

# Meeting Report

## NATIONAL HIV, HEPATITIS AND STI PROGRAMME MANAGERS MEETING FOR SELECTED ASIAN AND PACIFIC ISLAND COUNTRIES



27–30 June 2017  
Manila, Philippines



National HIV, Hepatitis and STI Programme Managers Meeting for Selected Asian and Pacific Island Countries  
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WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR THE WESTERN PACIFIC

RS/2017/GE/43(PHL)

English only

MEETING REPORT

NATIONAL HIV, HEPATITIS AND STI PROGRAMME MANAGERS MEETING  
FOR SELECTED ASIAN AND PACIFIC ISLAND COUNTRIES

Convened by:

WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR THE WESTERN PACIFIC

[AND OTHER PARTNERS IF APPLICABLE]

MANILA, PHILIPPINES

27-30 JUNE 2017

Not for sale

Printed and distributed by:

World Health Organization  
Regional Office for the Western Pacific  
Manila, Philippines

January 2018

## NOTE

The views expressed in this report are those of the participants of the National HIV, Hepatitis and STI Programme Managers Meeting for Selected Asian and Pacific Island Countries and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the National HIV, Hepatitis and STI Programme Managers Meeting for Selected Asian and Pacific Island Countries in Manila, Philippines from 27-30 June 2017.

# CONTENTS

## ABBREVIATIONS

## SUMMARY

1. INTRODUCTION .....	1
1.1 Meeting organization .....	1
1.2 Objectives .....	1
1.3 Meeting participants .....	1
1.4 Programme .....	1
2. PROCEEDINGS .....	1
2.1 Opening session .....	1
2.2 Plenary presentation: setting the scene .....	2
2.2.1 Recommendations from the 2015 and 2016 HIV/STI and hepatitis programm managers meetings .....	2
2.2.2 On the Fast-Track to end AIDS: UNAIDS 2016-2021 strategy .....	2
2.2.3 Regional process against elimination targets on HIV, hepatitis and STI.....	3
2.2.4 New recommendations for viral hepatitis and HIV: What is in the pipeline for 2017-2018? .....	3
2.2.5 Universal health coverage and the Sustainable Development Goals: moving away from disease-specific to system approach .....	4
2.3 Country presentations on elimination efforts.....	5
2.3.1 Elimination of HIV in China .....	5
2.3.2 Elimination of hepatitis in Mongolia.....	6
2.3.3 Elimination of STIs in Fiji.....	6
2.4 Country poster session.....	7
2.5 Parallel session: country dialogue .....	7
2.6 Plenary session: global and regional targets and health information systems .....	7
2.6.1 Global and regional target for HIV, hepatitis and STIs .....	7
2.7 Parallel session: HIV and STI data revolution for achieving elimination.....	9
2.7.1 The need for data revolution to make the information strategic for achieving Fast-Track targets ..	9
2.7.2 Setting things in motion: strengthening the Philippine HIV response through analysis of cascades .....	9
2.7.3 Key population cascades: experiences from community lay provider testing cascades and approaches to obtaining risk behaviour data .....	10
2.7.4 Discussion: country needs and plans for improving patient follow-up across care services: referral systems, unique identifiers .....	10
2.7.5 Discussion: implications of global HIV and STI targets for the Western Pacific Region .....	11
2.7.6 Discussion: HIV drug resistance surveillance: updates and discussion on surveillance needs and country plans .....	12
2.7.7 Antimicrobial resistance of gonorrhoea .....	12
2.7.8 Regional GASP in countries in the Western Pacific Region .....	12
2.7.9 Experience in strengthening laboratory and reporting systems for gonococcal drug resistance surveillance in China .....	13
2.8 Parallel session: HIV and STI data revolution for achieving elimination.....	14
2.8.1 Strategic information for hepatitis elimination .....	14
2.8.2 Mongolia: surveillance and laborator systems strengthening efforts .....	14
2.8.3 HBV and HCV surveillance in Japan .....	15
2.8.4 Group work: country plans for hepatitis surveillance and monitoring and evaluation framework .....	15
2.8.5 Discussion: approach to calculation and setting regional hepatitis targets for the Western Pacific .....	16
2.8.6 Viral hepatitis: regional laboratory network: terms of reference .....	16
2.8.7 Discussion: feedback on the draft terms of reference for the viral hepatitis regional laboratory network .....	17
2.9 Plenary session .....	18
2.9.1 Transition to Xpert – operational considerations.....	18
2.9.2 DHIS2 Integrated Surveillance Systems in the Lao People’s Democratic Republic .....	18
2.9.3 Working groups .....	19

2.10 Interventions for elimination .....	19
2.10.1 Draft regional framework for triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis B in Asia and the Pacific 2018-2030 .....	19
2.10.2 Hepatitis B elimination in China-triple elimination as an opportunity .....	20
2.10.3 Elimination of HIV and STI .....	21
2.10.4 Piloting community-based delivery of peer-driven HIV pre-exposure prophylaxis for MSM and transgender women in Manila, Philippines .....	22
2.10.5 HIV and TB twin epidemics in Papua New Guinea .....	22
2.10.6 Discussion points .....	23
2.11 Interventions for elimination .....	23
2.11.1 Hepatitis screening and linkages to care in Japan .....	23
2.11.2 Access to hepatitis treatment in Australia .....	23
2.11.3 Discussion points .....	24
2.11.4 Working groups .....	24
2.12 Sustainable financing mechanism .....	25
2.12.1 Transitioning to sustainable domestic financing for priority public health programmes in the Western Pacific .....	25
2.12.2 UNAIDS Strategy for transition from external to domestic financing of HIV response .....	25
2.12.3 Role of private philanthropy in public health – fund for hepatitis elimination .....	26
2.12.4 Health insurance and sustainable financing for ART in Viet Nam: prospects and challenges ....	27
2.12.5 Financing for the HIV services in Hong Kong SAR (China) .....	27
2.13 Improving access to medicines .....	28
2.13.1 Chronic hepatitis C: equitable access to affordable treatment: DNDi complementary approach to an immediate access strategy .....	28
2.13.2 Role of advocacy in increasing access to hepatitis medicine .....	28
2.13.3 Mongolia: financing the hepatitis response .....	29
2.14 Closing remarks .....	30
3. CONCLUSIONS AND RECOMMENDATIONS .....	30
3.1 Conclusions .....	30
3.2 Recommendations .....	32
3.2.1 Recommendations for Member States .....	32
3.2.2 Recommendations for WHO .....	32
ANNEXES .....	33
Annex 1. List of participants	
Annex 2. Meeting programme	

Keywords:

HIV infections / Acquired immunodeficiency syndrome / Anti-retroviral agents / Sexually transmitted disease / National health programs

## ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
AMR	antimicrobial resistance
ART	antiretroviral therapy
DAA	direct-acting antiviral
DNDi	Drugs for Neglected Disease Initiative
EMTCT	elimination of mother-to-child transmission
EPI	Expanded Programme on Immunization
EQAS	external quality assessment scheme
GASP	Gonococcal Antimicrobial Surveillance Programme
GHP	Global Hepatitis Programme (World Health Organization)
HBeAg	hepatitis B e antigen
HBsAg	hepatitis B surface antigen
HBV	hepatitis B virus
HCC	hepatocellular carcinoma
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HIVDR	HIV drug resistance
IPT	isoniazid preventive therapy
MIC	minimum inhibitory concentration
MNCH	maternal, newborn and child health
MSM	men who have sex with men
NGO	nongovernmental organization
NRL	national reference laboratory
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
PVST	post-vaccination serological testing
PWID	people who inject drugs
RMNCH	reproductive, maternal, newborn and child health
RRL	regional reference laboratory
QMS	quality management system
SDGs	Sustainable Development Goals
STI	sexually transmitted infection
TB	tuberculosis
UHC	universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
US CDC	United States Centers for Disease Control and Prevention
WHA	World Health Assembly
WHO	World Health Organization

## SUMMARY

HIV, viral hepatitis and sexually transmitted infections (STIs) pose major public health burdens in the Western Pacific Region. In 2015, there were an estimated 96 000 new HIV infections and 1.4 million people living with HIV in the Region. Globally, there are 257 million persons living with chronic hepatitis B – 45% of which are living in the Western Pacific Region. Similarly and with wide geographical and subpopulation variation, the Region bears nearly one fifth of the 71 million people estimated to be living with chronic hepatitis C. An estimated 142 million in the Western Pacific Region contracted an STI in 2012. The incidence and prevalence of curable STIs in the Western Pacific remain the highest in the world.

Countries have made remarkable progress in the Western Pacific Region in responding to HIV, viral hepatitis and STIs. However, further efforts are needed to achieve the Fast-Track targets for HIV by 2020 and to end the epidemics by 2030 in line with Sustainable Development Goals (SDGs) and the global health sector strategies for the three diseases.

A National HIV, Hepatitis and STI Programme Managers Meeting for Selected Asian and Pacific Island Countries was held from 27 to 30 June 2017 in Manila, Philippines. National programme managers from 12 countries and areas – Australia, Cambodia, China, Fiji, Hong Kong Special Administrative Region (China), Japan, the Republic of Korea, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam – attended the meeting. Representatives from government, WHO, UNAIDS other international organizations and civil society organizations working in the Region also attended.

The objectives of the meeting were to:

review and discuss progress on the recommendations from the 2015 and 2016 programme managers meetings for HIV/STI and viral hepatitis; and

discuss common issues, plans of action and targets towards reaching the 2030 goals of the global health sector strategies for HIV, hepatitis and STIs and the 2020 targets of the *Regional Action Plan for Viral Hepatitis in the Western Pacific 2016–2020*.

Meeting participants made detailed operational recommendations to help ensure that requisite progress is made towards attainment of the 2030 goals of the global health sector strategies for HIV, hepatitis and STIs and the 2020 targets of the *Regional Action Plan for Viral Hepatitis in the Western Pacific 2016–2020*.



## 1. INTRODUCTION

Three interlinked global health sector strategies for HIV, viral hepatitis and sexually transmitted infections (STIs), endorsed by Member States in May 2016, set the global targets of ending AIDS, STIs and viral hepatitis as public threats by 2030. While HIV prevalence in the Western Pacific Region remains low at 0.1%, an estimated 100 000 new HIV infections continue to occur annually, in particular among key populations. The Region bears the highest number of new curable STIs with a serious level of gonococcal antimicrobial resistance, and the highest burden of viral hepatitis with 33% of the global mortality. In 2015, Member States endorsed the *Regional Action Plan for Viral Hepatitis in the Western Pacific 2016–2020*. There is a need to raise awareness and identify resources for HIV, viral hepatitis and STIs, which are often co-infected and share similar prevention, testing and treatment interventions.

### 1.1 Meeting organization

A National HIV, Hepatitis and STI Programme Managers Meeting for Selected Asian and Pacific Island Countries was held in Manila, Philippines from 27 to 30 June 2017.

### 1.2 Meeting objectives

The objectives of the meeting were:

- 1) to review and discuss progress on the recommendations from the 2015 and 2016 programme managers meetings for HIV/STI and viral hepatitis; and
- 2) to discuss common issues, plans of action and targets towards reaching the 2030 goals of the global health sector strategies for HIV, hepatitis and STIs and the 2020 targets of the *Regional Action Plan for Viral Hepatitis in the Western Pacific 2016–2020*.

### 1.3 Meeting objectives

The meeting was attended by 75 participants from 12 countries and areas, namely Australia, Cambodia, China, Hong Kong SAR (China), Fiji, Japan, the Republic of Korea, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam. Participants included national HIV, hepatitis and STI programme managers as well as representatives from governments, WHO, UNAIDS, other international organizations and civil society organizations based in the Region.

### 1.4 Programme

Participants reviewed progress on the recommendations from the 2015 and 2016 programme managers meetings for HIV/STI and viral hepatitis and discussed plans of action and regional targets towards reaching the 2030 goals of the global health sector strategies for HIV, hepatitis and STIs and the 2020 targets of the *Regional Action Plan for Viral Hepatitis in the Western Pacific 2016–2020*. They also examined country efforts to achieve elimination of HIV, hepatitis and STI; identified the main challenges for reaching elimination by 2030 and discussed how to address them; and identified important public health functions needed for reaching elimination and opportunities for synergies across three diseases and other programmes. The meeting agenda can be found in Annex 1.

## 2. PROCEEDINGS

### 2.1 Opening session

Dr Shin Young-soo, WHO Regional Director for the Western Pacific, welcomed meeting participants and commented that this was the first joint meeting of national HIV, hepatitis and STI programme managers. He expressed his hope that this meeting would set the direction for achieving the elimination

of the three diseases by 2030 and that this, in turn, would be a major contribution to achieving the health-related SDGs. He noted that this meeting was very crucial and timely as the Western Pacific Region contributes 40–50% of the total global burden of hepatitis B and STI, and the number of new HIV infections continues to rise in several countries. He raised concerns about the difficult funding scenario for communicable diseases, particularly for HIV, hepatitis and STIs, as most of the countries in this Region either were or were on their way to becoming upper–middle- or high-income countries.

Stuart Watson, Senior Adviser, UNAIDS Regional Support Team, Asia and the Pacific, highlighted the importance of moving beyond vertical disease response approaches in many countries, and to start sharing lessons learnt from countries that had already had some experience and success in breaking down delivery silos. He cautioned that the Region is not on track to achieve many of the HIV diagnosis and treatment 90-90-90 goals for the year 2020 and that there are signs of increasing complacency in the HIV response and growing epidemics among key populations.

Dr Ying-Ru Lo, Coordinator, HIV, Hepatitis and STI, WHO Regional Office for the Western Pacific, stated the objectives of the meeting. The expected outcomes of the meeting would be recommendations to countries, WHO, UNAIDS and other partners on approaches towards eliminating HIV, hepatitis and STIs for the next two years.

## **2.2 Plenary presentations: setting the scene**

### **2.2.1 Recommendations from the 2015 and 2016 HIV/STI and hepatitis programme managers meetings**

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

Dr Lo presented the conclusions and recommendations from the 2015 HIV/STI programme managers meeting and the 2016 hepatitis programme managers meeting. He then gave a summary of the key follow-up actions taken by WHO and others in support of the recommendations (see meeting reports at [http://www.wpro.who.int/hiv/documents/types/reports/HIV\\_PMM\\_2015/en/](http://www.wpro.who.int/hiv/documents/types/reports/HIV_PMM_2015/en/); [http://www.wpro.who.int/hepatitis/hepatitis\\_resource\\_publication/firstfocalpointsmeeeting/en/](http://www.wpro.who.int/hepatitis/hepatitis_resource_publication/firstfocalpointsmeeeting/en/)).

### **2.2.2 On the Fast-Track to end AIDS: UNAIDS 2016-2021 strategy**

*Stuart Watson, Senior Adviser, UNAIDS Regional Support Team, Asia and the Pacific*

The session provided an overview of the UNAIDS 2016–2021 strategy and an assessment of progress made in reaching the 2020 targets in Asia and the Pacific. The UNAIDS strategy seeks to achieve a set of far-reaching, people-centred goals and targets to be met globally by 2020. The goals include achieving fewer than 500 000 people newly infected with HIV; fewer than 500 000 people dying from AIDS-related causes; and elimination of HIV-related discrimination.

Mr Watson presented a summary analysis of the progress made in Asia and the Pacific one year into the Fast-Track strategy. The region is far from reaching its 2020 target of no more than 90 000 new infections annually with the current trend of approximately 290 000 new infections per year. With regards to prevention, only four (soon to be five) countries in the region have started pre-exposure prophylaxis (PrEP) pilot or demonstration projects, and no country in the region has begun a large-scale roll-out. The share of new infections who are men who have sex with men (MSM) is growing in all countries, accounting for 50–80% of new HIV infections in the countries with disaggregated data. Treatment scale-up has been around 15% annually between 2013 and 2015, which puts the region very close to achieving the 2020 target of having 4.2 million people on treatment in the next three years – an

estimated 2.2 million people were receiving antiretroviral therapy (ART) in the region as of June 2016. However, the region is not on track to meet testing targets for any key population group in most countries. Testing coverage for the region is around 43% of female sex workers; 49% of male sex workers; 43% of MSM; 30% of people who inject drugs (PWID); and a very small percentage of transgender people.

For greater community and key population involvement, sustaining momentum and political commitments remain complicated because of continuing legal barriers: 37 of the 38 United Nations Member States in Asia and the Pacific criminalize some aspect of sex work; 17 criminalize same-sex relations; 11 confine people who use drugs in compulsory detention centres; 15 impose the death penalty for drug-related offences; and 10 impose some form of HIV-related restriction on entry, stay or residence.

### **2.2.3 Regional progress against elimination targets on HIV, hepatitis and STI**

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

In 2015, there were an estimated 96 000 new HIV infections and 1.4 million people living with HIV in the Western Pacific Region. Globally, there are 257 million persons living with chronic hepatitis B – 45% of which are living in the Western Pacific Region. With wide geographical and subpopulation variation, the Region bears nearly one fifth of the 71 million people estimated to be living with chronic hepatitis C. Whereas mortality over the last 10 years for HIV, tuberculosis and malaria has decreased, mortality due to hepatitis is increasing with 1.34 million deaths in 2015. An estimated 96% of mortality from viral hepatitis is attributable to the sequelae of hepatitis B virus (HBV) and hepatitis C virus (HCV) infections. About 33% of global deaths occur in this Region.

An estimated 142 million people in the Western Pacific Region contracted an STI in 2012. The incidence and prevalence of curable STIs in the Western Pacific remain the highest in the world. Syphilis, for example, is increasing in China and Mongolia in both men and women. Syphilis incidence is also increasing in particular among MSM in most countries.

In 2016, WHO released three interlinked global health sector strategies on HIV, viral hepatitis and STIs with ambitious elimination targets. Anticipated challenges in achieving these targets include declining donor interest in health and disease-specific funding and limited funding available for viral hepatitis and STIs. These targets also need to be achieved in the context of sustainable development and universal health coverage.

### **2.2.4 New recommendations for viral hepatitis and HIV: What is in the pipeline for 2017–2018?**

*Marc Bulterys, Team Lead, Global Hepatitis Programme, Department of HIV and Hepatitis, WHO headquarters*

Dr Bulterys provided a global overview of the status of hepatitis B, hepatitis C and co-infection with hepatitis C and HIV and highlighted key features of WHO's *Global Health Sector Strategy on Viral Hepatitis 2016-2021*. The strategy calls for the elimination of hepatitis as a public health threat by 2030, defined as a 90% reduction in incidence and 65% reduction in mortality (from the 2015 baseline). Five core interventions are needed to reach elimination: three-dose infant hepatitis B vaccine; prevention of mother-to-child transmission of HBV (especially increasing the birth-dose coverage of hepatitis B vaccine to 90%); blood and injection safety in health-care settings; comprehensive harm reduction for PWID; and testing and treatment, with a target to diagnose 90% of persons living with hepatitis B or C and placing 80% of eligible patients on treatment.

It was observed that, globally, countries are doing well for three-dose infant vaccination, blood safety and injection safety, yet more needs to be done for the prevention of mother-to-child transmission of HBV (particularly birth-dose coverage, especially in Africa) and for PWID. We are far from reaching the testing and treatment targets. Regarding hepatitis B treatment, measurement of the progress towards the treatment target is currently limited by the absence of data on the proportion of persons eligible for treatment.

The Global Hepatitis Programme has issued a series of guidelines for hepatitis B and C testing and for the care and treatment of people living with chronic infections. For hepatitis C, Dr Bulterys highlighted the recommendation on the use of non-invasive tests for staging liver fibrosis and assessing all people living with chronic hepatitis C for treatment. The treatment guidelines will be updated later in 2017 to include the use of pan-genotypic regimens and will also address considerations for treatment prioritization with the recommendation to treat all people living with chronic hepatitis C. With respect to hepatitis B, Dr Bulterys highlighted the recommendations specific to pregnant women: 1) tenofovir should be provided to HBV-monoinfected pregnant women; and 2) fixed-dose combination of tenofovir + lamivudine (or emtricitabine) + efavirenz should be provided to pregnant women co-infected with HIV.

Recent developments in WHO's HIV normative guidance include HIV self-testing and assisted partner notification, which should be offered as part of a comprehensive package of testing and care to PLHIV. Oral PrEP that contains tenofovir disoproxil fumarate (TDF) is now recommended for any person at substantial HIV risk including MSM, sex workers and PWID. WHO will launch a *PrEP Implementation Tool* at the International AIDS Society meeting in July 2017 and the WHO-led Global PrEP Coalition later in 2017, through which WHO will support PrEP implementation in several countries, including Brazil, China, India, Kenya, Mozambique, the Philippines, South Africa and Thailand.

### **2.2.5 Universal health coverage and the Sustainable Development Goals: moving away from disease-specific to systems approach**

*Anjana Bhushan, Acting Coordinator, Integrated Service Delivery, Division of Health Systems, WHO Regional Office for the Western Pacific*

Dr Bhushan gave a comprehensive presentation on the concepts and principles underlying a whole-of-systems approach to health systems strengthening that simultaneously accelerates the achievement of both universal health coverage (UHC) and the health-related SDGs by countries. The guiding document *Universal Health Coverage: Moving Towards Better Health* details WHO's recommended guidance to Member States on achieving UHC.

Tackling public health challenges requires context-specific decisions that balance cultural expectations, social norms, political leadership, and negotiation across diverse interests. The SDGs enable governments to work across sectors (a whole-of-government approach) and across a range of new and old stakeholders (whole-of-society approach) to achieve health for all. Actions will be needed to link individual-level interventions with population-level interventions in all health programmes so that social determinants of health and health equity become a core part of the health system. Given their comprehensive and interlinked nature, the SDGs also imply a new role for the health sector in advancing this agenda and a fundamental mind-set change.

The *Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific*, which was endorsed by the WHO Regional Committee in October 2016, organizes its guidance to Member States under the following four guiding questions:

- 1) What are countries aiming to achieve, and how will they know?

- 2) What are the policy and programme priorities for leaving no one behind?
- 3) How will countries put their priorities into effect?
- 4) How can the health sector drive the agenda?

Guided by these four questions, the Regional Action Agenda provides a menu of actions and policies, organized around 12 action domains that Member States can consider, based on their specific context (Table 1).

**Table 1. Regional Action Agenda on achieving the SDGs in the Western Pacific**

Guiding questions	Action domains
<b>1. What are countries aiming to achieve, and how will they know?</b>	1.1 Country-led selection of health goals, targets and indicators 1.2 Robust monitoring and review process 1.3 Adequate information capacity
<b>2. What are the policy and programme priorities for leaving no one behind?</b>	2.1 Equity in health services 2.2 Realizing win–wins through collaboration across sectors 2.3 Financing strategies for promoting equity
<b>3. How will countries put their priorities into effect?</b>	3.1 Collaboration across government 3.2 Engagement of stakeholders beyond government 3.3 Participation of affected communities
<b>4. How can the health sector drive the agenda?</b>	4.1 Capabilities for knowledge exchange 4.2 Leadership skills to navigate the policy system 4.3 Institutional capacity for present and future challenges

## 2.3 Country presentations on elimination efforts

### 2.3.1 Elimination of HIV in China

*Wu Zunyou, Chief Epidemiologist, Chinese Center for Disease Control and Prevention, China*

Dr Wu explained that geographically the distribution of cases of AIDS in China is disparate and that the drivers of HIV infection can differ significantly from location to location. Consequently, China is dealing with several types of HIV epidemics.

The main modes of transmission of HIV in China over a 10-year period spanning from 2005 to 2015 have changed significantly – from injecting drug use and blood and plasma products in 2005 to sexual transmission (heterosexual [66.3 %] and MSM [28.3%]) in 2015. China has seen a steady yearly increase in new HIV infections between 2007 and 2015, which can be explained, in part, by increases in the number of people tested for HIV.

The significant decline in HIV transmission among PWID is primarily attributable to the introduction and scale-up of methadone maintenance treatment and needle exchange programmes. Getting discordant couples on ART was associated with a 66% reduction in HIV incidence among discordant couples.

Significantly, seroconversion among sero-discordant couples has reduced from 2.61% in 2011 to 0.78% in 2016, a drop of 70.1%.

Dr Wu emphasized that the practice of setting targets in all of their strategies has greatly facilitated implementation and helped China achieve impressive results in reducing HIV transmissions. The 90-90-90 targets are included in China's National AIDS Plan, and China will implement "treat all" policies.

### **2.3.2 Elimination of hepatitis in Mongolia**

*Tsatsralt-Od Biraa, First Deputy Director, National Centre for Communicable Diseases, Mongolia*

Mongolia has a high burden of viral hepatitis. Prior to the introduction of hepatitis A vaccination, hepatitis A was one of the common causes of acute jaundice. Mongolia has been able to substantially reduce incidence of hepatitis A with vaccination, but hepatitis B and C are still endemic. Prevalence estimates were 9.1% for HBV and 6.4% for HCV. Two recently conducted studies revealed that in 2013 HBsAg prevalence was 10.6% and that HCV antibody prevalence was 11% in apparently healthy adult population. Hepatitis D is highly endemic among individuals with chronic HBV infection. Due to nationwide introduction of hepatitis B vaccine among newborn infants, prevalence of HBsAg among children under 5 years of age was reduced to 0.53%, enabling Mongolia to reach the regional goal set by WHO. Mongolia has the highest annual mortality rate in the world from hepatocellular carcinoma (HCC). The rate of liver cancer is 8 times higher than the global average. Chronic HBV and HCV infections account for 95% of liver cancer.

The national "Healthy Liver" programme was approved by the Government of Mongolia in April 2017. It aims to eliminate hepatitis C by 2020 and substantially reduce mortality due to liver disease including chronic hepatitis, cirrhosis and liver cancer. This programme focuses on prevention of viral hepatitis, strengthening surveillance for chronic and acute hepatitis, expanding immunization to high-risk groups, improving infection prevention and control in the health sector, screening, early diagnosis and treatment of viral hepatitis by providing evidence-based, good-quality, accessible, comprehensive health services, implementation of research and innovation, and strengthening public and private partnerships.

### **2.3.3 Elimination of STIs in Fiji**

*Torika Tamani, National Adviser, Family Health, Ministry of Health and Medical Services, Fiji*

Fiji's *National Strategic Plan for HIV and STI* covers the period 2017–2020. The Government of Fiji directly funds routine services for HIV and STIs, and donor funds will support the development of various guidelines, communication materials and community mobilization, as well as technical support in terms of laboratory equipment, consumables and staff trainings. Aggregate data for STIs are collected from service levels through the National Notifiable Disease Surveillance System.

In 2015, the most commonly reported STIs in Fiji were gonorrhoea, syphilis and candidiasis. Fiji is making progress towards the elimination of mother-to-child transmission of HIV, hepatitis B and syphilis. Funding for Fiji's efforts to eliminate STIs is a mixture of national and donor funding. Surveillance and treatment of STIs are funded nationally, while prevention and treatment efforts are a mix of national and donor funding.

Fiji will look for synergies in the following areas as it pushes towards elimination of STIs: linkages between public health systems and clinical services; good governance structures; matching of training institution with training needs; and Fiji's multisectoral partnership with civil society, key populations, faith-based institutions and organizations and the private sector.

## **2.4 Country poster session**

Countries participating in the meeting prepared posters addressing the question: “What does it take to eliminate HIV, hepatitis and STI in your country as a public health threat?” Participants were given the opportunity to examine and discuss the posters with representatives of the presenting country.

## **2.5 Parallel session: country dialogue**

Meeting participants were divided into four groups to discuss and report back on issues and actions towards the elimination of HIV, hepatitis and STI as public health threats:

Group 1: Australia, China and Mongolia;

Group 2: Japan, the Philippines and Viet Nam;

Group 3: Cambodia, the Lao People’s Democratic Republic and Papua New Guinea; and

Group 4: Fiji, Hong Kong SAR (China) and the Republic of Korea.

Each group was asked to consider, discuss, reach conclusions and report back on three key questions.

- 1) What are the biggest issues for reaching elimination by 2030? How to address them?
- 2) What are the three most important public health functions needed for reaching elimination?
- 3) What are existing opportunities for synergies across three diseases and other programmes?

Representatives from each group reported key points garnered from discussions. Recommendations are included in Section 3.2.

## **2.6 Plenary session: global and regional targets and health information systems**

### **2.6.1 Global and regional targets for HIV, hepatitis and STIs**

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

Linh-Vi Le provided an overview of the 2020 and 2030 elimination targets at the global and the Western Pacific regional level for HIV, hepatitis and STIs. She noted that baseline data for the 2030 elimination targets for HIV and hepatitis were from 2015 and that baseline data for elimination targets for STIs would be established in 2018.

The 2030 global elimination targets for HIV, hepatitis and STIs are shown in Table 2.

**Table 2. Global elimination targets for HIV, hepatitis and STIs for 2030**

	<b>HIV</b>	<b>HEPATITIS</b>	<b>STI</b>
Incidence	200 000 new infections (from 2.1 million, ~90% reduction)	90% reduction (equivalent to 0.1% HBsAg in children)	90% reduction in incidence of gonorrhoea and syphilis
	Zero among infants, or ≤50 new paediatric infections per 100 000 live births	0.1% HBsAg in children	≤50 cases of congenital syphilis per 100 000 live births
Mortality	300 000 deaths (from 1.1 million, ~75% reduction)	65% reduction	
Vaccination		90% coverage with the third-dose of hepatitis B vaccine; 90% coverage with the birth dose	Sustained 90% national coverage and at least 80% coverage in every district in countries with human papillomavirus vaccine
Diagnosed	95% of PLHIV are diagnosed	90% of PLHBV and PLHCV are diagnosed	
Treated	95% of PLHIV diagnosed are on ART	80% of eligible PLHBV and PLHCV receive treatment	
Virally suppressed	95% of PLHIV receiving ART are virally suppressed		

ART, antiretroviral therapy; PLHBC, people living with hepatitis B virus; PLHCV, people living with hepatitis C virus; PLHIV, people living with HIV.

In the Western Pacific Region, the 2020 target for the number of new HIV infections is 24 000 – a reduction of 75% from the 2015 baseline of 96 000 new infections. With regards to the 2020 target for the number of deaths per annum from AIDS, the Western Pacific Region’s target is set at 15 000, a 65% drop from the 2015 baseline of 44 000 deaths annually from AIDS. The Western Pacific Region is currently trending at 96 000 new infections annually, and it will be a challenge to get to 24 000. Similarly, it will be a challenge to drop from 44 000 AIDS-related deaths in 2015 to 15 000 in 2020. The baseline for the cascade of care in 2015 was 65% diagnosed and 67% on treatment, so intensive scale-up is still needed to reach the 2020 90% targets.

With regards to hepatitis, the Western Pacific Region’s 2020 targets call for a 30% reduction in incidence equivalent to 1% HBsAg in children. As of 2016, HBsAg incidence in children stood at 0.9%, so that target has already been achieved. Third-dose hepatitis B vaccination coverage in 2016 was 93%, almost equal to the 2017 95% target set by resolution WPR/RC66.R1. However, more has to be done to reach the 2017 95% target for birth-dose coverage, which was 83% in 2016. With respect to the 2020 30% diagnosis target, only 15% of people living with HBV and 21% of people living with HCV have been diagnosed. Globally and regionally, data on treatment eligibility are limited and studies are needed in order to better monitor treatment uptake. However, only a few patients are on direct-acting antiviral (DAA) treatment.

Targets for STI elimination have been set at the global level for 2030, but not for 2020 given the limited data available globally. The Western Pacific Region is in the process of setting its 2030 STI targets and determining baselines for the targets. The Region has achieved the global target of 50 or fewer cases of congenital syphilis per 100 000 live births with a baseline of 6.6 cases in 2014.



## **2.7 Parallel session: HIV and STI data revolution for achieving elimination**

### **2.7.1 The need for data revolution to make the information strategic for achieving Fast-Track targets**

*Taoufik Bakkali, Regional Programme Advisor, UNAIDS Regional Support Team, Asia and the Pacific*

Mr Bakkali emphasized the importance of strategic information systems to monitor and assess progress towards achieving 2020 HIV targets. He urged that the following critical actions be taken to produce a shift in data systems:

- Set up sustainable health information systems. Key actions include updating health information systems, developing unique identifiers, mandating HIV case reporting and supporting community-based data collection, including for key populations.
- Use data to identify programme gaps. Key actions include refining models based on routine data and disseminating and displaying data in an accessible format.
- Adjust the response. Key actions include fast-tracking the HIV response to locations and populations with service delivery gaps and linking monitoring data with expenditure data to identify efficiencies.

Mr Bakkali proposed that a data system that is “fit for purpose” should: 1) provide real-time data on programme performance; 2) inform on outcome and impact; 3) be able to quickly inform on epidemiological change; 4) aggregate individual health outcomes; 5) be detailed enough to inform decision-making at national, subnational, local and population-specific levels; 6) help identify and resolve implementation bottlenecks; 7) help to improve performance and quality; and 8) provide reliable data for the purpose of advocacy.

### **2.7.2 Setting things in motion: strengthening the Philippine HIV response through analysis of cascades**

*Genesis Samonte, Epidemiology Bureau, Department of Health Philippines*

A cascade analysis effectively helped to identify gaps in the HIV care continuum in the Philippines. With regards to HIV testing, the analysis found that only 67% of estimated PLHIV have been tested and diagnosed; the operating hours of testing facilities did not match the availability of clients; and the numbers of people testing among key populations, especially youth, were low.

To address the identified gaps in testing, the following actions were taken: sundown clinics with more flexible operating hours were opened; community-based testing by local organizations was established; age-targeted services were introduced; and ways to provide (proxy) consent for young key populations were explored.

At the level of “linkages to care”, the cascade analysis established that significant numbers of people who were tested were not coming back to receive their confirmatory test results, and that baseline laboratory tests were not readily available in the testing facility. Subsequently, programme managers addressed these gaps by implementing a rapid HIV diagnostic algorithm to be administered in community-based services and issuing a policy on enhancing linkages to care for PLHIV.

The evidence and lessons learnt from the cascade analysis and the remedial measure to address the identified gaps in the response to HIV treatment were utilized by the national programme on HIV to

convince decision-makers at the municipal level to adapt their HIV responses in line with the cascade analysis results.

### **2.7.3 Key population cascades: experiences from community lay provider testing cascades and approaches to obtaining risk behaviour data**

*Nguyen Thien Nga, UNAIDS, Viet Nam*

The presenter described a recent pilot project featuring HIV testing by community lay providers and approaches to obtaining risk behaviour data in Ho Chi Minh City, Viet Nam. The objective of the pilot was to generate evidence to inform advocacy for changes to local and national policies on HIV testing. The implementing partner for this demonstration project was a nongovernmental organization based in Ho Chi Minh City – Center for Applied Research for Men and Community Health (CARMAH). The project aimed to test 1000 people using a finger-prick HIV test in order to identify HIV-positive people and refer them to treatment.

The UNAIDS Country Office for Viet Nam supported CARMAH with the development of an online form and database for capturing and storing project-related information and data. With the clients' consent, confidential information about people tested through the project was recorded on the online form. The name of the client was not recorded, but a unique identifier was used.

Support to the lay testers was provided online. The project plotted the residences of PLHIV and clinics, which facilitated an analysis of geographic data and service accessibility. These data, along with the periodic analysis of other data, helped identify gaps in the testing and treatment cascades. Identification of these gaps enabled remedial action to address them while the project was still being implemented.

Lessons learnt from the pilot project were as follows: community members can provide reliable and effective lay testing; building the capacity of local nongovernmental and/or community-based organizations to use data to inform programme responses is necessary; it is possible to collect risk behaviour/key population information that helps to better understand the risk, age and location of subgroups of key populations; a cohort-based cascade using a unique identifier code helps identify bottlenecks along the linkage at the individual level and along the cascade; and using unique identifiers helps trace clients for the purpose of evaluation.

### **2.7.4 Discussion: country needs and plans for improving patient follow-up across care services: referral systems, unique identifiers**

Mr Taoufik Bakkali and Dr Naoko Ishikawa co-facilitated discussions on the following two questions:

- 1) What are the main issues that countries face regarding improving patient follow-up across care services?
- 2) What recommendations can be made to improve patient follow-up across care services, including changes to how strategic information is collected and used?

Discussion points included: 1) the challenge of achieving the first of the three 90-90-90 targets (i.e. 90% of PLHIV know their HIV status); 2) the need to improve the reliability of data for all three targets, especially the third target (i.e. 90% of all people receiving ART will have viral suppression); 3) the tracking system is challenging even when we use a unique identifier; 4) mortality is underreported in many countries; and 5) the need for more information about adherence and PLHIV retention in care.

Participants also engaged in a lively discussion on the need for and use of unique identifiers. Some argued that if identifiers can be traced back to individuals, it can be very stigmatizing to be in a health

system information database for key populations. Some participants urged a more creative approach to collecting key population data because of stigma and discrimination. While acknowledging concerns that were raised about unique identifier codes, other participants were firmly of the opinion that they are crucial for ensuring the reliability and utility of data needed to measure progress toward the achievement of targets, including but not limited to the 90-90-90 targets. In addition, the suggestion was made that unique identifier codes should identify not only male and female but also transgender.

The issue of disaggregated data for key populations was discussed. While the *Global AIDS Monitoring 2017* encourages disaggregated cascade data for key populations, participants raised concerns about the dynamic nature of key population status (e.g. PWID or sex worker status is not for lifetime), potential discrimination (e.g. status recorded in health record), and limited reliability of data. It was agreed this issues require continued discussion.

### **2.7.5 Discussion: implications of global HIV and STI targets for the Western Pacific Region**

Dr Teodora Wi and Mr Taoufik Bakkali were appointed as the co-facilitators for this discussion. Mr Bakkali opened the session by highlighting the elimination goals for ending AIDS by 2030: eliminate new infections; eliminate AIDS deaths; and eliminate HIV-related morbidity and mortality. It was noted, however, that two WHO regions (that is, South-East Asia and Western Pacific regions) had not yet set Fast-Track targets. Mr Bakkali raised the question whether instead of setting numerical benchmarks for elimination, we should define an environment that would guarantee elimination. The presentation concluded with the observation that there are many factors that must be considered by countries when they adapt targets for use at country level, including the defining features of the epidemic or epidemics at country level. For example, in a country with mature epidemics where major gains have already been achieved, the potential for more progress would be minimal, difficult and very costly.

Dr Wi presented a series of slides that stressed the challenges in setting elimination targets for STIs at every level: global, regional, subregional and country. In her closing remarks, Dr Wi emphasized that WHO can provide technical support and guidance to complement or strengthen country efforts to address challenges regarding STI surveillance and reporting.

Major issues raised in the discussions that followed the two presentations included: 1) countries face many barriers in setting targets for HIV, hepatitis and STIs due to shortcomings in how data are collected; 2) many countries do not have quality baseline data, especially for STIs; 3) there is a need for a practical, universal and simple case definition of STIs, especially for syphilis; 4) even in the absence of good baseline data on STIs, it will still be possible to set elimination targets for curable STIs in most countries (examples were given); and 5) countries face challenges and issues in setting HIV-related targets.

Participants were asked if they were comfortable with the proposed WHO Western Pacific Region targets for HIV, hepatitis and STIs that were presented in an earlier session. In response, it was pointed out that while the targets were very ambitious, they were necessary to get relevant stakeholders to focus on the responses required to achieve the targets. It was recommended that all countries develop action plans or roadmaps to reach the targets and that they must feature priority actions that must be implemented. The development of the roadmap should bring all key stakeholders to the planning process including national authorities and United Nations Country Teams, including but not limited to WHO and UNAIDS.

### **2.7.6 Discussion: HIV drug resistance surveillance: updates and discussion on surveillance needs and country plans**

Dr Masaya Kato and Dr Anup Gurung described the objectives of the session as to: 1) update the countries' plan for HIV drug resistance (HIVDR) surveillance; 2) discuss key challenges for implementing HIVDR surveillance; and 3) explore the way forward in strengthening HIVDR prevention, surveillance and response, and how WHO and other partners could potentially support the countries' effort.

Countries shared their experience in conducting and/or developing national plans for HIVDR surveillance. Participants identified a number of issues and challenges: 1) HIVDR is a threat and is very important for achieving the 90-90-90 targets, especially the third one; 2) HIVDR surveillance is expensive; 3) HIVDR surveillance is a real challenge for Cambodia and the Philippines where laboratory services are limited; 4) there is a need to convene national teams from different disciplines when developing national HIVDR surveillance plans, including epidemiologists who can play an important role. Country plans benefit from a good thematic working group. WHO could provide technical support to countries in developing these plans; and 5) HIV programmes need to expand routine HIVDR surveillance (for example, Australia genotyping). Participants recommended that countries to allocate resources for routine drug resistance survey alongside implementation of routine services.

### **2.7.7 Antimicrobial resistance of gonorrhoea**

*Teodora Wi, Medical Officer, WHO headquarters*

WHO recently launched a global action plan to control the spread and impact of antimicrobial resistance (AMR) in *Neisseria gonorrhoeae*. The plan outlines several critical areas for action including: advocacy, STI prevention and control, surveillance including monitoring treatment failure, rational drug use, capacity-building and research for new drugs, and molecular methods for detecting AMR.

In 1994, WHO established the Gonococcal Antimicrobial Surveillance Programme (GASP), a worldwide laboratory network that is coordinated by focal points and regional coordinating centres. GASP's objectives are to: ensure adequate sentinel AMR surveillance to inform treatment guidelines in all countries; establish a strategy to rapidly detect patients with gonococcal infections; and ensure effective clinical management of infected patients and their sexual partners.

Other new developments to tackle the spread and impact of the growing problem of AMR in *Neisseria gonorrhoeae* include: 1) collaboration between Drugs for Neglected Disease Initiative (DNDi) and WHO – Global Antibiotic Research and Development Partnership (GARDP) – to identify new treatment for gonorrhoea; 2) promotion of molecular approaches to enhance surveillance of gonococcal AMR; 3) enhancing GASP; 4) increased sentinel surveillance in selected countries; and 5) vaccine development for gonorrhoea and other STIs.

### **2.7.8 Regional GASP in countries in the Western Pacific Region**

*Professor Monica Lahra, Medical Director, Division of Bacteriology and WHO Collaborating Centre for STD, The Prince of Wales Hospital, Sydney, Australia*

The GASP Coordinating Centre for the Western Pacific Region is the WHO Collaborating Centre for Sexually Transmitted Diseases at the Prince of Wales Hospital, Sydney, Australia, which is a foundation partner and has been an implementer of GASP since inception. In partnership with the WHO Regional Office, the Centre collates data on patterns of antimicrobial susceptibility in gonorrhoea in participating

countries. The Centre has provided continuous technical support in monitoring GASP in the Western Pacific Region for the past 25 years and providing quality strain panel and quality assurance since 2009.

The collection of data on AMR in *Neisseria gonorrhoeae* in the Western Pacific Region is not without its challenges. The GASP AMR data needs to be representative and to be reported using the minimum inhibitory concentration (MIC) levels for a panel of antibiotics including treatment antibiotics. These data must be comparable, and quality controlled and quality assured. However, in the Western Pacific Region the capability, scope, scale and methods of antimicrobial susceptibility testing vary widely between countries. There is no data or limited data from some countries where testing is limited or not performed. Factors contributing to the lack of GASP data include resource limitations for testing in terms of funds, skills, infrastructure and commitment in some settings, and the introduction and uptake of nucleic acid amplification testing that does not allow for antimicrobial susceptibility testing in other settings.

*Neisseria gonorrhoeae* AMR is increasing in the Western Pacific and globally. The next steps for treatment are uncertain, and accordingly, we need to focus more on the prevention of gonorrhoea and other STIs. Expanding, integrating and sustaining GASP is critical to inform treatment guidelines and ensure the use of appropriate antibiotics for treatment of gonorrhoea, to support disease prevention and control and to understand magnitude and trends of AMR and monitor effects of interventions. Capability for disease control strategies will be strengthened with improved surveillance data on *Neisseria gonorrhoeae* and other STIs. Molecular strategies are in use in Australia to enhance AMR surveillance in *Neisseria gonorrhoeae* and further developments will enable supplementary AMR data to inform the GASP.

### **2.7.9 Experience in strengthening laboratory and reporting systems for gonococcal drug resistance surveillance in China**

*Xiang-Sheng Chen, National Centre for Sexually Transmitted Disease Control (NCSTD), China*

In 2007, the China Gonococcal Resistance Surveillance Programme was established. It is a collaborative network consisting of 16 provincial-level central STD laboratories, sentinel clinic sites and local MIC laboratories. The main functions of the central STD laboratories are coordination, quality control, technical support, MIC determination, research, and reporting to the China National Reference Laboratory. The sentinel clinic sites are responsible for collecting, culturing, storing and transferring isolates to the central STD laboratories. At the local MIC labs, MICs are determined locally and MIC results are reported to the central STD laboratories.

The National STD Reference Laboratory serves as the headquarters of the China Gonococcal Resistance Surveillance Programme and its main functions are: develop and update the national gonococcal resistance surveillance guidelines; evaluate eligibility of clinics and labs to be included in the Programme; organize the annual working meeting and training course; manage external quality assurance (QA) and provide standard antibiotics for MIC tests; store isolates (>1000/year); analyse data; report China Gonococcal Resistance Surveillance Programme results at an annual HIV/STD meeting; and submit the report to the National Health and Family Planning Commission. In turn the responsible department of the Commission would report data to WHO.

In 2016, 14 ministries in China jointly issued the *National Action Plan to Contain Antimicrobial Resistance (2016–2020)*. Subsequently, the China Gonococcal Resistance Surveillance Programme has been renamed the China Gonococcal Resistance Surveillance Programme-plus.

## **2.8 Parallel sessions: hepatitis**

### **2.8.1 Strategic information for hepatitis elimination**

*Marc Bulterys, Team Leader, Global Hepatitis Programme, WHO, Headquarters*

Dr Bulterys presented the WHO guidelines and framework for monitoring and evaluating HBV and HCV elimination and introduced the recommended 10 core indicators for viral hepatitis. The framework involves both surveillance and patient monitoring systems. Chronic HBV and HCV seroprevalence surveys are needed for monitoring the epidemic and estimating testing and treatment needs, while monitoring of incidence and deaths from liver diseases attributable to HBV and HCV infection are needed to measure programme impact. Patient registries are needed to monitor the cascade of care or cure, specifically for: people living with HBV and/or HCV diagnosed, treatment coverage for HBV or treatment initiation for HCV, and viral suppression for chronic HBV patients treated or cure for chronic HCV patients treated.

Surveillance systems follow the natural history of viral hepatitis. Acute surveillance can be established at sentinel surveillance sites with high epidemiological and laboratory capacity to ensure that acute infections can be differentiated from chronic infections. Ideally, chronic infection surveillance is conducted routinely through nationally representative surveys, but it can be estimated through programme data and modelling. Sequelae surveillance can be conducted at centres of excellence that can provide the proportion of cirrhosis and hepatocellular carcinoma caused by HBV and HCV, and multiplying this fraction with the number of deaths from cirrhosis and hepatocellular carcinoma obtained from national vital statistics records.

Programme monitoring consists of surveys and programme data collecting information on HBV immunization coverage, blood donation screening, syringe and needle coverage per person who inject drugs, and health-care injection safety. Patient cards and databases should contain minimal but important clinical records to monitor the cascade of care. Dr Bulterys explained that surveillance and programme monitoring systems should be separate as they address different data needs.

### **2.8.2 Mongolia: surveillance and laboratory systems strengthening efforts**

*Jadamba Naraa, Technical Officer, WHO Mongolia*

Mongolia has a well-established system for the reporting of infectious diseases. The system includes a variety of actors at the primary, secondary, tertiary and national/management levels. Milestones in hepatitis surveillance in Mongolia were highlighted as: 1952 – started to report acute hepatitis A; 1981 – started to report acute hepatitis B; and 1998 – started to report acute hepatitis C.

The main strengths of laboratories in Mongolia were identified as: public and private laboratories diagnose acute and chronic hepatitis using serological and nucleic acid tests; rapid diagnostic tests are used in peripheral health-care facilities; 22 laboratories located in Ulaanbaatar, the capital city, are authorized to perform viral load testing; the cost of two viral load tests will be covered by health insurance; and a new network of private laboratories was created to improve the quality of laboratory services so that they meet national and international standards and improve the quality assurance system.

Laboratories in Mongolia should address priority issues such as specimen referral, transportation and storage, quality assurance, test kit procurement, human resources and laboratory reporting.

The next steps to improve hepatitis surveillance in Mongolia are to: 1) develop national surveillance guidelines; 2) ensure the integration and interoperability of different data systems; 3) undertake

laboratory capacity assessments in all 22 laboratories that perform hepatitis confirmatory testing and nucleic acid testing in the country; and 4) strengthen the quality assurance system for laboratories.

### **2.8.3 HBV and HCV surveillance in Japan**

*Hideki Aizaki, National Institute of Infectious Diseases, Japan*

Milestones in the development of a programme for HBV and HCV surveillance came in 1987, when Japan commenced monitoring of hepatitis B and C infection on a monthly basis at 500 sentinel hospitals, and in April 1997, when legislation was passed – Infectious Diseases Control Law – requiring a physician who has made a diagnosis of hepatitis B or C to notify the case to the health centre within 7 days. Subsequently the health centre is required to notify the Ministry of Health who in turn must report the information to the National Institute of Infectious Diseases (NIID).

In Japan, many people living with HBV or HCV are unaware of their infection until they receive a liver function check. The main transmission route of acute hepatitis B is sexual contact, while that of acute hepatitis C is uncertain. In recent years, the number of men infected with hepatitis B or C through sexual contact with other men has increased. Efforts to raise awareness among HIV-positive MSM of possible acute hepatitis infection through sexual contact were undertaken in public health centres and AIDS clinical hospitals from 2012 and 2014, but occurrences of acute hepatitis infection among HIV-positive MSM have been observed since then.

The following lessons were identified: 1) the surveillance system for hepatitis in Japan does not capture all cases primarily because of underreporting by physicians (no penalty for physicians who do not notify health centres when hepatitis infection is discovered); 2) an awareness and education campaign directed at physicians about their obligation to report cases of hepatitis B and C in people they have tested is required; 3) voluntary screening for hepatitis B and C viral infection is recommended for people who have not been tested; and 4) there is an ongoing need for education efforts targeted at HIV-positive MSM to prevent further HCV infection among them.

### **2.8.4 Group work: country plans for hepatitis surveillance and monitoring and evaluation framework**

Using a template, country participants conducted a quick assessment of their strategic information activities and developed plans for strengthening surveillance. The current situation by country is as follows:

Australia does not have enhanced surveillance for acute hepatitis; has an annual vaccine, blood screening and health facilities survey; has extensive national coverage of chronic infection surveys; reports key population prevention indicators annually; and has an ongoing longitudinal study among 30 000 individuals treated for hepatitis C.

Cambodia does not yet have a surveillance system in place; has early warning systems using syndromic reporting; and has ongoing data collection for disease estimates modelling.

Hong Kong SAR (China) has mandatory reporting for acute hepatitis; has conducted a seroprevalence survey among 5-year-olds; has prioritized increasing access to treatment for HCV; and has suboptimal antiviral drugs for pregnant women.

Japan has robust acute infection surveillance; recently started hepatitis B vaccination for infants; undertakes selective screening for HCV; has patient registries operated by local governments but no national registry; and has a cancer registry for mortality surveillance.

Mongolia has robust acute infection surveillance; conducts serosurveys for chronic infection surveillance among adults and 5-year-olds; has too many patient registries; and has completed analysis on the cascade of diagnosis and treatment.

Papua New Guinea has conducted an HBsAg serosurvey among 5-year-olds but has no plan for future testing; HBV test results from key populations and blood donors are available; HBV screening is reported in the national health information system.

The Philippines has a reporting system for acute infection surveillance; have conducted serosurveys among key populations; has access to blood donor and ANC testing and seropositivity data; and is carrying out disease modelling.

Viet Nam is conducting serosurveys for chronic infections among adults and children separately this year; is reporting screening tests into the notifiable diseases system; has not yet set up patient registries; and is prioritizing treatment access.

Next steps for countries to strengthen surveillance of hepatitis were discussed. As countries are at different stages in developing robust surveillance systems, they plan to carry out different activities in the near future. For example, Australia will look at long-term outcomes for HCV treatment, rate of reinfection and risk for treatment failures. Cambodia and the Philippines will work on disease burden analysis and national hepatitis action plan. Hong Kong SAR (China) will focus on access to HCV treatment, development of the diagnosis and treatment cascade, and development of HBV prevention guidelines to reach 0.1%. Japan will add screening to residential medical examinations and workplace health check-ups and continue to educate health-care coordinators on follow-up of asymptomatic HCV patients. Mongolia will work to develop national surveillance guidelines, monitoring and evaluation frameworks, and laboratory assessment.

### **2.8.5 Discussion: approach to calculating and setting regional hepatitis targets for the Western Pacific**

Dr Marc Bulterys and Dr Joe Woodring were co-facilitators for this session. Dr Woodring explained that the *Regional Action Plan for Viral Hepatitis in the Western Pacific 2016–2021* has set targets and milestones for stopping transmission. The Western Pacific Region has reached the 2017 milestones and targets for hepatitis B vaccination, with 18 countries verified to have reached target, and it is well positioned to reach the regional goal of <0.5% HBsAg among children by 2025. Seven serosurveys are planned for verification. Most of the countries are likely to meet the regional goal. A new regional goal for 2030 is proposed to be <0.1% HBsAg among children by 2030. Lowering the goal would require a larger sample of children under 5 years of age to conduct serosurvey for validation. The Western Pacific Region has met the 2020 immunization target, but there is a long way to go to reach the proposed 2030 target. Validation criteria and mechanisms for triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis B were introduced.

Member States should apply WHO guidelines for surveillance and programme monitoring to prioritize activities for the next two years to address data needs reflecting the different stages of their national viral hepatitis programme. Most countries still need patient registry systems for chronic infections to track progress across the cascade of testing and treatment outcomes.

### **2.8.6 Viral hepatitis regional laboratory network: terms of reference**

*Sue Best, National Serology Reference Laboratory, Australia*



The WHO Regional Office for the Western and Pacific developed a five-year *Regional Action Plan for Viral Hepatitis in the Western Pacific 2016–2020* to provide concrete, prioritized, and actionable items for consideration by countries to address the national burden of viral hepatitis. The Regional Action Plan calls for the establishment of a national hepatitis reference laboratory at country level as well as a regional laboratory network to provide laboratory technical assistance to domestic laboratory networks on viral hepatitis.

Membership in the regional laboratory network would be open to national viral hepatitis laboratories that agree to participate. Currently laboratories in Australia (2), Japan, the Republic of Korea and China (in discussion) have expressed interest in acting as regional reference laboratories (RRLs) for the network.

RRLs will be asked to: assist with the development and implementation of national testing strategies for diagnosis, monitoring, surveillance; develop systems for test kit regulation; assist in establishing national quality management systems (QMS) and external quality assessment schemes (EQAS); provide EQAS to national reference laboratories; provide confirmatory testing and training; conduct assessments; facilitate data collection and improve data collection systems.

Activities for national reference laboratories (NRLs) will be to: foster implementation of national QMS and provide national EQAS; train, monitor and supervise the country's hepatitis testing laboratories; evaluate hepatitis test kits; conduct confirmatory testing; support improved data collection for surveillance and related activities; and advocate for necessary resources.

The terms of reference for the Secretariat are to: invite designation of RRLs; develop operational policies; facilitate relationships within the network; identify resources; and coordinate and communicate reports and advocacy. The WHO Regional Office will assume the Secretariat role.

The intended outcomes of the regional laboratory network are: designated RRLs and NRLs; quality assured test results for diagnosis; strengthen lab support to therapeutic monitoring and surveillance activities; EQAS participation encouraged for all; improved surveillance underpinned by reliable laboratory services; an annual regional meeting; an annual network report to showcase the network's achievement of the Viral Hepatitis Global Health Sector Strategy priorities.

### **2.8.7 Discussion: feedback on the draft terms of reference for the viral hepatitis regional laboratory network**

Dr Sue Best was appointed as the facilitator for this session. She led a discussion with participants on key issues concerning the terms of reference, including:

- What criteria should be used to designate RRLs?
- Is regional laboratory network accreditation desirable for the RRLs and NRLs?
- If accreditation is desirable, which mechanism should be used?
- How should network data be shared within and among countries?
- What data should be shared?

Criteria for designation as a RRL need to be developed. It was noted that any laboratory designated as an RRL would not only need high-level capability, but also capacity to provide support to NRLs in kind. It was suggested that the viral hepatitis regional laboratory network be integrated with existing laboratory networks rather than be developed as a new network.

Potential mechanisms for laboratory accreditation were discussed. ISO 15189 would be required for RRLs; however, this level of accreditation is not practical, or required, in the first instance for NRLs. Nevertheless, there is no simplified standard based on ISO 15189 to which the NRLs could be accredited. Resources for technical assistance would be needed to further accreditation aspirations. Laboratory systems would need to be assessed for their readiness for accreditation, irrespective of which standard was applied, and technical assistance would most likely be necessary to bring the systems to the required level.

It was noted that sharing information from relevant studies in the Region would be very beneficial and avoid duplication. A process for sharing information should be documented as a policy of the regional laboratory network to cover aspects such as data ownership, confidentiality and publications. Mechanisms proposed for sharing information included videoconferencing and having a dedicated section on the WHO Western Pacific Regional Office website.

Overall, identifying the financial resources required for technical assistance was seen as a significant challenge to the success of the regional laboratory network. Estimates for these activities are necessary so that funding proposals can be prepared and/or ministries of health can allocate budget.

## **2.9 Plenary session**

### **2.9.1 Transition to Xpert – operational considerations**

*Kalpeshsinh Rahevar, Medical Officer, Stop TB, Communicable Diseases Control, WHO Regional Office for the Western Pacific*

GeneXpert is a molecular platform launched in 2004. Xpert MTB/RIF is a cartridge-based, automated nucleic acid amplification test that uses the GeneXpert platform. It detects *Mycobacterium tuberculosis* (MTB) complex DNA and rifampicin resistance (*rpoB* gene mutations) in less than 2 hours. Sample DNA extraction, amplification and detection are all carried out within this self-contained “laboratory in a cartridge”. WHO endorsed GeneXpert in December 2010 after demonstration/validation studies. By 2016, 130 countries were utilizing GeneXpert for diagnosing TB and rifampicin resistance.

The presenter, Dr Rahevar, explained operational considerations for using the Xpert platform and the associated tests/cartridges as well as the challenges identified by selected countries – Lao People’s Democratic Republic, Papua New Guinea and the Philippines – in using GeneXpert. The presenter also noted that the use of GeneXpert offers great opportunities for collaboration between TB, HIV and hepatitis programmes, significant system efficiencies, cost savings and improved patient access.

The following conclusions were identified: GeneXpert is a polyvalent molecular system that can be used for multiple diseases and placed close to the point of care; Xpert MTB/RIF has revolutionized TB detection; the GeneXpert platform is underutilized in many countries (30–40% of its capacity); existing sites, human resources and referral mechanisms provide great opportunity and advantages for integration; and TB, HIV and hepatitis programmes need to plan together for integration of diagnostics for improving efficiencies and access.

### **2.9.2 DHIS2 Integrated Surveillance Systems in the Lao People’s Democratic Republic**

*Bounpheng Philavong, Director, Centre for HIV/AIDS and STI, Ministry of Health, Lao People’s Democratic Republic*

Health information systems strengthening is one of five prioritized areas in the Lao People’s Democratic Republic health sector reform plan. At the core of this priority activity is the web-based health

information system. The following components were crucial for establishing a web-based system to function in Lao People's Democratic Republic: leadership, legislation and coordination; internet connectivity and information communication technology solutions; technical capacity of human resources at all levels; and financial sustainability. The process requires capacity-building and mentoring according to functions and responsibilities of staff at different levels.

An integrated District Health Information System (DHIS2) was developed to provide data to different users at different levels using one platform. Hospital managers can know what is going on in the hospitals (outpatient, inpatients, logistics, infrastructures and finance). Programme managers can focus on progress and implementation of interventions (service coverage, targeted interventions, logistics supply, and integrated services). And other managers can look at the overall cross-cutting performance of the health sector (service coverage, impacts, etc.). The advantages of an integrated DHIS2 in the Lao People's Democratic Republic are that: all users can have access to the system and obtain the information they need; manager can see the big picture as well as drill down to see specific areas (type of intervention and geographical location); and summary reports and dashboards can be tailored for each manager to get automatic information updates on regular basis.

The main challenges experienced in the Lao People's Democratic Republic in using the DHIS2 effectively are: data analysis and statistics skills among users are limited; data quality is still questionable despite efforts and progress made; the need for data is not constant and clear to all users; and users' capacities for system management and connecting data to actions are suboptimal.

Lessons learnt to date are: a high level of commitment is required from all stakeholders to share resources with other diseases; instant messaging applications, such as WhatsApp, facilitate discussion, and consultation between technical and supervision team and data managers at sites levels; monthly technical meetings can improve functioning of the system; and DHIS2 can be a platform to share all data including surveillance data, results from studies for everyone to access.

### **2.9.3 Working groups**

Participants were assigned to one of two working groups:

- Group 1 – Approaches to expanding molecular diagnosis for HIV, hepatitis and STI
- Group 2 – Approaches to integrating health information systems.

Group 1 focussed their discussions on issues that need to be considered in expanding the use of molecular diagnosis for HIV, hepatitis and STI testing. Group 2 identified approaches and principles for integrating health information systems and the characteristics that an integrated system should have.

Representatives from each of the working groups reported on the main discussion points and/or conclusions reached in a plenary session. Recommendations drawn from this session are included in Section 3.2.

## **2.10 Interventions for elimination**

Dr Kenny Chan of Hong Kong SAR (China) and Dr Ly Penh Sun of Cambodia were named as the chairpersons for Day 3 of the meeting.

### **2.10.1 Draft regional framework for triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis B in Asia and the Pacific 2018-2030**

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

Dr Ishikawa observed that while there are multiple global strategies and regional action plans calling for the highest attainable standards of health for all and the elimination of mother-to-child transmission (EMTCT) of HIV, hepatitis B and syphilis, there was a need to develop an EMTCT strategy to address the particular needs of Asia and the Pacific. The process of developing a regional framework for triple EMTCT of HIV, hepatitis B and syphilis has involved the participation of Member States, the WHO regional offices for South East Asia and Western Pacific and WHO headquarters. In addition, experts in maternal, newborn and child health (MNCH), HIV, Expanded Programme on Immunization (EPI), hepatitis, and STI experts from global, regional and country levels have reviewed and commented on drafts of the regional framework.

The objectives of the draft regional framework are to suggest a coordinated approach towards achieving triple EMTCT and to provide guidance for decision-makers, managers and health workers of reproductive, maternal, newborn and child health (RMNCH) and from HIV, hepatitis, STI and immunization programmes. The draft framework's vision is "Every infant free of HIV, hepatitis B and syphilis", and its goal is to "achieve and sustain EMTCT of HIV, hepatitis B and syphilis and better health for women and their families through coordinated approach and efforts by 2030". The draft framework has three pillars – policy, service delivery and monitoring and evaluation – with set milestones to be achieved by 2020 and targets to be attained by 2030. The milestones and targets were described.

The draft framework will be shared with delegations attending the sixty-eighth session of the WHO Regional Committee for the Western Pacific in October 2017 to consider and hopefully endorse it. In the meanwhile, a costing tool and cost-effectiveness analysis for integrated triple EMTCT for countries as well as a baseline report (2017) for triple EMTCT in the region are under development. Various communications materials will also be produced to support the roll-out of the framework.

### **2.10.2 Hepatitis B elimination in China – triple elimination as an opportunity**

*Fuzhen Wang, Zunyou Wu, Chinese Center for Disease Control and Prevention, China*

Between 1992 and 2006, China moved from being a country with a high burden of hepatitis B to having a mid-burden status. In large part, the reduction in the hepatitis B burden can be attributed to China's escalating vaccination policy. The presenter, Dr Zunyou Wu, identified several milestones in China's approach to hepatitis B vaccination and explained that China is currently implementing its 13th Five-Year Plan (2016–2020) for EMTCT of HIV, hepatitis B and syphilis. The Plan features a pilot project to strengthen prevention of mother-to-child transmission (PMTCT) of HBV through integration of additional interventions with HBV immunization such as HBV screening of and antiviral interventions for pregnant women as well as hepatitis B immunoglobulin for the baby. The project will be piloted in three provinces before the approach is ready for validation at the national level. The Plan also aims to screen 15–18 million women annually, avert 60 000 new infections and case-track 1 million ± HBV-exposed children.

The following challenges regarding HBV elimination were discussed:

- 1) HBV birth dose vaccination remains the priority for prevention of hepatitis B. The implementation of timely birth dose policy needs to be strengthened further.
- 2) PMTCT of HBV can be improved in particular in provinces with high HBsAg prevalence among childbearing women. Screening and antiviral interventions for PMTCT could provide better prevention, albeit HBV DNA testing rates in HBsAg-positive pregnant women are low and

antivirals are not widely available.

- 3) Routine monitoring can be strengthened: post-vaccination serological testing (PVST) is not included in the integrated PMTCT programme and not a standard of care; and there is limited availability of data on feasibility, cost-effectiveness and acceptability. A pilot evaluation could help determine value and desirability of post-vaccination serology testing.

### **2.10.3 Elimination of HIV and STI**

*Richard Steen, Consultant*

The virtual elimination of HIV and several STIs is now technically feasible. As such, the aims ought to be the virtual elimination of new HIV infections and death, and advanced control of other STIs with select elimination targets.

Accomplishing these aims requires a two-prong approach with a three-population focus:

- interrupt primary upstream transmission in high-incidence sexual and injecting networks with high transmission potential; and
- prevent secondary infection downstream in the low-risk general population.

It was suggested that to maximize impact we need to implement interventions along three dimensions: 1) Scale: identify new hotspots and mobilize new peer outreach teams; 2) Intensity: maintain existing outreach strategies for saturation coverage (microplanning), increase peer ratios to 1:50, and reach the highest-risk key populations; and 3) Effectiveness: raise or maintain high levels of condom use; strengthen STI control; and introduce “Test and Treat” and pre-exposure prophylaxis (PrEP).

Epidemiological targeting is efficient. Modelling shows that reaching sex workers with the most clients has the largest impact on transmission. More targeting of high-risk populations and locations is needed to make additional progress toward elimination.

Five key steps for more effective responses to STI and HIV were discussed.

- 1) Focus efforts where needed and know your catchment areas: scale and saturation, sharper epidemiological targeting and monitor denominators.
- 2) Strengthen outreach: high uptake, frequent contact and prioritization by risk.
- 3) Improve clinical services: regular check-ups, cascade performance and STI control.
- 4) Address other needs: less violence, financial security and children protected.
- 5) Manage and monitor programme: common minimum programme, focus on key indicators and data used (dashboard).

Categorization criteria by elimination status, for example poor control, low incidence and pre-elimination, and elimination status matched by priority areas and interventions were proposed.

Dr Steen identified the following crucial next steps for progressing towards the elimination of HIV and STIs in the Western Pacific Region:

- 1) Develop a two-prong, three-population approach.
- 2) Describe stages of elimination for HIV and select STIs based on regional data.
- 3) Propose elimination targets and indicators (outcomes and process) for HIV and STIs for different stages.
- 4) Sketch out sharper targeting and operational aspects.
- 5) Capture regional innovations.

#### **2.10.4 Piloting community-based delivery of peer-driven HIV pre-exposure prophylaxis for MSM and transgender women in Manila, Philippines**

*Gerard Belimac, Manager, National AIDS/STI Prevention and Control Programme (NASPCP), Department of Health, Philippines*

Dr Belimac presented the background to and challenges faced in getting a PrEP project for MSM and transgender women in Manila, Philippines. He explained that the Philippines has one of the fastest growth rates of HIV incidence in the world, primarily driven through sex between men. The overall objective of the project is to “evaluate feasibility and acceptability of community-based delivery of preventive HIV PrEP services” and the specific objectives are to: 1) assess eligibility and uptake of PrEP among MSM and transgender women; 2) measure PrEP adherence and HIV risk behaviour; 3) collect self-reports of project-related stigma and discrimination; 4) determine breakthrough infection, antiretroviral drug resistance and prevalence and incidence of STI; and 5) identify factors associated with the above-mentioned outcomes.

Dr Belimac concluded his presentation by sharing the lessons learnt to date: 1) the National AIDS and STI Prevention and Control Programme (NASCP) intends to move toward combination prevention (including PrEP) as the HIV epidemic continues to increase in the Philippines; 2) PrEP can be an entry point to other STI/hepatitis prevention and treatment services; 3) broad-based community support (including PLHIV community) is necessary for PrEP implementation; 4) gaps in health sector services can be filled in by community-based organizations; and 5) research functions can be delegated to community-based organizations with assistance from partners.

#### **2.10.5 HIV and TB twin epidemics in Papua New Guinea**

*Nick Dala, STIs, HIV/AIDS Programme Manager, National Department of Health, Papua New Guinea*

In Papua New Guinea, there is a generalized HIV epidemic in the highland regions and the National Capital District (NCD), whereas there is a TB epidemic in all provinces. Coverage of isoniazid preventive therapy (IPT) is low and mortality is high in people with HIV who are not screened for TB and those with active TB. This is a missed opportunity to TB and HIV elimination. Development partners encouraged the Government to develop a TB/HIV Collaborative Framework. The Framework emphasizes the need for the integration of the responses to HIV and TB, and reprioritization of needs based on both diseases. It also promotes community support and advocacy and calls for provincial-level implementation along the lines of a decentralized model. In this model the national level is less involved in the delivery of services but must play a supportive role to the province at the policy level and the provision of technical assistance to the subnational levels.

Dr Dala described the main features of Papua New Guinea’s decentralization model under the TB/HIV Collaborative Framework and concluded that the integration of TB and HIV and the decentralized approach has the following implications: 1) Principal Recipients of the Global Fund grants who are responsible for TB and HIV (including but not only TB-HIV co-infection) will need to follow similar implementation modality; 2) all provinces will receive basic packages ensuring equity (with extra for targeted provinces); and 3) there will be greater reach and more people will be served.

### **2.10.6 Discussion points**

Participants discussed and agreed on the need for and the benefits of setting ambitious 2030 targets for the elimination of syphilis in the Western Pacific Region and moving aggressively towards that target. It was noted that another curable STI – chancroid – is quickly disappearing from the Region.

With regards to eliminating new HIV infections, one participant commented that a high percentage (75%) of new infections show no obvious route of transmission and that consequently, “We are not sure if they are recently infected or not.” Other participants identified the need for technical support from the WHO Regional Office to help achieve the elimination of HIV in pregnant women. The WHO Regional Office acknowledged these requests and welcomed the opportunity to work with any country requiring support to strengthen their HIV elimination efforts.

## **2.11 Interventions for the elimination of viral hepatitis B and C**

### **2.11.1 Hepatitis screening and linkages to care in Japan**

*Takaji Wakita, Deputy Director-General, National Institute of Infectious Diseases, Japan*

In 2002, Japan began to implement comprehensive and urgent measures against hepatitis C. A national hepatitis screening effort commenced in 2002, and 8.7 million residents over 40 years old were tested for HBV and HCV. Approximately 1.2 % (100 983) of those tested were identified as HBV carriers and 1.2% (99 959) were identified as having HVC. HBV was most common in people between the ages of 20 and 60 years, and HCV was most common in people over 65 years old.

Between 2002 and 2015, approximately 16 million people in Japan were tested for both HBV and HCV. Approximately 1.1% of people tested during this time were positive for HBV and 0.9% for HCV. It is believed that many hepatitis patients are still submerged. In Japan, as many as 0.53 million hepatitis patients are diagnosed but do not seek care in hospitals.

There are four important steps to curing hepatitis B and C in Japan: 1) screening HBV and HCV carriers; 2) clinical and laboratory assessment 3) treatment; and 4) follow-up. Public awareness campaign for hepatitis testing is also undertaken and is an integral part of hepatitis control efforts. Educating the public has definitely increased the number of people testing for hepatitis in Japan. Educating people who test positive as well as the physicians testing and treating people for hepatitis also produces good results.

### **2.11.2 Access to hepatitis treatment in Australia**

*Rebecca Newton, Director, Blood Borne Viruses and Sexually Transmissible Infections Section, Department of Health, Australia*

Access to hepatitis treatment in Australia is part of the *Fourth National Hepatitis C Strategy (2014–2017)*. On 1 March 2016, four new direct-acting antiretroviral (DAA) treatments became available to the Australian public for the first time on the Pharmaceutical Benefits Scheme. Three additional DAAs have since been added. The new DAA treatments can be prescribed and dispensed in community settings. Hepatitis C treatment is available to all eligible people no matter their current condition, circumstances, or how they acquired the infection. An estimated 25 890 individuals initiated DAA treatment for chronic hepatitis C infection from March to September 2016, equating to approximately 11% of the people living with chronic hepatitis C in Australia.

Australia was one of the first countries in the world to subsidize these medicines for all people over the age of 18 years who have chronic hepatitis C, regardless of their disease severity or genotype. The Department of Health in conjunction with community-based organizations developed a number of projects to prepare affected communities for the availability of the new DAAs. These projects included targeted information to priority populations to: 'prime' them for the new DAA treatments; encourage them to know their hepatitis C status; establish linkages to care, and encourage usage of clean needle and syringe services. In addition the projects aimed to: educate and raise awareness among people who inject drugs about hepatitis; educate staff in clean needle and syringe services on barriers experienced by people who inject drugs; and educate both drug users and health service providers to help minimize effects of stigma and discrimination.

Dr Newton concluded her presentation with a description of the comprehensive action taken to prepare health-care professionals and the Department of Health for the availability of the new DAAs.

### **2.11.3 Discussion points**

The discussion centred on what actions were taken in Australia and Japan to convince policy-makers of the need for action to increase access to hepatitis treatment. In Australia, the key to success in developing and implementing a new national hepatitis C strategy was to engage a wide range of stakeholders in the process of elaborating a response, particularly community voices, including but not limited to advocacy groups. With regards to Japan, it was observed that patient groups were instrumental in influencing government policy, particularly the court actions they instigated, one of which directly led to the Government of Japan to enact the Basis Act on Hepatitis Measures of 2002. Participants also discussed why the price for different DAAs varied greatly. One explanation was that the pharmaceutical ingredients in some DAAs were not that expensive and this kept costs down for some DAAs.

### **2.11.4 Working groups**

Meeting participants were assigned to one of four working groups for in-depth discussions. The four working groups, and the respective objective(s) and expected outcome(s) of each group, are:

Group 1: New approaches for elimination of HIV, STI and hepatitis targeting key populations

- Objective: To discuss new approaches to prevent HIV, syphilis, other curable STIs and hepatitis among key populations by nongovernment and government sector.
- Expected outcome: Identify new approaches for incidence reduction and interaction of HIV, other curable STIs and hepatitis focussing on the three top priorities for each key population.

Group 2: Optimized diagnosis and treatment for HIV to reach elimination

- Objective: To discuss approaches to provide optimized diagnosis and treatment for HIV and STI to reach elimination.
- Expected outcomes: i) HIV: a set of key actions for countries, WHO and partners to achieve 90-90-90, 95-95-95 and reach elimination; and ii) STI: a set of priority actions for countries, WHO and partners to achieve global STI targets.

Group 3: Hepatitis screening, testing and linkages to care

- Objectives: To identify: i) shared barriers and strategies to address a rapid scale-up of viral hepatitis testing in the Region; ii) testing and treatment targets for countries in the Region; and iii) the reasons for the breakdown in the linkage to care continuum from screening to referral to diagnosis to treatment.



- Expected outcomes: priorities for action in whom and where to test for viral hepatitis and how to make use of existing lab infrastructure.

Group 4: Synergy and integration for prevention, diagnosis and care

- Objective: identify key areas and challenges of potential cross-programme synergy and integration between HIV, hepatitis and STI programmes towards elimination in countries and regions.

Representatives from each of the groups reported back on the key points garnered from discussions. Recommendations drawn from this session are included in Section 3.2.

## **2.12 Sustainable financing mechanisms**

Dr Gerard Belimac and Dr Rebecca Newton were named as the chairpersons for Day 4 of the meeting.

### **2.12.1 Transitioning to sustainable domestic financing for priority public health programmes in the Western Pacific**

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

Great progress has been made in reducing the burden of communicable diseases in the Western Pacific Region over the past few decades, but reductions in external funding for disease control programmes pose challenges to sustaining progress. Population ageing, urbanization, and health security threats heighten the need for sustainable, resilient health systems that can deliver essential services.

Many countries are beginning to transition away from funding from the Global Fund and Gavi, as well as other donors. The challenge is pressing for countries facing imminent reductions in external funding for disease control programmes and is also relevant for countries undergoing health service delivery and budget reforms. A whole-of-system approach to deliver essential public health functions is needed for sustainable and resilient systems to deliver the best health outcomes. Essential public health functions entail surveillance, health protection and promotion, disease prevention and management, and emergency response. To transition from a vertically funded to a whole-of-system approach, countries must first map existing elements in disease control programmes and how they are arranged to support broader public health functions, and then coordinate and integrate those functions into the general health system. This enables countries to do more with available resources and achieve efficiencies at the health system level.

Wrapping up the presentation, Ke Xu emphasized the following lessons learnt from country experiences to date during the transition process: 1) the transition from donor funding to domestic financing is happening in parallel with overall health system reforms in many countries; 2) while increasing domestic funding to health sector is critical, strengthening domestic financing institutions and improving coordination and efficiency is equally important; and 3) progress made by priority programmes can be maintained only with a sustainable health system. Taking a whole-of-system approach is key to the transition.

### **2.12.2 UNAIDS Strategy for transition from external to domestic financing of HIV response**

*Taoufik Bakkali, Regional Programme Adviser, Strategic Information, UNAIDS Regional Support Team for Asia and the Pacific*

Implementing the Fast Track strategy requires action in the following areas: resource mobilization; efficiency gains; universal health coverage (UHC); and human resources for health.

Regarding resource mobilization, more focus needs to be put on increasing the domestic share of HIV financing (and health financing) to offset declining international funding. This includes not only central government funding, but also funding at subnational and local levels (e.g. cities), as well as integrating HIV into broader health financing systems.

In terms of achieving efficiency gains in the response to HIV, the following actions were proposed: setting priorities on locations and populations in the allocation of resources; reducing the cost of health products; encouraging competition among pharmaceutical companies including taking advantage of TRIPS flexibilities; identifying and using innovative service delivery models; and expanding community service delivery. It was also noted that countries with concentrated epidemics will realize the greatest efficiency gains by shifting resources towards key populations.

In planning HIV responses, countries should progressively address the following three dimensions of UHC: 1) define the essential, high-impact HIV interventions that should be integrated into the national health benefit package; 2) ensure this package is adapted and equitably delivered to populations in need; and 3) ensure the national health financing system covers costs of HIV services to minimize out-of-pocket expenditure and risk of financial hardship.

The current model of human resources for health remains too facility-based, doctor dependent and disease-focused, and is neither sustainable nor able to support rapid scale-up. Critically, approaches to delivery must become more inclusive of the community and private sectors and maximize opportunities to utilize HIV services as an entry point to other health services

### **2.12.3 Role of private philanthropy in public health – fund for hepatitis elimination**

*Wangsheng Li, President, ZeShan Foundation*

In June 2016, the ZeShan Foundation, in collaboration with the United States Centers for Disease Control and Prevention (US CDC) and WHO, convened a meeting in Hong Kong SAR (China) to articulate the critical needs and gaps in resources to support the achievement of the 2030 global viral hepatitis elimination goals. Participants included leaders from an array of sectors, including philanthropy, government, international nongovernmental organizations and public health bodies. The meeting stimulated critical thinking and discussion around the establishment of an international funding mechanism to support the implementation of the WHO global hepatitis strategy and regional action plans by fostering strategic partnerships and building collaboration. In addition to taking the decision to establish a dedicated fund (Hepatitis Elimination Partnership 2030, D.B.A. EndHEP2030) for the elimination of viral hepatitis, the June 2016 meeting elaborated the fund's vision, mission, governance architecture, scope and priorities.

The fund's vision is "a world where viral hepatitis has been eliminated as a major public health threat by 2030 as defined by the WHO global elimination strategy" and its mission is "to catalyse actions to engage, prepare, and assist countries with high prevalence to reach the targets for eliminating viral hepatitis". The fund will be a grant-making organization to be governed by a board of directors and staffed by a small executive team. It is explicit in its intention to create a streamlined organization that will focus on funding proposals that are evaluated to be catalytic. The intention is not to fund countries' response to viral hepatitis wholesale, but rather to identify projects that can catalyse action and bring about transformative change in global responses to viral hepatitis. Scheduled for launch at the World Hepatitis Summit, November 2017, the fund will: focus on capacity-building and advocacy for sound public health policy development within the context of national health systems, have US\$ 50–100 million

at launch and raise US\$ 1 billion over its lifespan. The lifespan of the fund will be up to 25 years, with a targeted sunset date by the year 2035.

Elimination of viral hepatitis is one of the strategic foci of the health programme of the ZeShan Foundation, a privately funded family foundation based in Hong Kong SAR (China) with an international reach. The ZeShan Foundation provides direct funding and secretariat support activities by the EndHEP2030 Steering Committee, including periodic convening, communications, research and professional services. In addition, ZeShan has made a commitment to providing seed funding for the fund.

#### **2.12.4 Health insurance and sustainable financing for ART in Viet Nam: prospects and challenges**

*Duong Thuy Anh, Head of Finance and Accounting Division, Vietnam Authority of HIV/AIDS Control*

There is an upward trend in domestic financing for the response to AIDS in Viet Nam. From 2009 to 2015, the percentage of funds from domestic sources for national AIDS expenditures increased every year, from 13% in 2009 to 29% in 2015. Domestic funds are expected to cover 59% of national AIDS expenditures by 2020. The Vietnam Authority of HIV/AIDS Control has developed a comprehensive plan to increase the use of social health insurance for antiretroviral drug purchases, and the process of transitioning to the use of social health insurance to cover the costs is well under way.

As of February 2017, 64% of HIV patients had social health insurance coverage, and 53% of outpatient clinics had signed contracts with Vietnam Social Services, the agency that manages the social health insurance fund.

Lessons learnt for the expansion of social health insurance for ART to date include: 1) strong policy guidance from central to local level is required; 2) intensive and targeted advocacy campaigns with the following stakeholders is required – central and local governments, relating ministries/sectors, local authorities, outpatient clinics and PLHIV; 3) timely issuance of guidance documents for enforcement of legally binding decisions is needed; 4) timely and clear communication messages on SHI, as well as training and education for PLHIV and health staff, are needed; and 5) even if full enrolment is achieved, the required co-payment can still be a barrier for PLHIV who want to access the needed services.

#### **2.12.5 Financing for the HIV services in Hong Kong SAR (China)**

*Kenny Chan, Consultant (Special Preventive Programme), Centre for Health Protection, Department of Health, Hong Kong SAR (China)*

HIV-related services provided directly by the Hong Kong SAR government include HIV day clinics and inpatient services; social hygiene clinics (for STIs); and drug rehabilitation centres, clinics and inpatient services (mainly for non-opioid users). Co-payments by service users, who are local residents, are required.

The AIDS Trust Fund, established in 1993, provides support to AIDS-related nongovernmental organizations for: medical and support services for people infected by HIV through blood/blood product transfusion in Hong Kong SAR (China) before August 1985; services for PLHIV; and prevention and education services. Funding for the AIDS Trust Fund is vetted by the Finance Committee of Hong Kong's Legislative Council. To access funding through the Fund, local nongovernmental organizations submit proposals for projects of one to three years in duration. Projects are reviewed, assessed and prioritized by three subcommittees according to set criteria.

The main issues and challenges concerning financing of the response to AIDS in Hong Kong SAR (China) were identified as: commitment to treatment for prevention and rising patient numbers have placed a strain on the health budget; prioritization of finite resources has been met with resistance from some stakeholders; and it is difficult to forecast financial commitment on PrEP (AIDS Trust Fund is expected to support clinical trials and there is a lack of consensus on financing of PrEP).

## **2.13 Improving access to medicines**

### **2.13.1 Chronic hepatitis C: equitable access to affordable treatment: DNDi complementary approach to an immediate access strategy**

*Francois Simon, Southeast Asia Regional Office, Drugs for Neglected Diseases Initiative, (DNDi)*

The Drugs for Neglected Disease Initiative (DNDi), created in 2003 to develop new treatments for neglected diseases, has a HCV strategy with two main pillars: 1) regional research and development (R&D) with a view to establish the safety, efficacy and ease of use of DAA regimens; and 2) Support Affordable Access: overcoming price, intellectual property and regulatory barriers to enable a public health approach to the HCV epidemic.

The focus of DNDi's regional R&D strategy is on developing a combination treatment that will be: as effective as the currently recommended treatment; affordable; available in a very large number of countries; and combined with a very simple strategy of screening and diagnosis in order to implement a public health approach. The focus of DNDi's Support Affordable Access strategy is based on: the use of drugs that have been developed to late stage but won't be taken further due to the lack of a profitable market; and the use of different options to overcome price barriers, for example a combination of favourable voluntary licensing, volume price negotiations, patent oppositions, and TRIPs flexibilities.

Affordable DAAs will enable countries to take a public health approach to curing and eliminating HCV. DAAs have revolutionized the treatment of HCV since the beginning of 2014, making cure possible within three months. However, only a small portion of the worldwide HCV population has access to them. Since 2014, only 3–4 million patients out of 150 million have been treated with DAAs. The DAAs are so expensive that payers ration them only to the most critically ill patients, those who have advanced liver disease. Price and resultant rationing make achieving the WHO elimination goal extremely difficult.

In support of its hepatitis C strategy, DNDi recently launched a five-year project to develop affordable treatments for people with hepatitis C. DNDi expects that the primary and immediate benefit of its current hepatitis C projects will be reduced morbidity and mortality among beneficiaries in Médecins Sans Frontières (MSF) projects and DNDi studies, with an estimated 12 000 project beneficiaries cured of HCV over three years in Cambodia, Malaysia, South Africa, Thailand, Ukraine and Viet Nam. An additional 30 000 patients are expected to be treated through the larger MSF operational centres in Paris and Geneva and DNDi projects, through additional funding. The improved models of care and increased access to treatments will bring immediate benefit to MSF projects where hepatitis C care and treatment is either already provided to patients co-infected with HIV (supported by the UNITAID grant), or will be introduced shortly.

### **2.13.2 Role of advocacy in increasing access to hepatitis medicine**

*Rajiv Kafle, Asian Network of People who Use Drugs (ANPUD)*

People who use drugs have historically faced numerous challenges because they do something that is considered to be “not normal” or “immoral” and illegal. Mr Kafle expressed concern over two parallel

crises: 1) a massive drug contamination-led overdose crisis; and 2) a senseless war on drugs. He urged all parties to the war on drugs – especially leaders, governments and law enforcement entities – to “take a deep breath and calm down. The road that you are taking leads nowhere. It is literally a ‘dead-end’.

He read a statement on behalf of the affected community: “With regards to the role of communities in increasing access to hepatitis medicine, I would first like to explain the challenges faced in accessing hepatitis C treatment. Like with HIV treatment access we are again faced with the issue of high cost of both the diagnostics and treatment. Secondly, because the prices of these drugs are so different from place to place, the chances that someone ends up paying more than they should is also a major issue.

Concerning the roles of people who use drugs in facilitating access to treatment, affected communities want to be part of the price negotiations wherever possible, but they cannot do that on our own. Hence communities urge WHO to involve them at every level for treatment as well as diagnostics price discussions. Communities can also play a key role in creating awareness as well as creating demand. Their roles do not end after the person is treated. There is a need to follow up continuously to make sure that reinfections do not occur and monitor any treatment failures or drug resistance. Communities are hoping that WHO can support them, specifically in ‘treatment literacy’ programmes. However, while WHO is not expected to help in everything from involvement to funding, it is felt that WHO country offices can highlight the importance of their roles to other stakeholders and decision-makers during planning and implementation of programmes.

Like governments and communities, people who use drugs can be an integral part of this response. The community can assure that their contributions will be constructive and helpful in resolving the challenges faced.”

### **2.13.3 Mongolia: financing the hepatitis response**

*Ayurzana Unurjargal, Senior Officer in Charge of HIV/STI/TD, Ministry of Health, Mongolia*

The “Healthy liver” national programme is included in the Government Action Plan 2016–2020 and was approved by the Government of Mongolia in 2016. It was estimated that the majority of funds for implementation of the “Healthy liver” programme or 68% should come from national health insurance funds, 24% from the government budget and the remaining 8% from other sources such as donors. Approval of a joint ministerial order of the Ministry of Health and the Ministry of Social Protection and Labour allows insured citizens to enrol in screening programmes for hepatitis B and C with costs covered by health insurance. Currently, 89% of total population is covered by health insurance.

Five health benefit packages covered by health insurance were described. The first package is hepatitis B and C screening done at the primary health care level and some health centres. For this, about US\$ 630 000 is allocated in health insurance funds. According to 2016 data, about 516 000 people aged 40–65 years are covered by health insurance. The second benefit package is viral load testing for hepatitis C: US\$ 2 million is allocated. Twenty-two laboratories have been selected to perform viral load testing. Depending on semi-automated and fully automated equipment, the cost per test is estimated at US\$ 33 for semi-automated and US\$ 50 for fully automated. The third benefit package is prevention and early detection, which consists of three different types of packages. However, these three packages are for people aged 40, 45, 50, 55, 60 and 65 years old. The insured person can select only one package. About US\$ 3.7 million is allocated to the third package from health insurance.

The fourth benefit package is coverage of hepatitis C medicines; US\$ 87 per month is covered by health insurance. Five DAA drugs are available: one originator and four generic drugs. These drugs can be

prescribed only by authorized doctors. The fifth benefit package, which is organ transplantation, includes liver transplantation. It is planned to have 40 liver transplantation surgeries free of charge for the patients.

The current approach to financing the hepatitis response has some challenges, including: economic recession in recent years; the need to pay debt and uncertainty in economic development in the long term; priority setting (double burden of communicable and noncommunicable diseases); management of patients with HBV and HDV co-infection; and ongoing transmission in the health sector.

Finally, moving forward with the response to hepatitis in Mongolia, there is a need to: ensure sustainable financing for implementation of the programme up to 2020; undertake regular monitoring of the programme at the national and local levels; increase laboratory capacity for diagnosis of hepatitis; strengthen public and private partnership; improve data management; and strengthen infection prevention and control.

## **2.14 Closing remarks**

Dr Ying-Ru Lo delivered the closing remarks on behalf of WHO. She thanked all participants for their valuable contributions and noted her appreciation to participants for setting aside time in their busy schedules to attend this important meeting.

## **3. CONCLUSIONS AND RECOMMENDATIONS**

### **3.1 Conclusions**

- 1) Countries in the Western Pacific Region have made remarkable progress in responding to HIV, viral hepatitis and sexually transmitted infections (STIs). However, further efforts are needed for the Region to achieve the Fast-Track targets by 2020 and to end the epidemics by 2030 in line with Sustainable Development Goals (SDGs) and the global health sector strategies for the three diseases.
- 2) Countries have identified opportunities for synergy and collaboration across the disease programmes including triple elimination of mother-to-child transmission (EMTCT) of HIV, hepatitis and syphilis, and reaffirmed the values of integrated and coordinated approaches for effective, efficient and sustainable responses to diseases.
- 3) The 2020 targets as well as the 2030 targets will not be achieved without high-quality data to guide actions. We need strategic information systems that routinely track and report on impact and identify and address the gaps for location and populations. This is central to assessing real progress and keeping the spotlight on progress towards targets to motivate decision-makers.
- 4) Continued efforts and investment in expanding and/or maintaining high-impact interventions, combined with new innovative approaches and new technologies, are absolutely necessary. To achieve elimination, improved coverage and quality and sharper epidemiological targeting are needed.
- 5) Donor interest in health and disease-specific funding is declining, and funding for viral hepatitis and STIs in particular does not match the size of their burden. Countries are increasingly called upon to utilize domestic funds to sustain and move towards the ambitious elimination targets.

Particular issues highlighted included:

- 1) HIV – Coverage of priority HIV interventions among key populations is insufficient in many countries, and HIV incidence is increasing in some areas or populations in the Region. Gaps in prevention need to be closed, and testing and treatment scaled up, taking advantages of new approaches such as pre-exposure prophylaxis, self-testing and partner notification.
- 2) Hepatitis – Major progress has been made in prevention of viral hepatitis B and C except in the area of harm reduction. There is large variation between and within countries. However, testing and treatment are far behind.
- 3) STIs – STIs are still not given adequate attention, although the burden of curable STIs remains the highest in this part of the world. High levels of gonococcal antimicrobial resistance against multiple first-line drugs have been reported. Countries need to update their STI guidelines, particularly with regard to treating gonococcal infection.
- 4) High-level advocacy for strong country leadership and investment, and engaging various key stakeholders including affected communities, is essential to achieve the elimination goals, including allocating financial and human resources, introducing innovation, and addressing stigma and discrimination.
- 5) Strengthening whole-of-systems approaches and positioning disease programmes as an integral part of health systems towards universal health coverage is considered a high priority.
- 6) Key data for action, including baseline data, are still missing in many countries, especially those related to viral hepatitis and STIs. It is important to recognize the different types of epidemics within a country, and the data need to be used more aggressively to target responses for the greatest impact. New approaches to the way that data is collected, analysed and utilized are required to end the public health threat of HIV, hepatitis and STIs. The need for interoperable health information systems has been highlighted across disease control programmes, in support of case-based monitoring and case management.
- 7) Stigma and discrimination continue to hinder timely and regular uptake of the services, including enrolment for health insurance. In the efforts towards the elimination goals, considerable attention should be paid to ensure that “no one is left behind”.
- 8) Awareness and knowledge among the public and health-care workers on the diseases as well as up-to-date prevention and treatment services are often limited. More efforts are needed to raise awareness, especially to promote the uptake of testing and treatment for viral hepatitis.
- 9) Across the diseases, diagnosis of the diseases (the “first 90”) and linkage to care have been identified as the most critical challenges. A combination of facility-based and community-based approaches, integrating new approaches such as lay provider testing, self-testing and partner notification, needs to be promoted further.
- 10) Countries face challenges in expanding access to medicines and diagnostics. The solution requires engagement of various stakeholders, including regulatory authorities, financing and procurement agents, policy-makers, clinicians and patient groups.

- 11) An appropriate laboratory service network is essential to support the scale-up of and ensure the quality of testing and treatment. New technologies, such as multi-disease platforms and point-of-care technologies, are increasingly available.
- 12) With increasing antiretroviral therapy (ART) coverage, higher levels of HIV drug resistance are projected, which challenges the effectiveness and sustainability of ART programmes. Retention, adherence and management of treatment failure need to be strengthened through application of differentiated care, use of more potent and tolerant regimens, and close monitoring of viral load. Resources need to be allocated for surveys of HIV drug resistance and monitoring of the early warning indicators, in line with WHO recommended approaches, to inform prevention of and response to HIV drug resistance.
- 13) Limited gonococcal antimicrobial drug resistance surveillance in the Region is a barrier to the achievement of some of the 2020 targets. Laboratory and reporting systems for gonococcal antimicrobial drug resistance surveillance in some countries in the Region should be strengthened.
- 14) EMTCT of HIV, hepatitis B and syphilis has been identified as one of the examples of synergy across programmes and coordinated action towards elimination.

## **3.2 Recommendations**

### **3.2.1 Recommendations for Member States**

Member States are encouraged to:

- (1) urge decision-makers to translate commitments made on the global targets for HIV, viral hepatitis and STIs into financial and human resources, and engage stakeholders including communities and the private sector towards elimination of HIV, viral hepatitis and STIs, including EMTCT, as public health threats by 2030;
- (2) determine baseline data, particularly for viral hepatitis and STIs; set country-specific targets for HIV, viral hepatitis and STI; and develop and implement road maps to achieve targets;
- (3) increase demand for HIV, viral hepatitis and STI services by raising awareness among the public and health-care workers about new evidence and improvements in prevention, testing and treatment;
- (4) update and implement national guidelines on HIV, viral hepatitis and STIs in line with WHO recommendations and based on local evidence and context with the participation of the affected community;
- (5) intensify efforts for epidemiological targeting, and improve quality, coverage and accessibility of current and new approaches towards elimination;
- (6) explore and promote synergies and collaboration among HIV, viral hepatitis and STIs and other health programmes, for example provision of integrated services, within a whole-of-systems approach to achieve universal health coverage and elimination;
- (7) strengthen surveillance and monitoring systems across disease control programmes by:
  - a) establishing interoperable health management information systems,
  - b) expanding HIVDR and gonococcal antimicrobial resistance surveillance, and
  - c) developing a comprehensive framework for hepatitis strategic information;



- (8) strengthen laboratory service capacities and expand the application of point-of-care diagnostics and molecular diagnostics using multi-disease diagnostic platforms;
- (9) promote uptake of HIV, viral hepatitis and STI testing by capitalizing on existing services while introducing new approaches for active case finding (e.g. partner notification and self-testing) and case management;
- (10) ensure access to affordable essential diagnostics and medicines, ensure procurement meets demand and strengthen supply management to prevent stock-out; and
- (11) sustain disease control responses to meet elimination through a phased transition to adequate allocation of domestic resources in a transparent manner by increasing health insurance coverage and ensuring efficiency and integration of essential services into existing health systems.

### **3.2.2 Recommendations for WHO**

WHO is requested to:

- (1) support countries to translate commitments made on the global targets for HIV, viral hepatitis and STIs into action, including supporting countries in their advocacy with decision-makers, engagement of stakeholders including communities and the private sector, allocation of adequate domestic resources for elimination plans in a transparent manner and integration of essential services into existing health systems;
- (2) set clear definitions and criteria of elimination as a public health threat and support countries to set national targets, and develop operational tools for elimination, starting with HIV, and potentially for STIs and viral hepatitis, to provide guidance to countries on approaches and suggested actions to achieve elimination;
- (3) support countries to increase demand for HIV, viral hepatitis and STI services by raising awareness among the public and health-care workers about new evidence and improvement in prevention, testing and treatment;
- (4) support countries to update and implement national guidelines on HIV, viral hepatitis and STIs in line with WHO recommendations based on country context with participation of the affected community;
- (5) support countries to develop road maps or operational plans to achieve elimination, determine baselines for targets, implement actions to intensify efforts for epidemiological targeting, and improve quality and coverage of current and new approaches towards elimination;
- (6) support countries to promote synergies among HIV, viral hepatitis and STI and other health programmes within a whole-of-systems approach to achieve universal health coverage;
- (7) support countries to strengthen surveillance and data monitoring systems across disease control programmes including HIV drug resistance and gonococcal antimicrobial resistance surveillance;
- (8) support countries to strengthen laboratory services and to introduce or expand the use of molecular diagnostics, including but not limited to multi-disease diagnostic platforms;
- (9) support countries to obtain affordable diagnostics and medicines and to strengthen their supply management systems and capacities;

- (10) support countries to develop sustainable financing mechanisms for disease control programmes including development of transition plans in particular for HIV; and
- (11) facilitate technical collaboration including implementation research, sharing of information and experiences between countries through bilateral or regional platforms such as the Association of Southeast Asian Nations (ASEAN) to suggest actions towards elimination.

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## Annex 2 Programme

*Day 1 – Tuesday, 27 June 2017*

Time	Topic	Presenter
08:00–09:00	<b>Registration</b>	
09:00–09:30	<p><b>Opening session</b></p> <p>Opening speech by Shin Young-soo, Regional Director, <i>WHO Regional Office for the Western Pacific</i></p> <p>Remarks by Mr Stuart Watson, Senior Advisor, UNAIDS Regional Support Team</p> <p>Objectives of the meeting and introduction of participants</p> <p><i>Group photo</i></p>	Ying-Ru Lo, WHO Regional Office for the Western Pacific
09:30–10:00	<i>Coffee/tea break</i>	
10:00–11:30	<p><b>Plenary presentations: Setting the scene</b></p> <p>Recommendations from 2015/2016 HIV/STI and hepatitis programme managers meeting (5 min)</p> <p>UNAIDS Asia Pacific strategy in the context of declining resources (15 min)</p> <p>Regional progress against elimination targets on HIV, hepatitis and STI (20 min)</p> <p>New WHO recommendations on prevention, testing, diagnosis and treatment of HIV,</p>	<p>Ying-Ru Lo, WHO Regional Office for the Western Pacific</p> <p>Stuart Watson, UNAIDS Regional Support Team</p> <p>Ying-Ru Lo, WHO Regional Office for the Western Pacific</p> <p>Marc Bulterys, Department of HIV and Hepatitis &amp; Teodora</p>



Time	Topic	Presenter
	hepatitis and STI 2016 – what is the pipeline for 2017 (20 min)	Wi, Sexual and Reproductive Health, WHO Headquarters
	Universal Health Coverage and Health in the Sustainable Development Goals: Moving away from disease specific to systems approach (15 mins)  <i>Questions and answers (10 min)</i>	Anjana Bhushan, Division of Health Systems, WHO Regional Office for the Western Pacific
11:30-12:25	<b>Country presentations on elimination efforts</b>  Elimination of HIV (15 min)  Elimination of hepatitis (15 min)  Elimination of STI (15 min)  <i>Questions and answers (10 min)</i>	Wu Zunyou, Chinese Center for Disease Control and Prevention, China  Tsatsrait-Od Biraa, National Center for Communicable Diseases, Mongolia  Torika Tamana, Ministry of Health and Medical Services, Fiji
12:25-12:30	<b>Administrative announcements</b> Instruction for poster session	Naoko Ishikawa, Regional Office for the Western Pacific
12:30–14:00	<i>Lunch break</i>	
14:00-14:30	<b>Country poster session:</b> Dialogues on what does it take to eliminate HIV, hepatitis and STI as public health threats	<i>Visit country posters prepared by three programmes Foyer</i>
14:30-16:00	<b>Parallel sessions country dialogue:</b> Country presentations and facilitated discussion  Group 1: Australia, China, Mongolia Group 2: Japan, Philippines, Viet Nam Group 3: Cambodia, Lao PDR, PNG Group 4: Fiji, Korea, Hong Kong SAR	<i>See group work instructions day 1</i>  Group 1: Foyer Group 2: Room 210 Group 3: Upper lounge Group 4: Conference hall
<i>(15:00–15:30)</i>	<i>Coffee/tea break (served during parallel sessions)</i>	
16:00-17:00	<b>Plenary:</b> Feedback from the group work <b>Discussion:</b> Issues and actions towards elimination of HIV, hepatitis and STI	<i>Chairs will facilitate discussion</i>
17:00-17:05	Administrative announcements	Naoko Ishikawa, Regional Office for the Western Pacific
17:05-17:30	Facilitators and rapporteurs meeting	

Time	Topic	Presenter
18:00 – 20:00	Welcome reception	

**Day 2 – Wednesday, 28 June 2017**

Time	Topic	Presenter
<b>Plenary session: Global and regional targets and health information systems</b>		
08:30-08:40	Global & regional targets for HIV, hepatitis and STI (10 min)	Linh-Vi Le, WHO Regional Office for the Western Pacific
<b>Parallel session: HIV &amp; STI data revolution for achieving elimination</b>		(Conference hall)
08:50-09:10	<b>Presentations:</b> Data revolution for achieving HIV elimination (15 min)  <i>Questions and answers (5 min)</i>	Taoufik Bakkali, UNAIDS Regional Support Team
09:10-09:25	Applications of the HIV cascades for improving health outcomes in the Philippines (10 min)  <i>Questions and answers (5 min)</i>	Genesis Samonte, Epidemiology Bureau, Department of Health, Philippines
09:25-09:40	Key population HIV cascades: experience from community-based prevention cascades and approaches to obtaining risk behaviour data (10 min)  <i>Questions and answers (5 min)</i>	Nguyen Thien Nga, UNAIDS, Viet Nam
09:40-10:00	<b>Discussion:</b> Country needs and plans for improving patient follow-up across care services: referral systems, unique identifiers	Facilitators: Taoufik Bakkali, UNAIDS Regional Support Team  Naoko Ishikawa, WHO Regional Office for the Western Pacific
10:00-10:30	<i>Coffee/tea break</i>	
10:30-11:30	<b>Discussion:</b> Implications of global HIV and STI targets for the Western Pacific	Facilitators: Taoufik Bakkali, UNAIDS Regional Support Team  Teodora Wi, WHO Headquarters

Time	Topic	Presenter
11:30-12:00	<p><b>Discussion:</b></p> <p>HIV drug resistance surveillance - updates and discussion on surveillance needs and country plans</p>	<p>Facilitators:</p> <p>Masaya Kato, WHO Viet Nam</p> <p>Anup Gurung, WHO Papua New Guinea</p>
12:00-13:00	<i>Lunch break</i>	
13:00-14:00	<p><b>Presentations:</b></p> <p>Global and regional enhanced gonococcal antimicrobial surveillance (20 mins)</p> <p>Experience in strengthening laboratory and reporting systems for gonococcal drug resistance surveillance in China (10 min)</p> <p><b>Discussion:</b> Enhanced gonococcal antimicrobial surveillance: updates and discussion on needs and WHO and WHO Collaboration Centre support for countries (30 min)</p>	<p>Facilitators:</p> <p>Teodora Wi, WHO Headquarters &amp; Monica Lahra, The Prince of Wales Hospital, Australia</p> <p>Chen Xiang Shen, Center for Disease Control and Prevention, China</p> <p>Facilitators:</p> <p>Teodora Wi, WHO Headquarters</p> <p>Monica Lahra, The Prince of Wales Hospital, Australia</p>
14:00-14:30	<i>Coffee break</i>	
<b>Parallel session: Hepatitis</b>		(Room 210)
08:50-09:15	<p><b>Presentations:</b> Hepatitis surveillance guidelines and Monitoring and Evaluation Framework (15 min)</p> <p><i>Questions and answers (10 min)</i></p>	Marc Bulterys, WHO Headquarters

Time	Topic	Presenter
09:15-10:00	<p>Experiences from Mongolia on surveillance and laboratory systems strengthening efforts (15 min)</p> <p>HBV and HCV surveillance in Japan (15 min)</p> <p>Informing surveillance and laboratory systems plans with a rapid assessment in the Philippines (15 min)</p>	<p>Tsatsrait-Od Biraa, National Center for Communicable Diseases, Mongolia</p> <p>Hideki Aizaki, National Institute of Infectious Diseases, Japan</p> <p>Gerard Belimac, Department of Health, Philippines</p>
10:00-10:30	<i>Coffee/tea break</i>	
10:30-10:40	<i>Questions and answers</i>	
10:40-11:15	<b>Group work:</b> Country plans for hepatitis surveillance & M&E Framework	<i>See group work day 2</i>
11:15-12:00	<b>Discussion:</b> Approach to calculating and setting regional hepatitis targets for the Western Pacific	<p>Facilitators:</p> <p>Marc Bulterys, Department of HIV and Hepatitis, WHO Headquarters</p> <p>Joe Woodring, WHO Regional Office for the Western Pacific</p>
12:00-13:00	<i>Lunch break</i>	
13:00-13:15	Summarize country plans	
13:15-14:00	<p>Viral hepatitis regional laboratory network TOR (15 min)</p> <p><b>Discussion:</b> Feedback on TOR (30 min)</p>	Sue Best, National Reference Laboratory, Australia
14:00-14:30	<i>Coffee/tea break</i>	
<b>Plenary session</b>		
14:30-14:50	<p><b>Plenary presentation:</b> Operational consideration from microscopy to GeneXpert: example from TB programme (15 min)</p> <p><i>Questions and answers (5 min)</i></p>	Kalpeshsinh Rahevar, Stop TB, WHO Regional Office for the Western Pacific

Time	Topic	Presenter
14:50-15:15	<b>Plenary presentation:</b> Integrated surveillance systems: DHIS2 in Lao People's Democratic Republic (15 min)  <i>Questions and answers (10 min)</i>	Bounpheng Philavong, National AIDS Program, Lao People's Democratic Republic
15:15-16:15	<b>Working groups:</b>  Group 1 Approaches to expanding molecular diagnosis for HIV, hepatitis and STI  Group 2: Approaches to integrating health information systems	Group 1 (Conference hall)  Group 2 (Room 212)
16:15-16:55	<b>Plenary:</b> Feedback from the working groups	
16:55-17:00	Administrative announcements	Naoko Ishikawa, WHO Regional Office for the Western Pacific
17:00-17:30	Facilitators and rapporteurs meeting	

*Day 3 – Thursday, 29 June 2017*

Time	Topic	Presenter
<b>Interventions for elimination</b>		
08:30-10:00	<b>Plenary presentations:</b> Asia Pacific regional framework for triple EMTCT of HIV, hepatitis B and syphilis 2018-2030 (15min)  Hepatitis B elimination by 2030 in China – Triple elimination as an opportunity (15 min)  Operationalizing elimination of HIV and STI (15 min)  Use of antiretroviral pre-exposure prophylaxis in the Philippines (15 min)  HIV/TB collaboration for elimination (15 min)  <b>Plenary discussion:</b> Operationalizing	Naoko Ishikawa, WHO Regional Office for the Western Pacific  Wu Zunyou, Chinese Center for Disease Control and Prevention, China  Richard Steen, WHO consultant  Gerard Belimac, Department of Health, Philippines  Nick Dala, Department of Health, Papua New Guinea

Time	Topic	Presenter
	elimination of HIV and co-infections (15 min)	
10:00-10:30	<i>Coffee/tea break</i>	
10:30-11:00	Plenary discussion (continued)	
<b>Interventions for elimination of viral hepatitis B and C</b>		
11:00-12:00	<p><b>Plenary presentations:</b> Hepatitis screening and linkages to care in Japan (15 min)</p> <p>Access to hepatitis treatment in Australia (15 min)</p> <p><b>Discussion:</b> Access to hepatitis treatment (30 min)</p>	<p>Takaji Wakita, National Institute of Infectious Diseases, Japan</p> <p>Rebecca Newton, Department of Health, Australia</p>
12:00-13:30	<i>Lunch break</i>	
13:30-14:30	<p><b>Group work:</b></p> <p>Group 1: New approaches for elimination of HIV, STI and hepatitis targeting key populations</p> <p>Group 2: Optimized diagnosis and treatment for HIV and STI to reach elimination</p> <p>Group 3: Hepatitis screening, testing and linkages to care</p> <p>Group 4: Synergy and integration for prevention, diagnosis and care</p>	<p>See group work instructions</p> <p>Group 1: Pizza Room, 4<sup>th</sup> Flr</p> <p>Group 2: Room 212</p> <p>Group 3: Conference hall</p> <p>Group 4: Room 210</p>
14:30-15:00	<i>Coffee/tea break</i>	
15:00-16:00	(continued group work)	
16:00-16:55	<p><b>Plenary:</b> Feedback from the group work</p> <p><b>Discussion:</b> Critical approaches towards elimination</p>	
16:55-17:00	Administrative announcements	Naoko Ishikawa, WHO Regional Office for the Western Pacific
17:00-17:30	Facilitators and rapporteurs meeting	

*Day 4 – Friday, 30 June 2017*

Time	Topic	Presenter
<b>Sustainable financing mechanisms</b>		
08:30-10:00	<p><b>Plenary presentations:</b> Transition to sustainable domestic financing for public health priorities (20 min)</p> <p>UNAIDS strategy for transition from external to domestic financing of HIV response (15 min)</p> <p>Role of private philanthropy in public health—fund for hepatitis elimination (15 min)</p> <p>Application of health insurance for HIV treatment (15min)</p> <p>Financing prevention-related activities (15 min)</p> <p><b>Discussion:</b> Key issues and considerations for financing elimination efforts (15 min)</p>	<p>Xu Ke, WHO Regional Office for the Western Pacific</p> <p>Stuart Watson, UNAIDS</p> <p>Wangsheng Li, ZeShan Foundation</p> <p>Duong Thuy Anh, Viet Nam Authority of HIV/AIDS Control, Viet Nam</p> <p>Kenny Chan, Consultant, Hong Kong SAR (China)</p>
10:00-10:30	<i>Coffee/tea break</i>	
<b>Improving access to medicines</b>		
10:30-11:30	<p><b>Plenary presentations:</b> Access to hepatitis medicines (15 min)</p> <p>Role of advocacy on increasing access to hepatitis medicine (5-10 minutes statement)</p> <p>Financing of the hepatitis response in Mongolia (15 min)</p> <p><b>Discussion:</b> Facilitated discussion on access to hepatitis medicines (20 min)</p>	<p>Francois Simon, DNDi</p> <p>Rajiv Kafle, ANPUD</p> <p>Tsatsralt-Od Biraa, National Center for Communicable Diseases, Mongolia</p>
11:30-12:30	Conclusions and recommendations	Read by rapporteur

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