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ASEAN CITIES  
GETTING TO

**ZERO**

**NEW HIV INFECTION  
AIDS RELATED DEATH  
DISCRIMINATION**



# EXPERIENCES OF PARTICIPATING ASEAN MEMBER STATES IN THE ASEAN CITIES GETTING TO ZEROS AND OTHER GOOD PRACTICES – 2016



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Since the commencement of “ASEAN Declaration of Commitments: Getting to Zero new HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths” in 2011 and implementation of “ASEAN Cities Getting to Zeros Project in 2012 to 2016, substantial efforts have been made by ASEAN Member States (AMS) to implement targeted HIV responses and to scale up the implementation of effective prevention, treatment and care services. The project initially started with 13 cities/areas in 8 Member States, and it has now expanded to over 50 cities/areas. There have been outcomes, successes and challenges that will be useful to be shared for cross learning purposes among AMS in efforts to make the HIV responses more effective and efficient.

In preparing for the United Nations High Level Meeting on HIV/AIDS (UN HLM) in New York, from 8-10 June 2016, ATFOA planned to develop an information note with key messages that could be used by participating AMS and local communities in cities/ areas attending the UN HLM, to advocate for a city/ area-based approach or for a regional approach towards attaining the goal. For this purpose, AMS shared the new or updated good practice and lessons learnt, highlighting effective strategies for reaching and delivering quality prevention, treatment and care services to key populations. Based on the compilation and analysis of collected documentation of good practices, an information note with key messages is formulated to be used as discussion points at the United Nations General Assembly HLM.

There are ten (10) good practices from seven (7) AMS that were shared, highlighting outcomes of programme or project implementation and management, challenges, lessons learnt, recommendations –to improve sustainability and key messages. These are as follows:

1. Community-based Peer Provided HIV testing and Counseling - Cambodia
2. HIV & STI Prevention and Care for Gay, MSM and Transgender - Indonesia
3. Optimize Resources for Efficient Harm Reduction Programme in Health Clinic - Malaysia
4. Treatment Adherence Peer Support Programme: a Wise Investment for Sustainable ART Strategy in Malaysia – Malaysia
5. Good HIV Practice: Progress and Plan – Myanmar
6. Strengthening Local HIV and AIDS Response in the Philippines – Philippines
7. Anonymous HIV Testing – Singapore
8. Empowering Female Youths on Sexual Health and HIV/STIs Prevention through Collaborative Friendly Service Networks - Thailand
9. Thailand’s Experience in Adapting and Implementing HIV-Related Stigma& Discrimination Tools
10. Expansion of the Pediatric HIV Disclosure Model in Thailand

Strengthening and scaling up HIV service delivery are the main focus of the good practices documentation. HIV service delivery in efforts to increase coverage, reach and quality of program were designed and implemented mainly for key population (KP): sex workers, MSM, Transgender, and PWID and female youth engaging in sex. The programmes include outreach, HIV/STI education, HIV testing, counselling, peer support, Antiretroviral Therapy (ART), Needle and Syringe Exchange Program (NSEP), Methadone Maintenance Therapy (MMT), condom social marketing and distribution, and

training of health care providers to eliminate stigma and discrimination toward KP. There are some good descriptions on successful programmes as documented by AMS which contributed to the goal of getting to three zeros, such as:

- Increased number of KP being outreached, receiving HIV testing and counselling and ART
- Increased number of new cases detected and declined number in Loss to Follow-Up (LTFU)
- Cost sharing between private providers and government for HIV and STI services
- Increased number of clients enrolled in NSEP
- Integrated Harm Reduction and HIV/STI services in government or private clinics
- Increased the number of PLHIV reached, and supported at all levels of HIV continuum care
- Increased number of government HIV testing and counselling and treatment centers
- Increased number of youth-friendly service centers and condom use among sexually active students
- Increased number of G2Z participating cities (2014-2016): Philippines, Myanmar

## Successful models shared by AMS are:

- Community-based peer provided HIV testing and counselling (Cambodia)
- MSM and TG friendly services in public and private clinics (Indonesia)
- Integrated harm reduction program for PWID in the government health clinic (Malaysia)
- Treatment Adherence Peer Support Program (Malaysia)
- Female youth friendly service (Thailand)
- Measuring HIV-related stigma and discrimination in health care providers (Thailand)
- Pediatric HIV disclosure model (Thailand)

### Implementation and management challenges faced include:

- Slow/ Inadequate/ Lack of Increase in domestic funding for STI and HIV & AIDS services
- Stigma and discrimination towards KP
- Lost-to-follow up for confirmatory testing and enrolment in pre-ART/ ART due to migration, stigma in health setting.
- Inadequate Multi stakeholder coordination and internal coordination within HIV leading Ministries
- Need to level up Human resources' skills in HIV technical programming and management

capacity, strategic information analysis and use for planning and advocacy purposes

### Recommendations to improve sustainability of HIV Responses:

- Improve Resource mobilisation to sustain effective programmes and to integrate HIV services into existing health care system, social protection scheme, community system and increasing domestic funding;
- Strengthen service deliveries (coverage, reach and quality) and scale up effective programmes;
- Continue to provide supportive environment to reduce stigma and discrimination towards KP;

- Enhance multi-sectoral coordination and management capacity;
- Strengthen Community Participation in planning, implementation, monitoring and evaluation of HIV/ AIDS projects, programmes and policies; and
- Promote availability and use of strategic or evidence-based information for planning, advocacy and resource mobilisation for HIV/ AIDS projects, programmes and policies

## KEY MESSAGES

# TOWARDS SUSTAINING HIV AND AIDS EFFECTIVE RESPONSES IN ASEAN

The Heads of States/Governments of the Association of Southeast Asian Nations (ASEAN) made an unprecedented, historical effort in adopting the “ASEAN Declaration of Commitments: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths” at the 19<sup>th</sup> ASEAN Summit in Bali, Indonesia in November 2011. To operationalize the Declaration and deliver concrete results at the community level, the ASEAN with Indonesia as the lead country, implemented the “ASEAN Cities Getting to Zeros Project” after endorsement was given by ASEAN Task Force on AIDS (ATFOA) and by the Senior Officials Meeting on Health Development (SOMHD) in 2012. This project initially started with 13 cities/areas in 8 ASEAN Member States, and it has been expanded to over 50 cities/areas.

The ultimate goal of ASEAN Cities Getting to Zeros Project is the realisation of an ASEAN with Zero New HIV Infections, Zero Discrimination and Zero HIV Related-Deaths by 2015, by:

1. Reducing sexual transmission of HIV by 50%
2. Reducing transmission of HIV among people who inject drugs by 50%
3. Scaling up antiretroviral therapy, care, and support to achieve 80% coverage
4. Eliminating new HIV infections among children and substantially reducing AIDS-related maternal deaths
5. Reducing by 50% tuberculosis death among people living with HIV and AIDS

(Source: ASEAN Declaration at the 19<sup>th</sup> ASEAN Summit in Bali, Indonesia 2012)

To achieve this goal, substantial efforts have been made by ASEAN Member States (AMS) to scale up the implementation of effective prevention, treatment and care services in participating cities/areas. Beside scaling up and strengthening service deliveries (coverage, reach and quality), efforts in improving supportive policy and legal environment, strategic information, multi sector coordination, community participation and sustaining effective programmes have also been conducted by AMS and cities/areas using the Conceptual Framework of ASEAN Cities Getting to Zeros (Source: Concept Paper ASEAN Cities Getting to Zero).

This brief aims to assist participating AMS and Local Communities/Areas/Cities in showcasing and advocating for a city/area-based approach or for a regional approach in scaling up AIDS response.

The following are some important key messages derived from recent collected recommendations of AMS for consideration to strengthen, scale up and sustain the HIV & AIDS responses in the region:

**1. Scaling up and strengthening service deliveries (coverage, reach and quality)**

- Need to invest on increasing human resources' skills and capacity in providing good quality and effective HIV, STI and TB services.
- Innovative approaches/models and various tools need to be developed, piloted and adopted to respond to specific needs of the key population which then can be scaled up upon successful piloting. Some successful models are shared by AMS in 2014 and 2016 for cross learning and experience exchanges.
- National HIV policies and guidelines developed be communicated and implemented at the sub-national and city/township levels.
- Expand HIV services particularly to cities/areas which have: large number of migrants and mobile populations, socio-economic difficulties which increase HIV risk and vulnerability; high communicable diseases burden, including HIV, STIs and TB; and ethnic communities who are known to have higher risk and vulnerability to HIV.
- Continue to improve the accessibility of HIV testing to at-risk or key population which allows for early detection and linkage to care. Private health providers and NGOs/key population communities should be engaged to increase coverage and reach.

**2. Supportive environment to reduce stigma and discrimination**

- Continue to provide supportive environment to reduce stigma and discrimination towards key population: PLHIV, PWID, MSM, Transgender, sex workers, including female youth engaging in sex, to ensure effective HIV responses. Key stakeholders including NGOs and key population be engaged as appropriate in this effort.
- HIV-related stigma and discrimination in health care settings are common even in a country with a mature epidemic and response. Therefore, it requires attention and continuing advocacy efforts, as it exposes a significant obstacle to effective HIV responses.

**3. Strategic information**

- Strengthen the capacity of local government to conduct assessment, analyze and use strategic information in advocating key decision makers to support the local HIV AIDS responses as well as mobilise local resources. Evidence-based approach should be used to drive HIV responses.

**4. Enhancing multi sector coordination**

- Increase ownership and strengthen coordination of multi sectoral HIV responses at National, regional and city/township.
- Strengthen organizational capacity in coordinating multi stakeholders' responses including internal coordination of different departments within leading Ministries.

**5. Strengthening community participation**

- Continue in investing in the roles of key population, community and civil society including faith based organisations and religious leaders to actively engaged in the responses for effective programming and sustainability.

**6. Sustaining effective programmes**

- Integrate and institutionalise HIV and AIDS programme into existing health services, social protection scheme and community system to ensure its sustainability.
- Sustaining political leadership and ownership of HIV programmes at sub-national and local/city/township level, through a continuous advocacy.
- Mobilise domestic financing for scaling up of the project to sustain HIV respond.
- Donors should have clear funding plan, including exit strategies and transition plan to hand over the project and ensuring its sustainability.



# ASEAN CITIES GETTING TO ZEROS PROJECT

Lead by Indonesia, the “ASEAN Cities Getting to Zeros Project” was initiated to operationalise the ASEAN Declaration of Commitment: Getting to Zero New HIV Infection, Zero Discrimination, Zero AIDS-Related Deaths at the community level. This Declaration was adopted by the ASEAN Leaders at the 19<sup>th</sup> ASEAN Summit held in November 2011 in Bali, Indonesia.

The “ASEAN Cities Getting to Zeros Project” was started in 2012 and initially piloted in 13 cities/sites of 8 ASEAN Member States namely:

1. Cambodia: Battambang City
2. Indonesia: Badung, Denpasar and West Jakarta
3. Lao PDR: Hardxayfong District of Vientiane Capital & Saysettha District of Vientiane Capital
4. Malaysia: Historical City of Melaka
5. Myanmar: Mawlamyaing city at Mon State
6. Philippines: Quezon City
7. Thailand: Payao Province & Bangkok
8. Viet Nam: Can Tho City & Danang City

Up to 2015, the project has been expanded to more than 50 areas/cities in ASEAN.

## ASEAN Getting to Zeros Logo



This Logo was created by ASEAN Task Force on AIDS (ATFOA) focal points of Malaysia.

The different parts of the logo signify relevant meanings to the implementation of the Declaration through the Project. These are:

- **RED RIBBON**

*The red ribbon is internationally recognized as a symbol of the struggle around HIV/AIDS. It is a symbol of solidarity and a commitment to the fight against HIV/AIDS. It symbolizes care and concern, hope, and support.*

- ‘O’

ASEAN CITIES aim to achieve the targets:

- ✓ **ZERO** -> **New HIV Infections**
- > **AIDS Related-Deaths**
- > **Discrimination**

This logo was firstly used in the launching of ASEAN Cities Getting to Zero Project in Historical City of Melaka on 5 September 2013 at the Avillion Legacy Hotel, Melaka.



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# REGIONAL COUNTRY HIV PROFILES



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## Southeast Asian Region

### HIV Epidemic

There are approximately 1.7 million people living with HIV (PLHIV) in the ASEAN region of which close to a third are female. Of the total number of people living with HIV, at least 46% are adults who are eligible for antiretroviral therapy (ART) and of which just fewer than 60% are receiving ART. HIV is largely concentrated among key populations (KP), especially, though not exclusively, in large cities and urban areas. The fastest growing epidemics are among MSM and transgender.

The steady decline in HIV prevalence among female sex workers (FSW) is one of the great success stories of the HIV response in the ASEAN region. However, the burden of HIV infection among sex workers is disproportionately high relative to the general population in AMS. People who inject drugs (PWID) continue to be at high risk of contracting HIV but the introduction interventions listed in comprehensive package for the prevention, treatment and care of HIV among injecting drug users, in the *“WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users”* in a number of AMS, especially Indonesia and Malaysia, Viet Nam and Myanmar have significantly impacted on prevalence in this population.

### Getting to Zeros

The 2011 UN Political Declaration on HIV and AIDS called on member nations to intensify efforts to eliminate HIV and AIDS and focussing the efforts on prevention, treatment and care for key populations. Increasingly, AMS have recognised that KP need to be the primary targets of prevention efforts and ensure their access to prevention and treatment to achieve global targets. Getting to Zeros aimed to advance global progress in achieving ambitious country-set targets for universal access to HIV prevention, treatment, care and support, halting the spread of HIV and contributing to the achievement of Millennium Development Goals by 2015 and Target of 90-90-90 by 2020.

Overall, there has been significant progress across ASEAN in reaching the global targets. This has included collaboration by eight AMS in the ASEAN Cities Getting to Zero Project. Nonetheless, there are ongoing challenges in taking evidence-based programmes to scale, especially those programmes prioritising KP. At the regional level, there is a good understanding of what is needed to end HIV by 2030. However, at the individual AMS level, the capacity to scale up programmes varies significantly. While this is partly to do with resource allocation, it is also about leadership, increasing levels of community and stakeholders' engagement, decentralising HIV treatment and care, and focussing efforts where they are most needed.

### Challenges and Opportunities, and beyond 2015

All AMS face varying challenges in ensuring that KP do not experience stigma and discrimination that impact on their access to prevention and treatment services. There are common themes and issues in the reporting by AMS on their HIV responses, particularly around ART coverage, prevention for KP and financing the response. It is important that AMS take the opportunity to shape the regional programme so that in reflecting the new global targets, it does so in ways which best support and enable AMS to expand and consolidate their HIV responses.

Critical to achieving the global targets are well resourced and targeted HIV responses. To this end, AMS have been encouraged to develop investment cases which examine how countries can resource and finance their HIV responses, especially as international funding is reduced, and where best to target resources for the most impact. To date, five AMS have developed investment cases – Viet Nam, Indonesia, Myanmar, Philippines and Thailand. Regional Framework for Action on HIV & AIDS beyond 2015 has been endorsed to achieve universal access to HIV prevention, treatment, care and support in Asia and the Pacific.



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## Brunei Darussalam

### HIV Epidemic and Getting to Zeros National Response

The prevalence of HIV in Brunei Darussalam is very low, with just 93 reported cases from 1986 to the end of 2013. Between 2011 and 2014, 45 new cases of HIV were recorded. In 2014, there were 15 HIV confirmed cases, 40% of cases were reported in MSM. There is no known transmission through sharing of injecting equipment and only one case of mother-to-child transmission recorded in 2011. Despite the low HIV prevalence, an increase in STI has occurred over the past decade.

Self-supported, free and comprehensive health care, including HIV prevention, care, treatment and support is available to all citizens and permanent residents. First line ARV are available and provided through a specialist clinic. HIV is a notifiable disease and it is compulsory for all clinicians to report any positive cases to the Department of Health Services. HIV surveillance is conducted through routine screenings.

#### Gaps and Challenges, Strengths and Opportunities

There is no behavioural or prevalence data available in relation to general population or key populations. There is a lack of prevention and treatment services targeting KP, particularly MSM and TG. Current laws prohibiting homosexual acts and cross-dressing make these groups difficult to target. Although there is a gradual increase over time in the number of new diagnosis each year, the availability of ART for PLHIV can significantly contribute to viral suppression, especially if the country adopts the most recent WHO guidelines on ART provision.



## Cambodia

### HIV Epidemic and Getting to Zeros National Response

In 2014 there were an estimated 694 new adult infections and 156 children (0-14yrs). Sexual transmission is the primary mode of transmission, with around 48% of all new infections resulting from spousal transmission, 25% through sex work, and a further 11% from 'casual sex'. Sexual transmission among MSM is estimated to account for 3% of new infections and injecting 13%. HIV prevalence among the general population has been steadily declining over the past decade. The 2015 GARPR notes the high HIV prevalence 24.4% among PWID.

To respond to HIV prevalence among PWID, Cambodia has just developed National Harm Reduction Strategy and have completed the implementation of its 3<sup>rd</sup> NSP (2011-2015) aimed to provide a 'synergistic and comprehensive approach' to KP prevention and care through continuum of prevention to care and treatment. This approach aims to identify newly diagnosed PLHIV to ensure they are brought into, and retained in treatment, through targeting areas where new infections are occurring among KP.

#### Gaps and Challenges, Strengths and Opportunities

Cambodia faces a number of challenges over the next five years in relation to securing funding and ensuring the effective and efficient use of resources. Despite the increase of ART coverage in 2014, all health facilities dispensing ART experienced a stock-out of at least one required ART. Drop out occurs at every point of the cascade of prevention, diagnosis, treatment and care and there is a lack of strategic information to record both the number of people diagnosed and level of drop out. The percentage of referral cases for both TB and HIV has increased gradually, however, the proportion of HIV+ incident TB cases receiving treatment for both HIV and TB decreased significantly from 57.2% in 2014 to 23.6% in 2015.

Cambodia is developing its NSP for the period 2015-2020 in the context of the vision of the Three Zeros. One of the strengths of the Cambodian response is the recognition of the need to target and adapt responses to the changing epidemic and resource environment.



## Indonesia

### HIV Epidemic and Getting to Zeros National Response

Overall, HIV prevalence in Indonesia is low and vary across the archipelago. Epidemics in Indonesia tend to be concentrated among KP, with transmission routes a mix of sexual and injecting. While the general population prevalence overall is low, the prevalence in Papua is 2.4% and the primary mode is now sexual transmission. Recent data suggests HIV transmission may be slowing but continues to expand among some KP, particularly, MSM.

IBBS data (2013) suggests that progress has been made in stabilising sub-epidemics in some KP and in the general population in Papua. Some success has also been made in increasing ART coverage, but continues to fall short of the annual number of new infections. There are also insufficient ART retention rates, and as a consequence the potential impact of ART on prevention and mortality is limited. The Indonesia investment case (2015) shows that if the highest



level of investment were to be adopted, Indonesia could achieve substantial impact on its epidemic, however, it cannot end HIV by 2030.

### **Gaps and Challenges, Strengths and Opportunities**

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

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



Lao PDR

### **HIV Epidemic and Getting to Zeros National Response**

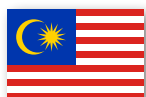
Lao PDR has a very low prevalence of HIV among the general population at 0.29% but shows an increasing trend from 0.16% in 2003 to 0.29% in 2014. This trend may reflect a rise in cross border migration, especially given there is higher HIV prevalence in nearby countries. It is estimated that there are 200,000 migrant workers, primarily in the construction industry. Sex is the primary mode of transmission and heterosexual contact accounted for the majority, 88% of transmissions between 1990-2014. The second most common mode of transmission is mother to child, 4.9%, followed by MSM 1.6%, injecting drug users 1.5%, and sex workers 1.4%.

The National Strategic and Action Plan (NSAP) 2011-2015, outlines a goal to maintain the present low level of GP prevalence below 1% and among KP is below 5% by 2015, a goal that has already been achieved. For the next NSAP, the aim is to reduce KP prevalence to below 3%. To achieve a decrease in HIV prevalence in KP, a number of strategies have been implemented including a successful condom social marketing, harm reduction, PMTCT and increase HIV testing and ART coverage.

### **Gaps and Challenges, Strengths and Opportunities**

The national HIV programme still falls short on several of its targets, with concerns that in the care and treatment cascade there is a significant loss to follow up. Testing rates for KPs need to be increased. It has been identified that there is a need to streamline and make services more accessible, improve technical and organisational capacity, create demand for testing among KP and promote ART adherence.

Funding for the HIV response in Lao PDR is 80% from international sources and 20% from public sources. The shift in the economy to lower middle-income country opens up the capacity to draw on more domestic funding to maintain some of the achievements around reducing prevalence in KP.



Malaysia

### **HIV Epidemic and Getting to Zeros National Response**

There has been a shift in transmission route trend overtime from injecting to sexual transmission. Overall, the epidemic is concentrated among key populations: PWID, sex workers, transgender and MSM. With the exception of MSM, prevalence appears to be declining among KP. In 2013, ART coverage was 47% of the 37,274 who were eligible. Although there is a significant gap in coverage, the retention rate at 12 months is strong at 95.1%.

NSEP and MMT are the cornerstone programme for PWID and have been undertaken in collaboration with NGOs. The harm reduction programme also offers HIV counselling and testing, job placements and drug rehabilitation. Of Malaysia's expenditure on HIV, 95% was through government funding with 66% spent on care and treatment.

### **Gaps and Challenges, Strengths and Opportunities**

A number of on going challenges have been identified, include addressing low knowledge levels among young people, and the need for an increased health workforce to scale up of testing and treatment including OST. Greater investment will be required to improve coverage and integration of HTC, PMTCT, ART, TB and sexual and reproductive health. There is a lack of HIV prevention programmes and implementing partners to address sexual transmission in the MSM population.

Malaysia is well placed to continue to strengthen the relationship between government and civil society and mobilise the same energy, policy shift, involvement of religious and political leaders that has occurred in relation to PWID to other KP and issues of sex and sexuality. On HIV financing, 95% of HIV's expenditure was covered through public funding.





## Myanmar

### HIV Epidemic and Getting to Zeros National Response

HIV is concentrated among MSM, PWID and FSW, with a general population prevalence of 0.54% in 2014. Unsafe injecting practices remain the primary mode of transmission, but there is also significant number of infections through heterosexual and MSM. Low risk women make up a high proportion of new infections through heterosexual sex, as a result of sex with husbands and regular partners where condom use is low.

HIV is priority disease in the current National Health Plan (2011-2015) and legal framework has been reviewed to reduce stigma and discrimination and operationalize NSP. Domestic contribution of US\$1 million was provided for MMT in 2015, and an additional US\$5 million was allocated for ART in 2015. Treatment services are decentralized in efforts to reduce cost and promote the normalisation of HIV disease. A consultative process with stakeholders including NGOs has been initiated to create a legal framework to support harm reduction.

#### Gaps and Challenges, Strengths and Opportunities

Prevention needs to focus on clients of sex workers and increase coverage for MSM and PWID. Stronger political commitment will be required to achieve legal reform. Identified priority areas include eliminating stigma and discrimination, scaling-up prevention services, early HIV testing and enrolment in ART, developing user-friendly services for MSM, strengthening the role of CSOs and HIV monitoring and evaluation system.

Myanmar's response to the HIV epidemic demonstrates the Government's commitment to creating an enabling environment. There is an increasing level of involvement of civil society and representation of PLHIV group. Surveillance systems are in place and bio-behavioral surveys among KP have been conducted. As HIV funding is mainly from international sources, the Government has developed a financial transition plan in 2015-2016 to ensure sustainable national HIV response.



## Philippines

### HIV Epidemic and Getting to Zeros National Response

The Philippines has a concentrated and rapidly growing epidemic among MSM and PWID, particularly in urban areas. General population prevalence is low and estimated to be 0.051%. The rapid spread of HIV infections among key populations is primarily due to the sharing of needles in PWID and unprotected sex in MSM and FSW and their clients. With regards to MSM, the data monitored since 2005 shows an upward trend nationally.

While ART coverage is improving, it remains low. Retention at 12 months is 86.0%. The ASEAN Getting to Zeros Project has been rolled out in 33 sites in the Philippines. The key achievements of the project have been to get Local Government Units (LGU) to assess their existing HIV response, provide an evidence base for planning and opportunities for the sharing of good practices among LGUs, and strengthen or reactivate local AIDS coordinating councils.

#### Gaps and Challenges, Strengths and Opportunities

The upward trend in PWID and MSM threatens the Philippines capacity to achieve the Three Zeros. There are challenges around the scale up of PMTCT; it is integrated in the health system but only in high burden sites of Manila and Cebu. There are continuing challenges around prevention among KP particularly PWID and MSM and low testing rates and late diagnosis. The Philippines has no NESP or OST programmes at present for PWID.

The Philippines National AIDS Council (PNAC) is proactive in many areas. All regional health offices have been instructed to prioritise HIV. With the support of Global Fund, the new project, started in 2015, focuses on prevention in PWID and MSM communities. The Department of Health (DOH) is moving toward fully covering the cost of ART, however, the Global Fund is the biggest external contributor.



## Singapore

### HIV Epidemic and Getting to Zeros National Response

Singapore continues to have a low level epidemic. Prevalence among the general population in 2014 was 0.15%. The primary mode of transmission is sexual contact with 59% of the total diagnosed cases attributed to heterosexual transmission and 35% to homosexual and bisexual transmission. Strict drug laws contribute to a low level of HIV transmission attributed to injecting drug users. HIV prevalence in MSM and sex workers was 3% and 0% respectively in 2014.

The National HIV/AIDS control programme adopts a multi-sectoral approach which comprises public education and education of KP, HIV testing and counselling, protection of the blood supply, management of PLHIV, HIV surveillance and supporting legislation. The National HIV Policy Committee is a high level ministerial-chaired platform which sets

the general direction for HIV management. The National AIDS Control Programme, under the MOH, actively involve Government agencies, community and private sectors.

### **Gaps and Challenges, Strengths and Opportunities**

Ongoing efforts are being made to address HIV-related stigma in the workplace and there is a strong focus on reducing the proportion of late stage diagnosis by continuing to promote testing especially among high risk heterosexual men and MSM.

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



Thailand

### **HIV Epidemic and Getting to Zeros National Response**

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

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

### **Gaps and Challenges, Strengths and Opportunities**

Non-discrimination, promoting human rights and gender equality remain a priority of HIV response. Nonetheless challenges remain including a lack of coordination around implementation to achieve targets such as the elimination of gender inequality, 50% reduction in discrimination and the expansion of the protective social and legal environment essential for HIV prevention and care.

Beside the 100% CUP, another potential strength of the Thailand approach to HIV is the setting of bold targets in conjunction with policy and programme initiatives that are designed to align with these goals. Thailand financed 89% of the total HIV expenditure through domestic funds in 2013, which is an increase from 85% in 2010. Closing the AIDS resource gaps for prevention services among KP, in particular for community based service delivery in priority provinces, is a national priority.



Viet Nam

### **HIV Epidemic and Getting to Zeros National Response**

The HIV epidemic in Viet Nam is concentrated in KP, and primarily affects PWID and their female partners, MSM and FSW. Injecting accounts for a total of 45% of new infections. Prevalence in 2013 was PWID 10.3%, FSW 2.5%, MSM 3.7%, with the epidemic mostly concentrated in urban areas and the mountainous Northern provinces.

Targets have been established in the National Strategy on HIV/AIDS Prevention and Control until 2020. A recent evaluation estimated that nearly 31,000 infections had been averted and 16,000 life years saved through the harm reduction strategies. However, in some provinces where free needles and syringes are available the HIV incidence is still high. Opiate substitution therapy has been associated with a 54% reduction in risk of HIV infection in PWID.

### **Gaps and Challenges, Strengths and Opportunities**

Current challenges include condom programmes for PWID and MSM, the level of testing among KP, late initiation of ART, and stigma and discrimination from health staff to KP. Positive prevention and outreach for wives/sexual partners of PWID are also identified needs. A key challenge is the need to significantly increase domestic spending for sustainable financing for HIV/AIDS prevention and control until 2020.

The MOH has developed an HIV investment case in consultation with stakeholders to provide a picture of the epidemic, future impact of proposed policy, coverage levels and size of investment required. Project on Sustainable Financing for HIV/AIDS Prevention and Control Activities in 2013-2020 Period has been endorsed by the Prime Minister with objective to use domestic resources for 50% of total spending prevention and treatment by 2015 and for 75% of total spending by 2020.

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# GOOD ARTICLES ON HIV AND AIDS RESPONSE IN ASEAN

## Community-based Peer Provided HIV Testing and Counseling - to Improve New Cases Detection Amongst Key Population, Cambodia

### Introduction to Practice

This Community-based Peer Provided HIV Testing and Counseling has been implemented at six priority cities of six provinces, where there is a report of high HIV burden and where there is a concentration of key populations. Those cities included Battambang, Pursat, Banteay Mean Chey, Siem Reap, Kampong Cham and Phnom Penh. The project has been implemented in midst 2013 to September 2015, funded by the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the USAID through HIV/AIDS Flagship project, managed by KHANA.



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Community – based peer provided HIV testing and counseling, known as “finger prick testing” in Cambodia, aims to increase the demand and uptake of HIV testing and counseling (HTC), reduce behaviors that put people at higher risk of HIV, strengthen enrolment for those who need it into health services and minimize loss-to-follow-up among members of key populations. As part of the core service package of Cambodia’s national “boosted” continuum of prevention, care and treatment, finger prick testing is delivered through existing outreach programmes for HIV prevention that target key populations and implemented by peers of the targeted key population who are trained on HIV community outreach and prevention education, pre- and post- HIV test counseling, as well as conducting HIV rapid testing using the finger-prick method.

This approach is implemented at “hot spot” locations where members of the targeted population work or congregate.

### How It Works

KHANA, working closely with the National Center for HIV/AIDS, Dermatology and STI Control (NCHADS) and in partnership with FHI360, began the implementation of a finger-prick testing approach for key population through its network of community-based and partner organizations in April 2013. Representatives of these key populations – men who have sex with men (MSM), transgender people (TG), female sex worker/entertainment workers (FSWs/EWs) and people who use/inject drugs (PWUD/PWID) were trained as Lay Counselors who provide on-the-spot counseling and finger-prick HIV testing. From April 2013 to September 2014, 643 peer outreach workers had been trained and provided voluntary confidential counseling and testing (VCCT) to their peers on a regular basis.

### Outcomes

- The proportion of people reached who accept finger prick between the three years increased from 34% to 53% to 75% and the number of KPs tested doubled.
- There was no significant change in overall yield which has held at 0.3% confirmed positive – but those who found HIV positive are in high CD4 count (419.3 cells/mm<sup>3</sup> average).
- There were 9.6% false positives in 2014/15 due to better tracking between finger prick and confirmatory testing and quality of testing.
- Number of new cases detected annually has doubled since 2012 and 2013 from 29 to 62 in 2013 and 14 and 59 in 2014 and 2015

- On ART proportions are declining, going from 48%, 47% to 44%. This needs more focus especially when they shift to test and treat.
- Loss to Follow-Up (LTFU): There is a decline in LTFU from 38% to 26% to 16% with improved tracking of transferred out and those who died.

### Challenges and How to Manage

- Lack of client confidentiality because of limitation of resources – as action of next step we have modified the HIV testing kit to smaller and manageable, which outreach worker/lay counsellor can bring along with them during the outreach and can perform finger-prick-HIV testing.
- Low capacity of lay counsellors affects quality of testing and counselling – thus the follow up for mentoring and coaching; QA/QC framework/systems and refresher training are required. The HIV Rapid Tests Quality Assurance Project aimed to measure and sustain improvements in the overall quality and accuracy of RDT results performed in selected HTC sites and Community Based testing settings has been conducted since April 2016.
- Unable to reach highest risk individuals through venue-based outreach approach. Thus, as the follow up action, mHealth tools have been initiated since last year to support in reaching out those people. Risk screening tools, which can assess the level of risk of those people, are also in use since March last year and this tool has help minimizing test for all, resulting of low yield.
- Lost-to-follow up for confirmatory testing and enrolment in pre-ART/ART due to migration, stigma in health setting. Again, as follow up action we join with the NCHADS in implementing the Boosted Integrated Active Case



Management (B-IACM), where the peer outreach workers/Community Case Managers are based at the VCCT to support the linkage between community and health facility for both confirming the testing as well as enrolling in HIV care and treatment.

- High turn-over of outreach workers/lay counsellors- as action of follow up we will need to reselect the outreach workers, train and provide incentives so they can continue performing their job.

### Lessons Learnt

- Community-based Peer Provided HIV Testing and Counseling using finger prick testing is an effective approach in normalizing HIV and increasing demand for and uptake of HTC among key populations.

- Community-based Peer Provided HIV Testing and Counseling Using finger prick testing is an effective entry point into the continuum of care, increasing the efficacy of utilizing Treatment as Prevention.

### Recommendation for Sustainability

- Test and treat should be implemented within the HIV high burden cities and where HIV epidemic is concentrated.
- Use proven technology innovation to reach those at high risk and hard to reach such as the PrEP (Pre-Exposure Prophylaxis) for MSM.
- Initiate the community based ART delivery, where community volunteers continue to play their roles in addition to HIV testing but to deliver the ARV for those who are stable and or in HIV treatment over three years.

- Continue investing in the roles of community and civil society for ending AIDS by 2030.
- Mobilize domestic financing to sustain HIV response and for ending AIDS.

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## HIV and STI Prevention and Care for Gay, MSM and Transgender in Greater Jakarta Area, Indonesia

### Introduction to Practice

While HIV prevalence in Indonesia is now on the decline among some key affected populations, it is rising among MSM. An Integrated Bio-Behavioural Survey (IBBS) in 2013 revealed that HIV prevalence among MSM increasing from 7.0% in 2009 to 12.8% in 2013, and declining among waria, from 9.2% in 2009 to 7.4% in 2013. In 2009, the National AIDS Commission (KPAN) supported by the Australian Agency for International Development (AusAID), developed a comprehensive National Action Plan for the prevention of HIV and AIDS among gays, waria (transgender, TG), and MSM. The project focused in 10 cities for the period 2010-2015 and continued until 2019. The project is now being scaled up into 38 cities for the period of 2016-2017, supported by the GFATM, through the New Funding Model (NFM) mechanism.

The goal of the project was to propose effective, evidence-based and scalable interventions that will address the barriers that MSM and

TG currently face in accessing HIV prevention, treatment, care and support services. The objectives were to develop one-stop comprehensive, affordable, well equipped, and friendly services for MSM and TG and mobilize resources and collaboration to replicate successful models developed by several public and private clinics. The project is being implemented through multi-sectoral collaboration among KPAN members, the Ministry of Health (MOH), National Network of Gay, Waria/TG and MSM Indonesia (GWL INA), and Puskesmas, Private Clinic, including local non-governmental organisations (NGOs).

### How It Works

GWL INA involved in planning and program development, responsible for managing outreach through face-to-face peer educator activities and social media approaches, and organized STI and organize HIV and GWL's health training. All clinic staff have received HIV clinical training

from the Ministry of Health, the district health authority, FHI360 and NGO partners. In addition to that, all clinic staff of MOH have been sensitized on MSM and TG issues. By December 2015, key personnel of 54 public health services and 4 private clinics in 10 cities have been trained.

Two health providers involved were PKM Pasar Rebo and Ruang Carlo, a private clinic. PKM Pasar Rebo provides STI and HIV services, located in a suburb on the southeastern edge of Jakarta. Clients include sex workers and their clients, MSM, and waria/TG. Offers STI testing and treatment and HIV testing. Ruang Carlo is a stand-alone HIV clinic embedded within a large private hospital in Jakarta. Offers STI and HIV testing and treatment services, including ART. Clients are predominantly MSM. Aspects monitored and evaluated in this project included: number of GWL outreached, referred to the clinics, counseled and tested, referred to Hospital for ART (in

case of PKM), receiving ART (Carlo) and psychologically and socially supported through peer group mechanism.

## Outcomes

### Effectiveness

- Patients served: PKM: a total of 3,083 visits to the VCT clinic were recorded in 2014, an average of 10-15 patients every day; with total 2168 of new clients in the last 12 months. Some 60% of the clients are male and around 55% are MSM and TG. The private clinic, Ruang Carlo recorded 10,768 visits in 2014, an average of 36 patients every day, with total of 2,520 new clients in the last 12 months.
- Counseling and Testing: PKM: in 2014, 3007 HIV counseling and testing sessions were conducted. There were 163 positive test results (5.4%); more than 85% of those positive were MSM or TG. Ruang Carlo: a total of 2,796 HIV tests were offered and there was a 100% acceptance rate. There were 22.5% positive test results and 86% of those who were diagnosed positive were linked to treatment.

### Ethical Soundness

- Both clinics equipped with counseling rooms and treatment rooms to assure some privacy and anonymity and provide a friendly, non-judgmental service to all clients.

### Cost Effectiveness

- Operational costs, including reagents, drugs and staff, are covered by the PKM/ Government.

- Ruang Carlo: the clinic operates on a cost-sharing basis between the hospital, NGO (YKS) and the government.

## Challenges and How to Manage

With the anticipated challenges of continuing MSM and TG as the main drivers of HIV epidemic, a study on effectivity of the project has been done in 2015 aimed to review the implementation of the models of existing GWL projects and developing recommendations to improve the quality of the next GWL programming in 2016-2017. In addition to that, a challenge to increase domestic funding, will be done through advocating HIV/AIDS to policy makers in the context of planning and budgeting for sustainability of prevention, treatment and support, particularly for key population. Public-private partnership for HIV prevention, treatment and support will also be explored and advocated through on-going dialogues with existing Private Sector networks by involvement of key population network organisations.

### Lessons Learnt

- Any service provider can increase its chances of sustainability by providing a quality service that is in high demand.
- MSM-friendly services can be delivered through generalised settings such as puskesmas; the key is the attitude of the health care providers and support from the top level management of the clinics. This will become more important as ART is more widely decentralised to the primary health care level.
- The clinics received new patients from NGO outreach activities or

social media and also church social institution. Resource mobilization to fund and support prevention programme for key population, is therefore very critical for sustainability of HIV health services.

## Recommendation for Sustainability

- HIV and AIDS health service delivery model can be sustained with continued financial support for the national response, supportive political climate, leadership of Mayor and Clinic/ PKM Top-level Managers, and contribution of private sectors, NGOs and communities.
- Being an integral part of a larger, established institution, both in private or public, may contribute to long-term sustainability as the institution mitigates against risks such as staffing shortages and fluctuations in funding.

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## KEY MESSAGES:

Several key messages can be outlined from the project:

- HIV and AIDS prevention, treatment, care and support need to be integrated in health services, social protection scheme and community system to ensure its sustainability.
- Continuing leadership and commitment of Mayor/Vice Mayor, High Level Management of Health Service Providers, both public or private, and community and faith-based organisations' leaders need to be pursued and advocated to mobilize resources for sustainability of HIV responses.
- Need to continue desensitizing health care workers on the key population issues related to their sexual health, STI and HIV to eliminate stigma and discrimination toward PLHIV, MSM, TG and other key population that can be a barrier for effective HIV response.

# Optimize Resources for Efficient Harm Reduction Programme Kuala Sungai Baru Health Clinic Model, Malaysia

## Introduction to Practice

Kuala Sungai Baru health clinic is situated in Melaka approximately 120km down south Kuala Lumpur. Serving an estimated population of 20,000, this clinic provides integrated health and medical services covering outpatient, Mother and Child Health Clinic services, Needle syringe exchange and Oral substitution therapy programme.



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As of end 2015, a total of 128 new HIV cases were reported in Melaka out of which 30% were among PWID. Kuala Sungai Baru being one of the hot spot of PWID has initiated needle syringe exchange programme (NSEP) and Oral substitution therapy (OST) since 2011. However, the uptake of the programmes is not encouraging. To improve uptake, a new concept of combining outreach programme by non-government organization (NGO) and linking them to various prevention and health care services including HIV care was planned in early 2015 and adopted for implementation in July 2015. The main objective of this initiative is to assist country in accelerating the MDG target which is to halt and reverse the epidemic of HIV through creating awareness among people who inject drugs (PWID) about HIV, its



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mode of transmission and prevention, participating in harm reduction services (NSEP and Methadone Maintenance Treatment-MMT), and providing screening services as well as linking to care for HIV and other related diseases.

The main component of this project is a group of outreach volunteer who were selected among ex-PWID users who were currently on MMT. The selection was based on crucial criteria among others are good adherence to MMT and good integrity. All outreach workers are equipped with good knowledge on HIV, MMT and communication skills in order to influence PWID to opt for harm reduction.



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## How It Works

Being ex-PWID is a strong point in assuring the success of the project since they are well verse with the community reached. The new concept requires strong collaboration between local NGO and the health clinic. These outreach volunteers will map and assess the PWID location and needs in the local context. In addition, they serve as bridge between the community and health care provider. Facilitated by appointed paramedic in the health clinic, the outreach volunteers will carry out their job scope as below:

- To educate PWID clients on knowledge of HIV and harm reduction programme specifically on NSEP and MMT.
- To encourage PWID clients to change from NSEP to MMT.
- To refer PWID clients to harm reduction programme, HIV screening and other health services in the health clinic.

- To give PWID clients for psychosocial support.
- To assess the client general health and refer them to the health clinic for further management.
- To submit monthly report on programme performance to District Health Office.



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## Outcomes

- The services provided by the outreach workers were psychosocial support, educations on harm reduction and HIV & AIDS and referral support to clinic.
- A total of 160 clients were enrolled in NSEP starting from July 2015 until February 2016 as compared to none before this programme implementation, 65 clients referred and enrolled in MMT programme; out of which 66.2% were enrolled in Melaka Tengah health clinic, 29.2% were enrolled in Kuala Sungai Baru health clinic, and 4.6% in the other health clinics as requested by the PWID clients.
- From 160 clients referred for NSEP, 102 PWID clients were referred and screened for HIV and other related diseases at the health care facilities. A total of five (5) PWID clients were found positive for HIV and knew their results. While four (4) were



positive for Tuberculosis. All nine of them were enrolled into HIV and Tuberculosis care and treatment.

- Since the positive impact shown by the programme, there will be 12 NGO throughout nation will be embarking this programme for 2016.

### Challenges and How to Manage

Over eight (8) months durations, a total of 203 clients were reached during outreach. There are some of PWID client were unable to be reached. Some of them were unaware that harm reduction services being provided at the clinic whereas some other still have doubt in getting the services at the clinic, fearing they will be detained. The availability of outreach workers in health clinic provide a good opportunity to approach these PWID through outreach activities and provide accurate information on harm reduction program as well as facilitating them during the services at the clinic. Community leader and health care providers also play a role in delivering the right message about the program and allow them to come voluntarily to the clinic for services. Advocacy and ongoing collaboration among stakeholders will need to be

strengthened to ensure that services can be provided to PWID in need. In addition to that, adequate working space, regular training, regular supervision from dedicated health care worker and proper human resource management were some of issues that need attention.

### Lessons Learnt

Although these outreach volunteer are health care services illiterate, but they are committed in helping PWID community in curbing HIV and changing PWID behavior. The implementation of programme by the NGO is carefully monitored and in line with the government aspiration. With respect to resource need, having NGO working from health clinic will save a substantial amount of overhead need (utility and office rental) to run the programme compared with implementation outside the health clinic. The harm reduction programme uptake will be increase and better linkages to various health services provided by the government.

### Recommendation for Sustainability

- The outreach workers based in the health care facility is the

way forward in attracting the PWID clients to harm reduction programme and ultimately linking them into health care services. Therefore, enduring partnership between the NGO and health care facility is crucial in sustaining the programme.

- All the constraints in implementing this programme should also be noted to ensure the continuity of this programme. Human resources technical and managerial capacity, regular supervision to ensure program quality and adequate working space are important aspects for the project's success.

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### KEY MESSAGES:

Partnership between Government and NGO has successfully shown good outcome in attracting the PWID clients towards harm reduction programme as compared to programme run solely by the health clinic. This leads to a huge reduction in the missing link between the PWID clients and the health care services. However, continuous training and supervision are needed for up-scaling and the success of the programme.

## Treatment Adherence Peer Support Programme: A wise Investment for Sustainable ART Strategy in Malaysia

### Introduction to Practice

Treatment policy reaffirmed the MOH's commitment as the lead actor in the national response to HIV. Having its sight set on halting and reversing the epidemic, supported by intensified targeted prevention

strategies that offer high-impact interventions, treatment was at the heart of national response. Treatment was provided at no cost to facilitate and enhance access to HIV treatment especially among the key populations including those in incarcerated settings. Gradually ART availability

was expanded to all government hospitals and health clinics. Soon the number of patients received at the government healthcare facilities increased as the availability and accessibility of ART expanded rapidly in the country. The patient load reached a level that was high



enough to challenge the capacity of human resource in the government healthcare sector.

Owing to its distinctive ability to anticipate the dynamics and evolving environment impacting its response, the MOH was quick to identify the urgent need for complementing approaches to support better ART delivery, retention in care and adherence to treatment for a sustainable ART strategy. There are gaps with regards to the delivery of care and support among the PLHIVs as the healthcare workers strived to spend sufficient amount of time with their patients to provide information, emotional and psychosocial support that are often cited as integral part in determining successful treatment outcome among patients. The situation raised concerns if gaps in care and support services would undermine the potential benefits of ART. To address this issue, the MOH introduced the Treatment Adherence Peer Support programme (TAPS) in partnership with the Malaysian AIDS Council. TAPS was previously known as Hospital Peer Support Programme until it was rebranded in 2014 as a new edge innovative approach.

### How It Works

In TAPS programme, peer support is provided by trained peer workers who themselves are PLHIV adhering to treatment. Peers whom are viewed as credible because of their life experiences that are similar to those encountered by the PLHIV are engaged to provide informal counseling and social support, serve as a role model to help clients adhere to ART, provide practical tips for managing ART and adherence, basic information about HIV/AIDS and safe sex, help clients navigate

the health system, and facilitate communication with other related service providers. The peers provide PLHIV with personalized information and emotional support, helping them integrate adherence into their life situations. They are based in hospitals to assist the healthcare workers in providing services and support to PLHIV for improved treatment outcome.

### Outcomes

In year 2015, TAPS reached out 5,397 clients living with HIV in 32 treatment centers through 12 partner organisations. This has shown an increase compared in 2014 where the clients reached were 4,924 in 24 centers involving 10 partner organisations.

### Challenges and How to Manage

The challenges faced by clients and peer support personnel were:

- Clients: unclear understanding of programme especially among the new clients, concern of being judge, lack of support from family members/caregivers and poverty.
- Peer support personnel: difficulties in dealing with other agencies especially new rope in agencies, conflict between supporters and family members/caregivers.

Efforts have been done to address these issues, such as promotion of TASP, regular monitoring and ongoing training of the peer support personnel to better improve the outcomes of the programme.

### Lessons Learnt

Although the peer support personnel are PLHIV who are compliance to

ART, they are committed in helping other PLHIV to engage at all levels of HIV care continuum. It ultimately helps in increasing the treatment adherence, reducing the client's viral load and reducing the risk for viral transmission. The implementation of programme by the NGO is carefully monitored and in line with the government aspiration. With respect to resource need, it will save the government for treatment resistant and increasing the national income. Regular monitoring and ongoing training of the peer support personnel and promotion of the programme must be regularly conducted to all PLHIV clients and related agencies.

### Recommendation for Sustainability

The Treatment Adherence Support Program is the way forward in attracting the PLHIV clients to treatment strategy and ultimately reducing morbidity and mortality. Therefore, enduring partnership between the NGO and health care facility and addressing all constraints in implementing TASP are crucial in scaling up and sustaining this programme .

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### KEY MESSAGES:

The TASP is the way forward in attracting the PLHIV clients to treatment strategy. It ultimately reduces the morbidity and mortality among PLHIV. This leads to a huge increase in the economic growth for the nation as PLHIV are able to work and generate their own income. However, continuous training and programme promotion to clients as well as other related agencies are needed for up-scaling and the success of the programme.

# Good Practices of the Myanmar National AIDS Programme Responding to ASEAN Cities Getting to Zero Initiative: Progress and Planning

## Overview of the current HIV situation

The Myanmar Global AIDS Response Progress Report (GARPR) 2016, reported that HIV prevalence among the general adult population in Myanmar is estimated at 0.6% in 2015. It estimates 11,000 new infections occurred in 2015 and nearly 9,700 people died from HIV related illnesses. The epidemic remains concentrated among key populations; female sex workers (FSW), men who have sex with men (MSM), and people who inject drugs (PWID). The report suggests that the prevalence remains high for PWID 28.3%, however among FSWs 14.6% in 2015, and among MSM is 11.6% in 2015. There are approximately 225,000 people living with HIV (PLHIV) of which 34% of them were females. The primary mode of transmission of new infections is through sharing contaminated needles (mainly male-male), followed by the transmission through sexual contacts including both male-male and heterosexual sex.



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Key factors that make the country more vulnerable to the HIV epidemic includes the larger size of key populations, high prevalence of risk behaviour, limited coverage of effective prevention and treatment programmes, high prevalence of tuberculosis and syphilis, HIV related stigma and discrimination, population mobility and poverty. Due to this recognized severe epidemic, Myanmar has been identified as a 'UNAIDS Fast Track Country' under the Joint United Nations Program on HIV/AIDS (UNAIDS) Strategy for 2016-2021 'On the Fast Track to End

AIDS', with an aim to end the AIDS epidemic by 2030 with "Zero new infections, Zero discrimination and Zero AIDS related deaths".



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## Progress and Challenges in Mawlamyine, Myanmar Getting to Zero Initiative City

Mawlamyine was selected as the first city in Myanmar to be included in the 'ASEAN Cities Getting to Zero Initiative' in 2013, due to its HIV prevalence higher than national prevalence. It was recognized that the population in Mawlamyine had increased vulnerabilities to HIV due to the: very high cross-boarder trading involving very mobile populations; large number of migrant populations; the presence of a large percentage of populations with high risk practices; and stigma and discrimination. All of this was compounded by the presence of a number of punitive laws which impacted the success of comprehensive prevention programmes.

Through the 'ASEAN Cities Getting to Zero Initiative', many of these challenges were addressed in Mawlamyine through its well established coordination mechanism between; the local Government authorities, developmental partners working within the city, and importantly the meaningful involvement of people living with HIV. Examples of good practices were the extensive focus of prevention efforts in recognized 'priority populations' and the formation of nine self-help groups for people living with HIV. Nationally, there has been concerted

efforts to address the barriers that punitive legislation brings to the success of HIV prevention, treatment and care efforts. Furthermore, through the collaborative efforts of Government and development partners working in Mawlamyine there has been an exponential expansion of targeted HIV testing, increased use of comprehensive prevention efforts, and the scaling up of ART services and availability of co-infection medications.

Despite the progress made, a number of challenges remain, such as: stigma and discrimination, which continues to impede both the prevention and treatment and care programmes; human resource limitations remain, which impede successful implementation of programmes; more work remains to be done about the barriers that punitive legislation brings; and lastly, there is a recognized need for a coordinated multisectoral committee, specifically for the 'Getting to Zero' initiative in Mawlamyine.

## Moving Forward: Cities getting to Zeros Initiative, Spearheading NSP III Approaches

Myanmar through its HIV National Strategic Plan (NSP) III will focus on strengthening local targeted responses, described below. Through stronger partnerships and coordination at the city level, the initial work of the 'Getting to Zero' initiative, will continue but with greater city ownership, empowerment and the design of localized targeted responses based on the burden of disease.

The challenge, unique and dynamic approach to HIV programming, being introduced through NSP III, requires careful and considered implementation. As such, the Myanmar National AIDS Programme, has decided to begin implementing a number of the key strategic activities of NSP III in Tachileik (Shan State-East), Myawaddy, Hpa-an (Kayin State) and Mawlamyine (Mon State). These are the Myanmar cities

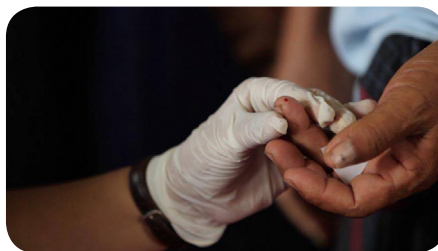
identified to be part of the 'ASEAN Cities Getting to ZERO Initiative'. The latter three townships, are new to the "ASEAN Getting to ZERO Initiative". These new cities (or townships) have been included in the 'ASEAN Getting to ZERO Initiative' because they: (a) have large number of migrants and mobile populations; (b) socio-economic difficulties which increase HIV risk and vulnerability; (c) are known to have high disease burden for communicable diseases including HIV, STIs and TB; (d) have populations in remote areas, who are hard to reach; and (e) have ethnic communities who are known to have higher risk and vulnerability to HIV.

To meet the 5 strategic areas of focus under NSP III, and to build on previous efforts in Mawlamyine; three broad strategies will be targeted in the 4 'Getting to Zero Cities': skills building of township workforce; development of policies and procedures at township level; and organizational strengthening. Focused activities within these 'Getting to Zero Cities' will include:

1. Training to improve results based planning and management coupled with strengthened localized research through programmatic mapping to develop a targeted evidence informed response. This will mean the implementation of prevention, treatment and care programming in partnership

with community based groups and national and international non-governmental organization working in each township.

2. Development and improvement of clear policies and procedures within these townships, to strengthen the ability to deliver a coordinated and strategically organized localized response and importantly increase local ownership of comprehensive HIV programming responses. Each township will have a committee dedicated to the 'Getting to Zero Initiative'.



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3. Lastly, in order to support the increased prevention and treatment and care responsibilities at the township level, a thorough assessments of health facilities including stakeholder analysis will be conducted in each of the four townships to determine support required for the scale up of services locally.

Funding for this initiative has been secured and the all activities have

begun. Getting to Zero in Myanmar will be achieved through strong national coordination and leadership and working in partnership with technical and development partners both nationally and more importantly at the 'Getting to Zero City' level.

The initial efforts in these 'Getting to Zero' cities will mark the beginning of a new era in Myanmar, in arming local communities and township national officials with the skills and resources to effectively research, plan and implement a localized evidenced informed response, which will contribute to Myanmar's vision of: 'by 2030, end HIV as a public health threat in Myanmar through fast tracking access to a continuum of integrated and high quality services that protect and promote human rights for all'.

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**KEY MESSAGES:**

- Concerted efforts need to be done to address the barriers of punitive legislation and policies to eliminate stigma and discrimination to ensure effective HIV prevention, treatment and care, by engaging key stakeholders including NGOs and networks of key population.
- Coordinated multi sectoral HIV responses at national, regional, city/township levels need to be strengthened to increase local ownership of comprehensive HIV programmes and ensure the implementation of policies and guidelines for effective HIV and AIDS responses.
- Strengthening human resources' skills and organizational capacity of city/township in providing good quality and effective HIV and AIDS services and coordinating multi stakeholder responses still need to be prioritized.
- Increased allocation of Government funding is critical for these efforts to ensure sustainability of HIV responses. At the same time, donors must have clear plan for reduction rather than abrupt change in policy and funding.



# Strengthening Local HIV and AIDS Response in the Philippines through the ASEAN G2Z Experience

## Introduction to Practice

The Philippines' undertaking of the ASEAN Cities Getting to Zero (G2Z) was realized as part of the steps in localizing HIV and AIDS responses among local government units (LGUs). The G2Z aimed to provide a brief description of the current HIV and AIDS situation in the participating cities/areas through the assessment of baseline epidemiological data, social network influence, behavior change interventions, and current levels of responses, including their strengths, opportunities, constraints, and gaps. Concrete activities undertaken for this initiative included advocacy and partnership building, adoption of the G2Z data collection tools, capacity development of partners, data gathering, data analysis and report writing, report presentations (dissemination) to stakeholders, and evidence-informed participatory planning.

It is more of strengthening the local government response for HIV and AIDS through the G2Z initiative. Initially, implementation to one city then to 16 other Metro Manila Cities and was rolled-out to a total of 33 cities.

## How It Works

The PNAC approved and adopted the initiative. Originally, Quezon City was the only site enrolled for the initiative but after recognizing its importance it was implemented additional 16 cities of Metro Manila and to another 17 cities from Visayas and Mindanao. Findings of the initiatives were used:

- To assess the effectiveness of LGUs local response for HIV and AIDS, and;

- As guide for local leaders on how to improve their HIV and programs.

Following the PNAC adoption of the G2Z, the Department of the Interior and Local Government (DILG) and the League of Cities of the Philippine (LCP) issued a Memorandum Circular and endorsement letter to local chief executives (LCE) enjoining their support to the initiative. To address challenge of availability of resources, The G2Z allowed each local government facility to have a better picture of their local epidemic, their responses, good practices and gaps.

## Outcomes

- The strategic information generated were used to advocate for their Local Chief Executives (LCE) and other key decision makers to support the local HIV and AIDS programs. Information was also used for resource mobilization for the program.
- This also paved the way for each LGU to come with a specific HIV and AIDS Plan and budget.

## Challenges and How to Manage

Sustained political support from the local authorities since there are many other issues competing with HIV and AIDS, this can be addressed through a continuous advocacy.

Conflicting policies that hinder interventions like harm reduction strategy among PWIDs. An operations research was conducted to generate evidence for possible interventions for PWID.

## Lessons Learnt

- Support for the HIV program from the key local officials will define the success of a local response.
- A multi –sectoral collaborative response hastens advocacy effort on key local officials.

## Recommendation for Sustainability

- The conduct of G2Z Assessment should be institutionalized and should be conducted at least every 3 years in conjunction with the implementation of the AIDS Medium Term Plan.
- By simplifying G2z tools can be used by the local implementers
- Capacity building on how to conduct the assessment and on how to use the information in advocating key decision makers. The capacity building should be conducted jointly by the implementers from the local and national level at least once every 2 years to be able to sustain the knowledge and skills needed by the local government to conduct the initiative.

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## KEY MESSAGES:

- A multi –sectoral collaborative response hastens advocacy effort among key officials.
- Support for the HIV program from the key local officials through continuous advocacy will define the success of a local response.
- Conflicting policies should be addressed to provide necessary HIV and AIDS Services.



# Anonymous HIV Testing in Singapore

## Introduction to Practice

The number of HIV cases in Singapore has continued to increase over the years. In 2015, 40% of the new cases already had late-stage HIV infection<sup>1</sup> when they were diagnosed. Studies have shown that individuals who are aware of their HIV-positive status will take steps to protect their partners. Therefore, early testing will help to control the spread of HIV. Early detection and treatment of HIV infection can also help to significantly delay the onset of AIDS, reduce the risk of death, and improve the quality of life.

Anonymous HIV testing was first implemented in 1991. The aim of anonymous HIV testing is to increase testing among at-risk populations. Anonymous HIV testing provides an alternative option to those who would like to be tested for HIV but would prefer not to be identified to healthcare personnel. It is a supplement to conventional name-based HIV testing where the confidentiality of a HIV-infected person is protected under the Infectious Diseases Act. The service was started at the Action for AIDS (AfA) Anonymous Test Site (ATS), and in a move to further encourage individuals at risk of HIV infection to go for testing and to do so early, anonymous testing was extended to nine General Practitioner (GP) clinics bringing the total ATSs in Singapore to ten.

## How It Works

Anonymous HIV testing is carried out on oral fluid or blood from finger prick using rapid HIV test kits. All doctors who wish to provide rapid HIV testing in their clinics are required to undergo training which includes an

explanation of the types of HIV rapid tests that may be used (only test kits registered with the Health Sciences Authority are permitted), how to perform the test and interpret test results, instructions on how to follow-up on positive rapid test results and a guidelines on pre- and post-test counselling, as well as the quality assurance standards that clinics are expected to maintain.

The use of rapid HIV tests allowed results to be ready in about 20 minutes, within the same clinic visit. Pre- and post-test counselling is provided to all individuals who undergo anonymous HIV testing and individuals with reactive rapid HIV test results undergo confirmatory HIV testing by clinical laboratories.

Although HIV is a legally notifiable disease under the Infectious Diseases Act (IDA), ATSs are exempted from the legal requirement to notify the Ministry of Health (MOH) any HIV positive cases detected via this programme. ATSs are, however, required to provide epidemiological information to MOH for surveillance purposes. This enables the Ministry to perform further epidemiological analysis. Patients pay a fee-for-service that ranges which includes the price of the test as well as consultation charges.

## Outcomes

The total number of HIV tests done each year in ATSs has been on an increasing trend. In 2015, more than 15,000 tests were performed. The percentage of positive HIV tests by rapid testing in ATSs has held stable at between 1% and 2% in the last 15 years.

## Challenges and How to Manage

Anonymous testing is an important alternative to confidential name-based testing. Individuals who know their HIV status are better able to take care of their health and take steps to prevent further transmission. Even though individual identifiers are not reported to the Ministry of Health, the programme allows for crucial epidemiological information to be gathered for surveillance purposes.

## Lessons Learnt

Making HIV testing services accessible via ATS has encouraged more testing as it lowers the initial barrier to accessing testing services. Clinics offering ATS are also located in convenient locations across Singapore to enhance accessibility for individuals. The use of rapid HIV test kits also makes it convenient for individuals as they are able to obtain the results within about 20 minutes.

## Recommendation for Sustainability

This programme is a self-sustaining collaboration between MOH, Action for AIDS and GPs.

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<sup>1</sup> CD4+ cell count of less than 200 per cu mm or AIDS-defining opportunistic infections or both.

## KEY MESSAGES:

Improving the accessibility of HIV testing allows for early detection and linkage to care.

# Thailand's Experience in Adapting and Implementing HIV-Related Stigma and Discrimination Tools

## Introduction to Practice

Thailand HIV strategy outlines the third goal regarding to reduction of S&D (S&D) to be achieved by 2016: revising all laws and policies that obstruct equal access to HIV prevention and treatment; making human rights and gender-specific needs part of all HIV responses; and reducing S&D towards PLHIV and key populations.



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At the global level, efforts have been focused on measuring stigma against PLHIV in the general population through surveys, stigma experienced by PLHIV through the *Stigma Index* and most recently on focusing stigma measurement in health care setting where it has the biggest impact on access to HIV services. A recently completed global effort to develop, test and standardize a measurement tool for measuring stigma amongst health facility staff provides a comprehensive tool ready for adaptation. This tool covers key areas necessary to develop effective stigma-reduction programs in health facilities, such as concerns about HIV transmission, attitudes towards PLHIV, self-reported stigmatizing avoidance behaviors, observed stigma, and environment for providing stigma-free services.

Adapting and piloting the globally standardized tool, Thailand is progressing to implementation for routine S&D measurement and monitoring in health facility settings at local levels with evidence informed S&D reduction interventions. Through this, the hope is that reduced S&D will encourage early access to HIV testing and treatment – two critical factors that will assure Thailand achieves the three zeros.

## How It Works

A collaboration team representing government, civil society and PLHIV and key populations networks, academia, RTI, USAID and UN agencies was created to oversee and support the adaptation and implementation process. This group, led by National AIDS Management Center (NAMC), Bureau of AIDS, TB, and STI and International Health Policy Program (IHPP) worked closely with national and international experts to adapt and refine the global measurement tool in two pilot provinces. Later, expand the adapted tool to other 5 provinces as the routine system. The national and international experts provided technical assistance throughout the process and helped build capacity within the Ministry of health to assure future sustainability.

The pilot tested health worker questionnaire, initially comprising 65 questions, involved 738 respondents in 32 public and private hospitals. Health workers who volunteered to participate in the survey answered queries as to their attitude towards PLHIV and key populations (KPs). A total of 714 PLHIV were interviewed at 17 different locations through nine PLHIV networks.

The streamlining process to identify core questions was essential to enable Thai authorities to scale up the surveys to as many provinces as possible and to make these part of routine monitoring in order to inform S&D reduction interventions at the local level. Through the analysis and consensus building processes, the questionnaires were adapted to be more user-friendly and are now being rolled out across the country.



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## Outcomes

The results of the surveys in the two pilot provinces and the 5 provinces in surveillance system, are an indication of how widespread and engrained S&D against PLHIV and key populations may be among health workers. High levels of HIV-related S&D were found among health workers in seven provinces. Over half the health workers declared taking unwarranted “precautions” when PLHIV are in their care; over 60% feared they might get infected while performing routine tasks and 90% admitted to at least one stigmatizing attitude. One health worker in five (23%) reported directly observing S&D by one of their colleagues in the past 12 months. The results of the surveys highlighted the way certain key populations and PLHIV are perceived. Some key populations (particularly PWID) seem to be subjected to higher levels of stigma than others. Many health workers may feel a certain way about their patients’ behavior and may affect to quality of care to key population.



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## Challenges and How to Manage

Based on evidence above, a facility-based S&D reduction package of interventions has been developed and will be introduced in Thailand in 4 pilot provinces in 2016 with evaluation before scaling up further. The proposed facility-focused S&D-reduction package of interventions includes activities at three levels within health facilities: individual (health facility staff), systems/health facility structure, and health facility-community linkages.

## Lessons Learnt

With leadership from MOPH, strong partnership from civil society, PLHIV and key population network, academic, provincial health office with financial and technical support from RTI, USAID and UN Joint team, we have learned:

- Measuring stigma in health care settings can be short, simple and routine. With the minimum effort, stigma survey tailored to proposed setting to ensure data is practical to local context. For example, we succeed to shorten health facility staff questions from 65 to 14 questions.
- Through this approach resulting in rapid scaling up the use of tools. Currently 23 provinces (30% of total provinces) are conducting the stigma surveys for health facility staff and PLHIV.

## Recommendation for Sustainability

- The data yielded by pilot-testing Thailand's new stigma

measurement tool confirms the need for increased monitoring and better-targeted action. Regardless of which angle Thailand's HIV response efforts are seen from, whether HIV-related deaths or late treatment initiation, HIV-related S&D in the health workforce can be considered as an important contributory factor.

- The Ministry of Public Health has already outlined a plan of action to broaden the use of the stigma measurement tool throughout the country so that a true national baseline can be established and progress measured routinely. In cooperation with other stakeholders, the Ministry is designing ways to address the situation through vigorous and sustained training of health workers in public and private hospitals to reduce HIV-related S&D in several priority provinces.
- In Thailand and elsewhere, the prevalence of S&D is likely to

remain a major obstacle to ending HIV for some time. However, with this tool, Thailand has demonstrated that, at the very least, the size and shape of the barrier can be measured—a very important first step in addressing an issue that has hampered the HIV response for decades.

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## KEY MESSAGES – THAILAND (STIGMA AND DISCRIMINATION)

Several key messages can be outlined from this pilot study:

### 1. Measuring stigma is easy and can be routine

Surveys can be short and simple, yet very effective in measuring HIV-related S&D. With minimum effort, stigma surveys can be tailored to the proposed setting and yield valuable data on a notably hard-to-gauge and blurry area of the HIV response. The survey should be part and parcel of the regular HIV surveillance work that most countries have been doing for over a decade.

### 2. Stigma is prevalent within health care settings

Results show that HIV-related S&D in health care settings are common even in a country with a mature epidemic and response. Thai health workers (in both pilot provinces) display high levels of stigma towards PLHIV and key populations. Reports of experienced stigma from PLHIV is therefore justified and based on both personal and collective experience that cannot be ignored. This finding is crucial, as it exposes a significant and previously unmeasured obstacle to an effective HIV response.

### 3. Evidence drives the response

The design of S&D measurement tools needs to be evidence-based, as does the development of S&D-reducing interventions. Data from multiple contexts and populations need to be considered for collection and analysis to inform programs and interventions appropriately.



# Empowering Female Youths on Sexual Health and HIV/STIs Prevention through Collaborative Friendly Service Networks in Thailand

## Introduction to Practice



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Female youth friendly service was a pattern of collaborative work between government sector and community including local government authority, education institute, religious, and civil society. Bureau of AIDS, TB and STIs had initiated this project according to the perceived situation that female youth had been victimized by a change of social environment; for instance, a lower age of sexual debut, more teenage pregnancies, an increase of sexually transmitted diseases. These reflected a higher risk to contract HIV. In addition, a survey revealed only a half of female youth use a condom at their last sexual intercourse. More capabilities of life skill were urgently needed among them. The project aimed to empower female youths on sexual health and HIV/STIs prevention through network of friendly health services in Songpeenong District, Suphanburi province in 2010. In 2012, the project was expanded to cover another 4 districts in Chiang Mai, Nakhon Sawan, Nongkhai and Chonburi (one district in each province) then scaling up to 43 provinces in 2014. Resource utilized for this project were derived from Government Budgets; and



อบรมให้ความรู้วัยรุ่นและเยาวชนป้องกันปัญหาท้องไม่พร้อมในสถานศึกษา



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Extra-Government Budgets and the Global Funds.

## How It Works

Working closely with local stakeholders, all related data were analyzed and a list of strategies was then identified. They were including 1) Empowerment of female; 2) Development of female youth friendly health service; 3) Development of networks of providers on female youth friendly services; and, 4) Development of assistance and follow-up on female youths in schools.

Stakeholders involved in the implementation of female youth-friendly service included personnel from state agencies, private sector, and civil society. There were 3 core groups of stakeholders involving in this project.



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## A. Technical Support Organizations:

- Bureau of AIDS, TB and STIs (BATs) and Department of Health, Department of Mental Health, Path2Health and universities

## B. Field Operational Organizations and Strategic Partners:

- Regional Offices of Disease Prevention Control, Provincial Health Offices and District Health Offices
- Regional hospitals, general hospitals and community hospitals

- Civil Society Organizations and Universities for preventive services
- Female youth leaders and health volunteers in communities, schools, villages, and drugstores
- Monks as spiritual leaders, involved in the attitude adjustment of school administrators and community members.

## C. Monitoring and Evaluating Organizations:

- The National AIDS Management Centre (NAMC) and the Global Fund's Office of Principal Recipient.

## Outcomes

- Outcomes of the project were utilized to formulate Ministry of Public Health policies which now included several strategic statements for prevention of STIs and reduction of teenage pregnancy.
- Youth-friendly service centre networks had increased from 2 centres in 2010 to 949 centres in 2014.
- The number of female youths who are educated about sexuality and AIDS and receiving services on STIs testing and access to condom had an increasing trend in 5 provinces.
- Condom use among sexually active students in 5 provinces had an increasing trend from 49.2% in 2010 to 54.1% in 2011. Pregnancy rates among female youths aged 15-19 years had dropped during 2011-2012 to 6.3-23.9 (/1000 population).



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- Effective implementation to protect female youths against HIV/AIDS infections could also save a national budget which currently costs 87,223.33 THB/person/year.
- The project has also expanded its scope to cover services for MSM, sex workers, PWUD, prisoners, and migrant workers to allow them to reach out to the service without stigma or discrimination.

### Challenges and How to Manage

- Stigma and discrimination towards female youth engaging in sex is still prevalent among the public. Campaigns on gender and sexual relationship and responsibilities were conducted to tackle stigma and discrimination.
- Condom use was not well accepted and available for female adolescents at the beginning of the project, which then provided at the condom distribution points. female youths were provided with knowledge on condom use in Drop-in Centres.
- Limited access to health services: this project's primary aim is

to promote access to health services among female youths through the development of friendly health services targeting female youths.

### Lessons Learnt

Factors leading to the success of this project are:

- Collaboration in the community for problem solving. Participation provides opportunities for youths and women to be part of the solution and ownership which contribute to project sustainability;
- Advancing policy implementation by setting it as a local policy is another important factor because this act literally responds to people's needs and problems;
- It is important that innovative models and various tools are adopted to respond to the needs to solve youths' sexual health problems.

### Recommendation for Sustainability

- Works under different departments within Ministry of Public Health should be

integrated and national policies and guidelines for services need to be developed to implement the project effectively.

- Resource mobilization for scaling up of the project need to be done to ensure sustainability. The National AIDS Fund to support works on HIV prevention has been established and a proposal to continue the project has been submitted for government budget allocation.
- Policies to solve and prevent children and youths' problems should be promoted to other relevant Ministries should be promoted by involving related partners and networks.

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## KEY MESSAGES – THAILAND (FEMALE YOUTH FRIENDLY SERVICES)

1. As Thailand is moving towards ASEAN Community, female youth-friendly services are required to respond to the needs of female youths in the region. Standards of services are needed to be maintained to serve the needs of female youths of all races and religions. Service provided should make them feel at ease. Expanding youth-friendly service operations to all female youths in the ASEAN is therefore a challenging task.
2. The funding for friendly service operation granted by the Bureau of AIDs, TB and STIs (BATs) has come to an end. As the Bureau of AIDS, TB and STIs (BATs) supported a body of knowledge, trainings and budgets for the operation in the field offices, efforts were made to integrate these activities in a regular system of the office including budgets for further operation.
3. Sustainability of partners' participation is another challenge. As the executives of different government offices are usually rotated in a certain period of time, strong networks of operational staff are required. Regular presentation on the project achievements will also help to emphasize the importance of female youth-friendly services.
4. This project has committed to work on the female youths. Knowledge and experiences have increased female youths' self-esteem and respect of their own rights including basic human rights, rights to health, rights to education, rights to be treated with dignity, gender equality and bargaining power in sexual relationships and the use of condoms for their own protection. These will enhance their quality of life and they will be recognized as a new generation of women with high self-esteem.
5. Once they have realized their own potentials and values, they will also respect the others' rights and sympathize with other fellowmen. Additionally, these knowledge and values can also pass to their friends, families and communities. Health education will be sustainable with the inter-generational transfer of knowledge and practice.
6. Long term solutions should therefore emphasize on the role of female youths. The outcome will be worthwhile as female youths are the future of the country - "The power of female youths can change the world".

# Expansion of the Pediatric HIV Disclosure Model in Thailand

## Introduction

In 2014, approximately 7,000 HIV-positive children received care and treatment from the Thailand National AIDS Program. More than 70% of them were 10 years of age or older. With increasing access to highly active anti-retroviral therapy (HAART) in the national AIDS program, perinatal HIV infection has evolved from a fatal illness into a chronic health condition. Many HIV-positive children in Thailand are now living into adolescence, highlighting the question of when and how best to disclose their HIV status. Such disclosure is a critical first step for the education of children living with HIV, helping them properly adhere to treatment, maintain good health, and avoid risk behaviors and transmission of HIV to others.

In the past, however, there was no disclosure model that was appropriate for the Thai context. Therefore, in 2005 a multi-disciplinary team of experts from Siriraj Hospital Mahidol University, the Queen Sirikit National Institute of Child Health, and the Thailand Ministry of Public Health (MOPH) - U.S. CDC Collaboration began to develop a disclosure model that could be used by all Thai health care personnel. The model was successfully piloted in two large medical school settings during 2005-2008, after which a training package was developed to teach health personnel in public health facilities throughout Thailand during 2009-2014. Funding for the model development was from the Thailand MOPH - U.S. CDC Collaboration. Funding for the model expansion was from the Global Fund for AIDS, TB, and Malaria (from 2009 to 2010) and the Thai Government (from 2011 to 2014) to Department of Disease Control and Prevention, MOPH.

## How It Works

The pediatric HIV disclosure model consisted of a counseling based 4-step model that guides healthcare providers to assist caretakers in disclosing HIV status to infected children, providing HIV-related health information to children and caretakers, and supporting children's emotional reactions related to

disclosure. The first step of the model involves screening HIV-infected children and their caretakers for eligibility. Step 2 involves assessing caretakers' and the children's readiness for disclosure. In this step, counselors explore caretakers' attitudes and perception about disclosure, review with caretakers about their child's general health status and development, and assist the caretakers through counseling to determine whether the caretakers and their child are ready. Step 3 involves disclosure HIV status to children, either by counselors or by caretakers with the presence of counselors who help with communication and provide emotional support. Children are counseled on medication adherence and preventing transmission of the virus and keeping the diagnosis confidential. After disclosure, children and caretakers are arranged for assessing the outcome of disclosure in step 4.

The model was implemented and evaluated at the two participating hospitals. Among 438 children aged above 7 years old who were screened, 398 (89%) were eligible. Readiness assessment was completed for 353 (91%) of eligible children and 216 (61%) were determined ready. Disclosure was done for 186 children. The mean age at eligibility screening was 10.5 years (range: 6.8-15.8 years); the mean age at disclosure was 11.7 years (range: 7.6-17.7 years). The mean duration between eligibility screening and disclosure was 15.2 months.

Several organizations involved in arrangement of training and adopting the disclosure model for use in public hospitals including Bureau of AIDS, TB and STIs, MOPH and with budget supported by National health security office (NHSO). The first training course was provided to 4 regional pediatric HIV training centers which then pediatricians and HIV counselors from these 4 training sites became regional trainers and further provided this training through their provincial pediatric HIV care networks. Internationally, the training curriculum and an English version of HIV diagnosis disclosure manual were shared to various international organizations e.g. Treat Asia, CDC

Viet Nam, Myanmar, and visitors from many countries who learned about pediatric HIV treatment and care in Thailand. The model was also used for trainings providers from other countries during 2010-2015 including Viet Nam, Myanmar, Nepal, Iran, Lao PDR, and Indonesia.

## Outcomes

As a result of training expansion, Pediatric HIV disclosure trainings were provided to more than 700 healthcare providers in 77 provinces throughout the country during 2009-2014. Many health care providers taking care of HIV-infected children in Thailand are now able to effectively and systematically discuss HIV with children living with HIV and their caretakers. Providers are enthusiastic about the benefits of the model, explaining that the training prepares them to conduct and follow-up on disclosure, while increasing their knowledge about relevant psychosocial issues and giving them the confidence to counsel children and their caretakers. Data from the national pediatric HIV quality improvement project, Bureau of AIDS, TB, and STIs reported proportion of HIV-infected children aged >10 years who were aware of their HIV status increased from 49% (of 11 hospitals) in 2007 to 75% (of 206 hospitals) in 2012 and maintain above 70% during 2013-2015.

There was neither significant negative behavioral nor emotional outcome reported in children following disclosure. Based on these results, we suggest that preparing children for disclosure process should begin as early as age 7, and ideally before the age of 10, to allow sufficient time for disclosure to be completed before children enter adolescence. The manual to this model was later developed both in Thai and in English (available online at <http://www.cqihiv.com/ViewDocumentDetail.aspx?ID=3> Pediatric HIV Disclosure Manual).

## Challenges and How to Manage

Following the training expansion during 2009-2014, there has been no continuous funding support from the government to continuously support



training for health care providers who are responsible for pediatric HIV treatment and care and have not been trained on this topic. Domestic resource allocation for continuity of such training at least for the next five years should be anticipated.

### Lessons Learnt

This highly impactful collaboration between national institutions and bilateral and multilateral donors has resulted in a new and important national HIV service in Thailand. The project was successful in part because it so carefully considered the Thai public health context and responded to an emerging, critical need. Without this project, many HIV-positive children would still not have benefitted from an HIV disclosure service. This small but important step for an HIV-infected child can make a huge impact in the later life of the child and family, strengthening all of society.

### Recommendation for Sustainability

This practice could be sustained by capacity building of key trainers in the country who can further provide this training through their provincial pediatric HIV care networks in their responsible region. Refresher trainings and continuous funding are needed periodically for new health care providers to maintain high uptake of pediatric HIV disclosure in the country.

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## KEY MESSAGES – THAILAND (PEDIATRIC HIV DISCLOSURE)

Several key messages can be outlined from this project:

- Pediatric HIV disclosure is a critical first step for the education of children living with HIV, helping them properly adhere to treatment, maintain good health, and avoid risk behaviors and transmission of HIV to others.
- The disclosure of HIV diagnosis to perinatal HIV-infected children with this provider-assisted pediatric disclosure model had no negative psychosocial effect on the children, and may reduce depression and improve quality of life. This disclosure model enables healthcare providers to confidently help children and caretakers with HIV disclosure, which is one of the critical steps in the comprehensive treatment of HIV-infected children.
- Thailand pediatric HIV disclosure model is successful and feasible. Pediatric HIV disclosure training has been conducted to more than 700 health care providers in all 77 provinces of Thailand.

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

1. We, the Heads of State/Government of the Association of Southeast Asian Nations (hereinafter referred to as “ASEAN”), namely Brunei Darussalam, the Kingdom of Cambodia, the Republic of Indonesia, the Lao People’s Democratic Republic, Malaysia, the Republic of the Union of Myanmar, the Republic of the Philippines, the Republic of Singapore, the Kingdom of Thailand and the Socialist Republic of Viet Nam, on the occasion of the 19<sup>th</sup> ASEAN Summit in Bali, Indonesia reviewing comprehensively the progress achieved in the decade since the adoption of the 2001 ASEAN Declaration on AIDS and the implementation of the 2007 ASEAN Commitments on HIV and AIDS;
2. Reaffirming the commitment of ASEAN Member States to accelerate progress in achieving the Millennium Development Goal 6 (MDG 6), which specifically refers to halting and reversing the spread of HIV and AIDS, and other related MDGs by 2015; and the 2010 High Level Plenary Meeting United Nations General Assembly on MDGs entitled: Keeping the Promise: United to Achieve the Millennium Development Goals;
3. Confirming our commitment to Resolution 66/10 and 67/9 of the 66<sup>th</sup> and 67<sup>th</sup> Sessions of the United Nations Economic and Social Commission for Asia and the Pacific, respectively, and the outcome of the 2011 United Nations General Assembly High Level Meeting on AIDS entitled, the “Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS” which reaffirmed the 2001 Declaration of Commitments on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS and called for efforts to end the epidemic with renewed political will and strong, accountable leadership, and to work in meaningful partnership with all stakeholders at all levels to implement bold and decisive actions;
4. Guided by the ASEAN Charter which entered into force in December 2008, and with a strong commitment to accelerate the establishment of the ASEAN Community by 2015 through the implementation of the Blueprints of the ASEAN Economic Community (AEC), ASEAN Political Security Community (APSC) and the ASEAN Socio-Cultural Community (ASCC);
5. Emphasising that under the ASCC Blueprint, concrete actions have been provided to improve our capability to control communicable diseases including HIV and AIDS, and particularly in reducing the transmission of HIV and the impact of the epidemic on individuals, community and society;
6. Acknowledge the relevant outputs of the 10<sup>th</sup> ASEAN Health Ministers Meeting (AHMM) last July 2010 held in Singapore that outlined goals, targets and activities for the regional collaboration on health, including HIV and AIDS initiatives through the Strategic Framework on Health Development (2010-2015);
7. Recalling that accelerated liberalisation of trade will enhance the region’s competitiveness and realise welfare gains for our peoples in the long run, and that efforts are also needed to ensure that access to affordable health care is not undermined and health policies will be equitable and pro-poor, as noted in the Declaration of the 7<sup>th</sup> ASEAN Health Ministers Meeting adopted on 22 April 2004;
8. Concerned that the HIV epidemic continues to threaten the realisation of an ASEAN Community, with socio-economic consequences that pose a formidable challenge in our community-building and our efforts to ensure access to affordable health care;
9. Noting the finding from ASEAN’s first regional report on HIV and AIDS of 2010 which observed that in the region, the HIV epidemic continues to affect more than 1.5 million people affecting Member States with varying intensity; that HIV prevalence remains high among key affected populations, including sex workers and their clients, people who inject drugs, and men who have sex with men and transgender population, while other populations continue

to be vulnerable (such as partners/spouses of key affected populations, migrant and mobile populations, children and youth, women and girls, people in correctional institutions, and specific occupational groups like uniformed services, people in conflict and disaster-affected areas), and that to be effective, AIDS responses must deliver focused, evidence-informed interventions that address the particular risks and vulnerabilities faced by these populations.

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

Do hereby declare and renew our commitments to:

16. Work towards an ASEAN with Zero New HIV Infections, Zero Discrimination and Zero HIV Related Deaths by:
  - a. Reducing sexual transmission of HIV by 50 percent by 2015;
  - b. Reducing transmission of HIV among people who inject drugs by 50 percent by 2015;
  - c. Scaling up antiretroviral treatment, care and support to achieve 80 percent coverage for people living with HIV who are eligible for treatment, based on WHO HIV treatment guidelines;
  - d. Eliminating new HIV infections among children and substantially reducing AIDS-related maternal deaths by 2015; and
  - e. Reducing by 50 percent tuberculosis deaths among people living with HIV.



17. Commit to work towards zero new HIV infections in ASEAN through the following:

- a. Acknowledge that prevention is the cornerstone of regional, national and international HIV responses and ensure that adequate financial resources are provided for scaling up evidence-based and targeted prevention programmes for key populations-at-risk;
- b. Ensure that national prevention strategies comprehensively target populations at higher risk, such as people who use drugs, sex workers, and men having sex with men, including transgender people, and that systems of data collection and analysis about these populations are strengthened;
- c. Develop and scale up community-led HIV prevention services to reduce sexual transmission of HIV and to address stigma and discrimination;
- d. Implement and expand risk and harm reduction programmes, where appropriate and applicable, for people who use drugs, taking into account the World Health Organization, United Nations Office on Drugs and Crime and UNAIDS Technical Guide for countries to set targets for universal access to HIV Prevention, treatment and care for injecting drug users in accordance with national legislations;
- e. Accelerate efforts to virtually eliminate parent-to-child transmission of HIV and preventing new paediatric HIV infections and eliminate congenital syphilis by 2015;
- f. Encourage and support the active involvement of key affected populations and vulnerable groups including young people, civil society and other community representatives as well as local governments in planning, implementing and evaluating responses;
- g. Promote access to timely and effective anti-retroviral treatment, as prevention strategy;
- h. Address the social protection, sexual and health needs of key affected and vulnerable populations; and
- i. Expand and promote access to HIV testing, including provider-initiated HIV testing that is voluntary, confidential and rights-based.

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

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

- iv. Addressing barriers, regulations, policies and practices that prevent access to affordable HIV treatment by promoting generic competition in order to help reduce costs associated with life-long chronic care;
  - c. Expand efforts to combat HIV comorbidities such as tuberculosis and hepatitis through integrated delivery of HIV and tuberculosis services in line with the Global Plan to Stop TB, 2011-2015; developing as soon as practicable approaches of prevention and treatment of hepatitis C; and rapidly expanding access to appropriate vaccination for hepatitis B;
19. Commit to work toward Zero HIV related Discrimination through the following:
- a. Promote the health, dignity and human rights of people living with HIV and key affected populations by promoting legal, political and social environments that enable HIV responses, including by establishing multi-stakeholder partnerships among the health sector, law enforcement and public security, academia, faith-based leaders, local government leaders, parliamentarians, workplace, civil society and other relevant stakeholders, with a view to removing legal and punitive barriers to an effective response, and to reduce stigma and discrimination;
  - b. Initiate as appropriate, in line with national priorities a review of national laws, policies and practices to enable the full achievement of universal access targets with a view of eliminating all forms of discrimination against people at risk of infection, living with HIV and key affected populations;
  - c. Pledge to eliminate gender inequalities and gender-based abuse and violence especially by protecting and promoting the rights of women and adolescent girls, strengthening national social and child protection systems, empowering women and young people to protect themselves from HIV, and have access to health services, including, inter alia, sexual and reproductive health, as well as full access to, comprehensive information and education;
20. Commit to ensuring financial sustainability, national ownership and leadership for improved regional and national responses to HIV through the following actions to take forward our commitments:
- a. Develop, update and implement evidence-based, comprehensive, country-led national strategic plans and establish strategic and operational partnerships with stakeholders at the national and community levels to scale up HIV prevention, treatment, care and support by 2015;
  - b. Mobilise a greater proportion of domestic resources for the AIDS response in line with national priorities, from traditional sources as well as through innovative financing mechanisms, in the spirit of shared responsibility and national ownership and to ensure sustainability of the response;
  - c. Reduce inefficiencies in national responses by prioritizing high impact interventions, reducing service delivery costs, and streamlining monitoring, evaluation and reporting systems to focus on impact, outcomes, cost-efficiency and cost-effectiveness;
  - d. Strengthen the mechanisms of South-South collaboration, especially ASEAN to ASEAN sharing of expertise, inter-regional cooperation, in the provision of technical assistance and support to build capacity at the regional and national levels;
  - e. Strengthen the role of ASEAN bodies responsible for health, that is, the ASEAN Health Ministers Meeting, Senior Officials Meeting on Health Development and the ASEAN Task Force on AIDS in enhancing cross-sectoral and multi-stakeholders coordination by facilitating the meaningful participation of all relevant key stakeholders, including that of public and private sector, and under the coordination of the ASEAN Socio-Cultural Community Council, with the view to effectively implement regional responses to HIV consistent with ASEAN's regional and international commitments;

- f. Tasks the relevant ASEAN bodies responsible for health to effectively implement the Fourth ASEAN Work Programme on HIV which was adopted by the ASEAN Health Ministers;
- g. Continue to support Global Fund to Fight AIDS, Tuberculosis and Malaria as a pivotal mechanism for achieving access to prevention, treatment, care and support by 2015; recognize the programme for reform of the Global Fund, and encourage Member States, ASEAN Dialogue Partners, the private sector, business community, including foundations and philanthropists to provide the highest level of support for the Global Fund, taking into account the funding targets to be identified at the 2012 midterm review of the Global Fund replenishment.
21. Task the concerned ASEAN Sectoral Ministerial Bodies as well as other relevant bodies to implement this Declaration including mobilising resources, and monitor its progress; Encourage all ASEAN Member States to support these ASEAN Sectoral Bodies in accomplishing this Declaration through maximum efforts by such appropriate instruments as may be necessary and consistent with their respective national laws and policies. Adopted in Bali, Indonesia, this Seventeenth Day of November in the Year Two Thousand and Eleven in a single original copy, in the English language.



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