report 2015

THAILAND

Thailand is a good example of an AMS where public policy has been effective in preventing the transmission of HIV on a national scale over an extended period of time. In the 1990s, a massive programme focussed on increasing condom use especially among sex workers, achieved substantial reductions in new HIV infections and decreased prevalence of STIs dramatically. The 100% Condom Use Programme (CUP) was copied and adapted by other AMS.

Using the AEM for adults 15+ and Spectrum for children less than 15 years, there were an estimated 7,816 new infections in 2014 (see Figure 11). The trend is downward with 10,215 in 2010 and 8,877 in 2012. The decline in new infections has slowed with a 65% reduction between 2000-2010 and only a 23% decline from 2010, which falls short of national target of two-thirds of half.

Estimated Number	2000	2005	2010	2012	2014
Total annual new infections	29.619	16.014	10.215	8.877	7.816
• New infections in all adults*	28.241	15.266	10.011	8.719	7.695
New infections in women adults*	15.716	7.237	3.294	2.576	1.944
• New infections in all children	1.378*	748*	204@	158@	121@
New infections in girl children	669*	363*	99@	76@	59@
Total annual AIDS mortality	55.531	31.211	20.670	20.477	20.492
• AIDS mortality in all adults*	55.079	30.805	20.422	20.270	20.325
AIDS mortality in women adults*	12.036	7.153	6.079	6.116	6.127
• AIDS mortality in all children	452*	406*	248@	207@	167@
AIDS mortality in girl children	221*	199*	133@	114@	94@
Total people living with HIV	683.841	555.808	493.932	471.811	445.504
• All adults living with HIV*	676.005	544.743	485.646	464.086	438.629
Women adults living with HIV*	217.860	212.351	199.978	198.013	172.454
• All children living with HIV	7.836*	11.065*	8.286@	7.725@	6.875@
Girl children living with HIV	3.843*	5.428*	3.998@	3.698@	3.262@
Total population (million)	60.6	63.1	63.9	64.5	65.1

Figure 16: Estimating HIV infections in Thailand

Getting to Zero- The National Response

The Thailand NSP 2014-2016 aims to reduce new HIV infections by two thirds, peri-natal transmission to less than 2%, AIDS related deaths by half, and reduce discrimination of KP by half. The National AIDS Committee (NAC) approved the policy of working towards the ending the AIDS epidemic in Thailand by 2030, and directed all related agencies at national and sub-national level to mobilise efforts to achieve this. A commitment has been made to apply test and treat strategies

where newly diagnosed people are immediately placed on ART regardless of CD4 levels.

Thailand is committed to the elimination of MTCT and have set a target to have 95.5% of pregnant HIV+ positive women to receive ART to reduce the risk of MTCT, 80% of infants born to HIV+ women to receive virological tests within two months of birth, and to reduce the rate of MTCT to 2.5% by 2014. The proportion of pregnant HIV+ women not receiving ART declined from 4.9% in 2013 to 4.2% in 2014 and the proportion of infants receiving PCR screening for HIV within two months increased from 73% in 2013 to 76% in 2014 but will need new and intensified strategies to reach target. In 2014, 121 children were estimated to be newly infected with HIV, representing a 41% reduction compared to 2010 data. Coverage of couple testing for HIV in ANC increased from 38% in 2013 to 41% in 2014, still well below the 2016 target of 60%.

Efforts to increase coverage of PMTCT include providing free ANC to all couples who register for care within the first 12 weeks of pregnancy designed to reduce problem of late initiation of ART or no ART; since 2014 outreach programmes to diagnose HIV infection include training staff in PMTCT and the provision immediate blood testing of infants born to HIV+ women. Guidelines that promote pregnant HIV positive women continuing ART post-partum will help increase ART coverage and further reduce MTCT. While there has been progress on aligning HIV and TB programmes there is a continuing need to improve access to ART for HIV/TB co-infected patients including strengthening monitoring and improving clinical practice to ensure early detection. Reporting for tuberculosis indicators is not complete with significant underreporting of HIV testing and treatment among tuberculosis patients at specific sites. Thailand is also committed to eliminating gender inequalities and some advocacy work has commenced to mobilise communities and networks on gender issues in relation to TG, MSM and women living with HIV. Further, work is needed in policy and service delivery for example gender sensitive HTC.

Thailand is on track to meet its target to eliminate stigma and discrimination. The legal barriers to parental consent for HTC for young people have been removed, legal and policy barriers to harm reduction and addressing migrants have been reduced. Development and scaling up of stigma and discrimination interventions in health care settings is underway. In 2013, 12,637 women and 19,299 children received services related to physical or sexual violence from intimate partners consistent with national survey in 2013 that identified 2,976 cases of domestic violence. To address gender inequalities, Women Living with HIV Network (WLHIV) now participates in reproductive health services in ANC clinics in 13 hospitals. Support has been given to the WLHIV network to build capacity. The draft gender equality law was submitted to the National Assembly in December 2014 and approved in January 2015. It includes the statement that

sexual expression that is different from one's sex at birth as a basis for gender discrimination is prohibited.

Thailand is committed to the strategic use of ART as a prevention strategy and has adopted a new approach – Reach, Recruit, Test, Treat, Retain (RRTTR) as the framework for addressing gaps in linkage between prevention and life-long treatment system – the plan also defines a tailored service package for each KP and lays out criteria for the 'intensity' of delivery at the provincial level. The plan has been costed at 9,214,862,566 THB for five years. HIV prevention for youth has been funded by the Global Fund through the ACHIEVED programme. Evaluation has shown that, overall, youth has a good knowledge of condoms but did not indicate improved HIV knowledge levels; evaluation of sex education in schools found improvements in knowledge, risk assessment and attitudes compared to schools that had not been exposed to programme.

Gaps and Challenges

Thailand recognises that stigma and discrimination are key drivers and barriers to progress to ending AIDS. Non-discrimination, promoting human rights and gender equality remain a priority. The NSP is focused on revising laws and policies on drug use, age of consent for HIV testing, health policy related to non-Thais, implementing ways to measure HIV-related stigma and discrimination and human rights. Nonetheless challenges remain including a lack of coordination around implementation to achieve targets such as the elimination of gender inequality, 50% reduction in discrimination by 2016 and the expansion of the protective social and legal environment essential for HIV prevention and care. Stigma still exists in many workplaces and to address this 93 workplaces participated in a project to create best practice workplaces which meet the national code of conduct - including such things as no HIV testing of job applicants, and support to HIV+ employees. A pilot study of in two provinces found stigma and discrimination in health care settings and among PLHIV remains 'resilient'; health care staff still a display high levels of enacted and observed stigma and PLHIV; are still report experiencing stigma and discrimination and actively avoid health services as they anticipate stigma and discrimination. A curriculum to address stigma and discrimination for health care staff has been developed by the Ministry of Public Health and will be rolled out in 2015. The implementation of PMTCT is hindered by the significant number of women not registered for ANC and access to non-Thai women is not universal, in part because they have to pay for service.

Towards 2030 - Strengths and Opportunities

Thailand's progressive public policy in most aspects of the HIV response has been effective in preventing the transmission of HIV on a national scale over an extended period of time. In the 1990s, a massive programme focussed on increasing condom use, especially among sex workers, achieved substantial reductions in new HIV infections and decreased prevalence of STI dramatically.

The 100% Condom Use Programme was copied and adapted by other AMS. Another potential strength of the Thailand approach to HIV is the setting of bold targets in conjunction with policy and programme initiatives that are designed to align with these goals.

Financing the Response

Based on the recent national AIDS spending Assessment (NASA) in 2013, total HIV expenditure was 8,827 million THB, reflecting an increase of 14% from 2010 (7,733 million THB). Thailand financed 89% of the total HIV expenditure through domestic funds (7,889 million THB), which is an increase from 85% or 6,588 million THB in 2010. Closing the AIDS resource gaps for prevention services among KP, in particular for community-based/led service delivery in priority provinces, is a national priority. Thailand has made efforts through different mechanism of central budgeting system including AIDS Care Fund, and Thai Health Promotion Fund, to support prevention services. In the meantime, Thailand is focusing on preparing for the transition to 100% domestic funding of the HIV programme to ensure sustainable financing of the HIV response into the future.

Data is drawn from Thailand Ending AIDS 2013 and Thailand Ending AIDS - Thailand AIDS Response Progress Report 2015

VIET NAM

There has been significant progress in Viet Nam's HIV response. However, the epidemic continues to provide a formidable public health challenge with AIDS still among the top causes of premature death. The HIV epidemic in Viet Nam is concentrated in KP, and primarily affects PWID, their long-term female partners, MSM and FSW. Injecting accounts for a total of 45% of new infections. Intimate partner transmission is primarily male to female and accounts for 28%, while female to male partner is 2%. Sex work accounts for 18% of infections, MSM for 5% and 'casual sex' 2% (see Figure 17). Prevalence in 2013 was PWID 10.3%, FSW 2.5%, MSM 3.7%, with the epidemic mostly concentrated in urban areas and the mountainous Northern provinces. The concentration of KP varies, indicating the need for targeting in appropriate geographic areas for different populations, for example MSM prevalence in Ha Noi and Ho Chi Minh City is up to 16% but as low as 2% in other provinces.

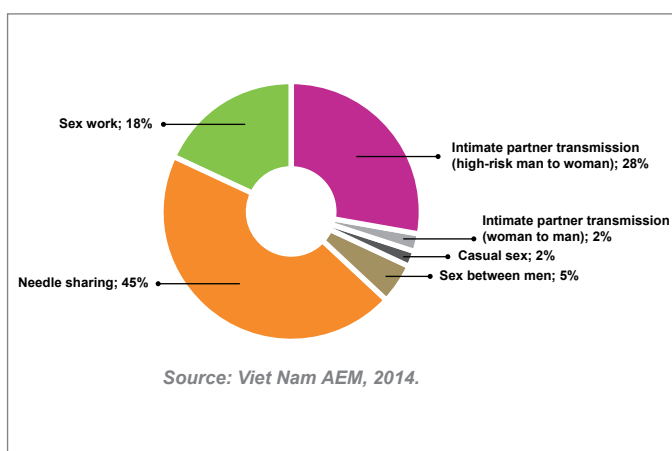


Figure 17: HIV transmission routes in Viet Nam 2014

Getting to Zero – The National Response

Viet Nam aims to achieve the ambitious targets established in the National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2020, with a vision to 2030 consistent with the global targets put forward in 2011. A recent evaluation estimated that nearly 31,000 infections had been averted and 16,000 life years saved through the implementation of harm reduction strategies. However, in some provinces where free needles and syringes are available the HIV incidence is still high. Consultations with CSO have indicated willingness for CSO to take on peer-to-peer distribution using a social marketing model, with pilot research indicating that this could be an effective approach. A pilot of the sale of subsidised needles and syringes through pharmacies also showed promising results and

indicates that moving forward, using a range of distribution methods, would be appropriate and effective.

Opiate substitution therapy has been associated with a 54% reduction in risk of HIV infection in PWID. It has also been found to reduce sharing of equipment, frequency of injecting and exchange of sex for money. In addition, there is evidence that it results in increased ART adherence. A cohort study of MMT patients in Hai Phong and Ho Chi Minh City showed a reduction in illegal drug use of 100% at enrolment and 19-26% after six months. The Government has indicated that the MMT programme will be protected as donors withdraw; legislation already exists to simplify enrolment and a co-payment system is being trialled. Moving forward, a strategic response is required: training will be necessary for relevant staff to increase implementation capacity (decree 96/2012/ND-CP); provinces will need to develop plans; resources allocated for scale up; MMT introduced in high need areas not currently covered; and, partnerships strengthened with private health providers.

Gaps and Challenges

Condom programmes for PWID and MSM are limited. The total market approach has been piloted in Viet Nam: this involves public provision, social marketing, and involvement of the business sector - the poorest get free commodities, the less poor are subsidised and those who can pay do. This approach is efficient as public funds are spent where they are most needed; profit from social marketing can be reinvested in the project and the commercial sector is not crowded out, allowing them to continue to provide a greater choice of condoms and lubricants. Consultations with CSO found that a social marketing approach is acceptable and KP and others will also pay market price if commodities are of good quality and available when needed.

The AEM process recently undertaken by Viet Nam showed that 152,583 new infections and 103,996 deaths could be averted by 2030 if the response was scaled up in line with the Ending AIDS scenario. Current challenges include the level of testing among KP, and as a consequence, late initiation of ART. An innovative test and treat programme for KP is needed that results in twice yearly testing, and if found to be HIV+, immediate initiation of ART regardless of CD4. To make this possible, services would need to be confidential and non-judgmental to address KP concerns about stigma and discrimination from health staff. There is also a need to increase the use of rapid HIV testing in community settings. The 'reach, test, treat and retain cascade' needs to be implemented, and success will require close collaboration between testing and treatment providers. Provision of peer support for ART patients to enhance adherence is also needed. Given the increase of intimate partner transmission male to female, there needs to be a shift to positive prevention and outreach for wives/sexual partners of PWID.



A key challenge for Viet Nam is the need to significantly increase domestic spending if the country is to achieve the aim of ending AIDS by 2030, especially as the transition from donor to domestic funding will produce a shortage of both funding and trained staff. Current staff working in HIV related services are not typically part of the formal public health system, and therefore existing public health staff will likely need to cover additional HIV services in the future. There is an urgent need to transition from the donor-led and funded project-based approach to an integrated and decentralised response financed with domestic resources. Funds need to be available to ensure there is no interruption to service provision as donors withdraw.

Currently, only 5% of ARV are purchased using domestic funds and donors are also responsible for the purchase and import of the majority of methadone for MMT. Viet Nam will need to scale up the efficient procurement of ARV and methadone including potentially moving to domestic production. Donors such as the Global Fund are able to procure ARV at a lower unit price by procuring larger quantities. The Government of Viet Nam will need to develop a centralised procurement process to reduce costs once donors withdraw. Advocacy plans are being developed for leaders to encourage National Assembly and government to take resource decisions that are in line with the commitments of the Project for Sustainable Financing for HIV/AIDS Prevention and Control activities 2013-2020. Financing efficiencies could be created by providing ART free of cost under the national insurance scheme as the infrastructure already exists and covers a significant proportion of the population, and some ARV drugs are already included in items payable.

Towards 2030 – Strengths and Opportunities

The MOH administration for HIV/AIDS Control has developed an HIV investment case in consultation with development partners and other stakeholders – the process has involved analyses of the epidemic and response, priority setting toward a more effective, efficient and sustainable approach to Ending AIDS by 2030. The investment case approach promotes targeted investment, better priority setting, a nuanced understanding of epidemics, and interventions that have been proven to work. It is premised on the idea that effective investment is in itself a more efficient strategy. UNAIDS has developed four steps to assist countries to tailor an investment case to national contexts; the steps are Understand, Design, Deliver, Sustain. Viet Nam's plan was developed through a review of available data, which was utilised in the AEM to provide a picture of the epidemic, future impact of proposed policy, coverage levels and size of investment required.

Financing the Response

Domestic funding has increased from US\$26 million (26.1%) in 2011 to US\$30 million (31.8%) in 2012. The Government of Viet Nam has initiated the *Project on Sustainable Financing for HIV/AIDS Prevention and Control Activities in 2013-*

2020 Period, which has been endorsed by the Prime Minister. Among the project's objectives is to use domestic resources for 50% of total spending prevention and treatment by 2015 and for 75% of total spending by 2020.

Data is drawn from Viet Nam AIDS Response Progress Report 2014 and Optimizing Viet Nam's HIV Response: An Investment Case 2014



Annexes



ANNEX ONE

ASEAN DECLARATION OF COMMITMENT: GETTING TO ZERO NEW HIV INFECTIONS, ZERO DISCRIMINATION, ZERO AIDS-RELATED DEATHS

1. We, the Heads of State/Government of the Association of Southeast Asian Nations (hereinafter referred to as “ASEAN”), namely Brunei Darussalam, the Kingdom of Cambodia, the Republic of Indonesia, the Lao People’s Democratic Republic, Malaysia, the Republic of the Union of Myanmar, the Republic of the Philippines, the Republic of Singapore, the Kingdom of Thailand and the Socialist Republic of Viet Nam, on the occasion of the 19th ASEAN Summit in Bali, Indonesia reviewing comprehensively the progress achieved in the decade since the adoption of the 2001 ASEAN Declaration on AIDS and the implementation of the 2007 ASEAN Commitments on HIV and AIDS;
2. Reaffirming the commitment of ASEAN Member States to accelerate progress in achieving the Millennium Development Goal 6 (MDG 6), which specifically refers to halting and reversing the spread of HIV and AIDS, and other related MDGs by 2015; and the 2010 High Level Plenary Meeting United Nations General Assembly on MDGs entitled: *Keeping the Promise: United to Achieve the Millennium Development Goals*;
3. Confirming our commitment to Resolutions 66/10 and 67/9 of the 66th and 67th Sessions of the United Nations Economic and Social Commission for Asia and the Pacific, respectively, and the outcome of the 2011 United Nations General Assembly High Level Meeting on AIDS entitled, *the “Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS”* which reaffirmed the 2001 Declaration of Commitments on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS and called for efforts to end the epidemic with renewed political will and strong, accountable leadership, and to work in meaningful partnership with all stakeholders at all levels to implement bold and decisive actions;
4. Guided by the ASEAN Charter which entered into force in December 2008, and with a strong commitment to accelerate the establishment of the ASEAN Community by 2015 through the implementation of the Blueprints of the ASEAN Economic
5. Community (AEC), ASEAN Political Security Community (APSC) and the ASEAN Socio-Cultural Community (ASCC);
6. Emphasising that under the ASCC Blueprint, concrete actions have been provided to improve our capability to control communicable diseases

including HIV and AIDS, and particularly in reducing the transmission of HIV and the impact of the epidemic on individuals, community and society;

7. Acknowledge the relevant outputs of the 10th ASEAN Health Ministers Meeting (AHMM) last July 2010 held in Singapore that outlined goals, targets and activities for the regional collaboration on health, including HIV and AIDS initiatives through the Strategic Framework on Health Development (2010- 2015);
8. Recalling that accelerated liberalisation of trade will enhance the region's competitiveness and realise welfare gains for our peoples in the long run, and that efforts are also needed to ensure that access to affordable health care is not undermined and health policies will be equitable pro-poor, as noted in the Declaration of the 7th ASEAN Health Ministers Meeting adopted on 22 April 2004;
9. Concerned that the HIV epidemic continues to threaten the realisation of an ASEAN Community, with socio-economic consequences that pose a formidable challenge in our community-building and our efforts to ensure access to affordable health care;
10. Noting the finding from ASEAN's first regional report on HIV and AIDS of 2010 which observed that in the region, the HIV epidemic continues to affect more than 1.5 million people affecting Member States with varying intensity; that HIV prevalence remains high among key affected populations, including sex workers and their clients, people who inject drugs, and men who have sex with men and transgender population, while other populations continue to be vulnerable (such as partners/spouses of key affected populations, migrant and mobile populations, children and youth, women and girls, people in correctional institutions, and specific occupational groups like uniformed services, people in conflict and disaster-affected areas), and that to be effective, AIDS responses must deliver focused, evidence-informed interventions that address the particular risks and vulnerabilities faced by these populations

Welcoming the finding that progress has been made in the region in the AIDS response, and that in some of the Members States the number of new HIV infections has declined with combined implementation of proven evidence-based interventions in prevention, treatment and care; noting the reduction in HIV prevalence rates in Cambodia, Myanmar and Thailand; noting also the efforts of other Member States on harm reduction, comprehensive condom use programming; use of TRIPS flexibilities and other prevention, treatment, care and support initiatives;

11. Welcoming the findings of recent studies that demonstrate that access to HIV treatment significantly reduces the risk of HIV transmission to a partner; and, that access to affordable medicines in the context of epidemics such as HIV is fundamental to the full realization of the right of everyone to enjoy the highest attainable standard of physical, social and mental health;
12. Concerned that intellectual property, trade policy barriers and social aspects such as stigma and discrimination, are hindering prevention activities on HIV and AIDS, access to HIV treatments and treatments for co-infections and opportunistic infections, as well as pose as serious threats to the quality of life and livelihood of people living with and affected by HIV;
13. Further acknowledging that the number of HIV infections could have been averted among newborn children with the implementation-proven strategy on prevention of mother-to-child transmission;
14. Realising that an effective response to HIV requires relentless efforts and continued commitment by all stakeholders in implementing comprehensive responses to prevent and reduce the number of new infections, and to provide appropriate treatment, care and support to key affected populations and other vulnerable groups;
15. Concerned that women and girls account for a high proportion of new infections, recall our commitment to the declarations and the outcomes of conferences on women and children such as 3 the UN General Assembly Resolution 48/104, 1993 on the Declaration on the Elimination of Violence Against Women; the Beijing Declaration on the Fourth Conference on Women; the Beijing Plus Five; and, the Ha Noi Call to Action for Children and HIV/AIDS in East Asia and Pacific Region, 2006, that aimed to undertake further responses.

Do hereby declare and renew our commitments to:

16. Work towards an ASEAN with Zero New HIV Infections, Zero Discrimination and Zero HIV Related Deaths by:
 - a. Reducing sexual transmission of HIV by 50 percent by 2015;
 - b. Reducing transmission of HIV among people who inject drugs by 50 per cent by 2015;

- c. Scaling up antiretroviral treatment, care and support to achieve 80 percent coverage for people living with HIV who are eligible for treatment, based on WHO HIV treatment guidelines;
 - d. Eliminating new HIV infections among children and substantially reducing AIDS-related maternal deaths by 2015; and
 - e. Reducing by 50 percent tuberculosis deaths among people living with HIV.
17. Commit to work towards zero new HIV infections in ASEAN through the following:
- a. Acknowledge that prevention is the cornerstone of regional, national and international HIV responses and ensure that adequate financial resources are provided for scaling up evidence-based and targeted prevention programmes for key populations-at-risk;
 - b. Ensure that national prevention strategies comprehensively target populations at higher risk, such as people who use drugs, sex workers, and men having sex with men, including transgender people, and that systems of data collection and analysis about these populations are strengthened;
 - c. Develop and scale up community-led HIV prevention services to reduce sexual transmission of HIV and to address stigma and discrimination;
 - d. Implement and expand risk and harm reduction programmes, where appropriate and applicable, for people who use drugs, taking into account the World Health Organization, United Nations Office on Drugs and Crime and UNAIDS Technical Guide for countries to set targets for universal access to HIV Prevention, treatment and care for injecting drug users in accordance with national legislations;
 - e. Accelerate efforts to virtually eliminate parent-to-child transmission of HIV and preventing new paediatric HIV infections and eliminate congenital syphilis by 2015;
 - f. Encourage and support the active involvement of key affected populations and vulnerable groups including young people, civil society and other community representatives as well as local governments in planning, implementing and evaluating

responses; Promote access to timely and effective anti-retroviral treatment, as prevention strategy;

- g. Address the social protection, sexual and health needs of key affected and vulnerable populations; and
- h. Expand and promote access to HIV testing, including provider-initiated HIV testing that is voluntary, confidential and rights-based.

18. Commit to work towards zero AIDS related deaths through the following:

- a. Accelerate efforts to achieve the goal of universal access to antiretroviral treatment by 2015, with the target of 80 percent coverage of people living with HIV who are eligible, based on World Health Organization HIV treatment guidelines to increase life expectancy and the quality of life.
- b. By 2015 improve treatment coverage, equity, effectiveness and efficiency by:
 - i. Fully implementing the most recent WHO guidelines and adopting the Treatment 2.0 approach that includes point of care diagnostics and treatment monitoring, decentralised and simplified service delivery and involvement of PLHA networks in service delivery;
 - ii. Addressing key obstacles such as drug stock- outs, financial barriers, stigma in health services, loss to patient follow-up, and access barriers for migrant and refugee populations;
 - iii. Securing and expanding access to affordable and effective HIV diagnostics, ARV and OI drugs, through the full use of existing flexibilities under the Trade-Related Aspects of Intellectual Property Rights Agreement, which are specifically geared to promoting access to and trade of medicines, including in particular the use of compulsory licensing to enable manufacturing or parallel importation of generic drugs;
 - v. Addressing barriers, regulations, policies and practices that prevent access to affordable HIV treatment by promoting generic competition in order to help reduce costs associated with life-long chronic care;

- c. Expand efforts to combat HIV co-morbidities such as tuberculosis and hepatitis through integrated delivery of HIV and tuberculosis services in line with the Global Plan to Stop TB, 2011-2015; developing as soon as practicable approaches of prevention and treatment of hepatitis C; and rapidly expanding access to appropriate vaccination for hepatitis B;

19. Commit to work toward Zero HIV related Discrimination through the following:

- a. Promote the health, dignity and human rights of people living with HIV and key affected populations by promoting legal, political and social environments that enable HIV responses, including by establishing multi-stakeholder partnerships among the health sector, law enforcement and public security, academia, faith-based leaders, local government leaders, parliamentarians, workplace, civil society and other relevant stakeholders, with a view to removing legal and punitive barriers to an effective response, and to reduce stigma and discrimination;
- b. Initiate as appropriate, in line with national priorities a review of national laws, policies and practices to enable the full achievement of universal access targets with a view of eliminating all forms of discrimination against people at risk of infection, living with HIV and key affected populations;
- c. Pledge to eliminate gender inequalities and gender-based abuse and violence especially by protecting and promoting the rights of women and adolescent girls, strengthening national social and child protection systems, empowering women and young people to protect themselves from HIV, and have access to health services, including, inter alia, sexual and reproductive health, as well as full access to, comprehensive information and education;

20. Commit to ensuring financial sustainability, national ownership and leadership for improved regional and national responses to HIV through the following actions to take forward our commitments:

- a. Develop, update and implement evidence-based, comprehensive, country-led national strategic plans and establish strategic and operational partnerships with stakeholders at the national and community levels to scale up HIV prevention, treatment, care and support by 2015;

- b. Mobilise a greater proportion of domestic resources for the AIDS response in line with national priorities, from traditional sources as well as through innovative financing mechanisms, in the spirit of shared responsibility and national ownership and to ensure sustainability of the response;
 - c. Reduce inefficiencies in national responses by prioritizing high impact interventions, reducing service delivery costs, and streamlining monitoring, evaluation and reporting systems to focus on impact, outcomes, cost-efficiency and cost-effectiveness;
 - d. Strengthen the mechanisms of South-South collaboration, especially ASEAN to ASEAN sharing of expertise, inter-regional cooperation, in the provision of technical assistance and support to build capacity at the regional and national levels;
 - e. Strengthen the role of ASEAN bodies responsible for health, that is, the ASEAN Health Ministers Meeting, Senior Officials Meeting on Health Development and the ASEAN Task Force on AIDS in enhancing cross-sectoral and multi-stakeholders coordination by facilitating the meaningful participation of all relevant key stakeholders, including that of public and private sector, and under the coordination of the ASEAN Socio-Cultural Community Council, with the view to effectively implement regional responses to HIV consistent with ASEAN's regional and international commitments;
 - f. Tasks the relevant ASEAN bodies responsible for health to effectively implement the Fourth ASEAN Work Programme on HIV which was adopted by the ASEAN Health Ministers;
 - g. Continue to support Global Fund to Fight AIDS, Tuberculosis and Malaria as a pivotal mechanism for achieving access to prevention, treatment, care and support by 2015; recognize the programme for reform of the Global Fund, and encourage Member States, ASEAN Dialogue Partners, the private sector, business community, including foundations and philanthropists to provide the highest level of support for the Global Fund, taking into account the funding targets to be identified at the 2012 midterm review of the Global Fund replenishment.
21. Task the concerned ASEAN Sectoral Ministerial Bodies as well as other relevant bodies to implement this Declaration including mobilising resources, and monitor its progress; Encourage all ASEAN Member States to support these ASEAN Sectoral Bodies in accomplishing this

Declaration through maximum efforts by such appropriate instruments as may be necessary and consistent with their respective national laws and policies.

Adopted in Bali, Indonesia, this Seventeenth Day of November in the Year Two Thousand and Eleven in a single original copy, in the English language.

ANNEX TWO

MATRIX OF STATUS OF IMPLEMENTATION OF ATFOA'S WORK PLAN 2011 – 2015

No.	Activities	Output Indicator/s	Status	Means of Verification (MoV)
To promote ASEAN's collective agenda at international and regional platforms utilising evidence-based epidemiological data and research findings towards achieving its goal;				
1.	ATFOA Workshop on ASEAN Priority Advocacy Agenda	<ul style="list-style-type: none"> List of Accomplishments of ASEAN in HIV & AIDS Regional policy advocacy Issues identified AWP4 fully funded 	Accomplished	<ul style="list-style-type: none"> Workshop was conducted on 28-29 March 2011 Declaration ASEAN Cities Getting to Zeros was adopted at the 19th Summit in Bali in 2011 AWP 4 is implemented
2.	ASEAN Participation at Universal Access Round Table	<ul style="list-style-type: none"> ASEAN progress discussed ASEAN Work on HIV & AIDS showcased and promoted in UA RTD 	Accomplished	ASEAN Participated the UA Regional Consultation to take stock of region's progress on 30 March 2011
3.	ATFOA Inter-sectoral collaboration with labour and foreign ministry	Support the implementation of the ASEAN Declaration on Migrant Workers	Accomplished	Second ASEAN High Level Multi-Stakeholders Meeting on HIV Prevention, Treatment, Care and Support for Migrant Workers was held on 29-30 Nov. 2011
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	Accomplished	Carried out during the Asia Pacific Consultation on UA. Indonesia as Chair of ASEAN represented ASEAN, 8-10 June 2011

No.	Activities	Output Indicator/s	Status	Means of Verification (MoV)
5	ATFOA Participation at 10 th ICAAP - Busan, 2011	<ul style="list-style-type: none"> ASEAN Work on HIV & AIDS showcased and promoted Leadership in AMS strengthened 	Accomplished	ASEAN Participated the 10 th ICAAP in 2011 in Busan and the 11 th ICAAP in 2013 in Bangkok
6	ASEAN Summit on AIDS to Commemorate the 10 th Anniversary of the ASEAN Declaration on HIV/AIDS	ASEAN Summit Declaration Statement	Accomplished	Commemoration related activities include (1) International Symposium on Getting to Zero in ASEAN, 21 Nov. 2011; (2) Adoption by ASEAN Leaders of the ASEAN Declaration of Commitment: Getting to Zero New HIV Infection, Zero Discrimination, Zero AIDS Related Death, 17 Nov. 2011, at the 19 th ASEAN Summit.
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	Accomplished	ASEAN Participated the ICAAP in 2012 and 2015
8	ATFOA Participation in the 11 th ASEAN Health Ministers Meeting in Thailand	AHMM endorsed ASEAN vision on HIV and AIDS (new)	Accomplished	An ATFOA's side meeting was conducted at the 11 th AHMM in 2012 in Phuket, Thailand and the 12 th AHMM in 2014 in Ha Noi, Viet Nam
9	Development of ASEAN WAD Messages to promote collective ASEAN advocacies	Annual ASEAN Message for World AIDS Day (WAD)	Accomplished	ASEAN WAD Message from ASEAN SG uploaded at ASEAN Web, 01 Dec 2011, 2012, 2013 and 2014

No.	Activities	Output Indicator/s	Status	Means of Verification (MoV)
To strengthen capacity to plan, implement and monitor and evaluate in both prevention and treatment through knowledge sharing among ASEAN Member States				
10	Document best practices of ASEAN regional initiatives to promote South to South learning and capacity	Best Practices identified in the ASEAN	Accomplished	The publication of ASEAN Good Practices and New Initiatives in HIV and AIDS was launched at the 12 th AHMM in September 2014 in Ha Noi, Viet Nam
11	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)	Publication of Directory of ASEAN Experts in HIV and AIDS and STI	On-going	The Publication of Directory of ASEAN Experts in HIV and AIDS and STI is currently being finalised
	<ul style="list-style-type: none"> Needs Assessment Workshop, including identifying mechanisms and funding support 			
	<ul style="list-style-type: none"> Propose development of 1-2 Training program on identified priorities 			

No.	Activities	Output Indicator/s	Status	Means of Verification (MoV)
12	<p>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.</p> <ul style="list-style-type: none"> • ASEAN Workshop on Evidence Based Programming (after Singapore activity with APEC) 	The publication of ASEAN Good Practices and New Initiatives in HIV and AIDS	Accomplished	Combined with the best practices' activity
13	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	Link with Schools of Public Health established (with ASEAN education sector)	Withdraw	The 21 st ATFOA Meeting in September 2013 in Melaka agreed to withdraw this activity from AWP IV since currently there are no concrete AUN activities that are relevant to ATFOA
14	'ASEAN Cities Getting to Zeros' - Concrete Follow up Actions on ASEAN Declaration in Getting to three Zero (2012 -2014) – 'ASEAN Cities Getting to Zeros' *	The project implemented initially in implemented in 13 pilot cities/sites	On-going	currently implemented in 13 pilot cities/sites
To leverage for increased access to affordable HIV-related care and treatment				
15	Addressing the 2010 WHO <i>Antiretroviral Therapy for HIV Infection in Adults & Adolescents</i> recommendations, including coverage and resource implications (Treatment 2.0)	AMS able to adapt to the new guidelines of WHO	Accomplished	A workshop on Addressing the 2010 WHO Antiretroviral Therapy for HIV Infection in Adults & Adolescents recommendations, including coverage and resource implications (Treatment 2.0 Initiatives) and TB/HIV was conducted on 6 September 2014

No.	Activities	Output Indicator/s	Status	Means of Verification (MoV)
16	Improve affordable access to ART through information sharing (as part of south-south collaboration's activity)		On-going	
17	Addressing Co-infection TB & HIV, (suggested directions) <ul style="list-style-type: none"> Joint Regional Workshop on Effective Strategies (3 I's) combined meeting with ATFOA and Stop TB Partnership 	ATFOA able to provide venue for strategy development	Accomplished	AMS had their respective workshops with WHO.

In number:

- Completed Activity: 16/16 = 100% (Accomplished or On-going)**

ANNEX THREE

CONCEPT NOTE ASEAN CITIES GETTING TO ZERO: FOLLOW UPS, 2015

I. BACKGROUND

In November 2011, back to back with the 19th meeting of the ASEAN Taskforce on AIDS (ATFOA) facilitated by the ASEAN Secretariat and hosted by Indonesia, an International Symposium, with theme “Getting to Zero New HIV Infection, Zero Discrimination, and Zero AIDS Related Deaths” was convened. The Symposium was also organized as a follow-up to the adoption of the ASEAN Declaration on Getting to Zero New HIV Infection, Zero AIDS Related Discrimination and Zero AIDS Related Deaths during the 19th ASEAN Summit, in Bali, Indonesia. The 19th ATFOA Meeting noted Indonesia proposal in developing regional proposal to implement comprehensive interventions in ‘getting to three zeros’ by establishing partnership among highly prioritized (selected) cities across AMS under ASEAN Work Programme IV (2011-2015).

Eight (8) ASEAN Member States agreed to participate in the scheme, namely: Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand and Viet Nam. The lead country for the activity is Indonesia. Indonesia has submitted a concept note to ASEAN Secretariat which was later on noted by leaders during the AHMM in Pucket, 2012. The 22nd ATFOA Meeting taking place in Mandalay City, Myanmar, reported that from the participating eight countries with thirteen cities, replications to other sites have taken place in Malaysia, Philippines and Indonesia. The meeting therefore noted that a consolidated follow up is needed, to capture the result from this initiative in the participating cities and other developments and to strengthen the M&E aspect of this initiative.

II. RATIONALE

Since the launching of the initiative at Sideline meeting of the 11th AHMM in Phuket (2012), AMS have commenced intensifying the AIDS response in participating cities. As part of assessing the needs and program gaps, ASEAN Secretariat supported by TSF & UNAIDS facilitated the conduct of a regional assessment. The Phase II Regional assessment identified programmatic gaps, issue of inhibiting factors optimal access of HIV prevention and treatment programs in these cities and the role of communities affected especially Key Affected Populations. Therefore, these gaps need to b filled, the problems spotted in the field should be appropriately addressed and lessons learned must be identified,

documented and analysed for the use among participating cities. A South-south approach with city-to-city platform for sharing expertise and technical assistance should be established within the ASEAN Cities Getting to Zero initiative to ensure sustainability. This approach is inline with the ASEAN Community spirit put forward by our leaders.

Hence, looking at the above mentioned issue, a follow up to the assessment involving the eight countries and participating cities must take place. To consolidate these issues, a Consolidation workshop aiming at: compiling, discussing the results of the assessments and lessons learned from each sites; finding commonalities in the approaches in each sites which can be replicated across the Region. This workshop will be preceded by a Courtesy meeting of Mayors from the participating cities that will generate the direction of the Consolidation workshop. Back to back of these activities is a training involving communities from all cities involved in the ASEAN Cities Getting to Zero initiative aiming at forging a network among them for further regional collaborations. Through these three activities, the issue found in the Phase II regional assessment may be addressed, cooperative efforts built and a strong documentation of the implementation of the ASEAN Cities Getting to Zero initiative be consolidated. The significance of these follow ups is to produce deliverables of the ASEAN Cities Getting to Zero initiative that can be evaluated especially since the proposed deadline is 2015.

III. PROJECT DESCRIPTION

There are three activities proposed herewith: (1) ASEAN Cities Getting to Zero Mayors Meeting (2) ASEAN Cities Getting to Zero Consolidation Workshop (3) ASEAN Cities Getting to Zero Community Training

Detailed descriptions:

1) ASEAN Cities Getting to Zero Mayors Meeting (1 day)	
Goals & Objectives	<ul style="list-style-type: none"> • Courtesy meeting for mayors of participating cities • To Consolidate directions from Mayors
Meeting Agenda	<ul style="list-style-type: none"> • Opening from host • Progress report from Lead Country • Progress report of the ASEAN Cities Getting to Zero initiative from each country (either by ATFOA or City-representative) • Response from Community-representatives • Discussion & directions from Mayors • Conclusion & Closing
Participants	<ul style="list-style-type: none"> • Mayors from participating cities (13 persons) • City technical official (13 prsons) • ATFOA Focal Points (10 persons) • Community representatives (13 persons) • ASEAN Secretariat (3 person) • International development partners

Anticipated Outcomes	<ul style="list-style-type: none"> • Directions from Mayors Meeting for the Consolidations Worksop • Mayors-based networking whitin the ASEAN Cities Getting to Zero platform
2) ASEAN Cities Getting to Zero Consolidation Workshop (2 days)	
Goals & Objectives	<ul style="list-style-type: none"> • To follow up on key recommendations/findings from the report phase II and issue related to monitoring and evaluation; • To identify and document god practices (streng in the response) from each site • To build a city-based mechanism • To agree on monitoring and evaluation framework
Workshop	<ul style="list-style-type: none"> • Opening
Agenda	<ul style="list-style-type: none"> • Goals, objectives and expected output • Result of the Phase II Regional Assessment + discussion • Identification of good practices: reports from each sites of their AIDS response with an overall description of the conduct of the assessment and replications when appropriate by AIFOA focal point • Group work: good practice Policy Brief • Identifying agreed Monitoring & Communication mechanism • Forward looking - consolidated ASEAN Cities Getting to Zero report • Dialogue with regional international partners • Conclusion & Closing
Participants	<ul style="list-style-type: none"> • City technical officials (13 person) • ATFOA Focal points (10 person) • Community representatives (13 person) • Facilitators (___person) • ASEAN Secretariat (3 person) • International development partners
Activities	<ul style="list-style-type: none"> • Panel Presentation • Group work • Dialogue/discussion
Anticipated Outcomes	<ul style="list-style-type: none"> • Good practice policy briefs from each site • Monitoring & evaluation framework • City-based communication mechanism • Step for a consolidated ASEAN Cities Getting to Zero report
3) ASEAN Cities Getting to Zero Community Workshop (1,5 days)	
Goals & Objectives	<ul style="list-style-type: none"> • To build a community-based forum of networks from each sites • To engage communities from each sites in exchanging experience
Workshop Agenda	<ul style="list-style-type: none"> • Opening • Seven sister: a regional perspective of community's role in the response • Successful advocacy (some examples) • Policy Brief of community-based advocacy-group work • What's next: Discussions • Building a city-based communication mechanism within the ASEAN Cities Getting to Zero platform • Conclution & Closing

Activities	<ul style="list-style-type: none"> • Panel Presentations • Group work • Dialogue/discussion
Participants	<ul style="list-style-type: none"> • ATFOA Focal points (10 person) • Community representatives (13 person) • Facilitators (___person) • ASEAN Secretariat (3 person) • International development partners
Anticipated Outcomes	<ul style="list-style-type: none"> • Documented successful community-based advocacy • Agree City-based communication mechanism

IV. IMPLEMENTATION

These three activities will be led by the ASEAN Cities Getting to Zero Initiative lead country, Indonesia as directed by the 22nd ATFOA Meeting, held in Mandalay City, Myanmar, in June 2014. Further facilitation by ASEAN Secretariat and other identified international partners.

Date : _____
Time : _____
Venue : _____

Preparation:

The following flow will be carried through to prepare these three activities which will be conducted back to back.



V. FINANCIAL SUPPORT & Workplan

Financial support will be provide by: _____

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ASEAN: A Community of Opportunities

