The WHO Regional Office for South-East Asia organized a regional workshop on improving HIV treatment, in Yogyakarta, Indonesia, 23–25 July 2013. The workshop brought together: participants from 10 countries in the South-East Asia Region; members from other UN agencies, AusAID, PEPFAR/USAID, The Global Fund and the Asia Pacific Network of Positive People including participants from civil society organizations. The workshop provided an opportunity to: share and discuss progress in HIV health-sector response at regional and country levels; discuss the recommendations of new WHO 2013 consolidated guidelines; and plan adoption and adaptation of the 2013 guidance at country level.
Report of the Regional workshop on improving HIV treatment

Yogyakarta, Indonesia, 23–25 July 2013
# Contents

<table>
<thead>
<tr>
<th>Acronyms</th>
<th>v</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2. Opening session</td>
<td>2</td>
</tr>
<tr>
<td>3. Regional overview of HIV epidemic and response</td>
<td>3</td>
</tr>
<tr>
<td>4. Global update – clinical guidelines across continuum of care for HIV diagnosis and ARV for prevention</td>
<td>4</td>
</tr>
<tr>
<td>5. Clinical guidance on managing coinfections and comorbidities</td>
<td>7</td>
</tr>
<tr>
<td>6. HIV testing approaches in the context of Asia</td>
<td>8</td>
</tr>
<tr>
<td>6.1 Country experiences</td>
<td>9</td>
</tr>
<tr>
<td>7. Panel discussion on scaling up testing and counselling for HIV</td>
<td>11</td>
</tr>
<tr>
<td>8. Group work 1</td>
<td>13</td>
</tr>
<tr>
<td>9. Recommendations for HIV service delivery</td>
<td>14</td>
</tr>
<tr>
<td>10. Challenges and opportunities for scaling up ART: Experiences from programme reviews</td>
<td>16</td>
</tr>
<tr>
<td>10.1 Indonesia</td>
<td>16</td>
</tr>
<tr>
<td>10.2 Thailand</td>
<td>17</td>
</tr>
<tr>
<td>10.3 Guidance for programme managers</td>
<td>18</td>
</tr>
<tr>
<td>11. Panel discussion: Scaling up the strategic use of ARV</td>
<td>20</td>
</tr>
<tr>
<td>12. Group work 2</td>
<td>22</td>
</tr>
<tr>
<td>13. Monitoring and evaluation</td>
<td>23</td>
</tr>
<tr>
<td>14. Programme monitoring</td>
<td>24</td>
</tr>
</tbody>
</table>
15. Treatment 2015 initiative ................................................................. 25

16. Panel discussion on the role of development and civil society partners ........ 26

17. Group Work 3 .................................................................................. 27

18. Recommendations from the meeting .................................................. 29
  18.1 General recommendations to Member countries, 
      WHO and partners ........................................................................... 29
  18.2 Specific recommendations to Member countries .............................. 30

19. References ....................................................................................... 31

Annexes

1. Agenda .................................................................................................. 33

2. List of participants ................................................................................ 35
**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3TC</td>
<td>lamivudine</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>antenatal care</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>antiretroviral</td>
</tr>
<tr>
<td>AUSAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
</tr>
<tr>
<td>EFV</td>
<td>efavirenz</td>
</tr>
<tr>
<td>FTC</td>
<td>emtricitabine</td>
</tr>
<tr>
<td>Global Fund</td>
<td>The Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV testing and counselling</td>
</tr>
<tr>
<td>ICTC</td>
<td>Integrated Counselling and Testing Centre</td>
</tr>
<tr>
<td>IPT</td>
<td>isoniazid preventive therapy</td>
</tr>
<tr>
<td>KAPs</td>
<td>key populations</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MSM</td>
<td>men who have sex with men</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President's Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLHIV</td>
<td>people living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted disease</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TDF</td>
<td>tenofovir disoproxil fumarate</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VCT</td>
<td>voluntary counselling and testing</td>
</tr>
<tr>
<td>VL</td>
<td>viral load</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>XTC</td>
<td>emtricitabine or lamivudine</td>
</tr>
</tbody>
</table>
1. Introduction

The South-East Asia Region of the World Health Organization (WHO) has the second highest burden of HIV after the African Region. As of 2012, the Region had an estimated 3.4 million people living with HIV (PLHIV) of whom around 1.7 million were eligible for treatment according to the latest WHO criteria (a CD4 count of under 350). Of those eligible, 938 000 were reported to be on treatment giving coverage of 54.5%, which is less than the global average of 64% for low- and middle-income countries.\(^1\) As treatment expands, the number of AIDS-related deaths has declined (210 000 in 2001 to 200 000 in 2012).\(^1\) Fortunately more than 90% of people on antiretroviral therapy (ART) in the Region are on first-line therapy. However, the issues of adherence and retention remain and it is important to ensure these are addressed to avoid increased resistance, which would force programmes into expensive second- and third-line regimens.

The price of antiretrovirals (ARVs) has reduced significantly, and safer and better regimens are now available. These need to be included as first-line recommendations in national action plans. New and emerging data on the use of ARVs for both treatment and prevention of HIV provide compelling evidence that ART not only saves lives but also keeps people healthy and prevents new infections. While all countries in the Region have adopted the WHO 2010 recommendations, the average CD4 count at initiation is below 200, and even below 100 in many cases. Late initiation not only jeopardizes the survival of HIV-infected individuals, but makes treatment more costly and increases the risk of transmission at population level.

Member States are committed to the targets of the United Nations General Assembly High Level Meeting on AIDS, held in June 2011, that commit to three zeros – zero new infections, zero AIDS-related deaths and zero discrimination against HIV. There is also a target to reach 15 million people in need of ART by 2015.
Objectives of the workshop

- Review the programme on HIV treatment and prevention coverage at national and regional levels;
- Share and discuss the WHO 2013 consolidated guidelines on HIV treatment for adoption and adaptation at country level;
- Share country experiences on the strategic use of ARVs;
- Discuss the various scale-up scenarios in programmatic contexts at country level;
- Identify the way forward at country level and technical support from WHO.

2. Opening session

Opening remarks by the Regional Director of the WHO South-East Asia Region were delivered by Dr Khanchit Limpakarnjanarat, WHO Representative to Indonesia.

Dr Samlee Plianbangchang congratulated participants for their commitment and efforts towards the many achievements that the response to HIV has seen during the last 30 years. He pointed out the opportune timing of this meeting, given the recent release of the latest WHO consolidated guidelines and the accelerated efforts that countries are making to meet the 2015 targets.

The Regional Director stressed the need for a sustainable course of action that is people centred; one that promotes healthy lifestyles and individual choice of treatments, integrates and links service delivery systems for better efficiencies and outcomes, ensures the safe use of medicines and prevention of drug resistance, and most importantly is anchored in public health principles and a focus on the twin pillars of HIV prevention and treatment.

In moving towards the post-2015 public health global agenda, the Regional Director stressed the need to work together to ensure that necessary resources continue to flow into the HIV response from both governments and development partners. He encouraged participants to help ensure that money is spent on interventions that have the highest
impact. Dr Samlee said that the tools of epidemiologic and economic analysis should be used to assess and improve the efficiency and effectiveness of HIV/AIDS programmes, while reminding participants that the HIV response should continue in an environment that protects human rights.

The opening address on behalf of Professor Dr Tjandra Yoga Aditama, Director General of Disease Control and Environmental Health, Ministry of Health, Indonesia was presented by Dr Nadia Siti, Head of the Sub-Directorate of AIDS. Dr Aditama in his message reiterated the commitment of Indonesia as part of the Association of Southeast Asian Nations (ASEAN) in reaching the three zeros. With an epidemic still on the rise, Indonesia is particularly interested and committed to scaling up its HIV response. Indeed, Indonesia had recently developed a roadmap for accelerating access to ART for treatment and prevention, and has set ambitious targets to achieve high levels of coverage for testing and treatment. The highest level of political commitment is in place to ensure that these targets are met.

3. Regional overview of HIV epidemic and response

A summary update of the epidemic situation in the Region was presented jointly by the WHO Regional Office for South-East Asia and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support Team from Bangkok. Current epidemiological data show that HIV prevalence is decreasing in many countries of the Region. Five countries – India, Indonesia, Myanmar, Nepal and Thailand – constitute 99% of the total burden of infections in the South-East Asia Region. Coverage has substantially increased in recent years with over 938,000 people currently on treatment; but there is still a long way to go to achieve universal access of 80% coverage. More than 50% of those in need are now receiving ART. The upward curve is starting to level regarding the number of children living with HIV in the Region. However, data on the progress in coverage of treatment show that children are lagging behind in treatment efforts and their coverage remains lower than for adults. Coverage of testing and counselling for HIV in pregnant women is still low at 39%. 
Treatment cascades from different countries were presented highlighting the need for programme strengthening to reduce leakage and improve retention in the continuum from HIV testing to viral suppression.

Despite the fact that Asia has a concentrated HIV epidemic, less than half of key populations in South-East Asian countries know their HIV status and not enough are reached by prevention services. The prevalence of men who have sex with men (MSM) in selected urban areas are a source of concern in the Region as it is increasing at an alarming rate in this group. Active syphilis among sex workers and MSM also indicate ongoing high rates of sexual transmission.

With regards to how countries are investing in their own responses in the Region, there is an increase in the share of domestic budgets with countries like India and Thailand leading the way. The level of spending by key population in prevention programmes varied substantially among countries of the Region but data indicate that in the context of concentrated epidemics more resources could be allocated to target the most affected groups. Countries like Indonesia and Thailand allocated a substantial part of domestic resources to treatment programmes and are thus less dependent on international support. This is, however, not true for other countries in the Region. As treatment scales up, countries will need to mobilize further domestic expenditure to ensure sustainability of their responses. Five countries – India, Indonesia, Myanmar, Nepal and Thailand – have taken initiatives to review and analyse the expansion of their treatment programmes and this even before WHO released the consolidated guidelines of 2013. Their experiences were shared and discussed later in the workshop.

4. **Global update – clinical guidelines across continuum of care for HIV diagnosis and ARV for prevention**

In her presentation, Dr Philippa Easterbrook guided participants through the recently released 2013 consolidated guidelines on HIV treatment.

For the first time, the new WHO guidelines included not only clinical but also operational guidelines as well as a decision-making framework for
managers, and a section on monitoring and evaluation (M&E). The guidelines are consolidated across age groups for pregnant and breastfeeding women, children, adolescents and adults, and include recommendations on HIV testing, prevention, and coinfections. New recommendations are combined with those from current WHO guidelines.

Development of the guidelines followed the standard process, and involved over 120 people as part of the Guideline Development Group with strong representation from resource-limited settings. The group reviewed the existing evidence together with data on the cost and cost-effectiveness derived from modelling work, feasibility studies, as well as values and preferences of the community, affected persons and health-care workers. The composite of all these elements formed the basis of the decision-making process for the recommendations in the guidelines.

The quality of the evidence was ranked (high, medium, low or very low) largely based on systematic reviews, and the strength of the recommendations (based on all the information available, including evidence from systematic reviews, resource use, feasibility, and values and preferences) rated as strong or conditional based on the Grading of Recommendations Assessment, Development and Evaluation (GRADE) method.

In total, over 50 new recommendations in the consolidated guidelines are presented in a variety of tables and algorithms for easy reference. Key themes of the new recommendations include the three following criteria.

Clinically relevant

- Earlier initiation of ART (CD4 ≤ 500);
- Immediate ART for children below 5 years;
- ART initiation for all pregnant and breastfeeding women (Option B/B+) and lifelong ART (Option B+);
- Harmonization of ART across populations (e.g. adults and pregnant women, Option B/B+) and age groups;
- Simplified, fewer, and less toxic first-line regimens (TDF/XTC/EFV).
**Operationally relevant**

- Use of fixed-dose combinations as a preferred approach;
- Improved patient monitoring to support better adherence and detect earlier treatment failure (increased use of viral load);
- Task shifting, decentralization, and integration;
- Community-based testing to complement broader HIV testing and counselling (HTC).

**When to start ART**

The most notable new recommendation is that ART is now recommended for all individuals with a CD4 count <500 cells/mm3. However, priority is given to individuals with severe or advanced clinical disease (clinical stage 3 or 4) and individuals with a CD4 count <350 cells/mm3. Moreover, the new guidelines expand the recommendations for starting treatment with CD4-independent conditions not only for tuberculosis/HIV and hepatitis/HIV but also to serodiscordant couples, pregnant women and children under 5 years of age. Key affected populations and individuals coinfected with hepatitis C are recommended to follow the same criteria as other adults and adolescents living with HIV.

Another important recommendation is the use of fixed-dose tenofovir + lamivudine (or emtricitabine) and efavirenz as a convenient, safe and affordable combination. Ten randomized control trials demonstrated the superiority of TDF + 3TC or FTC + EFV compared with other EFV-containing regimens.

For the prevention of mother-to-child transmission of HIV (PMTCT), the new guidelines propose moving towards Option B or B+, i.e. offering ART to all pregnant and breastfeeding women. The safety of efavirenz in pregnancy during the first trimester has been established and thus, this combination can be used for pregnant women allowing for harmonized and simplified treatment.

An important new recommendation is that viral load (VL), where available and feasible, should be the preferred monitoring approach to diagnose and confirm ARV treatment failure. If VL is not available, CD4 should continue to be used.
For children, the new guidelines recommend treating all those positive under 5 years old irrespective of CD4 count. For those over 5 years, the recommendation is similar to adults, i.e. CD4 <500. The rationale for this recommendation included the programmatic and operational advantages of reducing or removing the requirement for CD4 testing – one of the barriers to ART initiation – and thus to improve treatment coverage for children, which at less than 40% globally lags behind adults. For children under 3 years, the Lopinavir-based regimen is recommended irrespective of exposure to non-nucleoside reverse-transcriptase inhibitors (NNRTI). For children over 3 years old, the recommended regimen is the same as that for adults, i.e. TDF+3TC+EFV, further enabling harmonization and simplification.

5. Clinical guidance on managing coinfections and comorbidities

In her presentation, Dr Philippa Easterbrook highlighted that the consolidated guidelines summarized existing recommendations, and that no new recommendations were made in the 2013 guidelines for prophylaxis and treatment of comorbidities.

With regard to co-trimoxazole prophylaxis, new guidelines are being prepared for publication in early 2014. For tuberculosis (TB)/HIV coinfection, the guidelines summarize recommendations from existing global guidelines, including those on TB case finding and isoniazid preventive therapy (IPT), infection control and the new policy document on TB/HIV collaboration. Algorithms for TB screening and IPT for PLHIV are presented. The use of Xpert Mycobacterium tuberculosis/Rifampin (MTB/RIF) is recommended as the initial diagnostic test for PLHIV.

For TB treatment and ART in PLHIV with TB, the guidelines recommend ART for all TB coinfected patients regardless of CD4 count. The preferred first-line ART regimen is efavirenz based. Second-line ART includes a protease inhibitor-based regimen at standard dose if rifabutin is available, or if only rifampicin is available, a super boosted dose of ritonavir with the protease inhibitor, because of drug interactions with rifampicin. The guidelines also recommend the provision of ART in TB treatment
settings in high burden of HIV and TB, and emphasize the importance of task shifting.

Final guidelines on cryptocccal infections will soon be released. Early ART initiation in patients was not recommended due to the high rate of life-threatening immune reconstitution inflammatory syndrome (IRIS).

For HIV hepatitis B coinfection, the new guidelines recommend initiation in patients with a CD4 count < 500 cells/mm$^3$ and regardless of CD4 count for those with severe chronic liver disease. With regards to hepatitis C coinfection, ART should follow the same general principles as for all PLHIV.

6. HIV testing approaches in the context of Asia

Dr Ying-Ru Lo highlighted that in order to achieve the WHO target of 15 million people living with HIV receiving ART by 2015, major efforts are essential to expand access to, and coverage of universal HIV voluntary counselling and testing (VCT), and timely linkages to care and treatment. There are missed opportunities to access antiretrovirals for prevention of HIV transmission, and thus reduce morbidity and mortality. Although HIV mostly affects key populations, less than half of them know their HIV status. HIV testing coverage of pregnant women varied between less than 1% in Indonesia to near 99% in Thailand in 2012. Moreover less than 32% of newly registered TB patients have been tested for HIV in the South-East Asia Region.

In addition to provider-initiated testing and counselling in health facilities, HIV-retesting and testing and counselling for couples, WHO is recommending new approaches such as community-based HIV testing settings, and offering HIV testing for adolescents at highest risk.

The Project Accept (Thailand, United Republic of Tanzania and Zimbabwe) showed that 40.4% more persons accessed VCT in community-based settings than in standard VCT settings, resulting in 3.6 times more HIV-infected clients identified. Mobile testing offered at five departmental stores in metropolitan Bangkok on the occasion of World Aids Day 2012 resulted in 677 of the 688 (98%) registered clients taking the test. All tests
results were available within one hour and 80% of those found positive came back for CD4 testing.\textsuperscript{4}

WHO is also exploring new methods such as self-testing and the use of oral fluid HIV test kits. Early experience from Malawi has shown high acceptability of self-testing with good linkages to home ART initiation. Community-based HIV testing and counselling for men who have sex with men in Wuhan, People's Republic of China showed that uptake of HIV testing at drop-in centres increased HIV testing by 60% by September 2011 compared to a baseline in May 2010. The study used finger-prick rapid tests and oral fluid testing conducted by health care workers on site. Of all positive test results, 90% were sent to the Centers for Disease Prevention and Control (CDC) in China for confirmatory testing.

Recent interest has been generated in oral fluid-based testing for HIV following the United States Food and Drug Administration approval of Oraquick. However, the rapid point-of-care HIV test using oral fluid rather than whole blood specimens shows 2% lower pooled sensitivity and lower positive predictive values.\textsuperscript{5} Before self-testing and the use of oral fluid testing can be recommended, measures need to be put in place to monitor for adverse social and health outcomes that may arise due to self-testing and ensure linkages to ART.

Systematic reviews on retention in care show that high uptake of CD4 is possible when offered in combination with HTC using point-of-care diagnostics.

6.1 Country experiences

\textit{India}

Dr Rewari presented India’s experience on scaling up testing and linkage to care, including a brief history of the HIV epidemic and programme. HIV prevalence is on the decline in the country and there has been 29% fewer reported HIV-related deaths, thanks to ART scale-up. Operational guidelines for HTC are currently under revision. India uses different service delivery approaches to increase access to testing including stand-alone and mobile Integrated Counselling and Testing Centres (ICTC).
Clients are self- or provider-initiated. The latter is still based on symptoms and signs in TB patients, pregnant women, and patients with sexually transmitted infections (STI). Walk-in clients are referred from targeted intervention programmes. There is also a focus on migrants at source and destination services. The national programme uses only rapid HIV diagnostic tests with same-day results. Supervision of ICTCs is done with support from the Tata Institute of Social Sciences. Coverage with prevention interventions among key populations, despite expansion of ICTC, is still less than 50%. Detection among pregnant women is only 22–25%.

As part of the programme scale-up plans, all community health centres will have stand-alone ICTCs. There is also plan to offer HIV testing at all TB centres. Mobile clinics will be further scaled up in areas where stand-alone services are not feasible. The target is to reach 28 million HIV tests every year by the end of the current National AIDS Control Programme Phase 4. Distance and reluctance to have a test when feeling healthy are major barriers. To attract more people to test for HIV, the national programme has increased the number of link centres to ICTC, provision of CD4 testing facilities at link centres, and linkages with PLHIV and their community.

**Myanmar**

The next presentation was on HIV testing and counselling in Myanmar by Dr Myint Shwe, who gave a brief description of care and support interventions provided under the national programme. Antiretroviral treatment started in the public and private sector in 2003 and currently covers 53 000 patients, which is 43% of the total estimated need. Testing is both client- and provider-initiated. The plan is to expand the 28 HTC sites to 300 sites by the end of 2016.

The country has total of 575 service delivery points. PMTCT services were scaled up in 2011 to cover 250 sites. The key challenges to scaling up HIV testing in the country include the limited number of sites, financial resources, regular availability of rapid test kits, limited early infant diagnosis facilities and a lack of trained human resources. The national programme plans to procure more test kits for HTC scale-up, both in the nongovernmental organization (NGO) and government sectors with simultaneous demand generation and expansion of targeted testing. The
country has already developed a plan to decentralize HTC. Training materials have been developed and health-care providers are undergoing training. There are also plans for task shifting of HTC from laboratory technicians to trained health workers through the use of rapid, point-of-care technology.

During the discussion, the key issues raised included the issue of retesting; counselling for couples, and pre-exposure prophylaxis.

7. **Panel discussion on scaling up testing and counselling for HIV**

Panellists argued that communities need to be trained and accredited for HIV testing in the respective country’s legal context. The regulations would need to be amended to allow non-laboratory personnel to perform an HIV test. Quality management systems should include these testing sites and settings. Civil society organizations engaged as service providers need institutional and technical capacity and skills to deliver community-based testing services. This includes infrastructure and human resources capacity-building. National resources should include allocations for key affected populations and community-based organizations to offer such services.

In terms of couples counselling and testing there is need to define the term ‘couple’. Couples are generally seen as those who are formally married, but in a public health context this restrictive definition needs to be expanded to include same-sex relationships and those outside marriage. The WHO definition allows that flexibility.

The panellist from Bangladesh shared key issues for HIV testing and counselling in the country. He said that there was a need for ongoing political commitment and raising general awareness among people. The number of HTC centres is limited, the majority of which are stand alone, and only for high-risk groups. Referral systems for care and treatment are weak. Mobile teams are currently being formed that will start working soon to support the scale-up of HTC. A one-stop service model is also about to be launched to support better linkage between HTC and ART. The United States Agency for International Development (USAID) representative on the panel noted challenges related to transport, task shifting etc. at country
level for rapid scale-up of HIV testing. There are also challenges in coordination and collaboration among various partners and stakeholders, especially at country level. Procurement and supply system management across service delivery points run by different stakeholders, and recording and reporting in the absence of unique identifiers were other reported challenges, based on his experience in Myanmar.

The Clinton Health Access Initiative (CHAI) representative shared that the Initiative had been working with NGOs and the Ministry of Health in Indonesia. The focus of its work is to increase testing and establish linkages with care. It is important to look at service delivery from the perspective of the patient. Generally, services are designed and structured for the convenience of the providers rather than the client. Besides cost for services, the patient has to bear other costs, including opportunity costs and lost wages. From the patient’s perspective, an important issue is the time taken from getting into a service delivery point until the time services have been offered. Designing client-centred service delivery is fundamental to keeping people within the treatment cascade. At CHAI clinics, the turnaround time from walking into the clinic to getting a diagnosis is targeted at one hour. Support systems for people initiated into ART are crucial for initiation, adherence and retention in care. The key message is thus to be ‘client focused’.

The Ministry of Health representative from Sri Lanka shared the country’s experience with couples counselling and syphilis testing. Sexually transmitted disease (STD) clinics have historically been the point of care for HIV. Sri Lanka has 29 STD clinics that are easily accessible and these are used as counselling and testing centres, as well as prevention work with some key populations. Syphilis and HIV testing is also offered through outreach in prisons, NGOs and other settings. Antenatal syphilis screening has reached universal coverage levels. HIV testing and counselling in antenatal care (ANC) was routinely introduced in five districts in 2013 and the aim is to expand to all clinics by 2016. Each HIV, syphilis or STI patient is offered contact tracing, either via the patient or through health workers, including defaulter tracing.

During the discussions, Thailand shared the use of encrypted 13-digit national identity codes for monitoring. Some of the issues raised from the floor included the role of ‘secondary stigma’, whether patients who self-test actually go for care and treatment services, and the importance of counselling, especially post-test counselling, for linkage to care.
8. Group work 1

Participants broke up into five working groups to discuss key gaps and opportunities for scaling up testing and linkage to rapid eligibility and enrolment for HIV positive patients, and prevention activities for the HIV-negative population in the Region. They also discussed priority actions to be taken and support required from WHO and other partners.

The outcomes of the group work were synthesized and presented by the secretariat. Participants identified the following opportunities for scaling up HIV testing and linkage to care:

- favourable national and regional political momentum;
- availability and expansion of point-of-care diagnostics;
- the latest data in new guidelines and scientific evidence on the benefits of early initiation;
- integrated service delivery in the context of universal health coverage;
- the role of HIV in health systems strengthening;
- the feasibility of multi-disease testing at primary care level; and
- increasing acceptability of task shifting and decentralized service delivery.

The following were identified as key gaps:

- availability and accessibility of testing services closer to communities;
- Insufficient linkage to treatment and fragmented service delivery;
- varied interpretation and implementation of provider-initiated testing and counselling;
- health systems and human resource capacity to take on scaling up;
- agreement on models for task shifting;
- lack of commodities and weak procurement supply and logistics systems;
quality of counselling; and
continued stigma and discrimination both social, by patients, and within health-care settings.

Other gaps identified included policies and practice on retesting, especially for key populations; legislative and legal frameworks for task shifting; shrinking resources for HIV, especially international aid; and sustainability of the response.

The key priority actions identified by the working groups included making the case for scaling up HIV testing and early ART as a smart investment; guidance and an implementation framework on expanding HIV testing including task shifting and decentralization; capacity-building of health-care staff, especially at primary care level; documentation of lessons learnt, best practices and sharing with each other; strengthening procurement, supply and logistics systems; and working with other sectors like education, labour and justice.

9. Recommendations for HIV service delivery

In her presentation, Dr Philippa Easterbrook first highlighted the challenges and context for the development of the recommendations in the 2013 guidelines on key service delivery. These included low testing coverage and inadequate linkages from testing to care, delayed diagnosis and treatment initiation, inadequate retention in care, and low treatment coverage among key populations. Key operational and service delivery recommendations cover expanded testing scenarios, task shifting and decentralization to bring ART closer to community, with ART initiation and maintenance at different levels, service integration, strategies to improve adherence support, and retention in care. The recommendations were informed by both systematic reviews and experiences in many countries with experience in implementing community-based testing approaches in the workplace, mobile clinics and schools, task shifting and different models of service integration.

Service delivery recommendations also include integration of services and responding to comorbidities and multiple needs of patients that come for HIV care. Several entry points are used and opportunities maximized for early initiation and maintenance of ART through delivery of services in
antenatal/maternal and child health settings, TB care settings and opioid substitution therapy (OST) settings with linkage to continued HIV care and treatment.

Human resource challenges hamper expansion of HIV services, and task shifting or task sharing can and should therefore be considered. This can be done through trained non-physician clinicians, midwives and nurses, who could initiate and maintain first-line ART; trained and supervised community health workers would deliver ART between clinic visits. To be successful and acceptable to communities, it is important that an enabling policy/regulatory framework, quality assurance, and ongoing training, mentoring and supervision are put in place. Improved adherence to treatment (and retention in care) may be achieved through the use of interventions that may include reducing the pill burden by using fixed-dose combinations, minimizing out-of-pocket payments, strengthening drug supply, patient counselling and education, and mobile phone text reminders/messages. Retention in care is essential to optimize treatment outcome and programme effectiveness. There is no specific recommendation on this, but the new guidelines acknowledge that multiple interventions are necessary.

In the discussions following the presentation, several participants highlighted that these recommendations may be more relevant to the HIV care setting in sub-Saharan Africa, and less applicable to Asia. With challenges in quality of care, there are concerns about task shifting to lower level cadres. Regulatory issues related to ART being prescribed by non-physicians will also need to be addressed. However, the positive experience with task shifting in Thailand was shared, where inadequate doctors and nurses were available to take care of patients in the early years of the epidemic. Lower level health-care providers were trained and successfully provided HIV and ART care. The experience from Indonesia was also reported, where task shifting supported by community representatives has been done in select and suitable places with a scarcity of doctors.

In response to a request from community representatives for clear WHO guidance on hepatitis C/HIV coinfection management at country level, it was reported that WHO was currently preparing specific guidelines on the management of hepatitis C infection.
Participants asked whether WHO could provide further guidance and tools to countries in the implementation of both the clinical and operational recommendations, e.g. the appropriate levels and tasks related to task shifting (testing, ART initiation, maintenance, etc.). The response was that, while detailed, generic WHO guidance on task shifting exists, global guidelines may not be useful as these issues were very country/community specific.

10. Challenges and opportunities for scaling up ART: Experiences from programme reviews

Two countries – Indonesia and Thailand – have held national consultations on scaling up the strategic use of ARVs.

10.1 Indonesia

The country presentation from Indonesia highlighted the heterogeneous nature of the national epidemic and the concern over increased incidence in some pockets of the country. Currently 33,114 people are on treatment, which is around 30% of those in need. HIV prevention, treatment and care services are provided through a network of facilities that include 592 HTC services, 113 PMTCT sites, 378 care, treatment and support sites, 370 STI clinics, 83 methadone maintenance therapy (MMT) units and 197 national strategic plan (NSP) sites. There are 130 sites for CD4 testing and 22 for viral load measurement. ARVs are provided free to all PLHIV whose CD4 count is below 350. HIV testing is free only for pregnant women in high prevalence areas.

To review progress and prepare a scale-up plan, a joint rapid assessment on scaling up access to ARVs, including for prevention, was conducted in January 2013. Its main purpose was to obtain information to develop a roadmap to accelerate the expansion of ARVs for treatment, and to maximize the prevention benefit.

The assessment concluded that HIV treatment had expanded but there remained a huge gap in ART coverage. With the median CD4 count at treatment initiation less than 100 cells, the programme needs to expand testing to identify HIV-positive individuals early. For rapid scale-up, task
shifting/sharing is crucial as the health services in the country are already decentralized. The roadmap was informed by modelling carried out using the Spectrum Goals and the Asian Epidemic Model (AEM). Five scenarios were presented through the modelling exercise to establish best gains in coverage and cost-effectiveness. The scale-up strategies include expanding HIV diagnosis; improving integration of HIV testing into other health programmes like ANC, TB and STI; introducing couple HIV testing and counselling; task shifting, expansion of point-of-care diagnostics for HIV and CD4 testing; effective engagement and collaboration with key affected populations and civil society to expand HIV testing, treatment and retention in care.

The main challenges for scaling up ART include changing the mindset of health workers on HIV from specialized to general services. Most of health workforce needs to be trained on HTC and HIV treatment and care. There are many misconceptions among key populations about the benefit of testing and treatment, and the value of expanded diagnostic services to expedite eligibility and enrolment in care and treatment.

### 10.2 Thailand

HIV prevalence in ANC in 2017 is 0.64. The highest prevalence is among people who inject drugs at 25.2% followed by 12.2% among male sex workers and 7.1% in MSM. In terms of prevention, condom use is highest among female sex workers and lowest among people who inject drugs.

The first case of HIV was reported in the country in 1984. ART started as a single drug therapy in 1992 and changed to a multidrug regimen, or highly active ART (HAART) in 2000. Use of fixed-dose combinations started in 2002 with local production that also marked the decrease in drug prices. HIV treatment and care services are provided largely through 1086 ARV clinics that are located in government hospitals. The country has good laboratory support with 119 laboratories for CD4 testing, 44 for viral load testing and 14 for drug resistance monitoring.

ARV drugs are procured through a centrally pooled procurement mechanism while ARV logistics are managed through vendor inventory systems that ensure no drug stock-outs. There are four funding sources for ARV procurement – supported by the Government (National Health Security Office, Civil Servant Medical Benefit Scheme) and one through the
Global Fund to Fight Aids, Tuberculosis and Malaria (Global Fund). The latter mainly supports the supply of ARVs for non-Thai people. In 2011, ART coverage was 65% (CD4<350). In 2012, 239 000 people were on ART, representing a covering of 82% of those in need.

In near future, the Thai Government plans to include non-Thai residents in the health benefit package. From 2008–2011, 70% of national spending on HIV/AIDS was for care and treatment, of which only 13% was from the Global Fund. National AIDS spending amounts to 5.9% of Thai gross domestic product.

HIV testing has been scaled up over the last four years. By 2012, 599 126 persons were registered under HTC, not including ANC and the private sector, with 99.8% ANC clients having received HIV testing and counselling. Despite this, many challenges in scaling up testing and treatment remain. People are still reporting late and 50% had CD4 counts of 100–200 when they were diagnosed with HIV. The treatment cascade is still insecure and key populations like MSM and vulnerable groups like adolescents are still beyond the reach of HIV prevention, care and treatment services.

However, there are opportunities for initiating treatment early to accrue the benefit of prevention. The national consultation reviewed the evidence and made recommendations on the way forward to improve prevention, early treatment initiation, and link prevention with care and treatment. Recommendations were also made on how to stop leakage, look into task shifting/sharing, use data for local decision-making, strengthen PMTCT and early infant diagnosis for an HIV-free generation.

10.3 Guidance for programme managers

Dr Andrew Ball presented the programmatic recommendations of the 2013 guidelines. He mentioned that the new consolidated guidelines address three specific areas: what to do, how to do it, and how to decide. He mentioned that one-size-fits-all implementation is neither feasible nor desirable. This section of the guidelines aims to assist countries and partners to optimize decision-making for an equitable, sustainable and effective response and to identify optimal pathways to rapidly achieve the HIV treatment goals.
Dr Ball emphasized that decisions regarding the implementation of global recommendations should be made through a transparent, open and informed process that recognizes the multisectoral nature of the HIV response. Decisions on how to adapt and implement these guidelines should be based on a careful assessment of epidemiological dynamics and programme performance to identify programme strengths and weaknesses and necessary policy changes, consistent with the principles of “know your epidemic, know your response”. Quantitative and qualitative data should, whenever possible, be disaggregated by gender, age, subnational administrative categories (such as regions and districts) and other relevant stratifications, including key populations, to ensure that new policies address inequities in access.

Three main parameters should be used for assessing individual recommendations in different contexts. These are human rights and ethical principles, impact and cost-effectiveness and opportunities and risks. Dr Ball also mentioned that to identify better the potential impact of some of these recommendations – based on data sets from India, South Africa, Viet Nam and Zambia – the HIV Modelling Consortium, an independent group of research institutions, developed multiple independent mathematical models to examine the health benefits, costs and cost-effectiveness of various strategies for expanding eligibility for ART as well as testing and access to HIV care. The main conclusion was that expanding the ART eligibility criteria to CD4 cell count ≤500 cells/mm$^3$ was found to be highly cost-effective in low- and middle-income settings. However, combining expanded eligibility with a large increase in HIV testing and linkage to care produced the greatest benefits, especially in settings with low ART coverage.

Dr Ball also noted that key health system-related issues needed to be considered while implementing the adapted guidelines. These include human resources, drug supplies, costs, infrastructure, finances, leadership, and M&E, which need to be assessed in the context of the individual country epidemic. He concluded by giving examples of tools for costing and planning purposes, e.g. specific modules in Spectrum, One Health Tool, that are freely available on the web.
11. Panel discussion: Scaling up the strategic use of ARV

A panel comprising representatives of civil society from Bhutan, India, Nepal, United States CDC, USAID, United Nations Children’s Fund (UNICEF) and Kirby Institute discussed country experiences and challenges in scaling up ART with reference to the new guidelines. The session was facilitated by Dr Kumarasamy.

Sharing the experience from Nepal, Dr Suvedi mentioned that three important areas needed to be considered regarding the scale up of services: commitment towards universal access; commitment to PMTCT; and sustainability and quality of programmes. He welcomed the recommendations in the new guidelines, and felt that mentioning eligibility criteria like the CD4 levels might pose an indirect restriction to access. Further, there may be a need to provide ART to all who test positive, as they may not be initiated with ART if their CD4 are high and thus may end up with advanced disease and opportunistic infections, thereby adding to mortality and morbidity.

Dr Sonam from Bhutan mentioned that there are 321 reported cases of HIV in Bhutan, though the estimations are much higher. Key challenges observed in Bhutan include an increase in multiple sex partners, STIs, and vulnerable population groups like taxi drivers. To improve coverage of HIV testing, case detection and ART coverage, certain key areas need to be addressed. These include increasing the number of VCT sites for better access to HIV testing; strengthening human resources (as currently there is only one focal person at district level to coordinate all HIV-related activities); and increasing health system capacity from the sole care and support centre in the national referral hospital. As VCT services expand and more people are detected and referred for HIV treatment, there is a need for more ART centres. A support group has been formed by PLHIV who help in referral to voluntary counselling and testing, links from this to care and treatment and peer education. These services need to be expanded and supported. Dr Sonam also noted the important challenges of addressing the mobile/migrant population and cross-border migration.

Father Tomy, representative from the civil society from India, shared his experience of providing care and support to PLHIV. He emphasized the importance of peer groups and the fact that, in his experience, information
shared by peers is more effective and better retained than that provided by health workers. Hence, this mechanism should be more structured and institutionalized. The best way, possibly, to increase retention in care is to have a peer-based approach to patient education for treatment through the involvement of the community.

The panel member from USAID, Dr Robert Ferris, considered that the issue of sustainability in the face of scale-up and the quality of services needed to be addressed. He mentioned that certain systemic issues like the supply chain management, particularly for commodities, was vital and if this was weak, it would be a big bottleneck in the scale-up of services. At the same time, quality needs to be maintained.

Dr Amit Achara from Kirby Institute emphasized that the scale up of ARV should occur in parallel to the need to remain open towards clinical and implementation science research. He noted that two important trials were looking into simplification of second-line ARV and lower doses of rifampicin.

Dr Ball informed the audience that WHO would convene a summit on implementation/operational research comprising countries and key agencies involved in implementation to set an agenda for future research. Country and community involvement will be critical in the development process and the effective implementation of the new guidelines. The civil society reference group established by WHO has varied representation and WHO is discussing further with them on how best they can be engaged.

Dr Wing-Sie Cheng from UNICEF expressed concern that children lag behind in terms of availability of early infant diagnosis as well as paediatric ARV in many countries. The waiting period is as high as three months for infant diagnosis, which results in lost follow-up. This is of particular concern given the high mortality in HIV-infected children in their first two years of life. Dr Cheng shared experiences from Thailand and Cambodia. In Cambodia, there had been a general shortage of paediatric services since the 1970s, but the introduction of paediatric HIV care in the 1990s showed a notable revival in overall paediatric care. She also mentioned that the publication ‘Getting it Right’ can be referred to for paediatric services and is available on the UNICEF website.⁶
Participants from Indonesia sought clarification from the panel on how far international development partners were prepared to support the additional resources necessary to implement the new guidelines. Dr Andrew Ball clarified that a large number of stakeholders and funding agencies were involved in the process of guidelines development. Partners like the Global Fund and the United States President's Emergency Plan for AIDS Relief (PEPFAR) had agreed to support the guidelines as a standard document that could be referred to in country proposals to these agencies. While it was agreed that there would be an increase in resource requirements, there might also be a need to relook into current funding and resources, identify high-impact interventions and reprogramme existing resources for best use.

Panel members were also asked if they could suggest ways to reach the most at-risk and key populations. These key populations are often hidden and at the same time can change in composition. For example there is a slow shift observed from brothel-based female sex workers to street-based workers, which makes testing and linkages into care and treatment difficult. The panel responded that no defined interventions were available to address these dynamic changes. However, an example from Thailand showed that by using the Internet to communicate with key populations, particularly MSM, peers encourage each other to this mechanism to seek more information on sexual health, and where and how they can seek HIV testing. However, when these populations access the HIV testing services, they do not disclose that they belong to a vulnerable group.

12. Group work 2

This exercise asked working groups to identify key opportunities and gaps for strengthening service delivery to scale up ART in the context of the 2013 guidelines, i.e. to initiate ART at a CD4 threshold of <500. The groups were also asked to deliberate on key priority actions needed at country level for early initiation into care and moving towards a chronic care model for HIV treatment and follow-up.

During the feedback session, the groups reported that the key opportunities at country level are: community networks that can help expand testing and early treatment initiation; evidence from scientific
studies of benefits of early treatment that can be strong advocacy tools; the fact that HIV had potential for managing comorbidities through integrated service delivery; simplified drugs and diagnostics allow decentralization and task shifting; simplified fixed-dose combinations have the potential for price negotiations and the availability of funding through the new Global Fund rounds.

Participants identified the following key gaps/constraints: unclear role of communities and community-based organizations; poor funding for these organizations; restrictive legal frameworks that prevent task shifting and decentralization; poor skills and human resource capacity, especially at primary care level; weakness in procurement and supply systems; limited availability of point-of-care diagnostics; lack of data, especially for key populations; decreasing resources for HIV and challenges with adherence and retention when ARVs are started early and patients are not sick.

The following priority actions were noted in the working groups: define clear roles and build the capacity of communities; strengthen country capacity for forecasting, procurement and supply chain management systems; strengthen health systems and human resources for decentralized service delivery; disseminate and adapt the new guidelines nationally; carry out econometric analyses; document best practices; undertake implementation science research for ‘learning by doing’; update the essential drugs list to include new ARVs and opportunistic infection medications and to remove those that are no longer recommended.

13. Monitoring and evaluation

The WHO 2013 consolidated guidelines has a section on monitoring and evaluation (M&E) that was presented by Dr Andrew Ball. The presentation focused on tracking implications of new ARV recommendations; monitoring along the HIV care cascade; HIV drug resistance and toxicity monitoring; and implementation research and programme evaluation. Dr Ball suggested the following six key M&E systems considerations to be taken forward at the country level.

- Patient Monitoring System: update data elements according to new guidelines; ensure links and synergies with ART and PMTCT/TB;
Data Flow and Integration: establish country standards for service delivery and data flow including transfers from different service delivery points;

Quality Assurance: supportive supervision and standard operating procedures for data generation and aggregation;

Data Use: routine data use at all levels to review programmes and maintain database and regular dissemination;

M&E Capacity: build human and institutional capacity, institute e-health, and budget adequately to improve and sustain capacity;

M&E Coordination: coordinate changes in programme monitoring and reporting with key stakeholders and partners, ensure alignment with national strategy, and link with the health management information system (HMIS).

He informed participants that WHO would be issuing consolidated M&E guidance in 2014, e.g. on surveillance, needs estimates, HTC, ART, PMTCT and HIV drug resistance.

14. Programme monitoring

On behalf of WHO and UNAIDS regional teams, Dr Amaya Maw Naing presented the implications that the “cascade of care” will have on the current monitoring and reporting systems at the national level. The “cascade” – a powerful visual tool to monitor engagement in care and treatment at the national, state, and local levels – can provide valuable insights into the different steps in the HIV care continuum and inform programmatic and investment decisions, as well as research activities.

The WHO Western Pacific Regional Office is taking the lead in developing guidelines that will define the metrics for monitoring the quality of the cascade. The draft framework will be piloted in two countries in the Region (Cambodia and China) and the South-East Asia Region may also suggest two pilot countries.
In her concluding remarks, Dr Amaya emphasized that the “three ones” principle\(^1\) should continue to guide national efforts to strengthen one well-integrated national M&E system. Country teams were encouraged to discuss with HIV Strategic Information and Programme colleagues at the national level (using the existing technical forums, e.g. national M&E working groups) how to:

- Develop a national HIV treatment cascade framework;
- Use the available data to the fullest extent; and
- Use the cascade for decision-making.

During the discussion, the following important points were made:

- Indicators that will be used for the “cascade” should be defined (a well-defined set of indicators already exists within the national M&E systems that could be used, but additional indicators might be required);
- Data disaggregation on people on ART is lacking (e.g. age, risk behaviour, etc.);
- Unique identification codes are also needed;
- The presentation of cumulative cascade data over several years presents challenges; and
- The cascade will be limited to the use of annual cohort data.

### 15. Treatment 2015 initiative

Dr Vladanka Andreeva presented the recently launched UNAIDS framework, *Treatment 2015*, to accelerate action in reaching 15 million people with ARV treatment by 2015 – the goal set by United Nations Member States in 2011. *Treatment 2015*, developed in consultation with a range of stakeholders and endorsed by WHO, the Global Fund and PEPFAR, offers countries and partners practical and innovative ways to increase the number of people accessing ARV medicines. The framework

---

\(^1\) one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad based multi-sector mandate; and one agreed country-level monitoring and evaluation system.
takes into account the WHO 2013 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection as well as efforts made under the Treatment 2.0 framework. Treatment 2015 outlines three fundamental pillars to reach the 2015 target:

- **Demand**: increasing demand for HIV testing and treatment services;
- **Invest**: mobilizing resources and improving the efficiency and effectiveness of spending; and
- **Deliver**: ensuring more people have access to ARV therapy.

The framework is strongly routed in the rights-based approach (the right to know one’s HIV status; the right to HIV treatment; and the right to be protected).

*Treatment* 2015 encourages countries to enhance public health programmes and leverage services provided by civil society and community-based groups. In order to promote greater access to HIV testing and treatment services, especially for the key populations, the framework emphasizes the great need for decentralization of services and task shifting.

### 16. Panel discussion on the role of development and civil society partners

The last panel discussion discussed role of development and civil society partners. The moderator thanked all partners for their contribution to the development of the consolidated guidance.

Civil society representatives considered that their organizations play a crucial role in developing and implementing guidance. They also complement services provided by the public sector and interface between communities and the health sector. However, the role of civil society organizations is unclear and they largely depend on ad hoc funding.

Donors (Australian Agency for International Development (AUSAID) and the United States Government) strongly encouraged national partners to take into account the latest WHO recommendations. They shared the history of their engagement in the Region on HIV. AUSAID has been
particularly active in the area of harm reduction and capacity enhancement at country level. The agency will continue to engage in early testing and treatment strategies, strengthening M&E, retention in care and implementation research, as well as health systems strengthening.

CHAI and Family Health International also confirmed their readiness to work with partners at the national level to ensure successful roll out of the guidelines. CHAI has been supporting countries in the Region on medicines, diagnostics and procurement supply management issues. Technical support is provided at national and subnational levels. CHAI has also been involved in clinical mentoring and programme monitoring including strengthening referral systems. Both CHAI and FHI are also involved in implementation science research.

CDC Thailand has been supporting the Lao People's Democratic Republic, Myanmar, Papua New Guinea and Thailand national programmes through transfer of technical knowledge in the areas of PMTCT, MSM, laboratory support for HIV testing, CD4 and viral load quality assurance and strengthening M&E systems.

Kirby Institute works with countries in the Region on implementation science research, clinical studies, treatment optimization and modelling studies.

United Nations partners (UNAIDS and UNICEF) each described the current regional partnership framework and the need to increase country support by targeting geographically prioritized areas, focusing on key populations. The need to revamp testing approaches was also mentioned, as well as the need for further discussion on greater involvement of the communities in service delivery.

17. Group Work 3

The last working group exercise was for country teams to develop a dissemination/roll out plan for the 2013 consolidated ARV guidelines. In order to disseminate these guidelines, WHO South-East Asia Region Member States outlined a plan that focuses on five key areas: promoting and advocating the guidelines at the national level; providing technical overviews; supporting revisions and adaptations; promoting dissemination
and utilization; and supporting evaluation of the guidelines. The template outlines the activities and budgetary and support needs to implement the plan over the course of three years, from 2013 to 2015.

Countries suggested six activities to promote and advocate the WHO 2013 consolidated guidelines with the purpose of sensitizing and informing national governments and stakeholders. In 2013, almost all countries will organize press conferences and advocacy meetings to brief key policy- and decision-makers, high-level health professionals, donors and stakeholders. Bangladesh, India, Nepal, Thailand and Timor-Leste will develop fact sheets tailored to the national context and in local languages. Relevant materials will be developed and distributed through electronic media by Bangladesh, India, Myanmar, and Nepal. Four countries suggested translating global documents, such as frequently asked questions (FAQs); and India committed to educating journalists about HIV treatment and the new guidelines in 2013.

Another six activities were proposed to provide the rationale behind the recommendations to national HIV experts and key policy-makers and stakeholders. In 2013, Indonesia will hold a national expert panel meeting, finalize and provide a costing of the roadmap, and hold workshops to discuss the recommendations. The majority of countries also agreed to hold workshops and will distribute key materials and meeting summaries to in-country stakeholders between 2013 and 2014.

To support the revision and adaptation of the national guidelines by a national guidelines committee, all countries agreed to collaborate with national stakeholders to draft any revisions, adaptations, or updates between 2013 and 2014. Similarly, all countries agreed to hold workshops to review and propose new recommendations and include civil society, partners, and technical staff. Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal and Thailand committed to reviewing programmatic guidance and costing.

A total of seven activities are proposed to ensure that the new guidelines are distributed and utilized. Indonesia suggested socialization at the national level and Bangladesh socialization at the provincial, district, and health-facility levels. The development of electronic tools for dissemination was proposed by India, Maldives, Sri Lanka and Thailand. Most countries agreed to provide mentoring, curriculum revision, training as well as developing and printing job aids and key summaries. Additionally,
all nine responding countries agreed to provide revisions to M&E guidelines, registers, and data systems.

Finally, WHO South-East Asia Member States suggested five activities to help evaluate the use of the new guidelines by providing feedback to national programmes and policy-makers about the feasibility, utility and process. In 2013, Maldives will provide training on recording and reporting treatment data for physicians and programme staff, and Indonesia suggested creating a roadmap for the implementation of the M&E programme. India, Indonesia, Sri Lanka, Thailand, and Timor-Leste proposed surveying a sample of guideline users at the national, regional, and health-facility level. Similarly, an e-survey of individuals, groups and institutions involved in the revision and use of the guidelines was suggested by India, Indonesia, Maldives, Myanmar and Thailand. For many countries, the surveys will be carried out in 2015. Finally, India, Indonesia, Myanmar and Thailand agreed to draft a short report documenting the lessons learnt and recommendations for future guidelines dissemination efforts.

18. Recommendations from the meeting

18.1 General recommendations to Member States, WHO and partners

These recommendations take account of the commitments made and honoured since the ‘3 by 5 Initiative; Millennium Development Goals (MDGs), in particular 6A and 6B; revised and reaffirmed scaled-up targets of the United Nations High-Level Meeting on AIDS and the post-MDG health and development agenda. The recommendations can also be easily adapted and implemented in line with the 2013 WHO consolidated guidelines.

Recognizing that there will be an expansion of HIV testing and antiretroviral therapy, countries and partners will have to think about:

(1) the early adaptation, roll out, metrics, prevention and surveillance of drug resistance, toxicities and health systems requirements;
(2) evidence-based planning for human resources, short- and long-term financing in concert with national HIV strategic plans;

(3) adaptation of service delivery models to strengthen readiness of current health systems and legal frameworks in the context of decentralization plans of countries, including task sharing/shifting;

(4) use of routine monitoring data and implementation research to support decision-making;

(5) engagement of civil society as a critical element in this process;

(6) the fact that HIV is now a chronic disease condition and needs to be viewed in the context of chronic care models.

There is also a need to make the case for normalization of HIV testing, scaling up HIV testing and early ART as a smart investment. Special consideration needs to be given to key populations, particularly youth and internal and international migrants.

18.2 Specific recommendations to Member States

Countries are encouraged:

(1) to start the process for early adaptation and roll out of the WHO 2013 consolidated guidelines. This may involve a core group of stakeholders with designated roles and responsibilities to drive this process;

(2) to develop guidance and an implementation framework on how to expand clinic-based HIV testing approaches to include community-based testing approaches, the use of validated point-of-care testing algorithms, CD4 and advocate for legislative and legal frameworks to enable such approaches;

(3) to ensure inclusion and continue regular updating of HIV drugs in essential drug lists, and may wish to regularly review their pricing. In this regard, countries should improve current procurement and supply management systems to cater for the increasing demand for drugs and diagnostics, including second- and third-line regimes, through registration, special access programmes and a medicines patent pool. Countries should use
all opportunities in the Trade-Related Aspects of Intellectual Property Rights (TRIPS) to procure such drugs;

(4) to plan for increasing numbers of trained health-care workers, peer and outreach workers in the public and private sectors, workplaces, schools and community-based organizations as well as civil society;

(5) to consider promoting integrated service delivery with simplified implementation such as one-stop services for HIV, maternal and child health, TB, and sexual reproductive health;

(6) to apply quality improvement approaches to plug leakages in the treatment cascade: implementation research may help to identify interventions to increase uptake and retention along the cascade in HIV, PMTCT and TB;

(7) to consider planning for sustainable financing in the short- and long-term. This comprises increasing national resource allocations inclusive of government and community-based services and in the context of universal health coverage; ensuring that HIV responses are included in universal health coverage schemes; mainstreaming HIV testing and care into other sectors such education, labour, and the ministry of interior, e.g. justice (prison health), including allocation of financial resources;

(8) to adjust their M&E systems to monitor implementation and impact of the WHO guidelines; and

(9) to document lessons learnt and best practices and actively engage in knowledge sharing.

19. References


(2) Global AIDS Response Progress Reporting (GARPR 2013).

(3) Sweat M, Morin S, Celentano D, Mulawa M, Singh B, Mbwambo J, et al. Community-based intervention to increase HIV testing and case detection in people aged 16–32 years in


Annex 1

Agenda

(1) Objectives of the meeting

(2) Regional treatment cascade: progress, challenges and opportunities

(3) Global updates

(4) Guidelines: Clinical guidelines across continuum of care for HIV diagnosis and ARV for prevention, care and treatment

(5) Clinical guidance on managing coinfections and comorbidities

(6) Scaling up HIV testing

(7) HIV testing approaches in the context of Asia

(8) Experience from countries
   – India
   – Myanmar

(9) Key issues for scaling up testing in the Asia Pacific Region: Panel discussion
   – Civil society: Asia-Pacific Network of Positive People (APN+)
   – Bangladesh, Sri Lanka
   – Partners - USAID, CHAI

(10) Group work 1 – Identify three key gaps and opportunities for scaling up testing and linkage to rapid eligibility for HIV-positive persons and prevention for HIV-negative persons in the Region. Key priority actions to be taken and support required from WHO and other partners

(11) Synthesis of Group work 1 (mixed group) - presentation by secretariat followed by discussion

(12) 2013 Guidance on operations and service delivery

(13) 2013 Guidance for programme managers
(14) Challenges and opportunities for scaling up ART: Experiences from programme reviews – Indonesia and Thailand

(15) Scaling up strategic use of ARVs for prevention and treatment
   – Nepal, Bhutan
   – Partners: USAID, Kirby Institute, UNICEF

(16) Group work 2 (mixed group) – Identify three key gaps and opportunities to strengthen service delivery for expanding ARV treatment in the Region. Key priority actions to be taken and support required from WHO and other partners. Early initiation (acute care to chronic care model); early infant diagnosis for exposed infants and treatment; starting KP at CD4 > 350

(17) Group work presentation

(18) Monitoring and evaluation

(19) Monitoring implications of the new recommendations

(20) Programme monitoring and reporting: key elements

(21) Role of partners for scaling up ART - Panel Discussion: USAID, CDC/Thailand Kirby Institute, CHAI, Family Health International, United Nations

(22) Treatment 2015 Initiative and its linkage to the consolidated guidelines 2013

(23) Group work 3 – (country groups)
   – Identify key actions at country level and support required to introduce/implement the 2013 WHO consolidated guidelines recommendations: immediate; within 6 months and 12 months
   – Priority actions needed at country level for scaling up ART and support required from WHO and partners

(24) Group work presentations

(25) Recommendations and next steps
Annex 2

List of participants

**Bangladesh**

Dr Md. Abdul Waheed  
Line Director, National AIDS/STD Programme  
Dhaka

Ms Zakia Akhter  
Assistant Director, Programme Monitoring  
IEM Unit, Directorate General of Family Planning  
Dhaka

**Bhutan**

Ms Sangay Wangmo  
Pharmacist  
Jigme Dorji Wangchuk National Referral Hospital  
Thimphu

Dr Sonam Yangchen  
Medical Specialist  
Central Regional Referral Hospital  
Gelephu

**India**

Dr B B Rewari  
NPO (ART)  
Ministry of Public Health and Family Welfare  
Department of AIDS Control  
National AIDS Control Organization  
New Delhi

Dr Sudhir Chawla  
Joint Director (CST) of Gujarat State AIDS Control Society  
Block, New Mental Hospital Complex  
Ahmedabad, Gujarat

Father Tomy  
BelAir Hospital  
Panchgani, Satara  
Maharashtra

**Indonesia**

Dr Indri Oktaria Sukmaputri  
Staff, Sub-Directorate AIDS and PMS  
Director-General of Disease Control and Environmental Health  
Ministry of Health  
Jakarta

Dr Wita Nursanthi  
Staff, Sub-Directorate Referral Hospital  
Director-General of Disease Control and Environmental Health  
Ministry of Health  
Jakarta

Dr Budi Risset  
Program Manager  
Indonesia AIDS Control Coalition  
Jakarta

Dr Erwin Astha Triono  
AIDS and STI Sub-Directorate  
Ministry of Health  
Jakarta Pusat

Dr Hariadi Wisnu Wardana  
Directorate General of Disease Control and Environmental Health  
Ministry of Health  
Jakarta Pusat

Mr Daniel Marguari  
Directorate General of Disease Control and Environmental Health  
Ministry of Health  
Jakarta Pusat

Dr Siti Nadia Tarmizi  
National AIDS Program Manager  
Directorate of Directly Transmitted Disease Control  
Director-General of Disease Control and Environmental Health  
Jakarta Pusat
Maldives
Mr Abdul Hameed Hassan
Senior Public Health Programme Officer
National TB-HIV Control Unit,
Communicable Disease Division
Health Protection Agency
Sosun Magu
Male
Dr Ali Nazeem
Consultant in Medicine
Indira Gandhi Memorial Hospital
Male

Myanmar
Dr Myint Shwe
Deputy Director (AIDS/STD)
Department of Health
Naypyitaw
Dr Moe Moe Sein
Regional AIDS/STD Control Officer
AIDS/STD Control Programme
Magway Region
Ms Nwe Zin Win
Chairperson
National NGO Network (HIV/AIDS)
Yangon

Nepal
Dr Bal Krishna Suvedi
Director, National Centre for AIDS and STD Control
Demographic Health Survey
Ministry of Health and Population
Teku, Kathmandu
Dr Basanta Kumar Tamrakar
Senior Consultant Physician
Western Regional Hospital
Pokhara

Sri Lanka
Dr Sisira Liyanage
Director
National STD/AIDS Control Programme
Colombo 10

Thailand
Dr Sument Ongwandee
Director, Bureau of AIDS, TB and STIs (BATS)
Department of Disease Control
Ministry of Public Health
Bangkok
Dr Natpatou Sanguanwongse
Medical Officer, Senior Professional Level
National AIDS Management Center
Department of Disease Control
Bangkok
Mr Apiwat Kwangkeaw
Chairperson TNP+
Thai Network of People Living with HIV/AIDS Foundation
Bangkapi, Bangkok

Timor-Leste
Sra Marta Abenia Paixao da Cruz Santos
National Programme Manager for HIV-AIDS
Ministry of Health Palacio da Cinza, Cai-coli Dili

Sra Saturnina Pereira Fernandes
ARV, T. Officer
Ministry of Health
Dili

Dr Vikas Inamdar
HIV Clinical Care Specialist
Ministry of Health, Communicable Disease Control Department
Division of Global Fund; Lahane Dili

Temporary advisers
Dr N Kumarasamy
Chief Medical Officer
YRGCARE
Principal Investigator, ACTG International Clinical Trials Unit-Chennai Site
YRGCARE Medical Centre, VHS Clinical Research Site/NIH Chennai
Chennai, Tamil Nadu, India
Report of the Regional workshop on improving HIV treatment

Dr RS Paranjape
Director
WHO Collaborating Centre for HIV Diagnosis and Monitoring of Antiretrovirals
National AIDS Research Institute (NARI)
Pune, Maharashtra, India

Dr Boonchai Kowadisaiburana
Head
WHO Collaborating Centre for Training and Research on HIV/AIDS
Clinical Management and Counselling
Bamrasnaradura Infectious Diseases Institute
Nonthaburi, Thailand

World Health Organization

South-East Asia Regional Office, New Delhi, India
Dr Razia Pendse
Scientist – HIV Prevention

Dr Amaya Maw-Naing
Acting Regional Adviser – HIV/AIDS

Mr Ankur Tanwar
Secretary – HIV/AIDS

Western Pacific Regional Office, Manila, Philippines
Dr Ying-Ru Lo
Team Leader HIV&STI

WHO Country Offices

Indonesia (Jakarta)
Dr Khanchit Limpakarnjanarat
WHO Representative to Indonesia

Dr Oscar Barreneche
Medical Officer – HIV/AIDS

Dr Janto Lingga
NPO - Clinical Mentoring

Ms Fetty Wijayanti
NPO Monitoring and Evaluation

Ms Yoana Anandita
National Consultant

Dr Tiara Nisa
National Consultant

Dr Bagus Rahmat
National Consultant

Dr Reginald Haposan Hutabarat
National Consultant

Ms Evi Fridayanti Hunter
Secretary – HIV/AIDS

Myanmar (Yangon)
Dr Vimlesh Purohit
TIP-Medical Officer-HIV/AIDS

Nepal (Kathmandu)
Dr Supriya Warusavithana
TIP, Medical Officer-HIV/AIDS

Thailand (Bangkok)
Dr Mukta Sharma
TIP-Technical Officer HIV/AIDS, STIs and TB

Observer

Dr Endang Budi Hastuti
Head of Standardization, AIDS and STIs
Sub-Directorate
Ministry of Health
Jakarta, Indonesia

Partners agencies

Asia-Pacific Network for Positive People
Mr Omar Syarif
Asia Pacific Network of Positive People
Bangkok, Thailand

Clinton Health Access Initiative
Dr Steve Wignall
Senior Medical Adviser – Indonesia & South-East Asia
Clinton Health Access Initiative
Jakarta, Indonesia

Dr Atiek Anartati
Clinton Health Access Initiative
Jakarta, Indonesia

Dr Amit C Achhra
The Kirby Institute for Infection and Immunity in Society
Faculty of Medicine, University of New South
Wales
Coogee, NSW, Australia

Family Health International
Dr Chawalit Natpratan
Deputy Director, Technical Support
FHI 360 Indonesia Office
Jakarta, Indonesia

Thailand Ministry of Public Health–United States Centers for Disease Prevention and Control Collaboration and GAP Thailand
Dr Achara Teeraratkul
Chief Strategic Information
Thailand Ministry of Public Health/United States Centers for Disease Prevention and Control Collaboration and GAP Thailand/Asia Regional Program
Nonthaburi, Thailand

UNAIDS
Dr Cho Kah Sin
UNAIDS Country Coordinator
Jakarta, Indonesia
Ms Lely Wahyuniar
Monitoring and Evaluation Adviser
UNAIDS Country Office
Jakarta, Indonesia
Dr Vladanka Andreeva
Strategic Intervention Adviser
UNAIDS Regional Support Team for Asia and the Pacific
Bangkok, Thailand
Dr Eamonn Murphy
UNAIDS Country Coordinator
Yangon, Myanmar
Mr Oussama Tawil
UNAIDS Country Coordinator
New Delhi, India
Mr Navneet Tewatia
UNAIDS
New Delhi, India
Dr Ruben del Prado
UNAIDS Country Coordinator
Kathmandu, Nepal

Mr Nikhil Gurung
CCM Member, CCM Secretariat
c/o UNAIDS
Kathmandu, Nepal

UNICEF
Dr Anfrida Kisesa-Mkusa
Regional Adviser (HIV and AIDS)
UNICEF Regional Office for South Asia (ROSA)
Lenkhnath Marg, Kathmandu, Nepal
Dr Wing-Sie Cheng
Regional Adviser, HIV and AIDS
East Asia and the Pacific Regional Office (UNICEF EAPRO)
Bangkok, Thailand

United States Agency for International Development (USAID)
Dr Robert Ferris
USAID Office of HIV/AIDS
Washington, DC, United States of America
Dr Bill Slater
USAID Office of HIV/AIDS
Myanmar
Ms Ellen Halbach
USAID Office
Jakarta, Indonesia
Ms Tetty Rachmawati
USAID Office
Jakarta, Indonesia
The WHO Regional Office for South-East Asia organized a regional workshop on improving HIV treatment, in Yogyakarta, Indonesia, 23-25 July 2013. The workshop brought together: participants from 10 countries in the South-East Asia Region, members from other UN agencies, AusAID, PEPFAR/USAID, The Global Fund and the Asia Pacific Network of Positive People including participants from civil society organizations. The workshop provided an opportunity to: share and discuss progress in HIV health-sector response at regional and country levels; discuss the recommendations of new WHO 2013 consolidated guidelines; and plan adoption and adaptation of the 2013 guidance at country level.