

**FASTTRACKING
THE HIV RESPONSE
IN THE SOUTH-EAST ASIA REGION**

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CONTENTS

Foreword	v
Introduction	1
State of the epidemic and response in South-East Asia Region: Beyond 2015	3
Ending AIDS: The stakes for South-East Asia	6
The SDGs and the quest to end AIDS: the prospects in South-East Asia	8
The way forward: Getting on track to end AIDS in Member States of the South-East Asia Region	18
References	22



FOREWORD



Two decades ago, as the AIDS epidemic was rapidly growing into a global health crisis, leading experts predicted that the WHO South-East Asia Region would be the region most heavily affected by this still-new disease. Tens of millions of new HIV infections were projected in our region, as epidemic models predicted catastrophic health effects across the WHO South-East Asia Region.

But something remarkable happened. While HIV did, in fact, evolve to become a

major health problem in our region, the predicted explosion of HIV infections and AIDS-related deaths in South-East Asia never occurred. Beginning in the 1990s, decision-makers and experts in the Region were using sound data to focus their prevention efforts, making South-East Asia home to some of the world's most celebrated successes in the AIDS response. Through early action, buttressed by strong political commitment at the highest levels, Thailand radically reduced the number of new HIV infections and averted a potentially devastating national epidemic. India and Myanmar likewise prevented hundreds of thousands of new HIV infections by focusing prevention efforts on such key populations as sex workers, men who have sex with men and people who inject drugs. Through early investments in community responses, Bangladesh prevented a large-scale epidemic from unfolding.

The annual number of people newly infected with HIV in South-East Asia declined by 47% from 2000 to 2015, and AIDS-related deaths have also fallen. Beginning in 2016, the WHO South-East Asia Region embarked on an even more ambitious effort – to end the AIDS epidemic by 2030, as called for in the Sustainable Development Goals. Indeed, Thailand became the first country in the region to eliminate

mother-to-child transmission of HIV in 2016.

However, as encouraging as these trends are, success is not assured in our effort to make AIDS a thing of the past. Most of the region's gains in reducing new HIV infections occurred prior to 2010, with only modest progress made over the last five years. In some countries of the region as well as parts of large countries and some key populations such as men who have sex with men, new HIV infections are on the rise. Life-saving treatment reaches less than 40% of people living with HIV in South-East Asia, and many countries across the region are failing to focus prevention efforts on the communities most in need.

Studies indicate that a failure to build on the gains till date will inevitably cause the epidemic to reemerge, costing substantially more in the long run. Spending to accelerate the end of AIDS is an essential investment, not merely another government expense. Yet, even as international HIV assistance is declining across South-East Asia, most countries in the region have not stepped forward to allocate the domestic resources that the fight against AIDS requires.

When it comes to fighting AIDS, South-East Asia can decide to invest now, or spend far more later. The choice is clear; doing the right thing will demand renewed commitment, smarter action and a greater focus on the most marginalized and affected.

This publication examines the human and financial stakes involved in the WHO South-East Asia's quest to end AIDS as a public health threat. It explores where and how programmes are working, where our efforts are falling short, and key actions that are needed to ensure that we get on track to end the epidemic.

Merely 35 years after AIDS was first detected, we now have the chance to write the final chapter in our historic struggle against this disease. Towards seizing this momentous opportunity, it is my hope that this report will help galvanize immediate action to bring this epidemic to an end in this region.

Dr Poonam Khetrpal Singh

Regional Director



INTRODUCTION

The world has embarked on a mission to end the AIDS pandemic.

To achieve the end of AIDS, the world aims at accelerating the momentum of what is possibly the most spectacular public health success in recent history, with the curbing of a devastating pandemic within 35 years of the time that it first came to scientific attention. Inspired by the once unimaginable gains made, world leaders have embraced the even more ambitious goal of ending AIDS as a public health threat by 2030 as a key aspect of the Agenda for Sustainable Development (SDGs)

Member States of the World Health Organization's South-East Asia Regionⁱ have been central to this headway made against AIDS. In 1996, when experts studied the likely course of the pandemic, they anticipated that the greatest future growth would be in the South-East Asia Region (1). But countries in the region defied these projections.

The South-East Asia Region was the first region to demonstrate a substantial reduction in HIV incidence in a large national epidemic – this was in Thailand, where robust political commitment, evidence-based action and an effective programmatic focus on key populations reversed an epidemic that had been growing exponentially. India eventually overcame the risk of an immense national epidemic by supporting community-based organizations of key populations, with the Government working closely with the World Bank, the Bill & Melinda Gates Foundation and the Global Fund. A potential large-scale epidemic was averted in Bangladesh as a result of early investments in community-based responses. Through these and other success stories, the South-East Asia Region has demonstrated the feasibility of countering AIDS through targeted investments and a sound policy response.

Yet, these advances, while meaningful, have failed to set the stage to end the epidemic in the region. While the South-East Asia Region as a whole achieved the Millennium Development Goal of halting and beginning to reverse HIV, it failed to achieve the key targets established in the 2011 Political Declaration on HIV and AIDS, specifically those of reducing new HIV infections by half and of reaching 80% of people in need of ART.

ⁱ Member States of the WHO South-East Asia Region include: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

The current response is simply not strong enough. Maintaining current trends of programmatic scale-up will not only allow the epidemics in the region to continue indefinitely but will probably lead to substantial epidemic growth in some countries. Consequently, unless political commitment and investments are renewed in every country in the region, lessons learned are acted upon and essential prevention and treatment services scaled up urgently, South-East Asia Region is unlikely to achieve the major reductions in HIV incidence and mortality required to end AIDS by 2030. The hope of ending AIDS in South-East Asia will remain just that – a hope – rather than a reality.

Recognizing the need for far stronger and effective efforts, 193 Member States of WHO at the World Health Assembly in May 2016, endorsed and adopted the Global Health Sector Strategy for HIV (2016-2021) that lays out the Framework for Action for accelerating progress towards ending the AIDS epidemic by 2030. The targets in the Strategy are aligned with the fast track targets of the UNAIDS Global Strategy and the UN General Assembly Political Declaration on HIV, 2016.

The targets in both the strategies aim to catalyse immediate and sustained action and investments to achieve major improvements in service coverage and health outcomes and lay the foundation to end AIDS as a public health threat by 2030.

Potentially transformative lessons have been learned in how best to respond to the AIDS epidemics, and powerful new prevention and treatment tools have emerged to enhance the efficiency and effectiveness of the AIDS response. Inspired by this extraordinary chance to end AIDS, leaders and stakeholders across the region now must act – to frontload investments, to use limited resources most effectively, to address the factors that impede progress, and to fully leverage the array of potent prevention and treatment tools at our disposal.

This report briefly surveys the current state of the epidemic and the response in the South-East Asia region, identifying the key challenges that must be addressed to end AIDS. It offers a roadmap for ending AIDS in the region, identifying proven ways to do more with limited resources and to accelerate progress in reducing new HIV infections and AIDS-related deaths.



STATE OF THE EPIDEMIC AND RESPONSE IN SOUTH-EAST ASIA REGION: BEYOND 2015

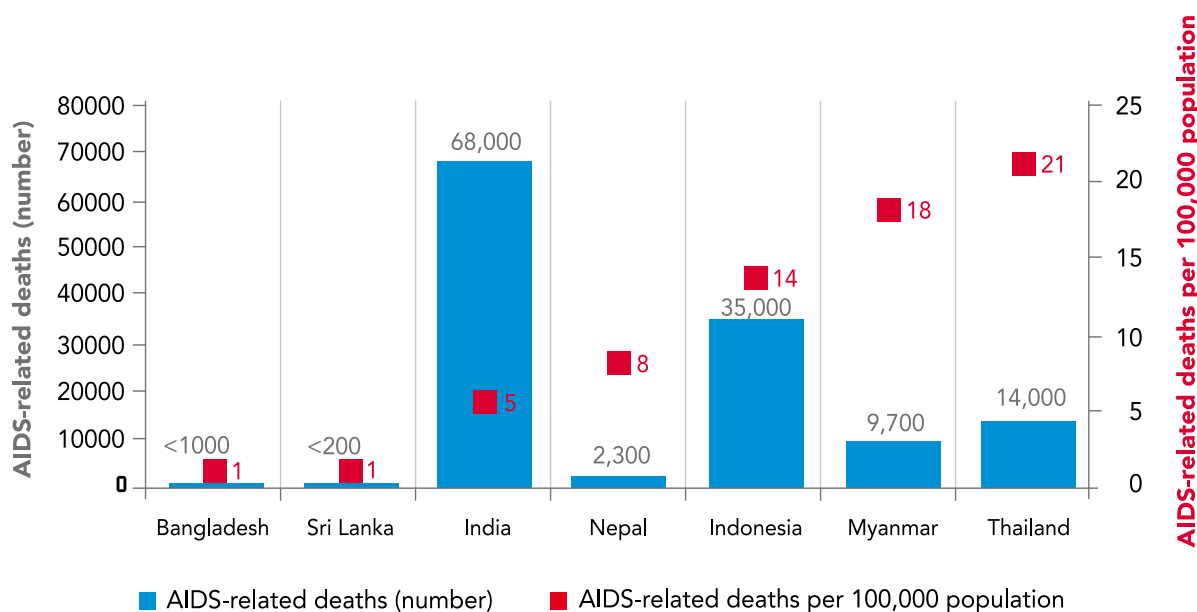
Nearly one in ten people living with HIV worldwide reside in South-East Asia, totaling 3.5 million in 2015. While regional prevalence is low at 0.3% compared to 4.4% in sub-Saharan Africa, the large population still gives it the second highest burden of all WHO regions (2).

There are wide variations between countries in the Region, with India, Indonesia, Myanmar, Nepal and Thailand

accounting for more than 99% of HIV burden in the region. Bangladesh, Bhutan, Maldives, Sri Lanka and Timor-Leste together represent less than 1% of all HIV infections (2). The Democratic People's Republic of Korea has reported no cases of HIV thus far.

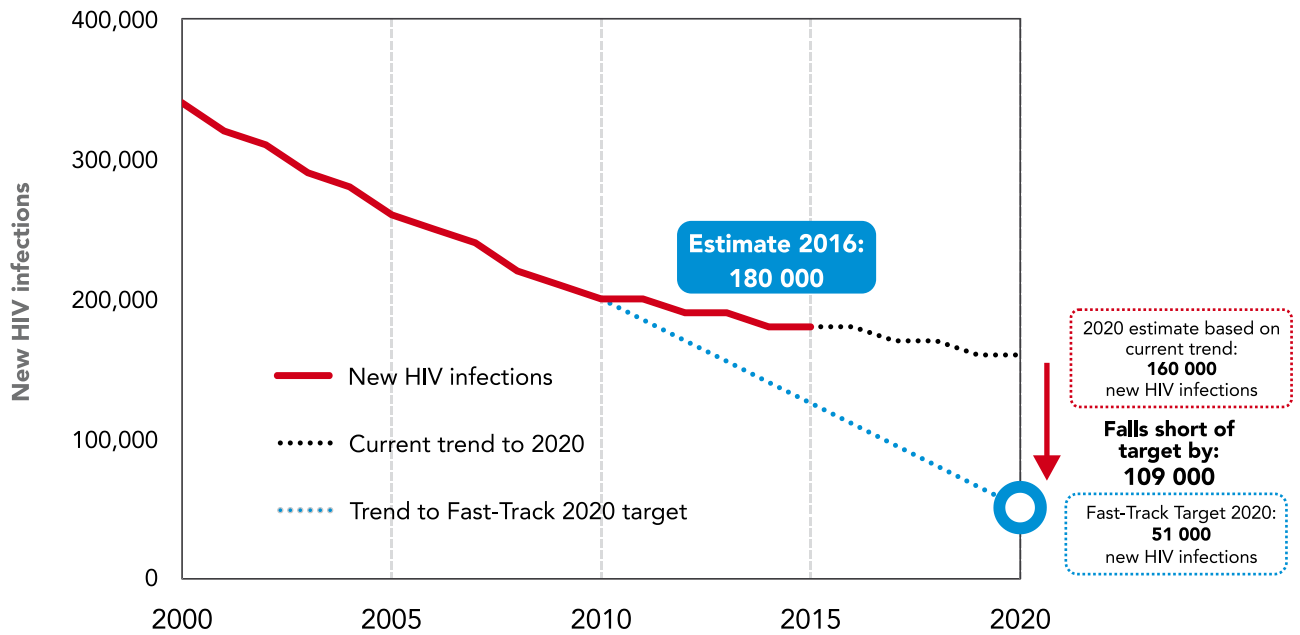
AIDS-related mortality also varies across countries. As the most populous country in the Region, India had the largest number of AIDS-related deaths in the Region in 2014, but AIDS-related mortality rates were highest in Indonesia, Myanmar and Thailand (Figure 1).

Figure 1
Impact of AIDS in SEA Region, 2015



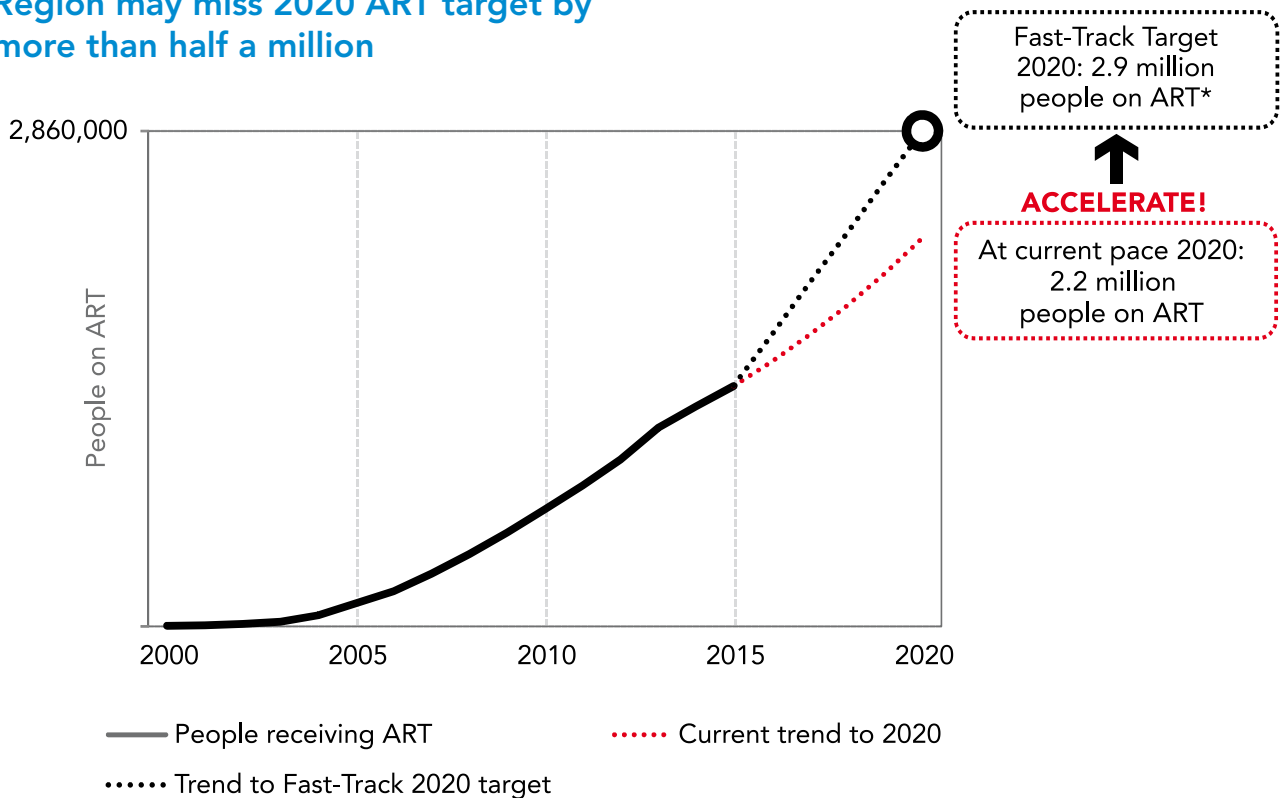
Source: UNAIDS 2016 estimates.

Figure 2
**Estimated new HIV infections in SEA Region:
 Current trend and trend to Fast-Track target**



Source: UNAIDS HIV Estimates 2016 and Global AIDS Response Progress Reporting 2016.

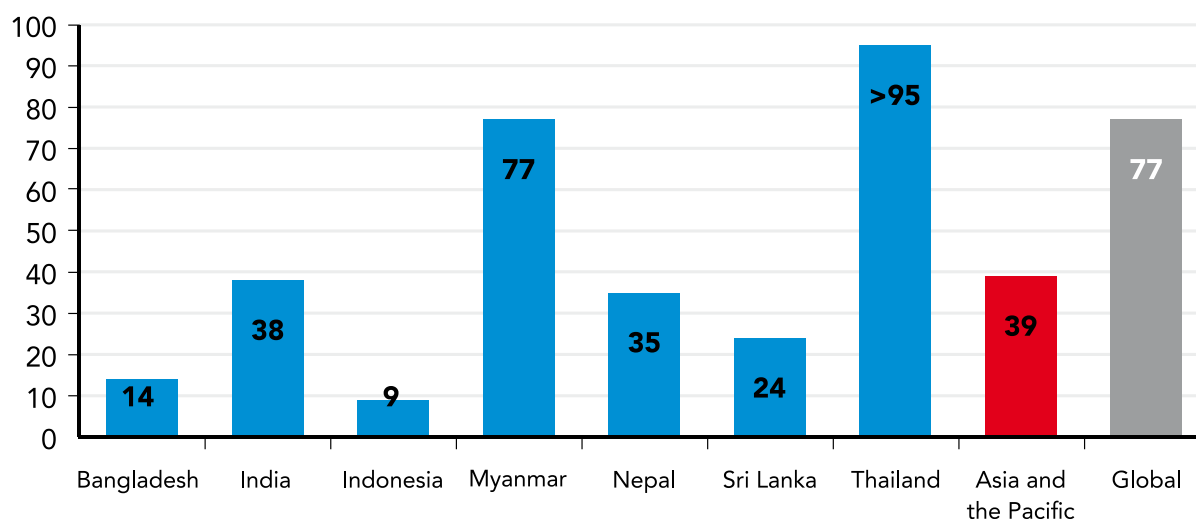
Figure 3
**Region may miss 2020 ART target by
 more than half a million**



*Estimated as 81% of PLHIV in 2020. Actual value will depend on how epidemic evolves over time.

Source: UNAIDS HIV Estimates 2016 and Global AIDS Response Progress Reporting 2016.

Figure 4
Prevention of mother-to-child transmission in
SEA Region countries, 2015



Source: UNAIDS 2016 estimates.

At the dawn of the new century, the world adopted the Millennium Development Goals (MDGs), with the aim of catalysing progress against some of the world's most serious and intractable development challenges. MDG 6 called for the world to halt and begin to reverse the global HIV epidemic. To achieve MDG 6, regional targets were agreed upon across the world to contribute to the global realization of the vision of a world where HIV had been halted and reversed.

Globally, the world has reached the mark for MDG 6, halting and beginning to reverse the global epidemic.

To accelerate progress towards MDG 6, United Nations Member States agreed on an updated set of ambitious targets as part of the Political Declaration on HIV in 2011.

Some of these were achieved; the world exceeded the global target of providing antiretroviral therapy to 15 million people, leading to a 45% drop in the number of AIDS-related deaths, compared with 2005 (2). The world also met the resource mobilization targets for 2015. However, other targets were badly missed, most notably the goal of reducing new HIV infections by 50% from 2010 to 2015.

The number of people newly infected with HIV globally declined by 6% in 2010-2015,

whole new HIV infections among children have declined by 50% since 2010 (2).

The South-East Asia region was one of the few regions to report progress on the target for reducing new HIV infections, with 180 000 people in the Region newly infected with HIV in 2015 which is a 47% reduction since the year 2000 (Figure 2).

In contrast, South-East Asia fell considerably short of its Regional treatment target while other regions recorded major success on this front. While antiretroviral therapy reached 46% of all adults living with HIV in low- and middle-income countries globally in 2015, HIV treatment coverage in the South-East Asia Region countries was lower, at 39% (2), (Figure 3).

Similarly, the Region is lagging in progress towards the goal of eliminating new HIV infections among children. While services to prevent mother-to-child HIV transmission reached 77% of all pregnant women living with HIV worldwide in 2015, coverage was only about half as high, 38% in the South-East Asia Region (3) (Figure 4). While a handful of countries of the region such as Thailand and Myanmar – have recorded impressive achievements in preventing mother-to-child transmission, with Thailand eliminating mother-to-child transmission in 2016, urgent action is needed in other countries of the region.



ENDING AIDS: THE STAKES FOR SOUTH-EAST ASIA

In 2016, the world transitioned from the MDGs to the Agenda for Sustainable Development, an even more transformative developmental vision that, among other goals for the year 2030, aims for universal health coverage and the elimination of AIDS and other major infectious diseases. In the 2016 Political Declaration on HIV and AIDS, the global community adopted new targets and made firm political commitments for 2020 and 2030. These targets aim to “fast-track” the response, leveraging frontloaded investments to accelerate scale-up in the next five years and lay the foundation to end AIDS by 2030.

These new benchmarks include:

- Achieving the “90-90-90” target: that is 90% of all people living with HIV know their HIV status, 90% of people with diagnosed HIV infection receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy achieve viral suppression.
- Elimination of new HIV infections among children.

- 90% combination prevention coverage for people at risk of HIV infection.
- Elimination of stigma and discrimination.

To reach these targets, the Political Declaration that calls for annual global spending on HIV will need to reach approximately US\$ 26.2 billion by 2020, or roughly 20% more than was projected to have been available in 2015.

The achievement of these fast-track targets will reduce the number of new HIV infections globally to fewer than 500 000 by 2020 and the number of AIDS-related deaths to below 500 000 as well. Sustaining these gains is projected to further reduce the annual number of new HIV infections to fewer than 200 000 by 2030, averting 28 million new infections over 15 years and effectively ending the epidemic as a public health threat.

As decision-makers and stakeholders contemplate the future of the AIDS response for Asia in the Sustainable Development Goals (SDGs) era, the stakes for the health and well-being of the people of the region are equally plain. Fast-tracking the regional response will reduce the annual number of new HIV infections by 86% and the number of AIDS-related deaths by 83% by 2030.

However, failing to build on the gains to date and to seize the opportunity to end AIDS will have consequences for South-East Asia.

If the Region fails to frontload investments and to rapidly scale up national responses, more people in South-East Asia will die of AIDS-related causes in 2030 than currently, while the number of new HIV infections will remain nearly as high as today. The epidemic that is now in decline will be requiring ever-increasing and larger expenditures on treatment, care and impact mitigation (Figure 5a and 5b).

In part, the risk of an epidemic build-up stems from a “demographic bulge” that will see a substantial increase in the population of sexually active young people in the coming years. In most countries of the South-East Asia Region, the proportion of the population under the age of 15 approaches or exceeds 30%. Over the next 15 years, these young people will become young adults, when the risks of acquiring HIV are highest. Failing to act now to scale up quality prevention, testing and treatment services will leave this demographic wave of young people exposed to elevated risks of HIV infection. Fast-tracking the response is essential if South-East Asia is to avoid this scenario. Special focus is needed on young key affected populations who are at elevated risk and the HIV incidence among them especially young men who have sex with men is reported to be rising in most countries of the region.

WHO SEA Region

Figure 5a

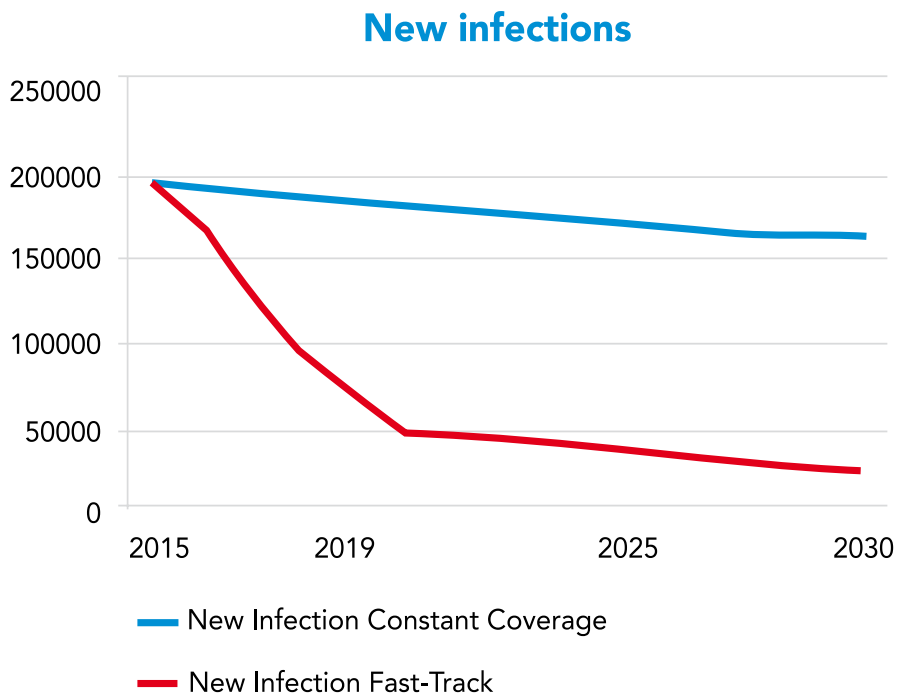
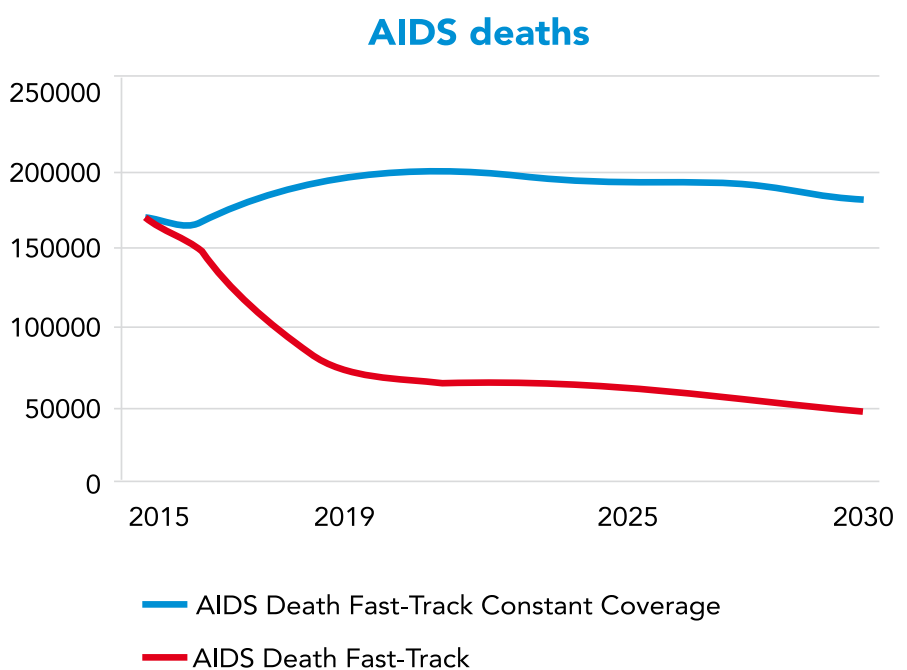


Figure 5b



Source: UNAIDS modeling.



THE SDGs AND THE QUEST TO END AIDS: THE PROSPECTS IN SOUTH-EAST ASIA

Although the SDGs offer an inspiring vision of a world without AIDS, the sobering reality is that this vision can only be translated into reality in South-East Asia through dramatic changes and improvements in national AIDS responses. A review of current trends makes clear that most countries in the Region are not yet on track to end AIDS as a public health threat.

HIV prevention

Overall trends in new HIV infections illustrate the urgency of renewing and refocusing national AIDS responses. Although the number of new HIV infections in countries of the South-East Asia Region declined by 47% from 2000 to 2015, only marginal progress has been made in reducing new HIV infections in the last five years, as nearly the entire decline since 2000 had occurred in the previous decade. In 2015, the number of new HIV infections in countries of the Region (180 000) was only slightly lower than in 2010 (200 000). Currently, the Region is not on track to reach the SDG fast-track target for reducing new HIV

infections and treatment targets (Figure 2 and 3). Indeed, in some countries, such as Bangladesh, India and Sri Lanka, new infections in 2020 will be as high as or higher than today, if current trends continue unchanged (Figure 6).

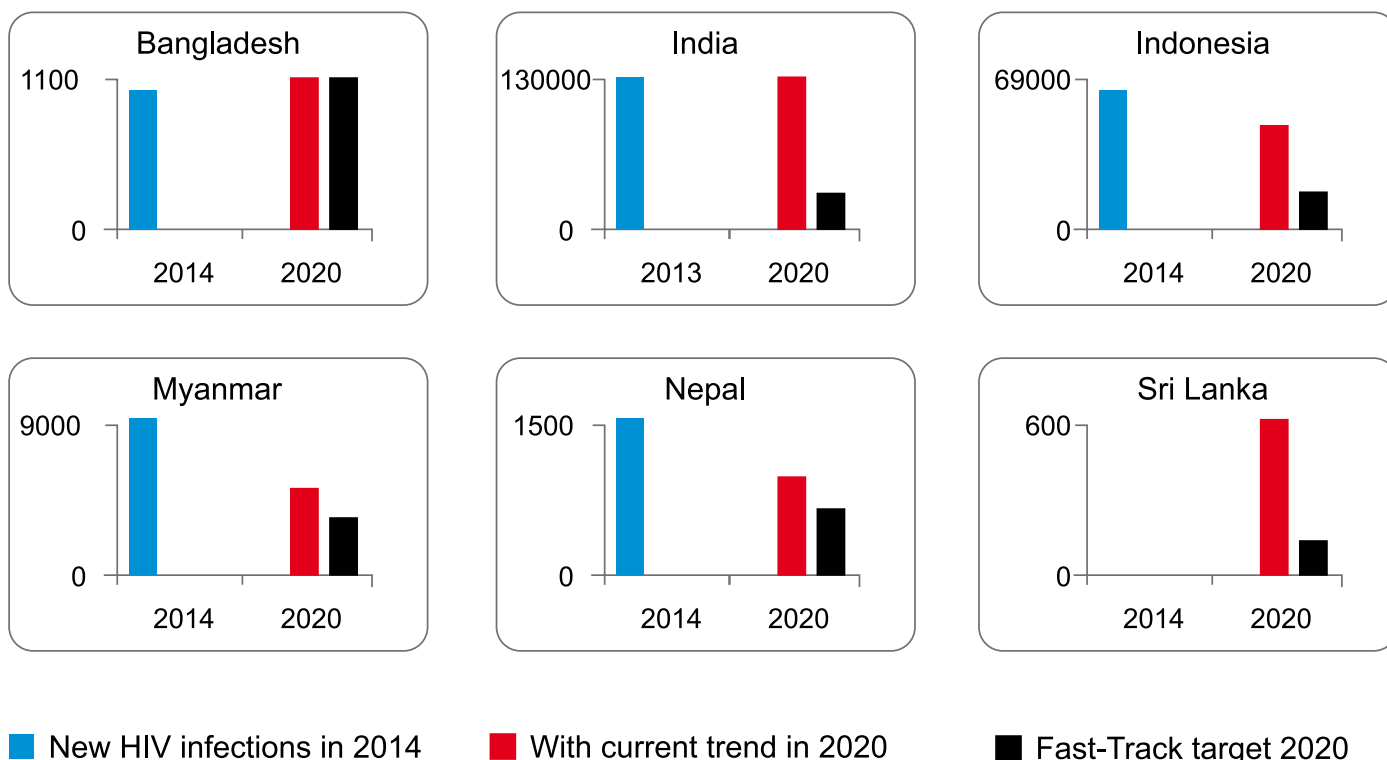
Nonetheless, across the region there is proof of positive momentum on which to build.

From 2010 to 2015, Nepal, Myanmar and Thailand experienced reductions in new HIV infections ranging from 20%–43%. Reported condom use is relatively high, ranging between 68% and 91% among sex workers and between 77% and 86% among men who have sex with men in the Region. Condom use among people who inject drugs is considerably lower varying from 23% to 77% in highest-burden countries.

Screening and treatment services for sexually transmitted infections are available for key populations in India, Indonesia, Nepal and Thailand. Most Member States make opioid substitution therapy and needle and syringe programmes available, with some countries such as Myanmar, recently taking steps to expand access to harm-reduction services for people who use drugs.

Figure 6

New HIV infections in various SEA Region countries: Fast-Track and current trend



Source: UNAIDS 2016 estimates; Global AIDS Response Reporting 2016.

Although the Region is home to some of the world's most successful programmes for the prevention of mother-to-child transmission, most Member States in the Region are not on track to eliminate new infections among children.

Countries in the Region have also exhibited variable commitment to evidence-based programmes to prevent HIV transmission through injecting drug use. The number of opioid substitution therapy sites remains negligible to meagre in most countries. Needle syringe programmes are variably implemented across countries, with Member States such as India and Indonesia doing well in securing access to clean injection

equipment while Maldives and Sri Lanka offering no such interventions.

WHO now recommends pre-exposure prophylaxis (PrEP) for all those at continued and high risk for HIV acquisition. This may as well be an important intervention to reduce new infections among key populations and sero-discordant couples. Member states in the region are planning to or have begun implementation science research projects on use and scale up of PrEP especially among key populations.



A historic global health milestone in Thailand

On 7 June 2016, WHO certified that Thailand had eliminated mother-to-child transmission of HIV and syphilis. Thailand becomes only the second country that is not a member of the Organization for Economic Co-operation and Development to achieve these goals, after Cuba (4). In 2015, 99.6% of infants born to HIV-positive mothers in Thailand received antiretroviral prophylaxis (5). WHO and UNAIDS estimate that Thailand's efforts prevented nearly 17 000 infants from acquiring HIV between 2000 and 2015 (5). In 2015, only 85 infants in Thailand were newly infected with HIV, rather than the estimated 1076 who would have acquired HIV if Thailand's comprehensive programme for prevention of mother-to-child transmission was not in place (5).

HIV testing and treatment

Knowing one's status is the cornerstone of the HIV response as the first step in the treatment cascade.

While testing services have been expanded to reach key populations in India, Myanmar and Thailand, still only one in two key populations in the region know their HIV status. Countries in the region need to accelerate and expand testing services that focus on and prioritize the most at risk with emphasis on identification of new infections rather than the number of tests performed (Figure 7).

Efforts to expand access to HIV treatment offer a similarly varied picture. Antiretroviral therapy is the core component of effective HIV treatment and prevention, sharply lowering the risk of HIV-related illness and death while also curtailing the risk of onward HIV transmission.

Differences in national rates of scaling up HIV treatment reflect, in part, differences in national policy and programme implementation. Although WHO in 2015 updated its antiretroviral guidelines to recommend initiation of antiretroviral therapy for all people living with HIV, regardless of CD4 countⁱⁱ, only Maldives and Thailand have implemented this Treat all approach. Other countries are yet to fully adopt and implement the latest evidence based recommendations. To fully leverage the therapeutic and preventive benefits of antiretroviral therapy, all Member States should ensure that their national guidelines are aligned with current global recommendations.

ⁱⁱ CD4 Tlymphocytes are key actors in the body's immune system and are depleted by HIV infection. The CD4 cell count is a measurement of the number of CD4 cells per cubic millimeter of blood.

PMTCT coverage data along the continuum of care in South-East Asia Region, 2015.

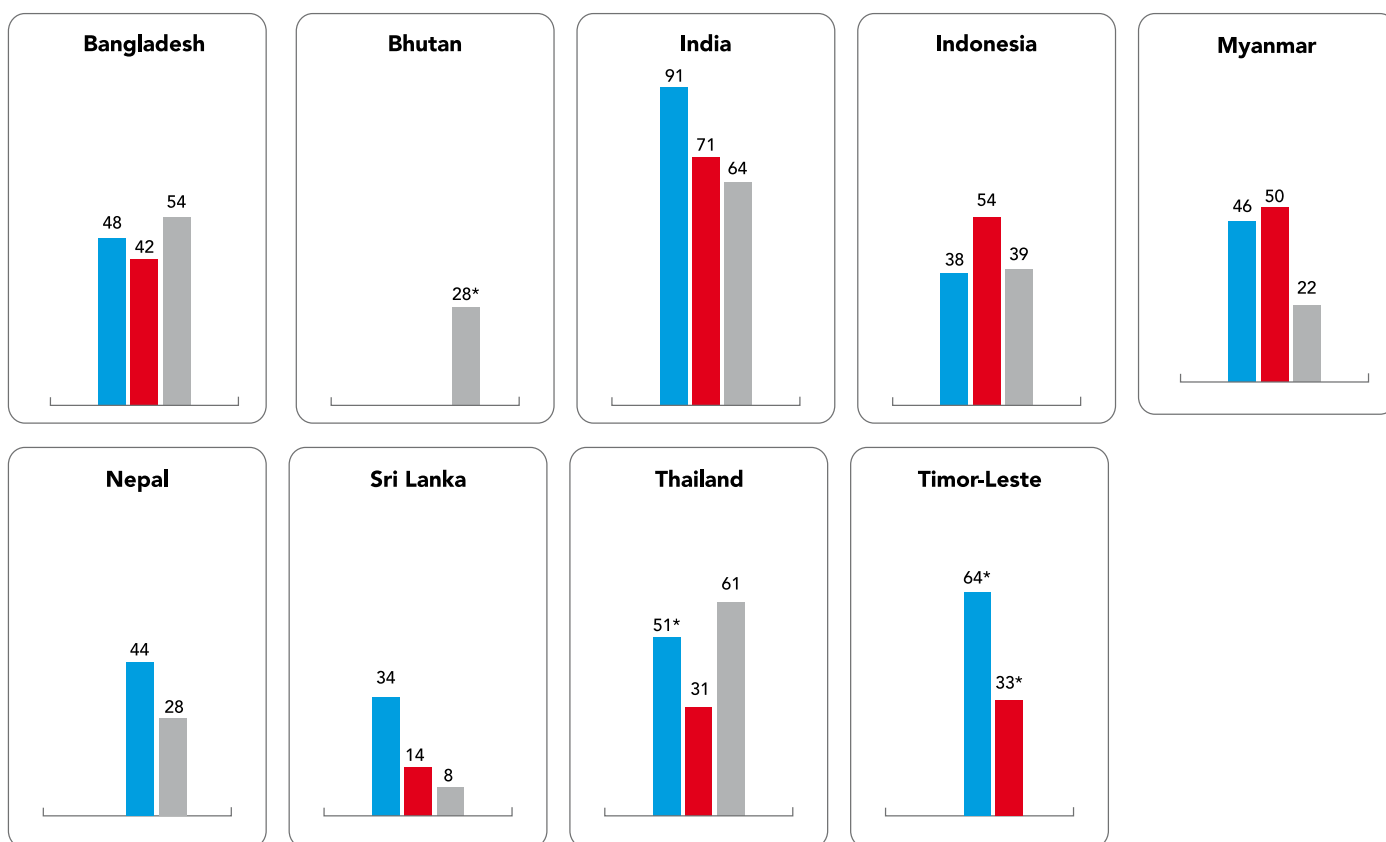
	No. of Pregnant women	ANC 1 coverage*	Tested for HIV	HIV + pregnant women			HIV exposed infants	
				Estimated	Diagnosed	On ARV	ARV prophylaxis	Received virological test
Bangladesh	4,957,242	53%	12,208	<200	21	21	19	14
Bhutan		97%						
India	20,012,379	85%	11,474,499	27,000	11,453	9,407	9,287	5,811
Indonesia	5,180,091	96%	3,545	14,469	1,588	1,558		731
Maldives	4,163	99%	3,705		1	1	1	1
Myanmar	1,107,312	83%	793,446	4,748	4,365	3,923	2,169	801
Nepal	724,839	87%	187,552	414	145	145	114	76
Sri Lanka	312,897	99%	262,051	67	16	9	10	10
Thailand	736,352	98%	733,390	4,497	4,497	4,280	4,404	4,173
Timor-Leste	48,316	84%	9,345	41	8	8	4	2

Source: UNAIDS 2016 estimates; Global AIDS Response Reporting 2016.

* At least one antenatal visit

Figure 7

Percentage of key populations who received HIV testing in SEA Region in the last 12 months



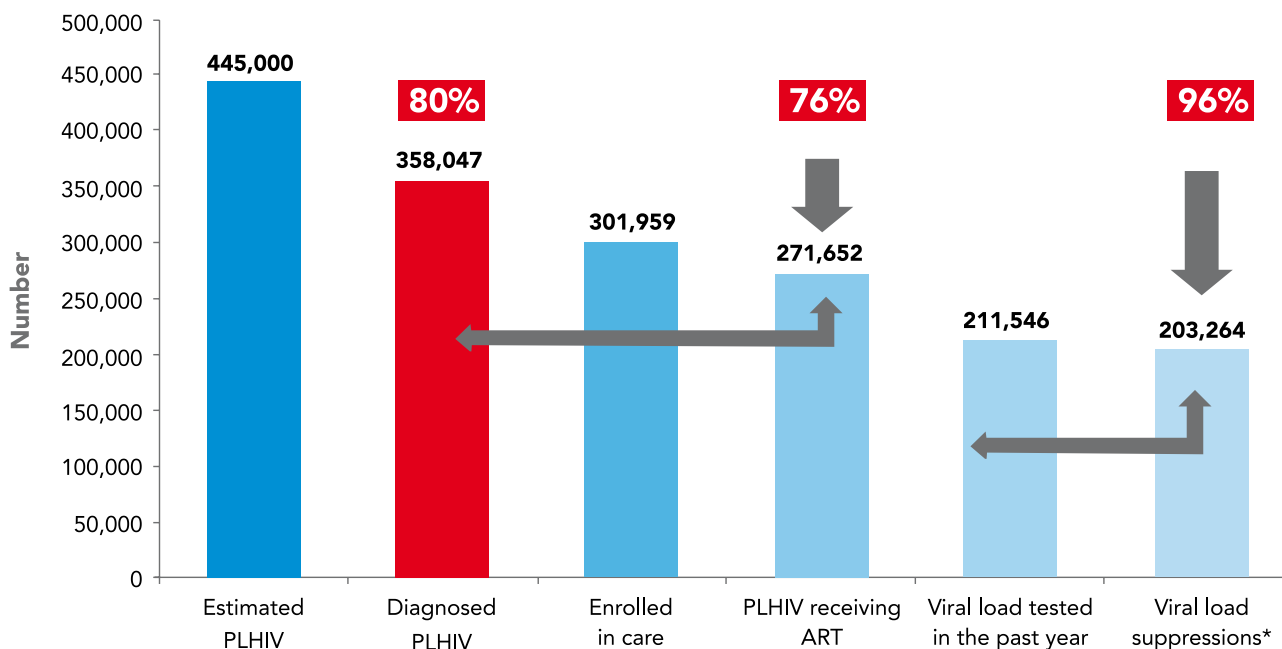
*2013

■ Sex workers ■ Men who have sex with men ■ People who inject drugs

Source: UNAIDS 2016 estimates.

Figure 8

Thailand is close to reaching the 90-90-90 targets if barriers are addressed



Source: Ministry of Public Health Thailand, 2015.

As the “90-90-90” target reflects, achieving the desired outcome of HIV treatment – viral suppression – depends on good outcomes across the HIV treatment cascade, which consists of HIV diagnosis, linkage to care, initiation of antiretroviral therapy, retention in care and strong treatment adherence. Achievement of the 90-90-90 target requires treatment coverage of 81% and viral suppression among at least 73% of all people living with HIV. Thailand appears to be closely on track to achieve the 90-90-90 target before the 2020 deadline, having achieved extremely high testing rates and antiretroviral coverage. Hopefully, it can address the barriers to diagnosis and treatment well ahead of 2020 (Figure 8).

Rates of retention in care for people who initiate antiretroviral therapy are generally favourable in Member States of the Region, with six countries for which information was available for 2015 reporting 12-month retention rates of 80% or greater. However, in India and Indonesia, the latest available data from 2014 found 12-month retention of 74% and 71%, respectively, highlighting the

need for intensified efforts to retain people in care and treatment.

To increase access to antiretroviral therapy, countries in the region have taken steps to expand the number of facilities offering HIV treatment services. In Nepal, the number of health facilities offering HIV treatment increased from two in 2004 to 61 in 2015. In Myanmar, the number of people receiving antiretroviral therapy increased more than five-fold from 2009 to 2015. To accelerate the pace of scale-up, further decentralization and increased use of community service delivery will be needed.

Monitoring viral suppression among people receiving antiretroviral therapy is hindered in many countries of the region by the shortage of viral load testing facilities. Periodic viral load testing enables clinic staff to intervene when adherence challenges emerge and to switch patients to second- and third-line regimens in a timely manner in cases of treatment failure. WHO has assisted Member States in the Region in procuring and implementing viral load testing, and

further such efforts will be required to ensure that every person living with HIV has ready access to essential viral load monitoring. In the spirit of integrated programme responses, there is an opportunity to use GeneXpert, used conventionally for TB also for HIV viral load estimations.

Challenges and bottlenecks:

Several factors explain why the Region is not currently on track to end the epidemic. While some countries like Myanmar and Thailand have reviewed and reprioritized the HIV health sector response and investments, many countries have yet to effectively prioritize their responses, in terms of focusing resources on the highest-impact interventions and targeting efforts towards the geographical settings and populations with the greatest need. Urgent efforts are also needed to increase the scale and improve the quality of HIV services.

Insufficient focus for strategic impact

A wealth of evidence shows that epidemics in Member States of the Region are principally driven by risk behaviours among specific key populations, notably sex workers and clients, men who have sex with men, transgender people and people who inject drugs and their sexual partners. Experience in South-East Asia has demonstrated that focusing resources and programmatic efforts on those most at risk has the potential to reverse both sub-national and national epidemics. In Karnataka state in India, for example, implementation of condom promotion efforts carefully targeted to female sex workers resulted in a dramatic decline in HIV prevalence among the general population as measured by rates among antenatal clinic attendees. In Thailand, early and focused efforts on sex work settings reversed the growth of the epidemic by the mid-1990s and has kept it in decline since.

The strategic impact, efficiency and return on investment of AIDS responses are intensified when resource allocation decisions and programmatic efforts take into account the populations and locations where the need for prevention and treatment services is the

greatest. For a comprehensive response, that aims to minimize both the risk of HIV transmission and acquisition, programmes should focus on populations where HIV incidence is highest.

Currently, however, resources are not strategically aligned with these epidemiological patterns, diminishing the impact of national responses and reducing the health return on investments.

According to UNAIDS, only 24% of domestic AIDS spending in countries in the broader Asia Pacific Region focus on programmes for key populations, even though most new infections are occurring among these groups. Less than 5% of domestic AIDS spending focuses on efforts to address the HIV-related needs of men who have sex with men, even as HIV rates in this population continue to rise across the Region. Most of the prevention funding for key populations come from external development aid.

Although it is common to speak of national epidemics, HIV rates actually vary considerably within countries, underscoring the need to focus services strategically on the communities and districts where HIV burden is greatest (Figure 9). Thailand, for example, is working to focus resources and programmatic efforts on the 33 provinces that account for 70% of all new HIV infections. A similar phenomenon is evident in India, where HIV prevalence is generally low nationally but much higher in four southern states and two north-eastern states. While focus and prioritization is important, surveillance in “low level” areas needs to be maintained especially among key populations to avoid unexpected outbreaks.

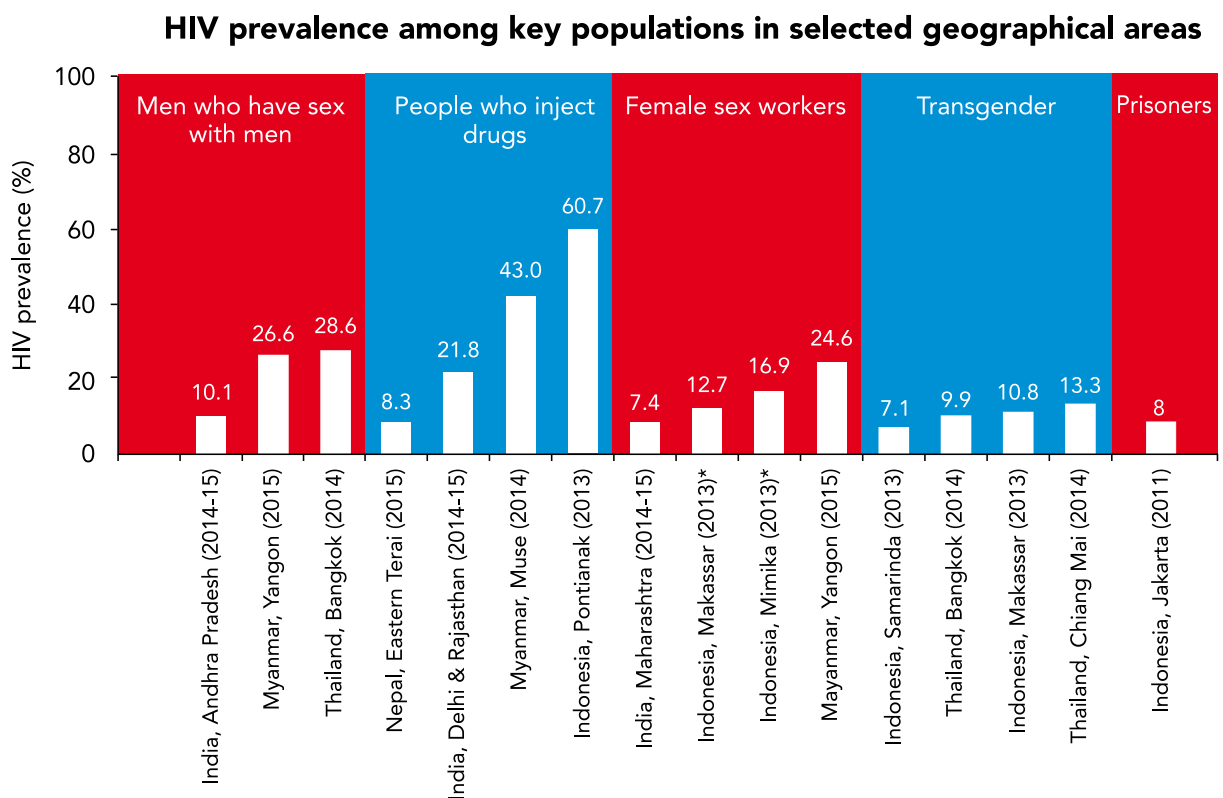
To target programmes most effectively towards the populations and locations that most need HIV services, robust strategic information systems are essential. More granular epidemiological and programme utilization data must be collected, rapidly analysed and used to inform the allocation of finite resources, assessment of programme effectiveness at multiple levels, and the performance management of HIV programmes. In particular, information systems and protocols should be implemented to collect close-to-real-time information on outcomes across the HIV treatment cascade at subnational levels. A cascade-oriented data system can help identify key gaps in national and sub-national responses and inform policy and programmatic efforts to close these gaps.

Building local data systems and local capacity to use the data to strengthen programmes is an urgent necessity. Effectively used strategic information can help decision-makers target resources towards “hot spot” settings and populations in greatest need and identify programmes which are not working to focus urgently on their improvement.

Missing adolescents and young people

According to the report of the Commission of AIDS in Asia, over 95% of all new HIV infections among young people occur among most-at-risk adolescents (6).

Figure 9
National prevalence masks high prevalence in local geographical areas



Source: HIV sentinel surveillance reports and integrated biological and behavioral surveillance reports

While adolescents and young people comprise around 12% of the people living with HIV (PLHIV) in the region, they account for 38% of all new HIV infections, most of these occurring in young key populations (7). And yet, lesser numbers of young key populations are being reached by prevention programmes and have limited access to HIV testing services: 3 in 4 young key populations do not know their status. With the demographic transition in the region, policies and programmes that reach young people and especially young key populations will be decisive in the quest for ending AIDS.

The quality and scale of programmes remain inadequate

While countries in the South-East Asia Region have in large measure established strategic policy and coordinating frameworks for sound national responses, attention to the targeting, quality and scale of programmes is often insufficient to achieve the needed public health impact. This problem is evident with respect to prevention programming for people who inject drugs. Although most countries in the Region officially support harm reduction programming to reduce the risk of injection-related HIV transmission, the reach of these programmes is often limited.

Similar weaknesses are apparent in other areas of HIV programming. In six of eight countries in the Region for which recent data are available, HIV testing services currently reach less than half of all the men who have sex with men and people who inject drugs.

Better follow-through is also needed to translate policy frameworks into the kinds of effective programmes that can achieve the desired public health impact. Clear coverage and outcome targets are needed – both nationally and for individual programmes at the local level – and programmes must be more rigorously monitored and adapted as needed to improve results. As in the case of antiretroviral therapy programmes, prevention interventions also involve service cascades; by monitoring outcomes across these prevention cascades, programme implementers can identify where programmes are falling short and devise strategies to close these gaps. In case where programmes are failing to reach those who need them, these should partner with representatives of the target populations to identify and implement innovative approaches to link those in need of services with the services they require. Monitoring the prevention cascade will also enable strategic use and scale up of combination prevention services including pre exposure prophylaxis.

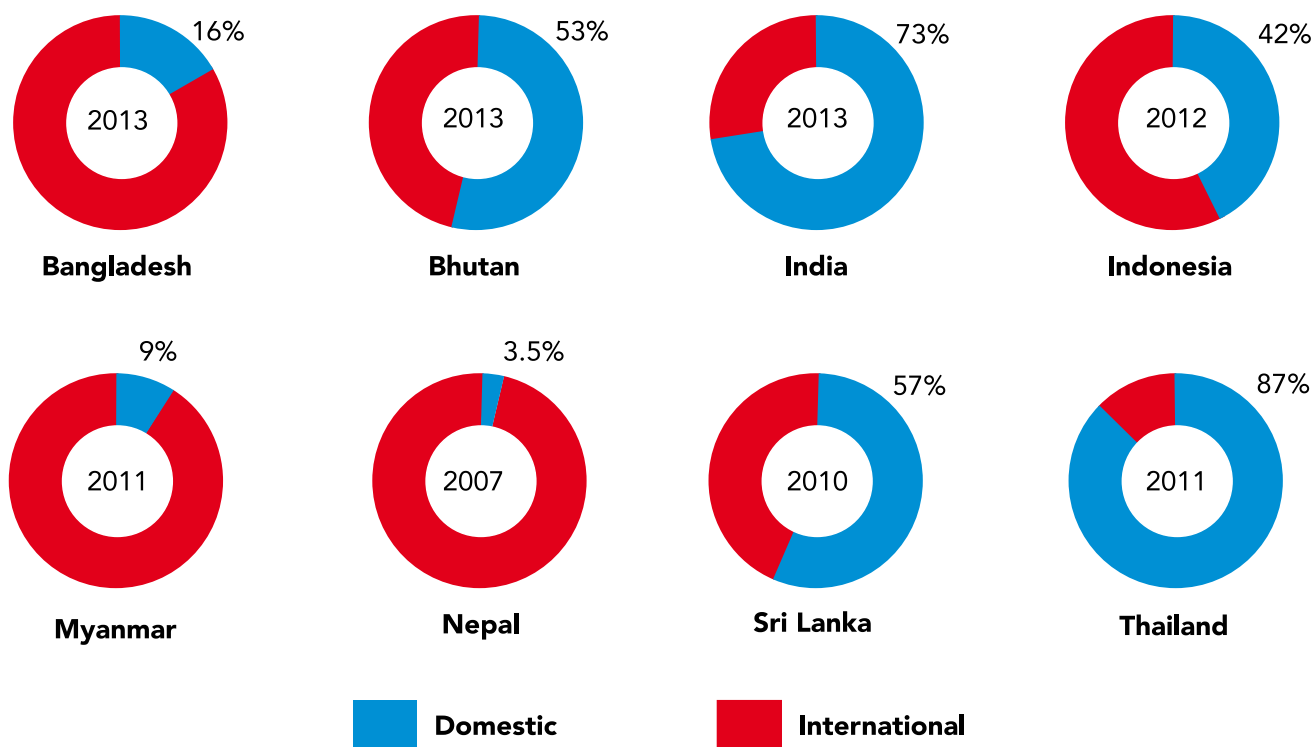
HIV financing is inadequate

Although globally the incremental rise in resources needed to achieve fast-track targets amounts to roughly 20% over current spending, greater increases in financing will be required in South-East Asia. In part, this stems from the fact that coverage for essential HIV prevention and treatment services is often lower in South-East Asia than in some other regions. In priority countries such as India and Indonesia, there is a considerable gap between current financing and the resources that will be needed to end the epidemic. Also more strategic spending will be needed for higher impact. In India, for example, more than double the resources available in 2015 will be needed to fast-track the response and end the epidemic. In Indonesia, greater and

strategic increases in resource allocations will be needed to place the country on track to end the AIDS epidemic. Success of HIV programmes and reduction in new infections in many countries in the region have diverted attention and resources from the HIV response. This could prove catastrophic in the long run and may wipe out the gains achieved till date.

Domestic resources account for roughly 57% of HIV spending in the South-East Asia Region countries – a share that is roughly comparable to patterns seen globally. To close the AIDS resource gap in countries of the Region, domestic financing will need to further increase. The space for additional international support for AIDS responses in Asia is likely to be limited, as countries in the region

Figure 10
Domestic and international funding for HIV in SEA Region



Source: UNAIDS estimates; Global AIDS Response Progress Reporting.

graduate to mid-income status, thanks to the economic growth. Strategic funding allocations and decisions on exit strategy will also be needed to sustain the HIV response. Already, India and Thailand are taking steps to assume greater domestic responsibility for financing their AIDS responses, but external support continues to predominate in Bangladesh, Myanmar and Nepal (Figure 10).

In particular, domestic public sectors in Member States of the Region will need to increase financing for prevention and treatment programmes for key populations, a vital responsibility that is currently being met by international donors.

As countries in the region embrace universal health coverage and pledge to “leave no one behind,” it is imperative that the HIV prevention, care and treatment interventions are also included in the benefit package, lest the people living with HIV are left behind.

Criminalization, stigma, discrimination and other structural barriers undermine the AIDS response

Stigma and discrimination undermine AIDS responses by deterring individuals living with HIV or those at risk of infection from seeking the needed information and services. HIV-related stigma also weakens the broader response by impeding efforts to develop strong political and popular support for a robust, inclusive, and evidence- and rights-based approach to addressing HIV.

Discriminatory attitudes towards people living with HIV remain common in South-East Asia. According to recent surveys, more than 60% of people in two countries report that they would not buy fresh vegetables from a shopkeeper or vendor if they knew the person was living with HIV (8).

In South-East Asia, where epidemics are heavily concentrated among marginalized groups, HIV-related stigma is often compounded by negative social and legal approaches. Six Member States in the Region criminalize same-sex relations, four

have criminal penalties in place for sex work, and four operate detention centres for people who inject drugs (9).

These popular misconceptions and prejudices regarding HIV widely affect the behaviours of health-care providers, who may withhold services to stigmatized groups as well as law enforcement personnel, who may harass members of key populations or make it difficult to implement evidence- and rights-based programmes for marginalized groups.

In addition to reforming laws and investing in anti-stigma programming, countries in the region can help minimize HIV-related stigma by rapidly scaling up HIV treatment and other HIV services. Surveys around the world indicate that HIV-related stigma declines as HIV treatment is made more widely available.



THE WAY FORWARD: GETTING ON TRACK TO END AIDS IN MEMBER STATES OF THE SOUTH-EAST ASIA REGION

To get on track to end the AIDS epidemic in Asia, Member States should couple renewed commitment to the AIDS response with more strategic, vigorous and tightly focused approach.

Following key actions are proposed to fully leverage the “Asia Advantage” and make South-East Asia the first region to end AIDS.

The WHO South-East Asia Region has unique advantages that should be leveraged to maximise progress in reducing new HIV infections and AIDS-related deaths.

- Most national epidemics in the region did not generalize, remaining concentrated among limited key populations. With an appropriate focus of prevention resources, this creates opportunities for rapid epidemic reversal unavailable to much of the rest of the world
- Countries in the region have also proven their ability to reverse epidemics and achieve other difficult progress indicators. These gains have stemmed from a combination of both political leadership and strong community

engagement. Several national AIDS control efforts were led by senior political leaders, and AIDS control programmes were given special status and authority.

- Recognizing the harmful effects of stigma and discrimination, political leaders took steps to combat stigma and create enabling environments for effective programming for key populations.
- Simultaneously, non-governmental organizations and other segments of civil society powerfully advocated for a rights-based approach and essential services. National governments partnered with affected communities to implement mission-driven strategies and coordinating mechanisms.

Immediate action is needed to accelerate progress towards the 90-90-90 treatment target.

AIDS cannot be ended in the South-East Asia Region without achieving the 90-90-90 treatment target. This will require enhanced efforts to monitor and respond to outcomes across the HIV treatment cascade, complementing the delivery of HIV treatment with support for retention in care and strong treatment adherence. Member States in the South-East Asia Region should place particular emphasis on achieving the needed scale for testing and treatment programmes, especially among the most affected key populations and their partners.

Primary HIV prevention must be massively scaled up in tandem with treatment services.

While AIDS cannot be ended without reaching 90-90-90 treatment targets, this on its own will be insufficient to end AIDS. The reduction in HIV transmission associated with massively scaled-up antiretroviral therapy needs to be matched by an equally robust reduction in HIV incidence rates. The fourth “90” - that is 90% coverage of combination prevention services among those most at risk, i.e., key populations and their partners in concentrated epidemic settings - will be critical.

New resources and more effective programmatic efforts will be needed to ensure that prevention efforts including combination prevention, pre exposure prophylaxis and treatment for prevention achieve the scale needed to radically lower the trajectory of the epidemic across the Region.

Granular, timely data is needed to focus efforts and maximise impact

Countries in the Region confront epidemics that are heavily concentrated in specific geographical “hot spots” and amongst particular key populations. This offers policymakers and programme implementers with the opportunity to ensure that prevention and treatment programmes actually reach these populations and areas. Locally relevant data should be collected and used at the facility and sub-national levels to provide real-time insights on actions needed to close gaps and improve outcomes. Programme planners and implementers should use this data to make mid-course corrections or adaptations needed to expand the reach and impact of programmes. The failure to identify and correct programmes that are not working or are not focused on the areas and populations of greatest need represents a key gap in the regional AIDS response, underscoring the need for more rigorous monitoring and better use of real-time data.

Ensure quality health services for key populations

In particular, governments should build the capacity of mainstream health service delivery channels to provide non-discriminatory and high-quality services to key populations. They should also work closely with the communities to strengthen linkages with community programmes and develop integrated community-government programmes to strengthen access to health care in order to build a sustainable system that can adapt and respond as the epidemics evolve. Reducing transmission risk in the community at large by reducing population-level viral load should be an important emphasis of HIV treatment programmes and requires that key populations receive equitable access and are retained in those programmes.

HIV prevention programmes must be in place in countries with very low prevalence

In several countries in the region – including Bhutan, Maldives and Timor-Leste – infection rates have remained insignificant. This provides the gift of time to put in place the range of combination prevention services needed to prevent future epidemic outbreaks of HIV.

Intensify responses where the epidemic is on the rise

AIDS cannot be ended in the region unless epidemics that are currently expanded are effectively reversed. Intensified action is especially needed in areas and populations where the new infections are stable or increasing and where prevalence is inching upwards like Indonesia.

Monitor the situation closely and respond quickly

Bearing in mind uncertainty about the future course of the epidemics, countries in the region should maintain strong strategic information systems to keep track of any changes. Decision-makers should remain vigilant to respond effectively if and when epidemics rebound or begin to involve new populations, especially as new generations of young people reach the stage in life when sexual risk taking is often most pronounced.

Empower communities with a central role in combination prevention service delivery

It is equally important that affected communities be empowered through funding and technical support to undertake to deliver HIV outreach and services. Programmes and services should not only focus on members of key populations, but also on their sexual partners who are at great risk of HIV transmission if appropriate measures are not taken, e.g., promotion of safer sexual practices, PrEP or antiretroviral treatment for their partner living with HIV.

Governments should commit to partnerships with communities

National responses need to prioritize evidence- and rights-based action to meet the needs of those who are currently being short-changed by efforts, including people who inject drugs, sex workers, men who have sex with men and transgender people

- In a region where transmission among marginalized populations is driving many national epidemics, political courage and commitment must be used to repeal or reform laws and policies that impede service access for key populations and endanger their general well-being.

- Given that governments have far more resources than communities; efforts should focus on ensuring that public sector services are open, welcoming and appropriate for all communities, including the key populations most affected by HIV. In addition, strong collaboration between governments and communities is essential to build the linkages needed to leverage community-generated demand for services.

Invest strategically and take steps to make AIDS resources go as far as possible to maximize public health

Member States should move immediately to mobilize investments in the AIDS response and to use these resources as effectively as possible.

- Sharply stepped-up investments in HIV testing, prevention and treatment programmes are urgently needed, as countries in the region have a narrow window of opportunity to lay the foundation of the road leading to the end of AIDS. Given trends in international development assistance, these increases have to come from domestic budgets. Fiscal space exists in every country to increase domestic resources for AIDS, and some countries in the region have already taken steps to assume greater responsibility for financing the response.
- Historically, AIDS resources have covered such costs as screening for blood safety, elimination of mother-to-child transmission, and screening and treatment for HIV/TB co-infection. These costs should actually be borne by general health budgets, especially as these are expanded towards universal health coverage by 2030. For example, ensuring the safety of blood supply is a core function of any effective health system. Likewise, preventing newborns

from acquiring HIV or congenital syphilis is a basic responsibility of maternal, newborn and child health services. All in all, the costs of vital HIV-related services - HIV testing, antiretroviral therapy, viral load monitoring and pre-exposure antiretroviral prophylaxis should be included in benefit packages for universal health coverage.

- Invest resources in those populations and locations where they will have the greatest return in infections averted and lives saved. Countries must strengthen their epidemiological and program monitoring systems to provide the information needed to guide the response effectively. They must also build the analytic capacity to use this information to guide resources for maximum impact, evaluate and consistently improve responses over time, and identify and fill gaps in the response as the epidemics evolve. Leaders should ensure that investments and responses are driven to maximize public health benefits rather than being constrained by stigma and discrimination. This will maximize their return on investment and avert the huge downstream costs of failing to address the epidemics effectively now.
- Make use of cheaper and more cost-effective service delivery modalities. Existing resources can have a greater impact if ways are found to deliver the same services at lower cost or more cost-effective modalities are chosen. Targeting testing to those populations which will identify the greatest number of infections increases the efficiency of testing resources and enables more people to get on treatment quickly – providing both prevention and survival benefits. Initiating ART earlier when people are

healthier combined with testing out less expensive delivery approaches – for example fewer follow-up visits or less frequent delivery of ART like quarterly delivery can stretch ART dollars to cover more people. Active efforts should be undertaken to develop less costly ways of delivering essential services in South-East Asian settings and these then brought to scale once they are proven

Ending AIDS in South-East Asia by 2030 is an achievable goal, but it will require commitment, courage and compassion on the part of South-East Asian leaders and the active engagement of all stakeholders in implementing a more targeted, more comprehensive and more effective response. Several countries and their provinces/states in WHO's South-East Asia Region have already demonstrated that this is feasible and affordable and that the benefits returned are huge. Let every country in the region now make the commitment that AIDS will be ended by 2030 and immediately take the steps necessary to make that goal a reality.



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