WHO SEARO-UNAIDS Asia Pacific Satellite Session

22nd International AIDS Conference (AIDS2018)

Amsterdam, 27 July 2018

Regional Office for South-East Asia
Background of the session

There has been significant progress in mankind’s battle against HIV in terms of reducing new infections & deaths, improving access to prevention services for key populations (KPs) and expanding ART coverage. A notable success has been the improvement of access to HIV prevention services for key populations.

Focus on key populations and ensuring community engagement have been two key factors in the success of programmes, especially in concentrated epidemic settings. However, this success cannot be sustained or taken for granted if the engagement of key populations within programmatic and governance frameworks are not fully realized. More worrying, the disease transmission reduction gains made could be reversed if urgent efforts are not made to ensure the full engagement of key populations to accessing prevention and treatment services within and beyond the commitments of universal health coverage (UHC), jeopardizing the goal of Ending AIDS by 2030.

Moreover, the nature of sexual networks have been changing over time from defined geographic area to the virtual network and advancement of technology is having an impact on the current practices; the prevalence among PWID & TG still not decreasing in India, MSM prevalence increases in Thailand. Considering the situation, the current key population strategies need to be revisited to achieve the new target and achieve Ending AIDS by 2030. Two thirds of the new infections are still occurring in key populations which calls for a continued focus on the key populations and these may be the KEY in ending AIDS epidemic.

Think Tank meeting

Keeping this in mind, WHIO SEARO, along with WHO headquarters and all UN partners, held a think tank meeting on “Revisiting the Strategies for Interventions among Key Populations for HIV” from 12-14 February 2018, which brought together more than 60 experts, partners, donors, civil society and key population representatives. The overall objective of this meeting was to strengthen the AIDS response in the context of
Universal Health Coverage (UHC), by intensifying the focus on Key populations and leveraging ‘AIDS Assets’ in leaving no one behind, and generating recommendations to increase the efficiency, responsiveness and uptake of HIV services with a focus on Key Populations.

The think tank meeting observed that the interest and investment on Key population interventions were on the decline while majority of new infections in Asia are still associated with the Key populations and their partners. Failure to render adequate services for the key populations and partners will result in the Universal Health Coverage remaining elusive for people who are left behind.

**This satellite session presented** key recommendations from think tank meeting on the evidence and way forward on intensifying the focus on Key populations and leveraging ‘AIDS Assets’ to guide UN agencies, donors, communities and other partners in re-aligning their current HIV programmes to reach 2020 targets on way to ending AIDS by 2030. The session was attended by around 70 participants. A copy of the agenda for the session is at Annexure 1.

**The key points from the session are highlighted below:**

Introducing the session, chairperson, Andrew Ball from WHO HQ, emphasized that in the era of SDGs and Universal health coverage, it is essential to ensure that the key populations (KP) are not left behind in the HIV response. More so, KP must lead the response. He also noted that due to developments with regard to changing behavioral patterns, sexual network mix, etc, the changing dynamics must be acknowledged for the way forward in the response.

In his opening remarks, Eamonn Murphy from UNAIDS APRST said that the nature of the concentrated epidemic makes the response incredibly challenging. The slipping political leadership must be addressed, and the critical role of community defined for a more efficient intervention. The importance of a public health response must be understood and not just a biomedical response as central to combating HIV/AIDS.

In his presentation on “Prioritizing and Modeling Key Population Interventions”. Tim Brown from Tim Brown, Senior Fellow, East-West Center, Hawaii said that the Asian Epidemic Model (AEM model) was tested in 11 countries and has exhibited diversity in the epidemic pattern. The salient points are

- Current infection rate of 65% recorded outside the KP
- 2/3 of new infections were found among KP
- MSM component of the epidemic found to be growing
- 3 factors contribute to the bulk of the epidemic among non- KP
  - Members of KP have intimate partners
  - Large turnover of KP to general population
  - Former members of KP-PLHIV transmitted the virus to spouse
• Difficult to curtail the epidemic because of limited ART provision due to the financial burden on countries

• Challenges and way forward:
  • Due to resource constraint target the right segment among KP
    o Young MSM
    o Protect lower risk women
  • Increasing financial challenges as external funding from donors are on the decline
    o Focus on resource for impact (highest coverage for high impact)
    o Geo-prioritize (identify highest risk provinces)
    o Look to achieve allocative efficiency and mobilize resources domestically to use every dollar to maximum effect
  • Invest in program management & evaluation

Speaking on the Governance Model for Elimination Agenda, Mr Prasada Rao, former special envoy to UN Secretary General was in favour of using the AIDS governance model for all eliminable diseases to achieve the SDG3.3. The key points highlighted during this presentation are

• Prevention has been unsatisfactory (14% decline in new infections over 17 years)
• 39% decline in deaths
• Intervention among KP is still very low. This is why we haven’t been able to control the epidemic
• Need for targeted surveillance among KP
• There is a diminishing priority to HIV compared to other communicable diseases
• Revised governance model should be based on taking AIDS out of isolation. Bifurcate health systems (regulatory and public health functions) at the national level. It is important that we don’t mix the two functions that have discrete roles.
• Introducing a multi-sectoral approach in health (Woman & Child department, Department of Social justice, etc)
• Ensure efficient fund flow mechanism such that adequate funds reach the destination on time. This can be done by setting up PPP models which will channelize resources to the implementers/programs.
• Have a single M&E framework to assess the progress of programs and see how the elimination of diseases is playing out
• Include community participation as a central tenet in the new governance model
The vice president of Blued, Guodong Mi, from China gave an overview of the Community-led intervention in HIV prevention through Blued. He was of firm belief that solutions should come from the people and then implemented back among the people. He gave an overview of activities of Blued:

- The various components of the program were risk assessment, online test booking, provision of PrEP, ICT and friendly clinician
- Risk behavior was assessed by 8 factors (oral/anal sex, sex role, group sex, STI, to name a few)
- In the pilot study 41% were assessed at medium to high risk
- Information delivery approaches included private messaging, live streaming, opinion discussion, splash screen ads. The methods had vast coverage, high respondents and high expressing rates.
- Through the pilot, 7305 tests were conducted, 3.98% of which was in Beijing alone.

Ms Sushena Reza-Paul, Assistant Professor, University of Manitoba and Advisor-Ashodaya Samithi shared the “Community Led Prevention Model: Experiences from Ashodaya, India”. The key points from presentation are:

- The site of Ashodaya is an example of moving from community-friendly to community-led approach. Through the experience we deconstructed science and handed it over to community for community insight.
- For sustainable solution make community think, decide, accept and own.
- The community-led approach carved out community identity, created safe spaces, was a ‘different attraction’ and was built on existing relationships.
- Various sources of data were presented. Program data from outreach (repeat contacts), clinic data on quarterly RMC, STI identification and treatment, HIV testing and diagnosis and treatment, data violence and survey data from IBBA were presented. All these data supported the success of this project in terms of interrupting HIV/STI transmission and decreasing violence among KP.
• However, important point was made that in 2014 and 2016 when government funding was interrupted all these indicators suffered. We saw a dip in outreach contacts, clinic visit but increase in symptomatic STI. This is very critical for policy makers to understand.

• Ashodaya’s goal is to keep the prevention agenda high. Recently concluded a ‘community-led PrEP delivery’ demonstration project. Self- reported adherence level and blood-tenofovir level consistently high. Need to have combination prevention was highlighted

Dr B.B. Rewari, Scientist HIV/Hepatitis/STI, WHO SEARO presented the back ground of meeting and summary of the key recommendations from the WHO SEARO think-tank meeting held in February 2018. These are:

• Follow the evidence & focus on KP (84% new infections among KP). Adopt a differentiated model based on high risk and vulnerability

• BOOST THE IMPACT OF PROGRAMMES. Reposition Combination prevention for KPs (& not the treatment for positives alone)

• Align governance structures to ensure KP centered response – targeted to elimination. Key features of AIDS response needs to be sustained and expanded to other eliminable diseases

• Fully fund the KP response to end AIDS (60%-90% of new infections but only 1/3 of the budget spent)

• Large scale IBBA doesn’t inform local data. We need to collect and use locally disaggregated data for local decisions.

• Keep communities at the heart of the response. Streamline fund flow to the CBOs. Ensure ongoing community engagement by creating an institutional mechanism at country level for key population interventions
This was followed by a panel discussion with representatives from Key populations, UNFPA, UNODC, UNAIDS, USAID, WHO and participants. The questions for the panel discussion were:

- How do we get the focus on key populations back into the national AIDS programmes in Asia and beyond?
- What actions are required to ensure that all programmatic interventions prioritise combination prevention among key populations?
- What governance & fund flow changes are required at global & country levels to ensure the sustained engagement of key populations and CBOs, and achieve elimination?
- What Agency accountability mechanisms are required to ensure continued key population focus within programmes?
- How to ensure collection and utilization of local level data for adequate key population coverage within the UHC agenda?

The key points from the panel discussion are:

- Continued communication with the government and advocacy is necessary to nurture political will and a clearer understanding at the national level is critical.
- There is a continued role for international donors to build mechanisms that allow community involvement and harness community knowledge.
- KP focus and strengthening of the government structures have to come together. Currently, these exist in parallel.
- From a programmatic view, it is difficult to reach adolescent KP. Innovative methods must be used to tap this population.
- Community based sexual education with concentration in SRH as part of combination prevention must be included.
- Ensure fund flow to the implementing organizations.
- Need for social contracting- a broader understanding between the government and civil society.
• Adopt a differentiated model of delivery for program to scale.
• There is a need to be clear on the type of support system available for civil society.
• HIV education should be included from the school level.
• Conservatism and religious beliefs are posing challenges to the HIV response.
• Public health outcomes should have priority over legal justice. We need to rethink strategies if we fail on the above.
• KP have a cascade of need which includes but is not restricted to HIV. We need to keep in mind the holistic well-being of the individual and design care, support and treatment accordingly.

The session ended with summary by co-chairs and need to carry this agenda forward at regional and country level involving the communities and devise integrated KP focused plan to work towards ending AIDS.
AIDS 2018
SATELLITE SESSION

Are Key Populations really the “KEY” to Ending AIDS in Asia?

Presentation and discussion on the recommendations from the recent
Think Tank meeting convened by WHO SEARO & UNAIDS AP
along with partners and communities on
“Revisiting the Strategies for Interventions among key populations for HIV”.

Friday, 27 July 2018 07:00 - 08:30
Venue: E105-108

Interest and investment on key populations interventions are on the decline while two-thirds of new infections in Asia are still associated with the key populations and their partners

Failure to render adequate services for the key populations and partners will result in Universal Health Coverage remaining elusive for people who are left behind.

PANEL DISCUSSANTS
Key population representatives
CDC
The Global Fund
The World Bank
UNAIDS
UNFPA
UNODC
USAID
WHO

Continue focus on key populations in national AIDS programmes
Reposition combination prevention for key populations (and not treatment for positives alone)
Change governance roles, at global & country levels, to focus on elimination
Institute streamlined fund flow mechanisms to CBOs
Empower communities to collect and utilise local level HIV data
Session Plan

FRSA03: Are Key Populations really the “KEY” to Ending AIDS in Asia?

07.00 — 07.10  Opening remarks - Co-Chairs
Rachel Baggaley, Coordinator – HIV/KPP, WHO HQ
Eamonn Murphy, Regional Director, UNAIDS Asia Pacific

07.10 — 07.50  Understanding key populations as key to ending the AIDS epidemic in Asia
Prioritising and modelling key population interventions
Tim Brown, Senior Fellow, East-West Center, Hawaii

Governance model for the elimination agenda
JVR Prasada Rao, Former Special Envoy to the UN Secretary-General

Community led prevention model: Experience from China
Guodong Mi, Vice President, Blued

Community led prevention model: Experience from Ashodaya
Sushena Reza Paul, Assistant Professor, University of Manitoba,
Advisor- Ashodaya Samithi

07.50 — 08.25  Recommendations from the think tank meeting on key populations in Asia
B B Rewari, Scientist, HIV, WHO SEARO

Panel discussion (Facilitator: Bobby John)
Participants:
Key population representative
CDC / The Global Fund
UNFPA / UNODC / UNAIDS
USAID / USG
World Bank / WHO

Main discussion points:
- How do we get the focus on key populations back into the national AIDS programmes in Asia and beyond?
- What actions are required to ensure that all programmatic interventions prioritise combination prevention among key populations?
- What governance & fund flow changes are required at global & country levels to ensure the sustained engagement of key populations and CBOs, and achieve elimination?
- What Agency accountability mechanisms are required to ensure continued key population focus within programmes?
- How to ensure collection and utilisation of local level data for adequate key population coverage within the UHC agenda?

08.25 — 08.30  Closing remarks by Co-Chairs