Beginning of the Decade of Action for ending viral hepatitis, HIV and STIs as public health threats by 2030 in the South-East Asia Region

The WHO South-East Asia (SEA) Region bears 10% of the global HIV burden and 20% of the global viral hepatitis burden, with almost 60 million people living with chronic hepatitis B virus (HBV) infection, over 10.5 million with chronic hepatitis C virus (HCV) infection, and 3.7 million people living with HIV. Mortality due to viral hepatitis in the SEA Region continues to be significant with over 218 000 deaths in 2019. The SEA Region has recorded a decline in syphilis prevalence; however, other bacterial and viral sexually transmitted infections (STIs) continue to increase and concerted efforts are needed to prevent linked antimicrobial resistance.

The Sixty-ninth World Health Assembly in 2016 had adopted the Global Health Sector Strategies (GHSS) on HIV, viral hepatitis and STIs (2016–2021). These were fully aligned with Target 3.3 of the Sustainable Development Goals. The GHSS called for ending HIV, viral hepatitis and STIs as public health threats by 2030. These are firmly placed under the umbrella of universal health coverage. The SEA Region developed two regional action plans (RAPS) for viral hepatitis (2016–2021) and HIV (2017–2021), respectively, aligned with the GHSS 2016–2021.

There has been significant progress in the response to the HIV epidemic in terms of reduction in new infections and AIDS-related mortality, and increase in coverage of antiretroviral therapy globally as well as in the SEA Region. However, the HIV response has reached a plateau in recent years. The hepatitis response has progressed relatively well on the prevention front, with increasing coverage of birth-dose and third-dose hepatitis B vaccination. However, the coverage has been limited for harm reduction interventions for persons who inject drugs (PWID), i.e. the use of evidence-based interventions such as sterile needle–syringe distribution and pharmacologically assisted therapies. Testing for and treatment coverage of HBV and HCV have been poor despite the availability of low-cost generic medications and multidisease diagnostic platforms.

The Seventy-fourth World Health Assembly in May 2021 requested the WHO Director-General to initiate the process of developing global health sector strategies (GHSS) on HIV, viral hepatitis and STIs for the period 2022–2030.
Aligned with the WHO GHSS for 2022−2030, Member States in the Region are requested to consider a draft resolution proposed by Indonesia at the Seventy-fourth Session of the WHO Regional Committee for South-East Asia, that calls for:

1. review and noting of progress on the implementation of the three global strategies 2016–2021 on HIV, viral hepatitis and STIs in the Region, specifically through progress on the 2016 United Nations High-Level Meeting on ending AIDS (UNHLM) Fast-Track Targets, and the RAPs for viral hepatitis (2016−2021) and HIV (2017−2021), respectively;

2. adopt a decision to request the Regional Director of the WHO SEA Region to build on the current RAPs and undertake a consultative process to develop an integrated RAP on and for viral hepatitis, HIV and STIs, for the period 2022−2026 with clear targets and milestones.

3. following the adoption of the above resolution, and an evidence-informed consultative process, present the new integrated RAP for endorsement by the Seventy-fifth Session of the WHO Regional Committee for South-East Asia in 2022.

This Working Paper was presented to the High-Level Preparatory (HLP) Meeting for its review and recommendations. The HLP Meeting reviewed the paper and made the following recommendations for consideration by the Seventy-fourth Session of the Regional Committee.

### Actions by Member States

1. Proceed with a draft resolution as proposed by the Republic of Indonesia with support from other Member States, for adoption at the Seventy-fourth Session of the Regional Committee; and engage further with the Secretariat while an integrated Regional Action Plan is developed through consultations and presented at the Seventy-fifth Session of the Regional Committee for endorsement.

2. Continue, at the policy level, to pursue their commitment on this matter, which is firmly rooted in the UHC agenda, and raise adequate resources for implementing the Regional Action Plan for viral hepatitis, HIV and STIs.

3. Adopt integrated, simplified and decentralized service delivery at the implementation level using primary care approaches and adopting innovations as well as strengthening rights-based, multisectoral and community-led responses, keeping in mind the need to focus on key populations and ensure their coverage with services, given that the majority of new infections are reported among them.

### Actions by WHO

1. Present an update on the progress and gaps in implementing the Global Health Sector Strategy (2016−2021) in the Region through the regional action plans for HIV (2017−2021) and viral hepatitis (2016−2021) to the Seventy-fourth Session of the WHO Regional Committee for South-East Asia.
(2) Undertake, following the adoption of the proposed resolution at the Regional Committee Session, evidence-informed preparations and consultations with Member States and other stakeholders to draft an integrated Regional Action Plan for viral hepatitis, HIV and STIs for 2022–2026, aligned with the targets and strategic directions of the upcoming GHSS (2022–2030); and present the Action Plan for endorsement by the Seventy-fifth Session of the Regional Committee in 2022.

(3) Continue to provide high-quality technical support to Member States in taking forward the work on viral hepatitis, HIV and STIs, as well as pursue its coordinating role in the technical areas to further collaborate with other UN agencies and partner organizations in advancing this agenda.

This Working Paper and the HLP Meeting recommendations are submitted to the Seventy-fourth Session of the WHO Regional Committee for South-East Asia for its consideration and decision.
Introduction

1. HIV, viral hepatitis and sexually transmitted infections (STIs) account for 2.3 million deaths per year, which represent 14% of the annual deaths from infectious and parasitic diseases, digestive diseases and cancer, and 4% of deaths from all causes worldwide. These result in 1 million people being newly infected every day and 1.2 million people developing cancer every year (Progress report on GHHS 2021). They continue to be a major public health burden in terms of mortality, morbidity and quality of life. These communicable diseases share common modes of transmission, determinants and call for a common public health approach along the continuum of prevention, diagnosis, treatment and care.

2. Three separate but interlinked global health sector strategies (GHSS) on HIV, viral hepatitis and STIs (2016–2021) were adopted at the Sixty-ninth World Health Assembly in May 2016. Aligned with the Sustainable Development Goals (SDGs), the three GHSS call for ending HIV, viral hepatitis and STIs as public health threats by 2030 under the umbrella of universal health coverage.

3. The Seventy-fourth World Health Assembly in May 2021 unanimously adopted the Executive Board decision contained in EB148(13) that requested the WHO Director-General to build on the current global health sector strategies (GHSS), i.e. for 2016–2021, and undertake a consultative process to develop a new GHSS on HIV, viral hepatitis and sexually transmitted infections (STIs), respectively, for the period 2022–2030.

4. The Governing Body decision requires that the strategies shall be evidence-based; aligned with SDG Target 3.3 and related goals/targets; and presented for consideration to the Seventy-fifth World Health Assembly in 2022 through the Executive Board at its 150th Session.

5. The SEA Region is home to 10% of the global burden of HIV, 20% of the global burden of viral hepatitis and 16% of the burden of four curable STIs. In line with the GHSS 2016–2021 and with due consultation with Member States as well as stakeholders, the Regional Office for South-East Asia developed two regional action plans (RAPs) for viral hepatitis (2016–2021) and HIV (2017–2021), respectively.

6. These RAPs offer action-oriented frameworks across five strategic directions, namely: (1) information for focused action; (2) interventions for impact; (3) delivering for equity; (4) financing for sustainability; and (5) innovation for acceleration. They envisage ending HIV/STI/hepatitis as public health threats by 2030.

7. An update on the progress of the RAPs will be presented to the Seventy-fourth Session of the Regional Committee, and the Regional Director requested to adopt an evidence-informed and consultative process to develop an updated, integrated regional action plan (RAP) for HIV, STI and viral hepatitis beyond 2021, which is aligned with the new GHSS 2022–2030.
Current situation, response and challenges

HIV

8. In 2019, 3.7 million of the estimated 38 million people living with HIV (PLHIV) globally were in the WHO SEA Region. This constitutes roughly 10% of the global burden.

9. Five Member States – India, Indonesia, Myanmar, Nepal and Thailand – constitute nearly 99% of the regional burden. The HIV epidemic in the SEA Region is a concentrated one and key populations (KPs) and their partners account for 98% of new infections in Asia and the Pacific.

10. In 2019, there were an estimated 160 000 annual new HIV infections in the Region. This is a 24% reduction from 2010 levels, against a target of 75% to be achieved by 2020, as per the RAP. In 2019, approximately 110 000 PLHIV died in the Region due to HIV-related causes. This is a 27% reduction from 2015, against a target corresponding to a 67% reduction by 2020. Reduction in new infections and deaths has plateaued in recent years (Global Aids Update 2020).

Fig. 1. The SEA Region is falling short of targets on reduction in new infections and AIDS-related deaths

Source: UNAIDS/WHO estimates, 2019

11. Coverage of antiretroviral therapy (ART) among PLHIV in the Region increased from 39% in 2015 to 60% in 2019 as per UNAIDS/WHO estimates. While this is a significant increase from 20% in 2010, there is considerable ground to cover to reach the target of 81% against the fast-track targets of 90-90-90 by 2020. At the same time, the progress in the Region is not uniform. While Myanmar and Thailand have reached 76% and 80%, respectively, of the estimated PLHIV with life-saving ART, Indonesia had a coverage of 21%. Thailand is the only country that has achieved the 2020 milestone of the third “90”, with viral suppression in 78% of PLHIV on ART in 2019. The Region is lagging behind the 2020 fast-track targets, and this has been exacerbated by the COVID-19 pandemic.

12. Among the major achievements in the Region, Maldives and Sri Lanka were certified by WHO in 2019 as having achieved the elimination of mother-to-child transmission (EMTCT) of HIV and congenital syphilis. Thailand was certified in 2018 and 2021 for having maintained the validation it was accorded in 2016.

The fast-track targets of 90-90-90 imply that by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression.
13. All Member States have adopted updated WHO guidance on treatment that includes “TREAT ALL”, irrespective of the clinical stage and CD4 count, with more robust dolutegravir-based antiretroviral (ARV) regimens. With paediatric formulations now starting to become available for dolutegravir, Member States need to expand coverage to include children as well. Most countries are in the pilot stages of implementing newer testing and prevention strategies, such as HIV self-testing (HIVST) and pre-exposure prophylaxis (PrEP). These interventions need to be scaled up urgently.

14. Key challenges in the HIV response include waning of political commitment and donor funding, lack of adequate domestic resource allocations, and declining support for the engagement of communities. Access to prevention and testing services by key populations (KPs) is still low and needs to accelerate as a large proportion (98%) of new infections in the Asia-Pacific Region are among KPs and their partners. The decline in funding has especially impacted primary prevention. The legal environment surrounding interventions for KPs is also a big challenge to realizing the prevention and treatment goals.

**Hepatitis**

15. Globally, there are an estimated 296 million people living with chronic hepatitis B and 58 million (46–76 million) with hepatitis C. Globally, hepatitis B and C caused 1.1 million deaths and 3 million new infections in 2019.

16. The SEA Region has an estimated 60 million (29–77 million) people living with chronic hepatitis B and around 10.5 million (8–19 million) with chronic hepatitis C. However, there is wide variation between countries in the Region in terms of prevalence of hepatitis B and C, with some being very low-prevalence countries and others where prevalence is generalized. (Regional progress report on viral hepatitis, 2020)

17. There were 260,000 incident cases of hepatitis B in 2019 and 230,000 of hepatitis C. Around 180,000 people died of hepatitis B and 38,000 of hepatitis C in 2019 in the Region.

18. Of the estimated 218,000 deaths due to viral hepatitis in 2019 in the Region, 81% are attributable to the chronic complications of hepatitis B and C. Mortality due to viral hepatitis is increasing, even as deaths due to HIV and TB are on the decline.

19. There has been significant progress on various prevention indicators. The birth dose coverage for hepatitis B vaccine in the Region increased from 34% in 2016 to 54% in 2019. Nine countries achieved the regional coverage target of 90%.

20. Four countries – Bangladesh, Bhutan, Nepal and Thailand – have been verified by an independent Regional Expert Panel to have achieved the 2020 hepatitis B control goal of less than 1% hepatitis B surface antigen (HBsAg) positivity among 5-year-old children.

21. However, the 2020 targets on harm reduction activities for people who inject drugs (PWID), such as supply of clean needles and syringes and coverage of opioid substitution therapy (OST), have been largely missed due to the pandemic. The average number of needles and syringes distributed per PWID in the Region is approximately 157 (against a target of 200 by 2020), ranging from 3 to 366 needles and syringes distributed per year. Bangladesh, India and Myanmar have already reached the 2020 target, while Indonesia, Nepal and Thailand have been distributing less than 100 syringes per PWID.
22. The progress on diagnosis and treatment is inadequate. The RAP outlined that 50% of all those living with HBV and HCV should be aware of their status by 2020. Of those eligible for treatment of hepatitis B, 75% should be put on treatment and retained in care. Similarly, for hepatitis C, 75% of those diagnosed to be viraemic should be initiated on treatment and 90% of those treated should be cured. Against these targets, only 10.5% of the estimated number of people who are eligible for antiviral treatment for hepatitis B know their status and, of them, 4.5% are on treatment. Similarly, for hepatitis C, 6.9% know their status and, of them, 23% have received treatment (Table 1).

Table 1. Progress on key indicators of the RAP on viral hepatitis (2016–2021)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Indicator</th>
<th>Baseline estimates (2015)</th>
<th>Targets in the RAP (by 2020)</th>
<th>Progress on the RAP targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B vaccination</td>
<td>HepB3 coverage</td>
<td>87%</td>
<td>95%</td>
<td>91%</td>
</tr>
<tr>
<td>HBV PMTCT</td>
<td>Hep B birth dose coverage</td>
<td>34%</td>
<td>90%</td>
<td>54%</td>
</tr>
<tr>
<td>Blood safety</td>
<td>Proportion of non-remunerated voluntary blood donations</td>
<td>77%</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Injection safety</td>
<td>Proportion of unsafe injections</td>
<td>5.2%</td>
<td>0%</td>
<td>5.2–6.6%</td>
</tr>
<tr>
<td>Harm reduction</td>
<td>Number of syringes and needles distributed/PWID/year</td>
<td>29</td>
<td>200</td>
<td>157 [3–366]</td>
</tr>
<tr>
<td>Testing services</td>
<td>Proportion of HBV-infected diagnosed</td>
<td>3%</td>
<td>50%</td>
<td>10.5%</td>
</tr>
<tr>
<td></td>
<td>Proportion of HCV-infected diagnosed</td>
<td>9%</td>
<td>50%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Treatment</td>
<td>Proportion of HBV-diagnosed persons initiated on treatment</td>
<td>NA</td>
<td>75%</td>
<td>4.5%</td>
</tr>
<tr>
<td></td>
<td>Proportion of HCV-diagnosed persons initiated on treatment</td>
<td>7%</td>
<td>75%</td>
<td>23.8%</td>
</tr>
</tbody>
</table>

Source: Regional Progress Report on viral hepatitis, 2020

23. Viral hepatitis is not accorded high priority in most countries within their national health policies and programmes, though it affects more people than HIV and TB combined. With curative treatment available for hepatitis C, and safer long-term treatment for hepatitis B, lack of prioritization will result in preventable long-term morbidity and mortality due to cirrhosis and liver cancer.
24. One of the key challenges in addressing hepatitis B and C is lack of awareness, with only 10% or less of people living with the infection being aware that they are infected. Other major challenges include insufficient data for advocacy and programmatic actions; long registration process for newer HCV medicines in countries; limited donor funds for hepatitis unlike other health programmes, and limited or no dedicated funds for hepatitis in the health budgets of countries. Further, elimination of viral hepatitis needs multisectoral interventions and coordination between departments, such as between the water and sanitation departments (for hepatitis A and E), immunization, universal work precautions, blood safety, among others.

Sexually transmitted infections

25. Globally, more than 1 million STIs are acquired every day. It is estimated that, in 2019, there were 374 million new cases of four curable STIs — chlamydia, gonorrhoea, syphilis and trichomoniasis. An estimated 500 million people are also infected with viral STIs and approximately one in every seven women harbour the human papillomavirus (HPV).

26. Annually, an estimated 60 million (32–107 million) cases of the four curable STIs occur in the SEA Region. The proportion of new cases estimated for the SEA Region has declined from a third of the total global estimate in the 1990s to 16% in 2019. However, success is not uniform across countries. The last-dose coverage for HPV vaccination in the Region is 2% against a global coverage of 15%. Many large countries are yet to introduce HPV vaccination in their national programmes.

27. Three countries in the Region have been validated for having eliminated mother-to-child transmission of HIV and congenital syphilis.

28. Key challenges to STI reduction are lack of adequate surveillance systems, scant epidemiological research on estimation of disease burden, lack of commitment and de-prioritization, and weakening of programmes leading to variable progress, which is inequitable. STI screening among KPs and antenatal women is inadequate and the threat of antimicrobial resistance to infections such as gonorrhoea looms large.

Impact of COVID-19 on HIV and hepatitis services

29. The COVID-19 pandemic has hindered the delivery of some of the core HIV-related services across the Region, though the degree of impediment varies widely among countries, depending on the different services and the stage of the pandemic. For example, for Round 1 of the Pulse Survey in June 2020, at least four countries had reported disruption in ART services, while such disruption was reported in only one country for Round 2 of the survey in March 2021. Seven countries in the Region had reported data on the continuity of ARVs in both rounds. While the number of countries reporting any disruption reduced to one by Round 2, the level of disruption reported in Round 1 was more than 50%, unlike in Round 2, where countries reported disruption in the range of 5–50% only.

30. In general, WHO data show that HIV testing and prevention are among the services most frequently disrupted by COVID-19 across all regions. The level of disruption of HIV prevention services was highest in the SEA Region at 63%, as shown in Fig. 2 on continuity of services pertaining to communicable diseases in the Region.
Fig. 2. Continuity of services pertaining to communicable diseases in the SEA Region, 2020–2021

<table>
<thead>
<tr>
<th>Service</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outbreak detection and control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV prevention services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV testing</td>
<td></td>
<td></td>
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<tr>
<td>Continuation of ARTs</td>
<td></td>
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<tr>
<td>Initiation of ARTs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B and C diagnosis and treatment</td>
<td></td>
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<tr>
<td>TB diagnosis and treatment</td>
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<tr>
<td>Malaria diagnosis and treatment</td>
<td></td>
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<tr>
<td>Malaria prevention ETT campaigns</td>
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<td>Malaria prevention IRS campaigns</td>
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<tr>
<td>Malaria prevention SMC campaigns</td>
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</tbody>
</table>

% of countries, territories and areas


31. Experiences during the COVID-19 pandemic show that full restoration of essential services across the continuum of prevention, testing, treatment and care requires regular monitoring and concerted efforts focusing on adapting services towards resilience. Some of the services are relatively less affected, while in the case of others, levels of service coverage are yet to reach pre-pandemic levels. There is also a risk that interventions for primary prevention, including those that provide services for KPs such as PWID, men who have sex with men, sex workers and the transgender population, take a longer time to be fully restored. Catch-up campaigns and specific measures in pandemic response plans are needed to achieve this objective.

The way forward

32. The year 2021 marks the beginning of the Decade of Action for ending viral hepatitis, HIV and STIs as public health threats by 2030. The 2021 UN Political Declaration calls on countries to “commit to accelerating integration of HIV services into universal health coverage and strong and resilient health and social protection systems, building back better in a more equitable and inclusive manner from COVID-19...”. It also calls for an end to all inequalities and for a community-led response and has defined targets on social enablers. Also, there is a strong need for service delivery, innovation and diversification.

33. On the way to ending AIDS by 2030, there are some key “mid-points” to be achieved by 2025 as agreed during the UN High-Level Meeting held in June 2021. These include:

- HIV treatment to 34 million people with a 95-95-95 cascade;
- reducing the annual number of new HIV infections to under 370 000;
- reducing AIDS-related deaths to 250 000;
- eliminating new HIV infections among children and ending paediatric AIDS;
- ensuring that 90% of people living with HIV receive preventive treatment for TB by 2025, reducing TB-related deaths among people living with HIV by 80% by 2025.
34. The 2025 mid-points for hepatitis and STIs shall be defined in the upcoming GHSS. The 2030 targets for viral hepatitis are a 65% reduction in mortality and 90% reduction in incidence as compared with the 2015 baseline. For STIs, the 2030 targets are 90% reduction in the incidence of infections due to *T. pallidum* and *N. gonorrhoeae* globally (2018 global baseline) and ≤50 cases of congenital syphilis per 100 000 live births.

35. Key features of the response need to include strong political leadership on viral hepatitis, HIV and STIs, adequate funding, genuine community engagement, rights-based and multisectoral approaches, and the use of scientific evidence to guide focused strategies.

36. Moving forward, the RAP will provide guidance to support countries:

1. to develop and operationalize integrated strategies at the country level, including coordination with various donors and other stakeholders. The RAP will include guidance on an integrated service delivery package leveraging the primary health care (PHC) network and engaging all providers. It is also proposed that guidance on an integrated monitoring and evaluation (M&E) framework be provided. Member States will be supported to update their strategic information and strengthen community capacity to use local-level disaggregated data for community action at a decentralized level.

2. to provide strong technical support to governments to use new cost-effective tools and innovations, e.g. oral and injectable PrEP, HIV and hepatitis self-testing, differentiated ART service delivery model. New technologies will have to be fully operationalized to reach the unreached through HIV self-testing, and to use ARVs for PrEP as a key prevention approach.

3. to achieve elimination of mother-to-child transmission of HIV, HBV and syphilis as part of the integrated triple elimination approaches.

4. to ensure equity in service access for KPs so as to reach those who are not yet linked to services such as in rural areas, as well as for some harder-to-reach KPs who need concerted efforts to access and get services where they are and according to their needs. Decentralization is key and fundamental to improved access.

5. to develop differentiated service delivery models and innovation to remove obstacles and ensure client-centred quality services that are acceptable to clients and meet their needs; scale up innovations such as self-testing, PrEP and use of technology; and maximize the community networks to reach the most vulnerable.

6. to engage with communities in the provision of quality-assured services, with clear roles defined for community providers in a larger framework of task-sharing to address human resource shortages and reduce programme costs. The recognition of the importance of community- and KP-led health services as being a critical part of the response is fundamental and must be supported by domestic resources to ensure sustainability.

7. to support countries in demonstrating the cost-effectiveness of diagnosis and treatment for hepatitis B and C so that country-specific health packages include these as part of their UHC response. Increased access must be promoted through simplification of diagnosis and treatment by general practitioners, more nurse-led clinics and point-of-care testing as well as self-testing to be delivered in the community and through mobile clinics.
(8) to address the social and structural determinants that impact vulnerability and access to services and tackle the stigma, discrimination, criminalization and inequalities that undermine the response.

37. The WHO Regional Office, in consultation with Member States and other stakeholders, shall prepare the next RAP for viral hepatitis, HIV and STIs in line with the targets and strategic directions of the new GHSS. A “WHO headquarters, South-East Asia and Western Pacific Joint Regional Consultation on Global Health Sector Strategies for HIV, viral hepatitis and sexually transmitted infections” was held virtually with all the stakeholders on 15–16 June 2021 to discuss the key priorities for the global and SEA Region strategies and how to achieve these goals. The summary key recommendations are reflected here. Further consultations will be planned to address the gaps identified in the progress reports on HIV and viral hepatitis. The development of the Action Plan will factor in the likely impact of COVID-19. Service delivery models will need to incorporate differentiated approaches, task-sharing and strengthening of community participation and primary health care.

Conclusions

38. Member States are requested to consider, at the Seventy-fourth Session of the WHO Regional Committee for South-East Asia, the draft resolution proposed by Indonesia calling for:

1. review and noting the progress on the implementation of the three GHSS 2016–2021 on HIV, hepatitis and STIs in the Region, specifically through the progress on RAPs for viral hepatitis (2016–2021) and HIV (2017–2021), respectively; and

2. adoption of a Regional Committee Decision to request the Regional Director to build on the current RAPs and undertake a consultative process to develop RAPs on HIV and STIs, and viral hepatitis, respectively, for the post-2021 period.

39. The resolution also requests that, following its adoption, and an evidence-informed consultative process, the new RAP be presented for endorsement by the Seventy-fifth Session of the Regional Committee in 2022, and also be aligned with the 2030 SDGs and the three GHSS on HIV, viral hepatitis and STIs (2022–2030).

40. The HLP recommendations in this regard shall be presented to the WHO Regional Committee along with progress reports on viral hepatitis and the HIV situation and response in the Region.