Ending AIDS as a public health threat in the South-East Asia Region: progress, challenges and the way forward

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The WHO South-East Asia Region is committed to achieving the 2030 Sustainable Development Goal (SDG) target of ending the AIDS epidemic as a public health threat. In 2016, Member States of the Region and across the world adopted the United Nations General Assembly (UNGA) Political Declaration on ending the AIDS epidemic. In the same year, Member States adopted the WHO Global Health Sector Strategy for HIV (2016-2021). To accelerate progress towards the SDG target, the UNGA High-Level Meeting on HIV/AIDS in June 2021 adopted the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030, and set new targets for 2025. In this Decade of Action to reach the SDGs, we must intensify action and drive real impact in the lives of the most vulnerable.

An estimated 3.7 million people in the Region are living with HIV. This amounts to nearly 10% of all people living with HIV globally. A key feature of the HIV epidemic in the Region is that most new HIV infections are occurring among key populations such as sex workers, men who have sex with men, transgender persons and people who inject drugs and their partners. At the close of 2019, on the fast-track target of 90-90-90, (which require 90% of those living with HIV to know their HIV status, 90% of all people diagnosed with HIV infection to receive sustained antiretroviral therapy, and 90% of all people on such therapy to have viral suppression by 2020,) the Region reported progress of 77%, 60% and 54% against a global progress of 81%, 67% and 59%, respectively. In 2019, around 160 000 new HIV infections and 110 000 AIDS-related deaths occurred in the Region.

Despite falling short of the targets, the Region has made considerable progress, which it must continue to build on. Between 2010 and 2019, the Region reduced new HIV infections by 23.8% and AIDS-related deaths by 26.7%. Nearly 60% of the estimated 3.7 million people in the Region living with HIV are now receiving lifelong antiretroviral therapy. Maldives, Sri Lanka and Thailand have eliminated mother-to-child transmission of HIV and syphilis. Bhutan, India and Nepal have decriminalized same-sex relations, reflecting Regionwide efforts to promote inclusivity, reduce stigma and increase access to HIV services. Six countries in the Region are providing rights-based harm reduction services, which not only help to prevent HIV and hepatitis C infections, but also address several other health issues faced by people who inject drugs.

As this regional progress report highlights, to reinvigorate the Region’s HIV response, community engagement will be critical, as will ensuring that all people can access preventive tools and antiretroviral drugs. Eliminating mother-to-child transmission of HIV, hepatitis B and syphilis must be a key priority in all countries, in addition to the continued provision of rights-based and evidence-informed services. Ending stigma and repealing discriminatory laws are essential. In addition to identifying these and other key priorities, this report provides an analysis of how COVID-19 has impacted HIV services and documents the innovative efforts of programme staff in countries to maintain HIV and other essential health services throughout the COVID-19 response.

I am certain that this report will contribute to the Region’s efforts to develop its next joint Regional Action Plan for viral hepatitis, HIV and STIs, which will define the Region’s onward trajectory against these diseases. I urge all stakeholders to make full use of this vital document, and to continue to intensify action to end the HIV epidemic as a public health threat, both in the South-East Asia Region and across the world.
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<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
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<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>antiretroviral (drug)</td>
</tr>
<tr>
<td>CBO</td>
<td>community-based organization</td>
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<tr>
<td>CBNAAT</td>
<td>cartridge-based nucleic acid amplification test</td>
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<tr>
<td>CSO</td>
<td>civil society organization</td>
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<tr>
<td>DTG</td>
<td>dolutegravir</td>
</tr>
<tr>
<td>EMTCT</td>
<td>elimination of mother-to-child transmission (of HIV)</td>
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<td>GAM</td>
<td>Global AIDS Monitoring</td>
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<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>GHSS</td>
<td>Global Health Sector Strategy</td>
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<tr>
<td>Global Fund</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HIVST</td>
<td>HIV self-testing</td>
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<tr>
<td>HPV</td>
<td>human papillomavirus</td>
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<td>IBBS</td>
<td>integrated biological and behavioural surveillance</td>
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<tr>
<td>KP</td>
<td>key population</td>
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<tr>
<td>LGBT</td>
<td>lesbian, gay, bisexual and transgender</td>
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<tr>
<td>MSM</td>
<td>men who have sex with men</td>
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<tr>
<td>MMD</td>
<td>multi-month dispensing</td>
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<tr>
<td>NAC</td>
<td>National AIDS Commission/Committee</td>
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<tr>
<td>NCPI</td>
<td>National Commitments and Policy Instrument</td>
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<td>OST</td>
<td>opioid substitution therapy</td>
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<tr>
<td>PLHIV</td>
<td>people living with HIV</td>
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<tr>
<td>PrEP</td>
<td>pre-exposure prophylaxis</td>
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<td>PWID</td>
<td>people who inject drugs</td>
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<tr>
<td>RAP</td>
<td>Regional Action Plan</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<tr>
<td>SEA</td>
<td>South-East Asia</td>
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<td>STI</td>
<td>sexually transmitted infection</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<td>UNGASS</td>
<td>UN General Assembly Special Session</td>
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<tr>
<td>UNHLM</td>
<td>UN General Assembly High-Level Meeting</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary

The year 2020 is an important milestone in the acquired immunodeficiency syndrome (AIDS) response, both globally and in the Region. Certain key milestones towards ending the AIDS epidemic as a public threat by 2030 were to be achieved by 2020. These include interim targets drawn from the Political Declaration adopted by the United Nations (UN) General Assembly High-Level Meeting on AIDS in 2016, the Global Health Sector Strategy (GHSS) on human immunodeficiency virus (HIV), 2016-2021, and the Regional Action Plan (RAP) for HIV in South-East Asia, 2017-2021. The year marked the beginning of the decade of action towards reaching the 2030 targets, as outlined in the Sustainable Development Goal framework.

An estimated 3.7 million people are living with HIV in the WHO South-East Asia (SEA) Region. This amounts to nearly 10% of all people living with HIV globally. In 2019, about 160 000 new HIV infections and 110 000 AIDS-related deaths occurred in the Region. A key feature of the HIV epidemic in the Region is that most new HIV infections occur among key populations (KPs) such as sex workers, men who have sex with men, transgender persons and people who inject drugs - and their partners.

This report reviews the progress on key HIV-related targets in the Region with the overall objective of documenting successes and identifying all shortcomings, challenges and specific bottlenecks faced by countries in their national responses. Further, it reviews the impact of the COVID-19 pandemic on HIV services, along with the mitigation efforts adopted by countries of the Region. The report also offers future directions based on lessons learnt from good practices in the Region. It will provide a baseline and strategic direction for the upcoming RAP for HIV in the South-East Asia Region (2022-2026).

The analysis in this report relies primarily on data collated from the country responses submitted to the Global AIDS Monitoring (GAM) in 2020, i.e. 2019 data. Some of the data points not available through GAM have been obtained from national programmes through focal points in WHO country offices and other sources, as acknowledged in the report. Further, on World AIDS Day 2020, the Regional Office organized a high-level meeting on reinvigorating public health responses to HIV in the WHO SEA Region. During the meeting, the health ministers from five high-burden countries presented key updates on and challenges to the HIV response and the impact of COVID-19 on meeting the 2020 targets as envisaged in the GHSS and RAP for HIV in the SEA Region. UN partners, academia and community representatives also highlighted some of the key gaps and challenges in controlling HIV and STIs in the Region and shared thoughts to mitigate the impact of
COVID-19. In the follow up to this event, the Regional Director appointed a Special Adviser on HIV to carry out virtual missions on the HIV response in all the high-burden countries of the Region. Key inputs from these meetings were also useful for the respective sections of this report.

Between 2010 and 2019, there has been substantial progress in the AIDS response in Member States of the Region. While epidemiological trends show that both new infections and HIV-related deaths are continuing to decline, the rate of decline has plateaued over the past few years. There has been a 24% reduction in the estimated number of annual new infections, but this falls short of the 2020 target of 75% reduction as the rate of reduction of 2.67% annually is inadequate. AIDS-related deaths have reduced from 150 000 in 2010 to 110 000 in 2019 - a 27% reduction against the target of 67%. The Region has missed this target by a big margin, since an additional 67 000 deaths in 2020 should have been averted in order to reach this target.

The coverage of antiretroviral therapy (ART) among people living with HIV (PLHIV) increased to 60% in 2019. While this is a significant increase from 20% in 2010 and 39% in 2015, there is considerable ground to cover to reach the 2020 target of 81%. The achievement on the 2020 fast-track 90-90-90 targets in the Region is 77-60-54 against a global achievement of 81-67-59. While there is overall progress on all fronts so far in the Region, it is still short of the 2020 targets and reaching these will require acceleration. Moreover, there are variations between and within countries as well, calling for renewed and granular focus.

The Region has also missed the target for elimination of mother-to-child transmission of HIV, barring Thailand, Maldives and Sri Lanka, which have been validated by WHO for having eliminated mother-to-child transmission of HIV and syphilis. Coverage of HIV prevention and testing services among KPs has not progressed at a pace that is required to reach the 2020 targets for reducing new infections, deaths and the 90-90-90 targets. Hence, KPs and their partners continue to be disproportionately affected by the epidemic. Similarly, the focus required on young people has also been inadequate, as analysed in this report. Given that programmes for KPs are heavily dependent on donor funding, it is an emerging challenge that international funding is diminishing. Further, domestic resources are not yet able to completely fill this void.

Other than high-level commitment and funding, an enabling environment with respect to laws and policies is essential to address the HIV epidemic. In this regard, several steps have been taken by countries to address the barriers faced by KPs and PLHIV. These
include favourable legislations for protecting the rights of PLHIV; steps towards
decriminalization of risk behaviours such as same-sex sexual relationships, sex work and
drug use; efforts to address gender-based violence and uphold the sexual, reproductive
and other rights of women and young people; and efforts towards greater recognition of the
rights of transgender persons. Yet, there is considerably more to be done in countries to
overcome the barriers created by laws and policies as well the stigma and discrimination
faced by PLHIV and those who are the most vulnerable.

Besides waning political support, reduced availability of resources and challenges in the
legal and policy environment faced by PLHIV and KPs, there are certain system-wide
challenges too, such as health systems that are vulnerable to shocks. The COVID-19
pandemic has exposed these vulnerabilities and there have been serious disruptions in HIV
services. Nevertheless, most countries adopted several service adaptations such as multi-
month dispensation of ARV drugs, teleconsultations, take-home doses of opioid
substitution therapy medicines for drug users who are stable on such treatment and
community-based service delivery. Thanks to such efforts, continuity of ART for those
already on treatment was ensured in all countries of the Region.

While some of the services are relatively less affected due to COVID-19, in the case of
others, levels of service coverage are yet to reach pre-pandemic levels. WHO data show
that HIV testing and prevention are among some of the most frequently disrupted services
caused by COVID-19 across all Regions. Among services for communicable diseases in the
Region, the level of disruption for HIV prevention services was the highest in the SEA
Region, at 63%. There is also a risk that interventions for KPs take a longer time to be fully
restored. Catch-up campaigns and specific measures in pandemic response plans are
needed to achieve full restoration and the necessary acceleration.

The problems posed by HIV to individuals and public health at large have not gone away. Yet,
the 2030 goal of ending the AIDS epidemic as a public health threat need not be daunting or
perceived to be impossible. The recent Political Declaration adopted by the UN General
Assembly High-Level Meeting on ending AIDS as a public health threat, along with the
GHSS for HIV, viral hepatitis and STIs, 2022-2030 and the upcoming RAP 2022-2026 will
provide further strategic direction for the world and the Region towards achieving this goal.
The efforts to achieve the 2030 goals, specifically, developing and implementing the new
GHSS 2022-2030 and RAP 2022-2026, will have to take AIDS out of isolation, and a strategy
for progressive integration of simplified biomedical interventions followed by community-
led services into decentralized levels of the health system must be adopted, depending on
unique country contexts. Governments should put into place strong governance structures
to have oversight during this process, until the 2030 goal is achieved. In addition to political commitment and fully funded programmes, effective participation of communities of PLHIV and KPs in all aspects of planning, implementing and monitoring responses is essential for going forward. Strengthened efforts for the generation and utilization of strategic information must guide this work, along with gender equality, health equity and human rights as guiding principles.

A renewed focus on prevention of new infections among KPs and young people is the key to success. Such a focus will not only help reduce new infections, but also help bridge the gap between the estimated number of PLHIV and those who know their status. A test-and-treat policy alongside these efforts will also have a direct impact on mortality, by bringing people to treatment centres at an early stage of infection.

Ending AIDS as a public health threat is possible within the overall framework of universal health coverage. But the next five years are very critical and present a make-or-break challenge for country-level leadership in most of the countries including those in the SEA Region. It requires resilient systems for health and resolute action by all levels of leadership - political, administrative and civil society. The next RAP (2022-2026) shall set ambitious targets and also identify key performance indicators to monitor and review the progress on a regular basis.
One billion more people benefiting from

One billion more people better protected from

One billion more people enjoying better

Universal Health Coverage
BACKGROUND
# 1. Background

Since the emergence of the first few reports of human immunodeficiency virus (HIV) in 1981, around 37 million people have died of HIV-related causes and around 38 million are estimated to be living with HIV worldwide in 2019. Around 1.7 million people were newly infected with HIV and 690,000 died of acquired immunodeficiency syndrome (AIDS)-related illnesses globally in 2019 (1). Overall adult prevalence in the South-East Asia (SEA) Region is low at 0.3% and an estimated 3.7 million (nearly 10% of all people living with HIV [PLHIV] globally) live in the SEA Region. Of these, 99% are in five countries - India, Indonesia, Myanmar, Nepal and Thailand. In 2019, about 160,000 new HIV infections and 110,000 AIDS-related deaths occurred in the SEA Region.

During the United Nations General Assembly High-Level Meeting (UNHLM) on Ending AIDS in 2016, the world committed to ending the AIDS epidemic by 2030 (2), in line with Sustainable Development Goal (SDG) Target 3.3 (3). In 2016, the World Health Assembly adopted the Global Health Sector Strategy (GHSS) on HIV (2016-2021) (4) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) developed fast-track targets towards ending AIDS (5). The GHSS offered an action-oriented framework across five strategic directions, namely: [i] information for focused action; [ii] interventions for impact; [iii] delivering for equity; [iv] financing for sustainability; and [v] innovation for acceleration.

The key targets of the GHSS to be achieved by 2020 were to: [i] reduce new HIV infections to below 500,000 globally, new infections among infants to zero, global HIV-related deaths to below 500,000 and tuberculosis (TB) deaths among PLHIV by 75%; [ii] ensure that 90% of PLHIV knew their HIV status, 90% of people diagnosed with HIV receive antiretroviral therapy (ART) and 90% of people who are on treatment achieve viral load suppression; and [iii] ensure that 90% of PLHIV and key populations (KPs) report no discrimination in the health sector.

In line with the GHSS, World Health Organization (WHO) Regional Office for South-East Asia developed a Regional Action Plan (RAP) (2017-2021) that outlined guidance for Member States on how to achieve the 2020 targets on HIV prevention, testing, treatment and viral load suppression (90-90-90) along five strategic directions of the GHSS. The RAP also included recommendations on the operational aspects, including strategic (granular) information, an enabling environment, financial sustainability and community systems strengthening (6).

The year 2020 marked an important year in the global AIDS response in the Region. It
was the year by which important milestones towards ending AIDS were to be achieved. These included interim targets for 2020 drawn from the UN General Assembly Political Declaration in 2016; UNAIDS fast-track targets to end AIDS by 2030; GHSS on HIV, 2016-2021; and the RAP for HIV in South-East Asia, 2017-2021. The year also marked the beginning of the Decade of Action towards reaching the 2030 targets, as outlined in the SDG framework.

On the occasion of World AIDS Day on 1 December 2020, the Regional Office organized a high-level meeting on “Maintaining essential health services in times of COVID-19: sustaining and reinvigorating public health responses to HIV in the WHO SEA Region”. During the meeting, health ministers from the five high-burden countries presented key updates on and challenges to the HIV response, and the impact of COVID-19 on meeting the 2020 targets as envisaged in the GHSS and RAP. UN partners, academia and community representatives also highlighted some of the key gaps and challenges in the area of HIV and sexually transmitted infections (STIs) in the Region and discussed various means to mitigate the impact of COVID-19 on national responses. To carry forward the various suggestions and recommendations from the meeting, the Regional Director appointed a Special Adviser on HIV to the Regional Director on HIV to carry out virtual missions on the HIV response in all high-burden countries in the Region.
OBJECTIVES
2. Objectives

This report aims to provide an update on the progress on key HIV-related targets in the Region with the overall objective of taking stock of progress and documenting successes, understanding the impact of the COVID-19 pandemic on HIV services in the Region and providing an analysis of the shortcomings, challenges and bottlenecks faced by countries. The report also offers future directions based on lessons learnt from good practices in the Region. This report will also provide a baseline status of the HIV response so far, as the Region moves towards developing the next regional action plan for HIV in the SEA Region (2022-2026).
METHOD
3. Methods

The data presented in this report have been collated primarily from the country responses in the Global AIDS Monitoring (GAM) reporting submitted by countries in 2020 (7). Some data points that were not available through GAM have been obtained from the national programmes through focal points in the respective WHO country offices.

In addition to the above data sources, the report also includes feedback to the Regional Director from virtual missions by the Special Adviser on HIV over the past six months. These missions were conducted with WHO country offices, ministries of health and national programmes, and discussed the ways by which the HIV response could be reinvigorated in member countries. These missions engaged the teams of WHO country offices and the national AIDS programmes in a constructive dialogue on what has succeeded, what has gone wrong, what are the critical gaps in the response and what needs to be done to overcome them. The missions also focused on primary prevention and treatment coverage within the universal health coverage (UHC) package. The impact of COVID-19 on maintaining essential services and meeting the gaps in the 2020 targets were also discussed in depth during these virtual missions.

In order to assess progress on financial investments, country-level data on spending on HIV were extracted from the UNAIDS HIV financial dashboard, which is part of the AIDS Info portal (8). Six countries were included for analysis, based on the availability of data on the domestic and international components of annual spending on AIDS for the baseline year as well as the most recent year with data. Data for the year 2010 were taken as the baseline except for Nepal, where 2009 data were considered as the baseline due to non-availability of 2010 data. Similarly, the latest data available between 2017 and 2019 were considered for assessing progress.

Similarly, for data related to the indicators on community engagement and service delivery, there is no direct measurement of these indicators from countries through GAM. Nevertheless, the National Commitments and Policy Instrument (NCPI)-related component in GAM asks certain policy-level questions in relation to this indicator. Compilation of country responses to these questions are available at the Laws and Policies Analytics platform managed by UNAIDS and WHO (9). The data on community engagement were collected from these instruments and other country reports.
GLOBAL SCENARIO AND RESPONSE
4. Global scenario and response

4.1. HIV

As of December 2019, an estimated 38 million (31.6-44.5 million) people were living with HIV, globally. In 2019, 1.7 million (1.2-2.2 million) people were newly infected with HIV and there were 690 000 (500 000-970 000) AIDS-related deaths [10]. About 4500 new HIV infections (adults and children) occurred each day and about 59% of these were in sub-Saharan Africa. About 400 of these were among children under 15 years of age. Of the 4100 infections among those who are 15 years and above, almost 47% were among women and about 31% among young people (15-24 years).

The global incidence has been declining from 0.32 new HIV infections per 1000 uninfected population in 2010 to 0.22 in 2019, but this has plateaued over the past few years. There has been a 23% decline in new HIV infections since 2010 (from 2.1 million in 2010 to 1.7 million in 2019) but this is still more than three times higher than the target of 500 000 for 2020. Similarly, there is a 39% reduction in AIDS-related deaths since 2010, but this is far from the 2020 target of less than 500 000 deaths (Fig. 1) [10].

![Fig. 1: Decline in new HIV infections and deaths, global, 1990–2019](https://aidsinfo.unaids.org/)

On the HIV testing and treatment cascade, 81% of PLHIV knew their HIV status, and 25.4 million of the 38.0 million PLHIV (67%) were on ART. Almost 59% of PLHIV globally had suppressed viral loads in 2019 (Fig. 2) [10].

![Fig. 2: HIV testing and treatment cascade, global, 2019](https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf)

4.2. Sexually transmitted infections

Globally, in addition to HIV, 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) (12). WHO’s GHSS on sexually transmitted infections (2016-2021) has set targets for 90% reduction in the incidence of syphilis and gonorrhoea infections between 2018 and 2030 (13).
REGIONAL SCENARIO AND RESPONSE
5. Regional scenario and response

5.1. Scenario in the South-East Asia Region

Out of 38 million globally, nearly 3.7 million PLHIV live in the SEA Region. In 2019, about 160,000 new HIV infections and 110,000 AIDS-related deaths occurred in the Region. Across the 10 countries of the Region, that have reported to have HIV 99% of the estimated PLHIV infections are geographically concentrated in five countries - India, Indonesia, Myanmar, Nepal and Thailand (Fig. 3).

The key feature of the epidemic in the SEA Region is that it is a concentrated epidemic. Around 98% of new HIV infections in the i.e. Asia Pacific Region occur among KPs and their partners.

Historically, STIs have been among the most serious public health problems in the Region, with the associated morbidity, mortality, disability and adverse pregnancy outcomes (14). 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 (from 118 million to 60 million). However, success is not uniform across countries. The last-dose coverage for HPV vaccination in the Region is 2% as against a global coverage of 15%. Many large countries are yet to introduce HPV vaccination in their national programmes (12).

**Fig. 3: HIV burden in SEA Region by country, 2019 (absolute and regional proportions)**

- **India, 2,349,000**: 63%
- **Indonesia, 640,443**: 17%
- **Thailand, 467,587**: 12%
- **Maldives, 72**: <1%
- **Myanmar, 241,361**: 6%
- **Nepal, 29,944**: 1%
- **Sri Lanka, 3,600**: <1%
- **Timor-Leste, 1,200**: <1%
- **Bhutan, 1,300**: <1%
- **Bangladesh, 14,000**: <1%


The key feature of the epidemic in the SEA Region is that it is a concentrated epidemic. Around 98% of new HIV infections in the i.e. Asia Pacific Region occur among KPs and their partners.

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---

*Analysis by the WHO SEA Regional Office based on UNAIDS–WHO estimates, 2020*
A rapid assessment of the STI epidemiology and response in the Region was conducted in 2018 [15]. The epidemiology of STIs in the Region remains highly heterogeneous. Evidence from multiple sources strongly support an overall declining trend of curable STIs in the Region over three decades. Shifting patterns are also apparent, with declining proportions of ulcerative and bacterial STIs compared to viral infections. Very low STI incidence and prevalence have been maintained over several decades in Sri Lanka and Thailand, while much higher and variable rates are reported elsewhere. Evidence of declining rates of syphilis, as well as progress in elimination of mother-to-child transmission (EMTCT) in Thailand, Maldives and Sri Lanka support the feasibility of regional elimination of syphilis as a public health problem. Weak STI surveillance and limited syphilis screening among KPs and pregnant women are the main barriers to elimination in the Region. Recent increases in syphilis among men who have sex with men (MSM) in several countries underlines the importance of routinely screening KPs for syphilis and monitoring prevalence trends [16].

Data on other STIs are less reliable, but combinations of syndromic and aetiological reporting have proven useful in guiding control efforts in several countries and can be adapted elsewhere. Reliable data on gonorrhoea come from Sri Lanka and Thailand, which use affordable microscopy with Gram stain to distinguish gonococcal from non-gonococcal infections.

5.2. Progress on key 2020 targets in the South-East Asia Region

The key 2020 targets from the UNHLM on ending AIDS, the RAP for HIV in the SEA Region (2017–2021) and the UNAIDS fast-track targets on the way to ending AIDS are summarized below.

- New infections need to decrease by 68% between 2017 and 2020 to below 50 000. HIV-related mortality will need to fall below 43 000 by 2020 and below 18 000 by 2030. In addition, there should be zero new HIV and congenital syphilis infections among infants.
- In terms of the 90-90-90 targets for the Region, at least 3.33 million PLHIV need to know their status; 3.03 million who are HIV positive need to initiate treatment; and 2.69 million of these need to be virally suppressed (Fig. 4).

**Fig. 4: Regional targets on reduction in new infections, deaths and ART coverage, 2020**

![Regional targets on reduction in new infections, deaths and ART coverage, 2020](source)

Source: Regional action plan for HIV in South-East Asia (2017–2021)
• The combination prevention services package, including self-testing, condoms, clean needles and syringes, opioid substitution therapy (OST) and pre-exposure prophylaxis (PrEP) should reach 90% of sex workers, people who inject drugs (PWID), transgender people and MSM.

• Ninety per cent of young people should have the skills, knowledge and capacity to protect themselves from HIV.

• Ninety per cent of young people in need should have access to sexual and reproductive health services and combination HIV prevention options.

• At least 30% of all service delivery should be community-led.

• TB-related deaths among PLHIV need to be reduced by 75% and hepatitis B- and C-related deaths reduced by 10% in people coinfected with HIV.

In order to achieve these targets, the RAP also provided some guidance to Member States, as below.

• Member States need to more than double their capacity for diagnosing PLHIV and linking them with treatment and care. Testing strategies need to strategically focus on those at highest risk or most vulnerable and in areas with high HIV prevalence (geographical prioritization). New approaches - testing for triage, self-testing, community-based and community-led testing, multi-disease prevention campaigns and new validated testing algorithms need to be implemented. For facility-based testing, stigma and discrimination by health-care providers towards KPs will need to be tackled in public sector health facilities.
• Testing will also need to be increased in people in TB clinics, at antenatal services, OST sites, STI clinics and through social media.

• Treatment coverage will need to be doubled and HIV-related mortality reduced by two thirds. For this to happen, various steps will need to be taken. Member States need to adopt and implement a “treat all” policy nationally.

• Member States will need to look into the decentralization of service delivery, differentiated models of care (including task shifting) and a robust supply chain to ensure minimal loss to follow up of people diagnosed with HIV and retained on treatment.

• Member States need to leverage the benefit of having a large number of cartridge-based nucleic acid amplification test (CBNAAT) point-of-care machines for scaling up viral load testing capacity.

The RAP Plan also stressed that collaboration with community-based organizations and networks is necessary for reaching KPs who face stigma and discrimination in health-care settings and in society, and whose behaviours are criminalized, such as sex work, sex between men and drug use. Punitive laws and other human rights violations, along with stigma and discrimination experienced by clients in health-care settings, would need to be targeted and eliminated to increase access by KPs.

The progress on selected 2020 targets from the RAP and UNAIDS fast-track targets is summarized in Table 1.
Table 1: Progress against selected targets from Regional Action Plan (RAP), UNHLM and UNAIDS fast-track targets*

<table>
<thead>
<tr>
<th>Key 2020 Target in RAP (2017–2021) UNHLM and UNAIDS fast track targets</th>
<th>Status by end-2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A Epidemiology</strong></td>
<td></td>
</tr>
<tr>
<td>1. Reduce new HIV infections by 75% by the end of 2020 compared with 2010</td>
<td>160,000 new infections estimated in 2019 (24% reduction from 2010, against a target of 75%)</td>
</tr>
<tr>
<td>2. Reduce HIV deaths to 43,000 from 130,000 in 2015 (Revised estimate for 2015 is 150,000)</td>
<td>110,000 deaths estimated in 2019 (27% reduction from 2015, against 67% as in the RAP)</td>
</tr>
<tr>
<td><strong>B Response - prevention</strong></td>
<td></td>
</tr>
<tr>
<td>3 Eliminate HIV and congenital syphilis in infants</td>
<td>Three out of 11 countries achieved EMTCT (27% against a target of 100%)</td>
</tr>
<tr>
<td>4 Ensure access to combination prevention options to at least 90% of KPs (measured as the percentage of people in a KP who report having received a combined set of HIV prevention interventions in the past three months [at least two out of four services: (i) given condoms and lubricants; (ii) received counselling on condom use and safe sex; (iii) tested for STIs among transgender people, sex workers and gay men and other MSM; (iv) received sterile needles or syringes for people who inject drugs])</td>
<td>Please refer to Section 5.2.4 summarizing the most recent data available during 2016–2019 for prevention coverage among KPs in five countries of the Region</td>
</tr>
<tr>
<td>5 Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV</td>
<td>Proportion of young people (15–24 years) with comprehensive HIV knowledge in the WHO SEA Region ranges from 11% to 46% (median 22%) according to the most recent data available during the period 2012–2017 in nine countries. For further details and sources of data, please see Fig. 15 (Section 5.2.5.)</td>
</tr>
<tr>
<td><strong>C Response - testing and treatment</strong></td>
<td></td>
</tr>
<tr>
<td>6 First 90: 90% of all people living with HIV will know their HIV status</td>
<td>Seventy-seven per cent of estimated PLHIV know their status as of December 2019 against the 2020 target of 90%</td>
</tr>
<tr>
<td>7 Second 90: 90% of all people with diagnosed HIV infection will receive ART. The RAP target is to double the number of people receiving ART by 2020</td>
<td>Sixty per cent of the total estimated PLHIV and 78% of PLHIV who know their status were on ART by December 2019 against the 2020 targets of 81% and 90%, respectively. The number of people on ART in 2019 (2.2 million) increased by 36% from the 2015 baseline (1.4 million). The RAP target is 100% increase by 2020</td>
</tr>
<tr>
<td>8 Third 90: 90% of all people receiving ART will have viral load suppression</td>
<td>Fifty-four per cent of all PLHIV and 90.9% of PLHIV on ART are virally suppressed as of December 2019 against the 2020 targets of 73% and 90%, respectively</td>
</tr>
<tr>
<td>9 Reduce TB deaths among people living with HIV by 75%</td>
<td>From 76,135 TB deaths among PLHIV in 2010, deaths reduced to 19,595 in 2019, which marks a 74.3% reduction*</td>
</tr>
<tr>
<td><strong>D Financing</strong></td>
<td></td>
</tr>
<tr>
<td>10 Increase overall financial investments for the AIDS response in Member States by more than 20% of current global spending and increase current levels of domestic funds</td>
<td>Based on data available, this was reviewed for six countries. There has been an increase in the domestic share of overall spending on HIV in all six countries compared with the baseline (2009–2010) and the most recent data available (2017–2019). However, overall spending on HIV has decreased in three countries during this period (see Section 5.2.6, Fig. 16)</td>
</tr>
<tr>
<td><strong>E Enabling environment and community engagement</strong></td>
<td></td>
</tr>
<tr>
<td>11 Ensure that at least 30% of all service delivery is community-led by 2020</td>
<td>Please refer to Section 5.2.7 for an update on this target</td>
</tr>
<tr>
<td>12 Ninety per cent of people living with HIV and KP report no discrimination in the health sector</td>
<td>Please refer to Section 5.2.7 for an update on this target</td>
</tr>
</tbody>
</table>

*While details on the data sources and analyses are mentioned in the methods section, please note that the base year for assessing progress for some indicators are 2010, while it is 2015 in the case of others. This is in line with the RAP, and also in alignment with the respective global commitments and targets. Further, 2019 data was used as obtained from the relevant publications and reporting mechanisms in 2020, as explained in the methods section, and few instances where this was not available, the most recent year data that is available was used.

Between 2010 and 2019, there has been substantial progress in the AIDS response in Member States of the Region. While epidemiological trends show that both new infections and HIV-related deaths are continuing to decline, the rate of decline has plateaued over the past four years.

### 5.2.1. Progress on reduction in new infections and deaths

There has been a steady decline in new infections in the SEA Region over the past two decades, though the decline has plateaued [Fig. 5].

**Fig. 5: New infection trends in the SEA Region, 2001-2019**

- 310,000 (2001)
- 210,000 (2010)
- 200,000 (2012)
- 160,000 (2017)

**Source:** Analysis by WHO Regional Office based on UNAIDS–WHO estimates, 2020

There has been a 24% reduction in estimated annual new infections, but it has levelled off of late. Also, it falls short of the 2020 target of 75% reduction (to 50,000) as the rate of reduction is inadequate [Fig. 6].

**Fig. 6: Falling short of targets on reduction in new infections**

**Target Gap 51%**

**Source:** Analysis by the WHO Regional Office based on UNAIDS–WHO estimates, 2020

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Ending AIDS as a public health threat in the South-East Asia Region: progress, challenges and the way forward
AIDS-related deaths reduced from 150,000 in 2010 to 110,000 in 2019, a reduction of 27%. An additional 67,000 deaths should have been averted in order to reach the 2020 targets. The SEA Region has missed the target by a big margin (Fig. 7).\(^b\)

Fig. 7: Reduction in AIDS-related deaths, 2010-2019

Source: Analysis by the WHO Regional Office based on UNAIDS–WHO estimates, 2020

Annual new infections and deaths vary greatly in Member States of the Region. Most countries in the Region are showing widely varying declining trends both for new infections and deaths (Fig. 8).

Fig. 8: Trends in new HIV infections and AIDS-related deaths vary in South-East Asia countries, 2019

Source: Prepared by www.aidsdatahub.org based on UNAIDS 2020 HIV Estimates
However, there are concerns that the rates of reduction in new infections and deaths are inadequate in most countries and that new infections are increasing in Timor-Leste, which has been a low-prevalence country so far (Fig. 9).

**Fig. 9: Annual new infections are on the rise in Timor-Leste**

There is a significant gap between the estimated number of PLHIV and the number of those who know their status, despite a scale up of facility-based testing sites (Fig. 10). Those who remain undiagnosed are likely to present late with advanced disease and have a higher mortality.

The coverage of ART among PLHIV has increased from from 20% in 2010 to 39% in 2015, and to 60% in 2019. While this is a significant increase, there is considerable ground to be covered to reach the 2020 target of 81%. The achievement on the 2020 fast-track 90-90-90 targets in the Region is 77-60-54 against a global achievement of 81-67-59. The overall progress so far is still short of the 2020 targets and will require acceleration (Fig. 10) [12].

**Fig. 10: Testing and treatment cascade, SEA Region, 2019**

Source: SPECTRUM HIV Estimation and Projection, Timor-Leste, 2021

### 5.2.2. Progress on testing and treatment cascade

Source: SPECTRUM  Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on UNAIDS 2020 HIV Estimates
There is wide variation in the testing and treatment cascade in different countries of the Region. Fig. 11 depicts the 90-90-90 status in different countries. Of the estimated number of PLHIV on lifesaving ART by the end of 2019, Myanmar and Thailand had reached 76% and 80%, respectively, while Bangladesh and Indonesia had coverages of 22% and 17%, respectively. Thailand has also crossed the 2020 milestone of 73% of PLHIV achieving viral suppression through ART, as the country had nearly 78% of PLHIV on ART who were virally suppressed in 2019.

**Fig. 11: Status of testing and treatment cascade**

![Status of testing and treatment cascade](image)

Sources: UNAIDS data book 2020 (reporting 2019 data) for all countries except Bangladesh, Bhutan and Indonesia, where it is UNAIDS data 2019 (data for 2018); and for India where it is UNAIDS data 2018 (data for 2017). All figures are reported by the respective countries through the GAM reporting system.

In large countries like India and Indonesia, a significant number of those who were tested and put on ART are lost to follow up (range 8-25% as per programme data from different countries). This not only affects the performance on the treatment front but is a huge loss of scarce resources. Such losses of varying degrees were reported from other countries in the Region as well (data from national HIV programmes).
5.2.3. EMTCT programme

The Region has also missed the 2020 target for elimination of MTCT barring Thailand, Maldives and Sri Lanka, which have been validated by WHO for having achieved EMTCT of HIV and congenital syphilis. Bhutan is on the verge of eliminating MTCT, but others will take a few more years before reaching the elimination target.

5.2.4. Key populations remain underserved

The testing coverage among KPs is below 50% on an average, though there are wide variations between countries and typologies [Fig. 12](17).
Prevention coverage among KPs varies widely between countries and needs to be scaled up significantly as the epidemic in most countries of the Region is driven by KPs and their partners (Fig. 13).

**Fig. 12: HIV testing coverage among key populations, SEA Region countries, 2016-2019**


**Fig. 13: Prevention coverage among key populations, 2016–2019**

Sources: Prepared by www.aidsdatahub.org based on Global AIDS Monitoring Reporting 2020; UNAIDS 2020 estimates; behavioural surveillance surveys; integrated biological and behavioural surveillance (IBBS) surveys.
The coverage of testing among sex workers, PWID and MSM remained low compared to the general population. In Thailand, testing coverage among transgender persons, MSM and PWID ranged from 47% to 52%. In Bhutan, testing coverage of sex workers and MSM was low at 18-19% [18]. Funding for prevention programmes among KPs has also progressively declined over the past 10 years. They had to bear the brunt of the epidemic in a highly disproportionate manner.

More details on adoption of newer prevention approaches like PrEP by KPs are described in Section 5.4.5.

Prevention among KPs remains heavily dependent on donor funding (Fig. 14). This is an emerging challenge as international funding is shrinking.

Fig. 14: Prevention for key populations – available financial resources, 2012–2017

<table>
<thead>
<tr>
<th>% Domestic</th>
<th>% International</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>73%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Note: Asia Regional aggregate based on available data from 12 countries - Afghanistan, Bangladesh, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Nepal, Pakistan, Philippines, Thailand, Viet Nam - between 2012 and 2017

Sources: Global AIDS Monitoring reporting, NASA reports and US President’s Emergency Plan for AIDS Relief [PEPFAR] programme expenditure
5.2.5. Inadequate focus on young people

Globally, young women and adolescent girls accounted for one in four new infections in 2019, despite making up about 10% of the total population (Fig. 15). However, less than one fourth of the young population in the SEA Region has comprehensive knowledge of HIV. This is a major impediment in the prevention of new infections.

Fig. 15: Comprehensive knowledge of HIV among the young population

Less than one in four young people (15-24) have comprehensive knowledge of HIV to protect themselves

Proportion of young people (15-24) with comprehensive HIV knowledge in South-East Asia, 2012-2017

Sources: Prepared by www.aidsdatahub.org based on: Global AIDS Monitoring (GAM) reporting; Demographic and Health Survey (DHS) reports; Multiple Indicator Cluster Survey (MICS) reports; and other population-based surveys
5.2.6. Financial investments for the AIDS response

The RAP, in line with the UNHLM, had recommended that countries should increase overall financial investments for the AIDS response by more than 20% and increase the share of domestic funds.

Data for all the six countries for which information was available showed an increased domestic share in their overall spending on HIV, when compared to the baseline year. The domestic component is particularly high for Indonesia, Sri Lanka and Thailand, where it has reached 71%, 63% and 92%, respectively. Data on total spending on AIDS, including from domestic and international funding sources combined, show that there is an increase in three countries. Of the remaining three countries, data from Bangladesh [-1%], Nepal [-23%] and Sri Lanka [-8%] show that there has been a reduction in total spending on AIDS. Expenditure data from Myanmar show that the country has increased total spending on AIDS by more than 1.5 times (163%) from the 2010 baseline level. This is followed by Indonesia (73%) and Thailand (22%) (Fig. 16).  

![Fig. 16: Spending on AIDS in South-East Asia – domestic share and change in total](image)

5.2.7. Community-led service delivery and stigma and discrimination in health-care settings

In line with global commitments, the RAP has a target that at least 30% of all service delivery should be community-led by 2020. Indicators and definitions for this target are yet to be included in the GAM guidelines and reporting mechanism. Nevertheless, the NCPI of GAM asks certain policy-level questions in relation to this target. Compilation of country responses to these questions are available at the Laws and Policies Analytics platform managed by UNAIDS and WHO. Information collated from different sources on this platform is summarized in Fig. 17.

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*Analysis by WHO Regional Office using country data extracted from the UNAIDS HIV financial dashboard/AIDS Info.*
Similarly, for the RAP target of 90% of PLHIV and KPs reporting no discrimination in the health sector, there was no data source to directly measure this indicator. Nevertheless, the Laws and Policies Analytics platform provides updates on two closely related aspects. Based on the most recent NCPIs of 2017 and 2019, data are available from national authorities in five out of 10 countries in the SEA Region. All five of them reported having policies that required health-care settings to provide timely and quality health-care, regardless of any grounds. Out of these five countries that reported having such policies, three indicated that they are consistently implemented, while they are not consistently implemented in the remaining two countries. Based on the same question asked to civil society counterparts as part of NCPI, data are available for only four countries - one country having consistent implementation and three of them having policies, but not consistently implemented. Out of the five countries reporting data, interventions targeting health-care workers on human rights and gender-based violence were implemented on a small scale in four countries, and at scale in one country (9).

For laws, policies and regulations enabling funding access for CSOs/CBOs, in six of the reporting countries, this was broadly favourable for domestic and international funding sources, while one country reported social contracting or similar mechanism allowing for funding of service delivery by communities from domestic funding. Regarding restrictions to registration/operation of CSOs or CBOs affecting HIV service delivery, two countries reported no such restrictions at all, while five countries had some form of restriction (9).

Regarding safeguards in laws, regulations or policies providing for the operation of community-based organizations (CBOs) or civil society organizations (CSOs), responses to questions were received from seven countries in the Region. All seven countries reported that favourable safeguards are available on the five parameters asked, including registration process of organizations and streamlined reporting mechanisms.

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**Fig. 17: Community-led service delivery**

**Laws / regulations / policies providing for CSO/CBO operation, SEARO countries, 2020**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Number of Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration of HIV CSOs is possible</td>
<td>7</td>
</tr>
<tr>
<td>HIV services can be provided by key populations if possible</td>
<td>7</td>
</tr>
<tr>
<td>Services to key populations can be provided by CSOs/CBOs</td>
<td>7</td>
</tr>
<tr>
<td>Reporting requirements for CSOs/CBOs delivering HIV services are streamlined</td>
<td>7</td>
</tr>
<tr>
<td>There are no safeguards in laws, regulations or policies that provide for the operation of CSOs/CBOs in the country</td>
<td>0</td>
</tr>
</tbody>
</table>

**Laws / regulations / policies enabling funding access for CSOs / CBOs, SEARO countries, 2020**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Number of Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>From International donors</td>
<td>6</td>
</tr>
<tr>
<td>Both from domestic funding and international donors</td>
<td>0</td>
</tr>
<tr>
<td>Social contracting or other mechanisms allowing for funding of service delivery by communities from domestic funding</td>
<td>0</td>
</tr>
<tr>
<td>There are no laws, policies or regulations enabling access to funding for CSOs/CBOs</td>
<td>0</td>
</tr>
</tbody>
</table>

**Source:** Lawsandpolicies.unaids.org - Analysis on indicator for Community-led service delivery for SEARO region
Box 1: From policy and advocacy to certification, accreditation and sustainability of KP-led health services (KPLHS) – Thailand

In 2015, Thailand developed a comprehensive operational plan to accelerate efforts towards ending AIDS by 2030, focused on effective interventions for KPs. The plan incorporates reach, recruit, test, treat, prevent and retain (RRTTPR) with three modalities of service provision: (a) hospital-based model; (b) government facility-led health services model with reach and recruit led by community-based organizations (CBOs); and (c) a KP-led health services (KPLHS) model focused on task-sharing in collaboration with government hospitals.

With national KP lay provider certification and CBO accreditation, KPLHS will register as CBO-National Health Service Organization (NHSO) services nodes within 2021. This registration will enable lay providers to receive financial support from the government, which will lead to the sustainability of CBOs’ HIV work in Thailand.

The timeline of achievements is summarized below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Men who have sex with men (MSM) and transgender women (TGW) communities design the KPLHS model and establish services at six CBO health centres in four high-burden provinces under the USAID LINKAGES Thailand Project.</td>
</tr>
<tr>
<td>2017</td>
<td>ENGAGE technical assistance and advocacy platform established to focus on capacity-building and certification systems to enable providers to deliver HIV and STI testing, prevention (including PrEP and PEP), and treatment services (same-day ART initiation, differentiated ART delivery when stable, and treatment of some STIs).</td>
</tr>
<tr>
<td>2018</td>
<td>The Division of AIDS and STIs (DAS), Department of Disease Control (DDC), and LINKAGES credit the established KPLHS for 55% of HIV testing and 55% of pre-exposure prophylaxis (PrEP) uptake among MSM and TGW. The Ministry of Public Health (MoPH) and other high-level policy-makers conduct formal and informal dialogues to address the concerns of the professional medical councils.</td>
</tr>
<tr>
<td>2019</td>
<td>The Minister of Public Health endorses a ministerial regulation legalizing KP lay providers’ delivery of HIV services. The Ministry’s gazette promulgates the regulation in September.</td>
</tr>
<tr>
<td>2020</td>
<td>DAS, DDC, in consultation and working with ENGAGE, key organizations and CBOs in Thailand, launch the first national HIV services standard for KPLHS and establish a national certification system for KP lay providers. ENGAGE certifies 106 KP lay providers working at 17 health services in 15 provinces. A standardized training curriculum is developed for KP lay providers.</td>
</tr>
<tr>
<td>2021</td>
<td>DDC and relevant organizations conduct assessments for CBO accreditation in HIV service provision based on the national HIV services standard for KPLHS. 100 KP lay providers complete the DDC standard training curriculum and exam, and KP lay providers previously certified by ENGAGE take part in equivalency testing administered by DAS. DAS will register all lay providers who qualify as MoPH-KP lay providers under the ministerial regulation in July.</td>
</tr>
</tbody>
</table>

Key stakeholders: Ministry of Public Health Thailand, Division of AIDS and STIs | DAS; Department of Disease Control (DDC); Thai Red Cross AIDS Research Centre; Institute of HIV and Research Innovation (IHRI); Service Workers In Group Foundation (SWING); Rainbow Sky Association of Thailand (RSAT); Caremat Organization (Caremat); and Mplus Foundation (Mplus), CDC Thailand

Linkages: Linkages across the continuum of HIV Services for KPs affected by HIV

ENGAGE: “Key Population-Led Health Services (KPLHS)” technical assistance platform (ENGAGE TA Platform) established by the Institute of HIV Research and Innovation (IHRI), Bangkok, Thailand, with funding from USAID.
5.3. Progress on the legal and enabling environment

PLHIV and KPs living in the SEA Region continue to face stigma and discrimination, often embedded in laws and policies. The overly broad application of criminal law to HIV nondisclosure, exposure and transmission continues to raise both serious human rights and public health concerns.

A number of steps have been taken by countries to address barriers faced by KPs and marginalized groups. India’s Supreme Court decision that decriminalized same-sex relations in 2018 was a landmark decision for the Region and globally. The Court read down Section 377 of the Indian Penal Code, which criminalized consensual sexual conduct between adults of the same sex. India also recognized transgender people as the “third gender” and affirmed that the fundamental rights granted under the Constitution of India are equally applicable to them, and gave them the right to self-identification of their gender as male, female or transgender (18). Further, the Transgender Persons (Protection of Rights) Act, 2019 was passed by the Parliament of India, which has provisions on antidiscrimination and welfare of transgender people (19).

India’s HIV and AIDS (Prevention and Control) Act, 2017 (20) is also a game-changing legislation, which addresses the HIV response through the application of human rights principles. This Act protects PLHIV from discrimination, breach of confidentiality and non-consensual HIV testing. It allowed for the creation of a formal mechanism such as the Ombudsman and Complaints Officer for inquiring into complaints of people with grievances regarding discrimination and other unlawful conduct.

The Nepalese Constitution, approved by the Constituent Assembly in 2015, includes several provisions pertaining to the rights of lesbian, gay, bisexual and transgender (LGBT) people. These are the right to acquire a citizenship certificate in accordance with one’s gender identity, a prohibition on discrimination on any grounds, including sex, by the State and by private parties, eligibility for special protections that may be provided by law and the right of access to public services for gender and sexual minorities. Nepal’s Safe Motherhood and Reproductive Health Rights Act, 2018 also includes protective provisions for transgender people and sexual minorities. The Act prohibits discrimination, including on the grounds of sexual and gender identity, in the provision of family planning, reproductive health, safe motherhood, safe abortion and emergency obstetric and newborn care services (21).

In Myanmar, consultations were held concerning the development of a human rights-based national HIV law from 2014 to 2017, and a bill was drafted as a basis for the consultations (19). In 2018, the Legal Affairs and Special Issues Assessment Commission was instrumental in moving the draft HIV law process forward. In 2019, under the leadership of the Ministry of Health and Sports, several review meetings were convened to
improve the draft law, which included the participation of relevant stakeholders. The 1993 Narcotic Drugs and Psychotropic Substances law was amended in February 2018 and compulsory registration for drug users was removed, which shifted the approach from a punitive one to that of drug treatment, and included harm reduction. The National Drug Control Policy now addresses all aspects of the drug problem with a significant shift to a more people- and health-focused approach, advocating for practical strategies to reduce the negative effects of drug production, trafficking and use [22].

In Thailand, a key development was an amendment introduced in 2014 to the Clinical guidelines for HIV testing and counselling, which provides that parental consent is not required for HIV testing of people aged under 18 years [23,24]. A person under 18 years of age can consent to HIV testing if they have the capacity to understand the information related to HIV and the meaning of a positive test result. In Thailand, antidiscrimination protections were extended to transgender people for the first time by passage of the Gender Equality Act, 2015 [25].

In Bangladesh, PLHIV and transgender persons are included in the National Social Security Strategy, and are thus eligible for applying for social welfare, if needed. I-Probono (a legal agency) is actively supporting sex workers in resolving issues that usually arise with law enforcement entities. The Narcotic Control Act, 2018, recognized methadone maintenance therapy as a means towards rehabilitation [26]. However, conflicting laws around sex work and Section 377 of the Bangladesh Penal Code remains (Fig. 18).

Across the Region, an increasing number of countries are adopting policies that enable PrEP access for KPs and other people at substantial risk of HIV (Section 5.4.5).

**Fig. 18: Summary of legal provisions in countries of the SEA Region**

<table>
<thead>
<tr>
<th>Enabling Environment: Access to justice</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEAR countries with mechanisms in place to promote access to justice, most recent data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes, legal aid systems applicable to HIV casework</th>
<th>Yes, pro bono legal services provided by private law firms</th>
<th>Yes, legal services by legal clinics</th>
<th>Yes, community paralegals</th>
<th>Yes, other</th>
</tr>
</thead>
<tbody>
<tr>
<td>National authorities</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Civil society</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: http://lawsandpolicies.unaids.org – analysis on indicator for access to justice and legal services for the SEA Region.
Despite progress and many positive changes in the legal and policy environments, laws and policies that perpetuate stigma, discrimination, violence and other rights violations remain significant barriers in this Region. Fig. 19 summarizes the status of key aspects of legal environments relevant to HIV responses in countries in the SEA Region.

### Sources:

### Fig. 19: Status of key aspects of legal environment relevant to HIV responses in countries in the SEA Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Criminalization of sex work</th>
<th>Criminalization of same-sex sexual acts</th>
<th>Criminalization of transgender people</th>
<th>Drug use or possession for personal use or an offence</th>
<th>Parental consent for adolescents to access HIV testing</th>
<th>Spousal consent for married women to access sexual and reproductive health services</th>
<th>Laws that criminalize the transmission, non-disclosure of, or exposure to HIV</th>
<th>Laws or policies restricting the entry, stay and residence of people living with HIV</th>
<th>Mandatory HIV testing for marriage, work or residence permits or for certain groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Thailand</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Singapore</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Indonesia</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Malaysia</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Brunei</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Ending AIDS as a public health threat in the South-East Asia Region: progress, challenges and the way forward.

In four countries where data are available, compulsory detention for drug use is practised in some settings. The practice of mandatory testing is still seen in some settings with military recruits, visa applications and prior to marriage.
5.4. Progress on implementing WHO HIV prevention and treatment guidance

Over the past five years, there have been significant advances in treatment and newer prevention approaches have been developed. A brief synopsis of these updates is given below.

5.4.1. Adoption of "treat all" policy

In 2016, WHO recommended that all PLHIV diagnosed with HIV be provided with ART, regardless of their clinical stage or CD4 count. All countries in the Region have implemented this policy. This has led to a significant rise in the number of people being initiated on ART [27].

5.4.2. Adoption of a dolutegravir-based regimen

In 2019, WHO recommended that all patients being initiated on ART should get dolutegravir (DTG)-based ART (more durable regimen with a high genetic barrier to resistance) [28]. It was also recommended that all existing patients on suboptimal regimens be transitioned to a DTG-based regimen in a phased manner, depending on country capacity and existing drug stocks [28]. By 2020, eight out of 10 countries in the Region had adopted DTG as the preferred regimen for initiating ART in treatment-naive patients, and are at various stages of transitioning existing patients who are on another regimen to the DTG-based one. Two countries which have adopted DTG in their guidelines are currently in the process of procurement.

5.4.3. Adoption of differentiated service delivery, advanced disease management

Member States in the Region adopted differentiated service delivery models in terms of multi-month dispensing (MMD), task-sharing, community distribution of antiretroviral (ARV) and OST drugs to different extents, and are in the process of firming up these delivery models for the future as well. Three countries have implemented WHO guidance on rapid initiation of ART, including same-day initiation. Two countries have adopted WHO guidance on management of advanced disease with a view to reducing the mortality and three other countries have added this in their Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) proposals.

5.4.4. Adoption of newer testing approaches

To reach the first 90, WHO has been focusing on innovative testing approaches, including expanding community-based testing and HIV self-testing (HIVST) [29]. National policies in several countries support community-based testing and lay provider testing. Five countries in the Region have expanded HIV testing out of health facilities, with both community-based and community-led testing. However, many countries have not yet developed supportive policies for new HIV testing approaches such as HIVST and social network-based testing.
In the Region, two countries have an HIVST policy in place and seven other countries have added HIVST to their national testing policy and strategies. Country implementation and scale-up plans were hindered by unavailability of registered HIVST products or unclear pathways for product registration. Also, implementation has been slow, with most countries planning to do a demonstration project in a smaller area before scaling-up use in other areas. These demonstration projects were severely delayed, and participation was affected due to COVID-19 lockdowns in many countries. A mitigation plan has been put in place by some countries, such as innovative online platforms for promoting, distributing and reporting HIVST uptake, apart from the traditional offline distribution methods. Most countries are using oral HIVST kits and are also planning to include blood-based kits.

5.4.5. Adoption of newer prevention approaches

WHO recommends pre-exposure prophylaxis (PrEP) as a key strategy for improving access to HIV prevention in the SEA Region and reducing new HIV infections among all those at substantial risk of HIV. Access to PrEP continues to expand across the Region and increasing commitment to PrEP is being demonstrated by countries through rolling out of PrEP programmes, incorporating PrEP into their national strategic plans, including PrEP in Global Fund grant requests and/or endorsing PrEP guidelines.

The estimated number of people who have used PrEP at least once in 2020 has grown to over 12,600 from approximately 10,700 in 2019. At least three countries have developed technical/operational guidance for rolling out PrEP, and four countries are considering PrEP in 2021. PrEP has been included in the national social benefits package in Thailand. In other countries, PrEP access is heavily reliant on external funding and self-pay models as of now. Scale-up continues to be too slow and insufficient to demonstrate population-level impacts. Implicit government commitment, including through the endorsement of
comprehensive clinical guidelines that include KPs and registration/availability of PrEP drugs, has been a significant challenge. The COVID-19 pandemic has impacted service delivery, outreach and information, education and communication (IEC) activities, capacity-building and other activities. However, differentiated approaches to service delivery, including community-led delivery, telehealth and virtual capacity-building models were utilized in some countries to mitigate the impacts of the pandemic and support service continuity for people who were using PrEP (30).

5.4.6. Regional response to sexually transmitted infections

The current programme response to STIs varies greatly across the Region, from highly effective to almost non-existent. Where STI declines have occurred, evidence strongly supports attribution to programmes that have increased condom use in sex work, while maintaining good clinical services (both targeted and general population) and reliable STI surveillance. National experience and subnational examples highlight multiple effective approaches to reducing STI incidence and prevalence, as well as surveillance and programme monitoring methods. In these countries, STIs have decreased by more than 90% (16). For example, in Sri Lanka, the incidence of gonorrhoea decreased from 61.6 to 3.5 cases per 100 000 population (94.3% reduction) between 1975 and 2000; while in Thailand, the incidence decreased from 445 to 7 cases per 100 000 population (98.4% reduction) between 1985 and 2005. In Myanmar, the incidence of gonorrhoea decreased from 15.4 to 1.4 per 10 000 male population (90.6% reduction between 1985 and 2005).

STI services for KPs - including regular quarterly medical check-ups, periodic presumptive treatment for asymptomatic infections and regular syphilis screening - have resulted in rapid STI control, including virtual elimination of common STIs in two Indian districts. Thailand and Sri Lanka have maintained strong commitment and funding over many years. Elsewhere, the national STI response varies greatly, with many countries struggling to support basic clinical services, maintain stocks of effective STI treatments, conduct outreach to KPs, maintain basic STI surveillance and monitor antibiotic resistance.

Nevertheless, good examples of improving STI control have been described at subnational levels (notably Kolkata and Mysore city in India and Tanjung Pinang city in Indonesia), even in large countries where implementation of control efforts has been highly uneven overall. These examples demonstrate the feasibility of improving STI control under a range of conditions. Data from the integrated biological and behavioural surveillance (IBBS) 2014-2015 and special studies from Indonesia demonstrate that STIs have decreased in some areas, particularly among sex workers, following interventions. Myanmar also demonstrated early success in a demonstration project of STI control and HIV prevention with 100% targeted condom promotion. Pilots in four townships demonstrated an increase in condom use among sex workers (from 61% in 2001 to 91% in 2020) and halving of syphilis prevalence. Limited data from Bangladesh show declining syphilis rates, largely due to sex
worker mobilization, raising awareness, condom promotion and provision of STI services [15].

5.5. Impact of COVID-19 on HIV responses and experiences from mitigation efforts

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 for different services and stages 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 reported data on continuity of ARVs for both rounds. While the number of countries reporting any disruption reduced to one by Round 2, the level of disruption reported for Round 1 was more than 50%, unlike in Round 2, where countries reported disruption in the range of 5-50% [Fig. 20] [37].

Fig. 20: ART disruption during the COVID-19 pandemic in the SEA Region, 2020–2021

<table>
<thead>
<tr>
<th>Continuation of ARVs</th>
<th>Average disruptions levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 2 n=7</td>
<td>Round 2 (January - March 2021)</td>
</tr>
<tr>
<td></td>
<td>◼ More than 50% ◼ 26-50% ◼ 5-25%</td>
</tr>
<tr>
<td>January - March 2021</td>
<td>Round 1 (May 2020 - September 2020)</td>
</tr>
<tr>
<td></td>
<td>◼ More than 50% ◼ 5-50%</td>
</tr>
<tr>
<td>Round 1 n=7</td>
<td>May 2020 - September 2020</td>
</tr>
<tr>
<td>14%</td>
<td>43%</td>
</tr>
</tbody>
</table>


Monthly new HIV diagnoses and monthly ART initiation were compared for the respective months of March to October in 2019 and 2020, i.e. the number of new HIV diagnoses and treatment initiation were compared for March 2019 versus March 2020, April 2019 versus April 2020, and so on. The differences were plotted as percentage changes, whereby any value higher/lower than 0% indicated increase/decrease, respectively in the number of people who were diagnosed as well as initiated on treatment. This analysis revealed that in five countries that provided data, services declined significantly in 2020. While recovery was noted during the latter part of the year, analysis based on these limited data shows that it is not a uniform trend and that it can decline further, depending on the stage of the pandemic in a particular country [Fig. 21].
In general, WHO data show that HIV testing and prevention are among the most frequently disrupted services caused 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. 22 on continuity of services pertaining to communicable disease services in the Region [31].

Fig. 21: Disruption in HIV diagnosis and ART initiation assessed by comparing monthly data for 2019 and 2020, during the COVID-19 pandemic in the SEA Region

C1-C5 denotes the five countries that shared data.


In general, WHO data show that HIV testing and prevention are among the most frequently disrupted services caused 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. 22 on continuity of services pertaining to communicable disease services in the Region [31].
Fig. 22: Continuity of services pertaining to communicable diseases in the SEA Region, 2020–2021


Considering the critical nature of HIV-related service delivery, the Regional Office worked closely with WHO country offices and national AIDS programmes in the Region towards mitigating the impact of COVID-19. Early efforts comprised undertaking rapid situation assessments at country level and adapting and implementing the global guidance on mitigation efforts in relation to HIV-related services and COVID-19. To contextualize global guidance, a regional advisory was also shared with all countries in March 2020 and later updated in June 2021. In addition, technical support was provided to countries according to their specific needs and requirements.

One of the key challenges that countries faced during the early days of COVID-19 was in the seamless supply of ARV drugs, the majority of which were manufactured by companies based in India. Even though there were no acute shortages as reported in March 2020, there were concerns about the supply of certain medicines in the medium- to long term. Hence this was closely monitored in the subsequent months, as was also necessitated by the evolving COVID-19 situation in the Region. In order to understand the issues further and inform longer-term mitigation efforts, the Regional Office contacted leading ARV drug manufacturers in India in May 2020, inviting them to take part in a survey. The objective was to identify constraints related to COVID-19 in ARV production and supply and disseminate the findings for wider discussions through a peer-reviewed publication. Fig. 23 summarizes some of the key findings from this survey. Through the survey, manufacturers got an opportunity to offer recommendations and solutions (32).
In line with these findings, early efforts by the WHO Regional Office to minimize COVID-19-related disruptions included support to overcome ARV drug supply challenges. These ranged from the facilitation of regular and alternative shipping arrangements for current ARV drug orders to recommending early new orders where required, leaving sufficient lead times for delivery.

In addition to support related to ARV stocks, technical guidance, advisory notes and related communications emphasized the importance of continuity of ART and other services. The Regional Office also promoted sharing of experiences and good practices among countries during this period (see Box 2). Most countries adopted several service adaptations such as MMD of ARV drugs, teleconsultations, take-home doses of OST medicines for drug users who were stable on such treatment and community-based service delivery, among others. Experiences on the ground have shown that communities of people affected by the disease can be effective partners in service delivery.

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 service adaptations 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 providing services for KPs, would take a longer time to be fully restored. “Catch-up” campaigns and specific measures in pandemic response plans are needed to achieve this objective.
Box 2: Good practices and mitigation measures
Summary of key measures to address challenges related to COVID-19

• Differentiated service delivery approaches including multi-month dispensing of ARVs and take-home dose of OST, where feasible.
• Remote means of interaction by clients with healthcare providers, such as through telemedicine and reinforcing of prevention outreach using social media and other channels.
• Greater promotion of innovations such as HIV self-testing to partly address the challenges to access certain services.
• Community-led initiatives and service adaptations including delivery of medicines at doorstep or locations closer to clients.
• Use of tele-education approaches to strengthen capacities of healthworkers and outreach workers, particularly at grassroot level.
• Adjustments in procurement and supply chain systems to address delays and challenges in shipping and delivery of essential health commodities.

Mitigating the impact of COVID-19 on ART services: Good practices pertaining to ART service delivery

• Community outreach workers arranged home delivery of ARVs for patients unable to reach the facility, using their own transport, walking or through donated ambulances. They created community refill groups, sensitized the police to allow peer workers to deliver drugs and encouraged home treatment for mild illness. Outreach workers protected themselves with masks and social distancing.
Online meetings were held with programme managers and community leaders to support state teams in addressing the crisis, coordination issues and facilitating cross-learning. Real-time information was also shared on clients, medicine requirements, good practices and handling emergency situations.

**Nepal**

**Thailand**

• Online meetings were held with programme managers and community leaders to support state teams in addressing the crisis, coordination issues and facilitating cross-learning. Real-time information was also shared on clients, medicine requirements, good practices and handling emergency situations.

**A story from field:**
During a reminder call to a woman for ART pill pick up by the Care and support centre team at Agra, she said that she had injured her leg and could not move. The team immediately visited her house, provided first aid and food to three starving children, and linked the family to district authorities for continued medical help and rations. Her condition improved and was able to resume her ART.
Bottlenecks and challenges to achieving the 2020 fast-track targets
6.  Bottlenecks and challenges to achieving the 2020 fast-track targets

The response to HIV accelerated both globally and in the SEA Region after adoption of the landmark political resolution at the UN General Assembly Special Session (UNGASS), 2001. Three specific factors that aided this response were:

- strong political will articulated through effective follow up of the Resolution at country level;
- introduction of innovative structures for AIDS governance through the “Three Ones” principle advocated by UNAIDS; and
- massive increase in available resources with the establishment of the Global Fund and bilateral assistance from the global north.

The period 2001 to 2010 witnessed a strong and determined response to AIDS in the SEA Region, in which all the above three features figured prominently. There was impressive progress during the decade in reduction of new HIV infections, provision of ART to PLHIV leading to reduction in AIDS mortality and empowerment of communities of KPs who were disproportionately impacted by AIDS. New infections reduced by 32%, from 310 000 to 210 000, during the period. ART was provided to 670 000 persons, which constituted 20% of PLHIV. In most countries, populations of sex workers, MSM, transgender populations, PWID and PLHIV felt empowered through direct programme interventions for prevention and treatment services.

During the second decade, 2010-2019, the Region witnessed a steady scaling down of some of these initiatives that were earlier responsible for bringing the epidemic under control. Paradoxically, political support for AIDS programmes has declined because of the initial success of the response. It was assumed that the battle had been won. The sense of urgency with which the AIDS response was steered by country leadership was lost and national AIDS programmes were relegated to a lower priority. The AIDS exceptionalism, which was the hallmark of the response, gave way to mainstreaming of the programmes with the health systems, with varying degrees of effectiveness.

The essential elements of AIDS governance introduced in 2001 were: (i) the constitution of a national AIDS Commission/Committee (NAC); (ii) a single national programme that was truly multisectoral with the participation of all stakeholders; and (iii) a single agency to monitor and evaluate the effectiveness of the response. Most of the countries in the Region constituted these bodies at the national level, which did a highly effective job in monitoring the response. During the second decade, the NACs lost their effectiveness in leading the multisectoral response. In some countries, the NAC has been abolished and the work has been handed over to the Ministry of Coordination, while in others, no meetings of the NACs were held in the past five years. Non-health stakeholders lost interest in the programme. National AIDS responses remained the health ministry’s mandate in most of the countries.

National AIDS control plans, which were truly multisectoral and fully costed and funded,
became more aspirational during the decade 2010-2019 with varying degrees of funding support. National strategic plans, which are for varying periods ranging from 2017 to 2025, were not assured of full funding, leaving a substantial gap in the availability of resources for priority programmes. For example, in Bangladesh, the gap was US$ 120 million out of the NSP outlay of US$ 170 million. In Timor-Leste, the funding gap was US$ 2.7 million out of the NSP outlay of US$ 9.3 million.¹

Decentralization of AIDS programmes to provinces and districts has rightly taken the response to the field level and aims to improve access. However, the pattern of decentralization has not been uniform and varies considerably across the Region. In India, the states get the bulk of programme funds from the Central Government and remain accountable for performance, through a system of regular monitoring and periodic reporting. In Indonesia, the funds do flow to provinces, but implementation is based on their own agreed priorities for the response. The accountability of the provinces for performance is not clearly defined in some countries. Interventions like prevention programmes for KPs have suffered in the process, even though they figured in the list of priorities at the federal level. The pattern of the epidemic in the Region is heavily skewed towards KPs who account for the majority of new infections. Prevention programmes, however, have not reached that level of coverage and effectiveness.

Most SEA Region countries conducted regular epidemiological surveys and estimated the prevalence and incidence levels of HIV. As part of the 90-90-90 targets, at least 90% of estimated PLHIV must be covered under testing, which has been reached only in one country, Thailand. The gap between the estimated number of infections and those covered by testing has been explained in Fig. 10, Section 5.2.2. In some countries, there is a 50% gap between the estimated and reported cases, mainly due to non-availability of testing services in hard-to-reach areas and populations.

Because of this consistent gap, many infected persons reached ART centres only at a late stage of infection when their CD4 count was below 200 cells/cubic mm. This was one of the reasons for the higher AIDS mortality in the SEA Region. In addition, a large number of people on ART are lost to follow up and discontinue treatment. The cumulative effect of these suboptimal interventions in testing, prevention and treatment shows that the achievement of countries of the fast-track targets for 2020 and in reducing new infections and coverage of ART services remained low (Figs. 10 and 11).

The progress on EMTCT in SEA countries was explained earlier in Section 5.2.3. A crucial issue in the EMTCT of HIV relates to pregnancies and deliveries that occur outside the government system. They may occur in private sector hospitals or even at home in many SEA Region countries. The mechanism that governments are adopting to get data on pregnancies and deliveries outside of public sector healthcare institutions and ensure provision of recommended services is not fully clear.

¹ Data from presentations by national programme officials to Special Adviser to the Regional Director on HIV, virtual country missions June–July 2021.
6.1. Key challenges

The 2021 UN Political Declaration calls on countries to “commit to accelerating integration of HIV services into UHC and strong and resilient health and social protection systems, building back better in a more equitable and inclusive manner from COVID-19” [33]. It also calls for an end to all inequalities and a community-led response, and has defined targets for social enablers. Also, there is a strong need for innovation and diversification in service delivery approaches.

On the way to ending AIDS by 2030, there are some key “mid-points” to be achieved by 2025 that countries have adopted in the Political Declaration during the UNHLM held in June 2021 [34]. These include:

- HIV treatment to 34 million people with a 95-95-95 cascade;
- reducing annual new HIV infections to under 370,000;
- reducing annual AIDS-related deaths to under 250,000;
- eliminating new HIV infections among children and ending paediatric AIDS;
- ensuring that 90% of PLHIV receive preventive treatment for TB and reducing TB-related deaths among PLHIV by 80% [34].

The biggest challenge comes from the most unforeseen event - the COVID-19 pandemic, which has engulfed the Region since March 2020. Most of the countries in the Region have been passing through successive waves of the epidemic. India, Indonesia, Myanmar, Nepal and Thailand had some of the highest numbers of COVID-19 cases during May-June 2021 [34]. In all the SEA Region countries, HIV-related services were severely impacted during the first wave, leading to disruption of prevention and treatment programmes and postponement of EMTCT target dates. The epidemic has also disproportionately impacted KPs who are vulnerable to HIV. Sex workers, MSM and transgender persons have lost their sources of livelihood and have been driven to destitution. Social protection schemes announced by governments for people affected by COVID-19 have not adequately reached these populations.

Nevertheless, the resilience of communities and innovative approaches adopted by governments have partially mitigated the impact. Multi-month dispensing and doorstep delivery of ART drugs have helped in avoiding disruption of treatment services in most countries of the SEA Region. Civil society volunteers travelled long distances on foot to reach ARV drugs to infected populations in India and Bhutan. In Bangladesh, the Sex Workers’ Network and Bandhu Social Welfare Society provided social protection to sex workers and MSM by providing direct benefits to those who lost employment. In Myanmar, rapid response teams were organized to provide prevention and treatment services such as MMD of ARV drugs. Despite these measures, COVID-19 will remain a huge challenge to reaching the 2025 targets.

The legal environment surrounding KPs remains a big challenge for the realization of
goals in the next five years. In the past decade, there have been positive developments in some countries in the Region. For example, India and Bhutan have decriminalized same-sex relations and provided third gender identity to transgender populations. India has enacted the HIV/AIDS Act after a long period of waiting, which is expected to deal with cases of stigma and discrimination in the workplace and educational institutions.

There has been a greater pushback on the legal front, especially governing sex work and drug use. No relaxation of laws governing sex work and decriminalizing it was taken up in any of the countries of the Region. Drug use continues to attract severe penalties under the drug laws that were enacted several decades back. However, Myanmar has amended its drug laws in February 2018, shifting from a punitive to a treatment approach and removing the provision for compulsory registration of drug users.

- Waning political support and reduced availability of resources are the most important challenges the Region will face in the coming years. Declining political support to AIDS programmes is likely to continue and resource commitment will follow normative criteria of an incremental budgetary allocation every year. Inter se allocation of resources for prevention of HIV among KPs will also continue to be a big challenge. The evidence that an overwhelming number of new infections are occurring among KPs can be a challenge and an opportunity. It is a challenge as these groups are not considered politically relevant but an opportunity as minimum investment in targeted interventions for prevention can turn the tide of the epidemic.

- The Global Fund remains one of the main external funding agencies for AIDS programmes in the Region. The decision of the Global Fund Board to phase out funding for low- and middle-income countries from 2024 will seriously impact resource availability for AIDS programmes. Domestic resources are increasing in most of the countries but not to the extent of compensating the loss of external funding from the Global Fund and other funding agencies. Sri Lanka will become ineligible for Global Fund grants from the 2023 to 2025 allocation period. Bangladesh, Bhutan and Thailand may join this list in the near future.

Presently, much of the funding for prevention among KPs is met out of Global Fund grants [Fig. 13]. These interventions, which are critical for reducing infection levels among KPs, have to be protected from discontinuance of critical financial resources. Governments and civil society need to be vigilant about declining support for prevention activities once the Global Fund withdraws from the scene.

- The devastating impact of the COVID-19 epidemic has its own lessons to be learnt in the Region. Barring one or two, most countries in the Region have poor health-care infrastructure, a result of decades of underinvestment in the health sector. Such shortcomings were exposed many times earlier too including when the global AIDS epidemic was at its peak in the nineties. The present crisis should galvanize governments and public opinion to undertake a quantum jump in public sector
investment in the health sector, doubling it as a percentage of the gross domestic product (GDP) in the next 3-4 years. The COVID-19 epidemic is a great opportunity for countries to strengthen their public health infrastructure, which is the only sustainable way to control waves of epidemics such as AIDS or COVID-19.
The way forward
7. The way forward

The 2016-2021 implementation period of the GHSS on HIV, viral hepatitis and STIs has seen tremendous progress in the SEA Region; yet, many gaps and inequalities persist. There has been a lack of focus on funding for viral hepatitis and STIs in the Region in particular, despite the high disease burden. These diseases remain high priorities in the SEA Region. There is a need to recommit to the 2030 SDG targets and accelerate the response by leveraging opportunities offered by integration, simplification and innovation. The health sector can be seen as driving these responses at the centre of a multisectoral approach.

Contrary to popular belief, AIDS has not gone away. It will not go away without resolute action by all levels of leadership - political, administrative and civil society. The goal of ending AIDS by 2030 as a public health threat may appear daunting but is not impossible to achieve. Providing strong political support and full funding for the national responses, coupled with effective participation of KPs in planning, programming and implementing critical responses will be the key to success. The Region cannot allow a rebound of the AIDS epidemic, as is the case with COVID-19, which is proving more and more costly with each successive wave.

National governments in the Region need to do a dispassionate evaluation of the AIDS responses in their countries and adopt measures ranging from mid-course corrections to radical shifts. The commitments made in the UNHLM in June 2021 need to be translated into effective action. Failure to achieve the 2025 goals will set the Region off-track in realizing the ultimate goal of ending AIDS as a public health threat by 2030.

The following priority actions are suggested for integration into national strategies to realize the 2025 goals.

- Governments should put into place strong governance structures or reinvigorate existing ones into effectively functioning entities. AIDS, like COVID-19, disproportionately affects vulnerable populations, which accounts for 90% of new infections in the Region. AIDS governance should have a strong component of civil society participation, not just in programme implementation but also in decision-making. Decentralized governance structures should be made accountable not just for the money spent but for the outcomes such as reduction of new infections and increased coverage of treatment services. Provinces and central/federal governments should agree on a common minimum set of interventions for which the provincial entities should remain accountable. Absence of alignment in the principles and priorities between the central/federal and provincial levels will be dysfunctional to the effective realization of targets.

- Countries should quickly update their strategic information, not just on the number of infections but on the size estimations of key populations. In a number of countries,
these estimations are old and outdated. There should be evidence-informed consensus between national governments and stakeholders on the methodology of estimations and periodic surveys. The risk factors keep changing in a dynamic environment, which can only be captured by regular IBBS surveys. The following surveys are of high priority:

- size estimations of KPs, which should be updated with 2020 as the base year;
- new HIV infections among KPs and the general population on an annual basis through sentinel surveys among KPs and the general population;
- behavioural surveys to identify risk factors for the spread of HIV once in three years.

Governments must accord priority to refining their data systems, which will ultimately be relied on to certify indicators like EMTCT and other targets for 2025.

Prevention of new infections among KPs is key to success. Just as it is important to advocate with governments, the role of CSOs is equally important in this process. Novel methods of moving funds directly to NGOs and CBOs for implementation should be evolved. The community intervention model developed in the nineties by many countries has become outdated and needs updating to suit the current dynamics. Emphasis on prevention and increasing awareness among the youth would also require partnerships beyond the health sector, particularly with sectors such as education, and be guided by implementation research on what works best in which setting.

New models of community testing, treatment and prevention interventions should be introduced for maximum effectiveness of treatment and prevention services. New technologies like PrEP and HIVST should be fully operationalized and added as important components of the national response.

As prevention of HIV among KPs is the key to controlling the epidemic in the SEA Region, it is necessary to continue providing prevention services such as condoms, lubricants, needles and syringes, PrEP and HIVST through CBOs as alternative service delivery channels. Extreme levels of stigma and discrimination of PLHIV and KPs deter them from availing prevention services through the health systems. The community-led model of service delivery for prevention should therefore be a very important component of the AIDS response in the SEA Region.

Because of the declining resource base, soft programmes like general awareness on HIV and school-based education programmes have suffered. An entire new generation of young people have grown up without any basic knowledge of HIV and its associated risks (Fig. 22). These programmes should attract adequate funding from different sectors such as education and social welfare. This will only be possible if the multisectorality of AIDS programmes is given due importance in countries of the SEA Region.
- Proactive efforts should be made to bridge the gap between the estimated and reported numbers of HIV infections. The first 90 in the 90-90-90 cascade will improve only if this gap is effectively covered by aggressive testing, and putting everyone who tests positive on ART. Testing coverage can be improved by expanding community-based testing facilities to cover KPs, a large percentage of whom are still untested. An aggressive test-and-treat policy will have a direct impact on AIDS mortality by bringing PLHIV to treatment centres at an early stage of infection.

- As AIDS “exceptionalism” (35) has given way to integration of programmes into health systems, each country should evolve a strategy for progressive integration of services into the health system. Thailand and Bhutan have developed good models for integration and have been largely successful in extending ART and EMTCT services through UHC. However, the epidemic in the SEA Region is still largely concentrated among KPs, who need special measures to secure access to services through the health system. Community-based alternatives should also be available for KPs to access testing and treatment services side by side with government systems.

- The legal environment governing KPs has a deep impact on the effectiveness of AIDS responses. Governments should initiate measures to decriminalize behaviours concerning sex work, drug use and same-sex relations. Reforms are needed both with regard to the law in the books and law on the streets. The law enforcement machinery and lower rungs of the judiciary need to be sensitized to the problem of access to services by KPs to create an enabling environment, where they will feel empowered and be free of AIDS-related stigma and discrimination.
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