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Economic and Social Commission for Asia and the Pacific

Regional Expert Group Meeting

Reviewing Implementation of Commitments from the Asia Pacific Intergovernmental Meeting on HIV and AIDS beyond 2015

27 November 2018
Bangkok

BACKGROUND PAPER*

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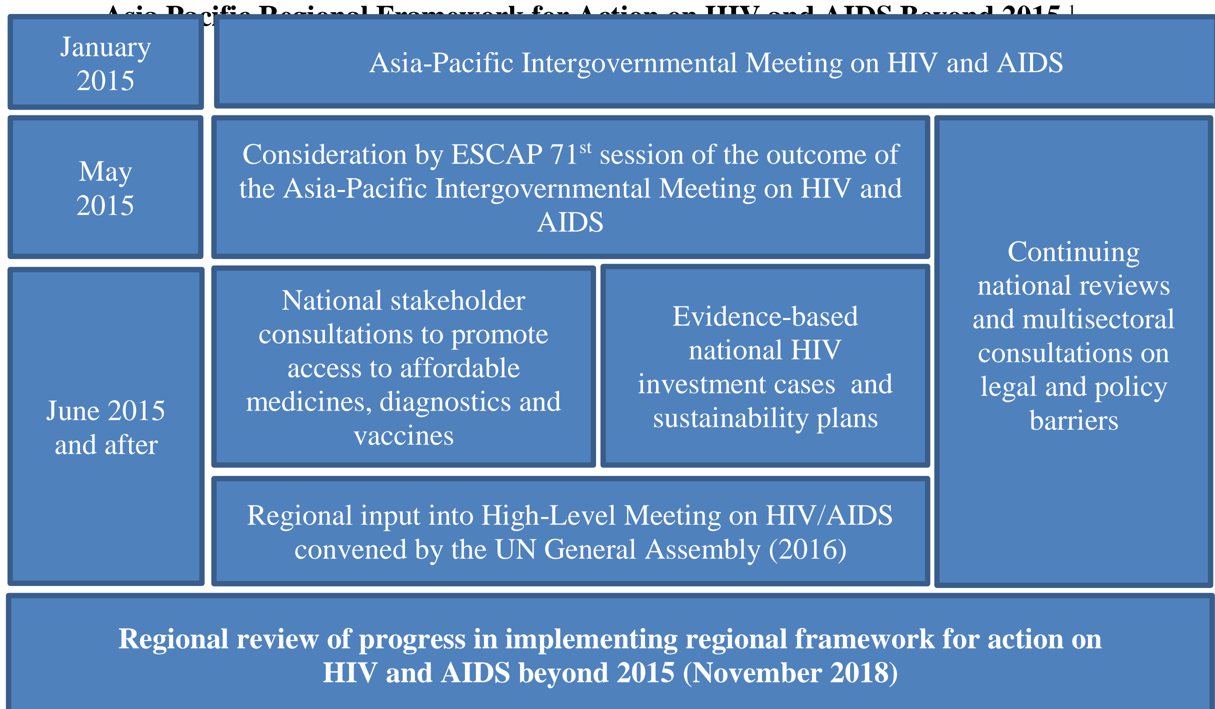
Background

The purpose of the Expert Group Meeting is to review national progress in meeting the commitments contained in the ESCAP Road Map Beyond 2015 (Asia Pacific Regional Framework for Action on HIV and AIDS Beyond 2015).

The Asia Pacific Intergovernmental Meeting on HIV and AIDS was held in January 2015. It adopted the Regional Framework (below) which was endorsed at ESCAP's 71st session in May 2015.

Figure 1

Asia-Pacific Regional Framework for Action on HIV and AIDS Beyond 2015[1]



The Regional Framework was developed in response to commitments contained in the 2011 UN Political Declaration on HIV/AIDS;[2] UNESCAP Resolutions on HIV/AIDS;[3] and the outcome of the 2012 Asia-Pacific High-level Meeting on AIDS.[4] The Framework was also informed by the 2014 Expert Group Meeting on Legal and Policy Barriers.[5]

The 2018 Expert Group Meeting provides countries with an opportunity to report on progress against the pillars of the Regional Framework, namely:

1. Pillar 1: Continuing national reviews and multisectoral consultations on legal and policy barriers

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[1] Economic and Social Commission for Asia and the Pacific, *Seventy-first session of the Commission, Bangkok, 25-29 May 2015* (E/ESCAP/71/43).

[2] UN General Assembly resolution 65/277 on the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS.

[3] UNESCAP Resolutions 66/10 and 67/9.

[4] Asia-Pacific High-level Intergovernmental Meeting on the Assessment of Progress against Commitments in the Political Declaration on HIV/AIDS and the Millennium Development Goals (2012).

[5] Expert Group Meeting on the Implementation of National Reviews and Consultations on Legal and Policy Barriers to Universal Access to HIV Services was organized by the Economic and Social Commission for Asia and the Pacific (ESCAP) in cooperation with UNAIDS and UNDP, on 4 and 5 March 2014 in Pattaya, Thailand.

2. Pillar 2: National stakeholder consultations to promote access to affordable medicines, diagnostics and vaccines
3. Pillar 3: Evidence-based national HIV investment cases and sustainability plans.

This will include:

1. Sharing of milestones achieved, lessons learned, local solutions to challenges, and strategic opportunities and entry points to integrate HIV in other national health and development programmes and sustainability plans;
2. Sharing experiences and lessons learned on progress to fast-track HIV responses towards achieving the commitments of the Regional Framework; and
3. Reviewing progress against the outcomes of the 2016 High Level Meeting on HIV where member states agreed to targets for 2020 and 2030, including the 90-90-90 by 2020 target (90 per cent of people living with HIV know their status; of whom 90 per cent are on treatment; of whom 90 per cent are virally suppressed).

This report summarizes responses to a survey distributed to ESCAP members in August 2018 which requested countries to report on progress under each Pillar, supplemented by additional material as relevant. A copy of the survey is in Annex 1. This report provides an update to the progress report on removal of legal and policy barriers issued by ESCAP in 2016, which drew from surveys of ESCAP members conducted in 2015 and 2016.[6]

Background – HIV in the Asia Pacific Region[7]

There were an estimated 280,000 new HIV infections in the Asia Pacific region in 2017 - the vast majority (84 per cent) of which were among key populations and their sexual partners. There was a 14 per cent decline in new infections between 2010 and 2017. However, the rate of decline in new HIV infections has stalled, especially, during the past 7 years. There are now rising or resurging epidemics in certain countries, locations and sub-populations. Certain key populations are at higher risk of exposure to HIV, namely men who have sex with men, sex workers, transgender people and people who inject drugs.

Success made in some countries, locations and populations is negated by the failure to make progress in other parts of the region. Rising new HIV infections are now being experienced in Philippines, Pakistan, Malaysia, Bangladesh and Papua New Guinea with varying rates of increase. Philippines, seen as a low-level epidemic until 2009, is now the fastest growing epidemic regionally as well as globally with a 174 per cent increase in new infections between 2010 and 2017. Pakistan, with a 45 per cent increase in new HIV infections during the same period, became the fourth largest epidemic in the region after India, China and Indonesia.

There are several warning signs that epidemics are escalating in certain locations and populations that may lead to a resurgence of new HIV infections regionally. For

[6] UNDP, UNAIDS, ESCAP (2016). *Review of country progress in addressing legal and policy barriers to universal access to HIV services in Asia and the Pacific*. (Bangkok: UNDP)
[7] AIDS Data Hub for Asia and the Pacific

example, Malaysia, well known for its successful harm reduction programme that turned the epidemic around in the past decade, is currently facing a second wave of epidemic with increasing new HIV infections among men who have sex with men. About 6 million people have died from AIDS-related illnesses in the region since the beginning of the epidemic. The annual death toll was 170,000 in 2017. 2.7 million people living with HIV in Asia and the Pacific were on treatment at the end of 2017 (53 per cent of all people living with HIV are on treatment). Progress varied between countries. Australia, Japan and Cambodia have treatment coverage at 80 per cent or more, while in Pakistan, Indonesia and Bangladesh fewer than 20 per cent of people living with HIV were receiving life-saving treatment.

1 Pillar 1: Legal and policy barriers faced by key populations

Punitive laws and policies pose as barriers for key populations to access prevention, treatment and other health-related services. They also impact on basic human rights and quality of life of people who are living with and affected by HIV. Of 38 countries in Asia and the Pacific, 37 criminalize some aspect of sex work, 16 criminalize same-sex relations, 11 confine people who use drugs in compulsory detention centres, 15 impose the death penalty for drug-related offences, and 10 countries impose some form of HIV-related restriction on entry, stay or residence.

Criminalization of key populations is not conducive to public health approaches to prevent the spread of HIV infections. It does not prevent nor deter risk behaviours of key populations but rather helps create the conditions that facilitate the spread of HIV, making services less accessible to key populations and people living with HIV, and preventing people from protecting themselves from infection. For example, when police take action against sex workers for carrying condoms, sex workers become less likely to carry condoms, leaving themselves and their clients more vulnerable to infection. As a result, AIDS strategies focus on addressing these factors through understanding the nature of legal and policy barriers in specific country contexts and consideration of reforms to policies and practices that have an adverse effect of health-seeking behaviours and violate human rights.

1.1 Survey findings

The survey requested updates on national reviews and multisectoral consultations on legal and policy barriers faced by key populations of sex workers, people who inject drugs, men who have sex with men (men who have sex with men) and transgender people. Of the 16 ESCAP members and associate members who completed the survey:[8]

1. 10 have conducted national reviews to identify legal and policy barriers faced by key populations (Bangladesh; Cambodia; Indonesia; Lao People's Democratic Republic; Macao, China; Nepal; Pakistan; Sri Lanka; Thailand; Viet Nam)
2. 15 have conducted multisectoral consultations on legal and policy barriers faced by key populations (Australia; Afghanistan; Bangladesh; Cambodia; Georgia; Indonesia; Japan; Lao People's Democratic Republic; Macao, China; Nepal; Pakistan; Russian Federation; Sri Lanka; Thailand; Viet Nam)

[8] Survey responses were received from: Australia; Afghanistan; Bangladesh; Cambodia; Georgia; Indonesia; Japan; Kiribati; Lao People's Democratic Republic; Macao, China; Nepal; Pakistan; Russian Federation; Sri Lanka; Thailand; and Viet Nam

3. 9 have made legislative or policy reforms to address these legal and policy barriers (Australia; Indonesia; Lao People's Democratic Republic; Macao, China; Nepal; Pakistan; Russian Federation; Sri Lanka; Thailand)

1.2 Pillar 1: themes and priorities

A common theme of many of the survey responses is the challenges faced by countries in balancing public health priorities with public security and criminal justice priorities. Several countries reported success stories in aligning public security policies with public health priorities:

1. **Afghanistan**'s Ministry of Public Health signed a Memorandum of Understanding with the Ministry of Interior Affairs to enable harm reduction services to be introduced into the national HIV programme, enabling introduction of opioid substitution therapy for prisoners and supervised injection facilities where people who use drugs can inject safely without fear of arrest.
2. **Bangladesh** reported that the Police Commissioner issued a memorandum to ensure that police in Dhaka understand the role of HIV prevention outreach services for people who inject drugs.
3. In **Cambodia**, HIV/AIDS has been integrated in the Village and Commune Safety Policy to align HIV/AIDS interventions with law enforcement at local level.

However, several survey responses illustrate the ongoing tensions that arise from differing priorities within Government. For example, the HIV legal review in **Lao People's Democratic Republic** resulted in a proposal to reduce the penalties that apply to sex work, based on the argument that heavy penalties deter sex workers from accessing HIV services. However, this proposal was not accepted by the drafters of the new Penal Code of Lao People's Democratic Republic.

Cambodia is the only country to report progress in developing policies that protect the rights of sex workers. This is an indication of the slow progress in removing legal and policy barriers faced by sex workers across the region.

The survey responses confirm that there has been little progress in removing legal and policy barriers faced by people who use drugs. **Viet Nam** reported problems arising due to inconsistencies between the health focus of the HIV law and the security focus of the law on administrative violations, which provides for detention of people who use drugs.

Georgia and **Lao People's Democratic Republic** reported on efforts to decriminalize use of small quantities of drugs for personal use. The public health argument for decriminalization or reduction of penalties for drug use is that it reduces the stigma attached to drug use and encourages people who use drugs to access harm reduction services. However, the reform proposals have not been accepted.

Across the region there has been uneven progress in implementing harm reduction services for people who use drugs. According to UNAIDS, fourteen countries across Asia were implementing needle and syringe programmes in 2016, providing clean needles and syringes to people who inject drugs to prevent needle sharing and thus potential exposure to HIV, but very few of them have expanded

their programmes in recent years.[9] In the countries where harm reduction programmes have been provided at scale, they have led to declines in HIV prevalence among people who inject drugs (for example in **Malaysia**). Loss of momentum in efforts to establish and scale up harm reduction programmes jeopardizes the achievement of 90-90-90 targets, particularly in countries with large populations of people who inject drugs.

There have been important developments in removal of legal barriers faced by men who have sex with men and transgender people in South- and South-West Asia. **Nepal's** Reproductive Health Rights Act 2018 and **Pakistan's** Transgender Persons (Protection of Rights) Act 2018 include protective provisions for transgender people and sexual minorities. A significant development was the Supreme Court of **India's** decision decriminalizing consensual adult same-sex sexual activity in September 2018.[10] The Court based its decision in part on the harms to HIV prevention caused by criminalization. The judgment itself provides an important advocacy tool. It provides a case study on how judicial leadership can be key to removal of legal and policy barriers. It provides a precedent for other countries that recognize the rights to health, privacy, equality and protection from discrimination as rights enjoyed by all citizens, including key populations.

1.3 Pillar 1: Country Specific Actions and Barriers

A. Barriers faced by men who have sex with men and transgender people

Cambodia's Second National Action Plan to Prevent Violence Against Women was launched in 2015. This national action plan specifically addresses prevention of violence against transgender women. Cambodia's National Strategy on Gender Equality and Women's Empowerment 2014-2018 pledged commitment for action across ministries to reduce gender inequalities. The strategic plan includes measures in thematic programmes including health, HIV, and legal protection. It specifically addresses issues of vulnerabilities of lesbians, gay, bisexual and transgender people.

In **Nepal**, advocacy efforts resulted in recognition of the need for legal protections and equal rights for persons with diverse sexual orientations and gender identities. Article 18 of the Constitution of Nepal promulgated in 2015 recognizes the rights of gender and sexual minorities and provides protection. The new Reproductive Health Rights Act 2018 also protects the rights of gender and sexual minorities to access uninterrupted health services.

In **Pakistan,** the Act on the rights of transgender people was passed in 2018. The Act allows transgender citizens to have their gender identity reflected on their national ID cards and all other official documents such as passports and education certificates, and prohibits discrimination in workplaces, schools and health care settings.

B. Barriers faced by sex workers

In **Australia**, sex workers face a range of regulatory and legal issues including criminalization, licensing, registration and mandatory testing in some jurisdictions.

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[9] UNAIDS, *Global AIDS Update 2018: Miles to go—closing gaps, breaking barriers, righting injustices* (Geneva: UNAIDS).
[10] Navtej Singh Johar v. Union of India, 6 September 2018. Available from: https://www.sci.gov.in/supremecourt/2016/14961/14961_2016_Judgement_06-Sep-2018.pdf

These barriers can impede evidence-based prevention, access to testing and health care services, and can result in increased risk of blood-borne viruses and sexually transmissible infections, loss of livelihood, and risk to personal and physical safety.

Cambodia has included reference to entertainment workers in national policies (venue-based sex workers are referred to as ‘entertainment workers’ in Cambodia). Cambodia’s Second National Action Plan to Prevent Violence Against Women was launched in 2015 after consultations. This national action plan addresses protection of entertainment workers from violence through legal protection and access to services. Another important policy initiative is Cambodia’s National Strategy on Gender Equality and Women’s Empowerment 2014-2018, which includes measures to foster gender equality in six thematic programmes including health, HIV, and legal protection. The Strategy addresses vulnerabilities of women who experience sexual violence, including entertainment workers.

Lao People’s Democratic Republic convened a national joint multi-sectoral consultation in 2015 to consider legal reforms relating to HIV. As a result, the Ministry of Health in partnership with UNAIDS, UNDP, WHO and UNODC proposed to the Penal Code Review Committee that the penalties imposed on sex workers be reduced, recognizing that heavy penalties deter sex workers from attending HIV services. However, the proposal was rejected and the penalties for sex work were increased in the new Penal Code.

C. Barriers faced by people who inject drugs

In **Afghanistan,** national reviews identified the urgent need for harm reduction services including for prisoners. A review of drug policy found that harm reduction was not addressed in national policy as a key way to deal with drug problems. In response to these reviews harm reduction services have been given higher priority. A dedicated chapter on harm reduction has now been included in Afghanistan’s drug policy. The government has agreed to provide opioid substitute therapy to prisoners. Service delivery has started in 6 prisons and the Government provides vocational training for people enrolled in the programme. Innovations include mobile drop-in centres and supervised injection facilities. The Government also established a hepatitis elimination programme from domestic resources which aims to treat 20,000 hepatitis C patients.

Australia has a strong enabling environment for HIV prevention among people who inject drugs, including regulation of needle and syringe programmes. However, there remain some key barriers that impact on HIV prevention and access to HIV services including laws and regulations in relation to drug use and peer distribution of injecting equipment.

Bangladesh reported that policy reviews resulted in increased police support for HIV prevention. In 2017, the District Commissioner of Police in Dhaka sent a memorandum to ensure that police understand the role of HIV prevention programmes in providing services to the people who inject drugs.

In **Cambodia** the Khmer HIV/AIDS Non-Governmental Organization Alliance (KHANA) conducted a review of harm reduction policies and programmes in 2015. The first National Harm Reduction Strategic Plan 2016-2020 was developed with specific strategies for ensuring an effective enabling environment in support of harm reduction interventions, including provision of legal assistance. From 2014 to 2017, KHANA organised an annual policy dialogue involving the National AIDS Authority,

National Authority for Combating Drugs, Ministry of Interior, Ministry of Health, harm reduction services, and representatives of people who inject or use drugs.

In **Georgia** several consultation meetings took place in 2018 initiated by the Georgian Narco-Policy Platform, which unites different non-government and community-based organizations. Two proposals for amendment of the Anti-Drug Law were submitted to parliament for review. Both amendment packages propose to alter the minimal permitted dosages of drugs, and one amendment submitted by the Platform proposes to lay the ground for decriminalization of drug use.

Lao People's Democratic Republic's national HIV consultation meeting was held in 2015 with participation of the Ministry of Health, Ministry of Justice, UNDP, UNAIDS, civil society organizations, development partners and key populations. The participants reviewed the findings of the 2015 Assessment on Legal and Protection Framework to Increase HIV Services for Key Populations. As a result, the Ministry of Health submitted a request to the Penal Code Review Committee to increase the quantity of drugs a person can possess for personal use. However, this proposal was not supported by the Committee.

Viet Nam has conducted a review of the Law on HIV/AIDS Prevention and Control and related policy issues. It found inconsistencies between the HIV legislation and the legislation on drug control and administrative violations for drug use, which pose challenges to the scale up of methadone maintenance therapy and other harm reduction interventions. Proposed policy changes to address these issues have been submitted to the Government and the National Assembly for the revision of the Law on HIV/AIDS Prevention and Control. An example of progress is the simplification of the paperwork for enrolment thereby ensuring easier access to methadone maintenance therapy. Decentralising methadone maintenance therapy to the commune level according to the Decision No.3509/QD-BYT dated August 21, 2015 of the Ministry of Health aimed to mitigate time and travel constraints for patients as well as reduce the pressure on treatment facilities at district level thereby providing an innovative solution for easier access to methadone maintenance therapy across the country.

D. Other legal and policy initiatives

In **Afghanistan,** national reviews conducted by the National AIDS Control Programme found that there was a lack of policy to address HIV-related stigma experienced by people attending health care services. In response, a policy was developed on stigma and discrimination in health care settings. Services are being scaled up. Voluntary counselling and testing services have increased from 9 to 13 hospital sites and the number of drop-in centres has increased from 11 to 16. The increased coverage focuses on those most at risk of HIV including men with high risk sexual behaviours. The Government developed or updated guidelines on harm reduction, overdose management, antiretroviral therapy, HIV testing services, prevention of mother-to-child transmission and surveillance.

Australia has strong anti-discrimination legislation. However, there remain barriers that impact on HIV prevention and access to services. These include the cost of services, including challenges with service delivery in regional and remote areas; a lack of culturally appropriate health services for culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander peoples; and laws on sex work, drug use and non-disclosure and transmission of HIV.

Consultations on Australia’s National HIV Strategy identified legal and policy barriers for people with HIV and priority populations. For people in custodial settings, barriers to HIV prevention include a lack of access to: sterile injecting equipment sterile tattooing equipment, pre-exposure prophylaxis, post-exposure prophylaxis, treatment as prevention, health promotion and condoms; as well as high levels of stigma and discrimination. Stigma and discrimination continue to be reported by people with HIV, and by lesbian, gay, bisexual, trans and gender diverse, and intersex populations, sex workers, people who use drugs, Aboriginal and Torres Strait Islander people.

Stigma and discrimination are influenced by intersecting characteristics such as sexual orientation, gender identity, cultural background, migrant or refugee status, disability, or being a sex worker or person in a custodial setting. Strategies to address stigma and discrimination must account for this.

Australia’s National HIV Strategy 2014-2017 includes a key action to ameliorate legal, regulatory and policy barriers which negatively impact equality of prevention, testing, treatment, care and support. It also focuses on implementing initiatives to address stigma and minimize the impact on people’s health seeking behaviour and health outcomes. Australia has developed an indicator to monitor progress in addressing stigma among priority groups. Australia has produced resources for health care workers to support understanding of legal and ethical responsibilities and guidelines for managing HIV transmission risk behaviours, emphasising early diagnosis and linkage to treatment and support.

Bangladesh has conducted reviews of six laws. Recommendations were sent by the Ministry of Health and Family Welfare to the National Law Commission (Ministry of Law, Justice and Parliamentary Affairs) and the Security Services Division (Ministry of Home Affairs) for further consideration. A draft Anti-Discriminatory Act has been developed. These processes were facilitated by the AIDS/Sexually-Transmitted Disease Programme, National Human Rights Commission and UNAIDS through an Inter-Ministerial Steering Committee. Policy changes are pending further inputs from the National Law Commission and the Security Services Division who are reviewing the recommendations.

Cambodia’s policy consultations built on the national HIV legal review conducted in 2013. Consultations informed the development of concept notes on addressing legal barriers for people living with HIV and key populations in the 2015-2017 and 2018-2020 Global Fund to Fight AIDS, Tuberculosis and Malaria Grants. In 2015, a national conference discussed the HIV issues of persons in street situations, in particular street-based entertainment workers and people who use drugs. In 2016, a stakeholder consultation addressed barriers to accessing HIV services at the Department of Social Affairs drop-in centre.

The national legal review report was used as a reference document for development of the National Strategic Plan for a multi-sectoral response to HIV/AIDS for 2016-2020, which includes strategies and interventions addressing laws and policies. Cambodia’s Strategic Plan for HIV/AIDS and Sexually-Transmitted Infection Prevention and Control in the Health Sector 2015-2020 is guided by a set of principles which include equity and gender. The plan aims to ensure equitable services to vulnerable groups and key populations and to reduce HIV stigma.

The HIV Stigma Index Survey 2.0 will be implemented in Cambodia in 2018-2019 by the Population Council, with support from the United States Agency for

International Development (USAID) and UNAIDS, in partnership with the Cambodian People Living with HIV Network and the Antiretroviral Users Association. Other platforms and mechanisms to address legal, policy and other barriers to access to HIV related services include: the Police Community Partnership Initiative, the Village and Commune Safety Policy, the National men who have sex with men/transgender technical working group, Country Coordination Mechanism meetings and Antiretroviral Treatment Coordination Groups at operational District level.

In **Indonesia**, the report of the National Consultation on Legal and Policy Barriers to HIV in Indonesia (2012) has been used as the main reference for HIV policy advocacy. It informed the 2015-2019 National Strategy and Plan on HIV, particularly the enabling environment section. The national advocacy process led to the adoption of the Health Ministry Decree on the Standard Minimum Rules for Health Services No. 43 of 2016. The Minimum Rules guarantee standards for health services, including prevention and treatment of HIV/AIDS.

In April 2018, UNAIDS held a workshop on National Commitments and Policy Instruments, attended by representatives from Indonesia's Ministry of Health, Ministry of Social Affairs, Coordinating Ministry for Human Development and Cultural Affairs, Director General of Corrections, the National Commission on Violence Against Women, and civil society organizations. The workshop facilitated dialogue between government and civil society on removing barriers. The workshop report was used to identify policy priorities for the next National Action Plan on HIV.

The Ministry of Health is developing the new National Action Plan on HIV. As part of the process, the Ministry has been consulting with civil society and development partners. Inputs on the enabling environment focus on policy reforms and strengthening access to justice for key populations and people living with HIV. The National Action Plan will be used as a reference for the National Mid-Term Development Plan (2020-2024). The National Action Plan is seeking to shift the current legal paradigm for key populations from being considered passive subjects of rehabilitation to being active citizens, so as to remove the economic burden of social rehabilitation.

In **Japan**, policy consultations took the form of sharing understandings among the related ministries on the current situation, policy measures and opinions from people living with HIV.

Nepal conducted a series of consultations and reviews in 2016-2017 related to HIV and access to services by key populations during the preparation of the Global Fund grant proposal and National HIV Strategic Plan 2016-2021. A thorough review of human rights related barriers was also carried out. This produced the Baseline Assessment of Scaling up Programmes to Reduce Human Rights-Related Barriers to HIV and Tuberculosis services and the Human Rights Related Barriers Meeting Report. In addition, the Global Fund committed to provide an additional USD 1.3 Million to match the same amount from the Government to address issues related to human rights-related barriers to services to key populations. Nepal is developing an operational plan for 2018-2021 to address human rights barriers. As a result of the consultations and reviews, the National HIV Strategic Plan 2016-2021 prioritized HIV investments for prevention, case finding and management to achieve the 90-90-90 targets. Nepal also adopted the 'test and treat' strategy and community-led testing approaches.

In **Pakistan** the legal aspects of the epidemic and frequent HIV outbreaks in different cities across the country are under discussion. Pakistan's Court has directed the national programmes and policy makers to develop a timebound action plan for enhancing the HIV response while taking into consideration the legal, human rights and policy reforms. HIV Bills are under consideration in the national and provincial assemblies of the country. Outcomes of the consultations and reviews include steps to increase uptake of HIV preventive and treatment services by key populations. There has been an increase to financial allocations by Provincial governments in their budgets for key population HIV prevention services as well as engagement of community members for programme implementation. This is expected to result in reduction in the disease burden as new HIV infections decline. Pakistan's economy will also benefit from a more healthy and productive workforce.

The **Russian Federation's** National Strategy to Combat HIV 2016-2020, Decree No 2203-R of October 20, 2016, includes reduction of discrimination and implementation of legal regulation measures that ensure the improvement of federal laws and normative acts relating to HIV. The outcome of national reviews of the HIV response was a plan for the State Strategy to Combat the Spread of HIV in the Russian Federation for the Period to 2020 and Beyond, approved by Decree 754-r of 20 April 2017. One of the goals of the Strategy is the development and implementation of interagency HIV prevention programmes aimed at working in key population groups, and involving socially oriented non-profit organizations in the implementation of these programmes. The Action Plan of the strategy includes improvement of the normative legal acts regulating HIV prevention and provision of social support for people with HIV.

In **Sri Lanka** consultations held in 2016 resulted in the Road Map to end AIDS by 2025. To reach 90-90-90 targets by 2020 it was highlighted that the country needs to identify more people living with HIV by scaling up testing services and making community-based and community-led testing accessible to key populations. A national communication strategy was developed to increase awareness and sexually-transmitted infection and HIV services are being promoted to key populations by social marketing.

Sri Lanka also developed a National Policy on HIV/AIDS in the World of Work which safeguards workers' rights in line with ILO recommendations. The Policy ensures promotion of decent and productive employment in a non-discriminatory environment, where the protection of fundamental rights is upheld as enshrined in the Constitution. The policy applies to all employers and workers involved in public, private and informal sectors, including self-employed and migrant workers, their spouses and children. Employers' and workers' organizations are advised to use this policy framework. Principles of the Policy include non-discrimination, gender equality, healthy and safe work environments, no HIV screening for purposes of employment, and confidentiality.

Thailand's laws, regulations and policies adhere to the principle of non-discrimination enshrined in the Constitution. Any citizen—including people living with HIV—may lodge a petition to the National Human Rights Commission to complain of a human rights violation. The Commission accepts complaints relating to human rights protected by the Constitution, Thai law, or treaties to which Thailand is a party. Thailand's Constitution prohibits discrimination based on health conditions and the Disabled Persons Promotion and Development Life Quality Act prohibits disability discrimination. To address workplace discrimination, the National Committee for HIV Prevention and AIDS

Alleviation issued a Code of Practice for HIV Prevention and Management in the Workplace. The Penal Code provides offences for sexual exploitation of persons in prostitution.

Thailand's Ministry of Public Health worked with stakeholders from civil society, people living with HIV and key population networks, academia, United Nations and the United States Government to develop a practical survey tool to measure stigma and discrimination in healthcare settings. The Ministry of Public Health is also rolling out a stigma reduction programme with civil society and concerned communities. HIV-related stigma and discrimination reduction training for health care staff is implemented in many provinces. An e-learning system is also being developed to complement in-person training and make sure that all health care staff receive training and support. Stigma and discrimination in healthcare should be measured and addressed systematically.

Viet Nam conducted a review of the Law on HIV/AIDS Prevention and Control, which found that regulations on HIV confidentiality are too narrow and not fully supportive of the rights to healthcare according to the Law on Medical Examination and Treatment. The review also found that current regulations on HIV testing for pregnant women and post-exposure prophylaxis are not fully enabling efforts towards the elimination of mother-to-child transmission and meeting the needs for post-exposure prophylaxis of all at-risk people. Legal and policy changes to address these issues have been submitted to the Government and the National Assembly. The Ministry of Health has issued a directive on intensifying efforts to reduce stigma and discrimination in health facilities and new policies in HIV testing and treatment to facilitate fast-tracking efforts to achieve the 90-90-90 targets.

2 Pillar 2: Access to affordable medicines, diagnostics and vaccines

2.1 Survey findings

The survey requested information on national consultations and other measures aimed at improving access to medicines, diagnostics and vaccines. Of the 16 ESCAP members and associate members that completed the survey:

- 13 have conducted national stakeholder consultations on access to affordable medicines, diagnostics and vaccines (Afghanistan; Bangladesh; Cambodia; Georgia; Indonesia; Lao People's Democratic Republic; Macao, China; Nepal; Pakistan; Russian Federation; Sri Lanka; Thailand; Viet Nam).
- 8 have reviewed and/or amended patent laws and other relevant laws that impact access to medicines, diagnostics and vaccines (Cambodia; Indonesia; Lao People's Democratic Republic; Macao, China; Russian Federation; Sri Lanka; Thailand; Viet Nam)
- 9 have taken policy or legal measures for addressing the cost of medicines, diagnostics and vaccines to ensure accessibility and affordability (Afghanistan; Cambodia; Georgia; Indonesia; Macao, China; Pakistan; Russian Federation; Sri Lanka; Thailand)
- 9 have taken measures to assess the cost effectiveness of essential medicines (Australia; Indonesia; Lao People's Democratic Republic; Macao, China; Pakistan; Russian Federation; Sri Lanka; Thailand; Viet Nam)

2.2 Pillar 2: themes and priorities

A. Intellectual property rights

The experience of **Indonesia** demonstrates that compulsory licensing alone is insufficient to ensure access to affordable antiretrovirals. Despite the utilization of compulsory licensing as permitted by Indonesian laws dating back to 2004,[11] antiretroviral drug prices in Indonesia remain some of the highest in the region. In response, the government is implementing a new procurement policy, which is expected to put downward pressure on drug prices. The lesson from this experience is that a comprehensive policy approach is required to support expanded access to medicines, of which supportive patent laws are only one component. For example, the Russian Federation is combining investment in domestic manufacturing of antiretrovirals, supportive intellectual property laws and use of generic antiretrovirals as an effective approach.

Cambodia's survey response has regional significance as it highlights the importance of the extension of the 'TRIPS transition period' to 2033.[12] This means that Least-developed Countries (LDCs) are exempted from the obligation to grant pharmaceutical patents under the Trade-Related Intellecteual Property Rights agreement (TRIPS) until 2033 or until they graduate from the LDC category. Currently, LDCs include Afghanistan, Bangladesh, Bhutan, Cambodia, Kiribati, Lao People's Democratic Republic, Myanmar, Solomon Islands, Timor-Leste, Tuvalu and Vanuatu. As many LDCs are expecting LDC graduation in coming years which will deprive them of the exemption on pharmaceutical products, pre-emptive policy discussions and measures are needed to protect their sustainable access to affordable medicines in the post-LDC period, as already done by some of the countries.

Cambodia's survey response conveyed a caution about the risks faced by countries in relation to trade and investment policies which require TRIPS-plus provisions in patent laws, which limit the flexibilities provided under the TRIPS agreement. These can prevent countries from accessing many generic medicines. Of concern is the possibility that multilateral trade agreements could interrupt generic medicine production in India, the main source of generic antiretrovirals globally.

Regional cooperation will remain an important strategy to ensure countries have access to latest trends, expertise and country experiences on TRIPS issues. Participants from Cambodia, China, India, Indonesia, Malaysia, Myanmar, the Philippines, Thailand and Viet Nam attended the Regional Consultation and Planning Workshop on Use of TRIPS Flexibilities and Access to Affordable antiretrovirals in Asia (2012). The same nine countries attended the Regional Expert Consultation on Access to Affordable Medicines, Diagnostics and Vaccines in 2016 to inform planning for national stakeholder consultations. Since the first regional workshop was held, an informal 'core group' was formed which has overseen the development and implementation of national work plans with the assistance of legal and public health experts.

[11] Presidential Regulation No 83/2004 on Compulsory Licensing of antiretroviral drugs. This was followed by Health Ministerial Regulation No 1190/2004 on the provision of antiretroviral and TB drugs as health programme; and Health Ministerial Regulation No 1237/2004 on the appointment of local pharmaceutical companies to exercise patent of antiretroviral drugs in Indonesia. This was further updated by Presidential regulation No 76/2012 on Compulsory Licensing of antiretroviral and Hepatitis C drugs.
[12] 'TRIPS' refers to the WTO Agreement on Trade-related aspects of international property rights (1994).

B. Pre-Exposure Prophylaxis and HIV testing

Improvements in prevention, testing and treatment are essential to meeting the United Nations fast-track 90-90-90 targets for ending the HIV epidemic. Pre-exposure prophylaxis (PrEP), the use of anti-retroviral drugs in a pre-emptive fashion to prevent infection on exposure to HIV, is a critical additional HIV prevention choice for people at substantial risk of HIV infection and is recommended by the World Health Organisation as part of combination HIV prevention approaches.[13] Evidence not only shows the high efficacy of PrEP, but also that when PrEP is implemented at scale and as part of a comprehensive HIV response, it contributes to substantial reductions in HIV transmission at a population level.[14] In the context of increasing transmission of HIV among key populations across the region, PrEP implementation is increasingly being recognised as an HIV prevention priority by national Ministries of Health who are adopting PrEP into their National Strategic Plans, developing clinical guidelines, and/or facilitating PrEP access through trials or rollout.

Since 2015, there has been an increase in the number of countries offering access to PrEP across the region. Nationally subsidised PrEP has been available in **New Zealand** and **Australia** from March and April 2018, respectively. **Thailand** began implementing a phased approach to expanding PrEP access to key populations in high prevalence provinces in 2018 building on successful trials and access programmes. **Viet Nam** is transitioning from pilots providing PrEP to approximately 1700 people in Ho Chi Minh City and Hanoi to programmatic rollout across 11 provinces. Several other countries have completed or are undertaking different models for PrEP trials focussing on key populations including for example in **India**, **Malaysia** and the **Philippines**, while trials are beginning in **China** and **Nepal**. Survey responses confirmed that **Cambodia**, **Indonesia** and **Pakistan** plan to pilot PrEP in the near future, and **Lao People's Democratic Republic** has conducted orientation activities on PrEP for men who have sex with men and transgender people. There have also been several acceptability and feasibility studies conducted in the region together with or as preliminary PrEP implementation activities. PrEP awareness and demand is increasing throughout the region with people at risk accessing PrEP outside trials and government endorsed programmes, including online pharmacies, 'buyer's clubs' and individual travel to countries like Thailand with affordable, confidential and relatively easy PrEP access.

The gap to achieving all three 90-90-90 targets in 2017 for Asia and the Pacific is the testing, treatment and viral suppression of an additional 1.4 million people.[15] To address this gap, innovations in HIV testing will play a critical role. Testing services at hospitals are not easily accessed by some key populations, many of whom fear stigma. Across the region, innovative health promotion interventions are being used to engage key populations through social media, apps and online tools. For example, the Thai Red Cross offers online supervised HIV self-testing in which a peer worker is video linked to the person using a self-testing

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[13] WHO Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV – September 2015;Grant RM, Lama JR, Anderson PL, et al. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. N Engl J Med 2010; 363: 2587–99; Grant RM, Anderson PL, McMahan V, et al. Uptake of pre-exposure prophylaxis, sexual practices, and HIV incidence in men and transgender women who have sex with men: a cohort study. Lancet Infect Dis 2014; 14: 820–29 ; McCormack S, Dunn DT, Desai M, et al. Pre-exposure prophylaxis to prevent the acquisition of HIV-1 infection (PROUD): effectiveness results from the pilot phase of a pragmatic open-label randomized trial. Lancet 2016; 387: 53–60; Molina JM, Capitant C, Spire B, et al. On-demand preexposure prophylaxis in men at high risk for HIV-1 infection. N Engl J Med 2015; 373: 2237–46.

[14] Grulich et al. 2018 Lancet HIV Oct 17. pii: S2352-3018(18)30215-7.

[15] *UNAIDS Data 2018,* (Geneva: UNAIDS).

kit.[16] Survey responses confirmed that **Afghanistan, Cambodia** and **Indonesia** are also piloting self-testing. **Indonesia** and **Macao, China** are making rapid HIV testing available at some sites. Sharing of lessons in community-based, voluntary and confidential testing approaches will assist countries to reach targets.

2.3 Pillar 2: Country Specific Actions and Barriers

A. Intellectual property rights

Survey responses indicated progress in amending patent legislation in several countries but that significant policy challenges are yet to be addressed. Intellectual property laws that permit Governments to manufacture or import generic antiretrovirals at low cost have been key to efforts to expand access to treatment in Cambodia, Indonesia, Thailand and the Russian Federation.

Cambodia reported that teams representing key Cambodian stakeholders (Ministry of Health, Ministry of Commerce, Ministry of Industry and Handicrafts, civil society and United Nations agencies) participated in the 2012 and 2016 regional workshops on patents and access. Regional workshops have been instrumental in maintaining Cambodia's momentum on reforming patent laws. A series of national consultation and planning workshops were organized to develop capacity and monitor implementation of the national action plan. One of the key results of such collective efforts is the promulgation of a Law on Compulsory Licensing for Public Health in May 2018. This law and its implementing regulations (Prakas) aim to ensure access to affordable generic essential medicines. Also, Cambodia actively supported the LDC group at the World Trade Organization (WTO) in achieving the extension of the TRIPS transition period until 1 January 2033.[17] This means that Cambodia is exempted from the obligation to grant pharmaceutical patents until 2033, provided the country remains an LDC.

Despite these successes, Cambodia faces policy challenges in balancing national policy priorities related to trade and investment and policy priorities related to health. The pursuit of sustained economic growth through the expansion of trade and investment is a national priority. Policy measures to strengthen the intellectual property rights of patent holders could negatively impact sustained access to affordable medicines in Cambodia. As multilateral trade negotiations at the WTO have stalled, the last ten years have seen an expansion in bilateral and regional Free Trade Agreements that include 'TRIPS-Plus' provisions. These TRIPS-Plus provisions are protective of the rights of patent holders and therefore can have the effect of restricting access to generic medicines.

In 2013, a National Intellectual Property Strategy was developed by the National Committee for Intellectual Property Rights. In line with Cambodia's new Trade Integration Strategy (2013-2018), Cambodia signed memoranda of understanding with the patent offices of Singapore (2015) and Japan and joined the Patent Cooperation Treaty (2016). These decisions strengthen the rights of patent holders by facilitating patent applications in Cambodia. As a member of ASEAN, Cambodia is expected to join the Regional Comprehensive Economic Partnership between ASEAN and Australia, China, India, Japan, Republic of Korea and New Zealand. Inclusion of 'TRIPS Plus' provisions under negotiation in the intellectual property chapter will strengthen drug patents and could threaten access to

[16] R Pebody, 'Digital innovation are promoting HIV testing and prevention to men who have sex with men in Asia', www.aidsmap.com, 30 July 2018.
[17] WTO decision of 6 November 2015.

affordable generic medicines.

The Government of **Indonesia** has also conducted reviews of its patent laws and other relevant laws which impact on access to medicines. Indonesia enacted a new patent law in 2016, which incorporated several TRIPS flexibilities that can promote greater access to affordable medicines. There have been multiple national stakeholder consultations on access to affordable HIV medicines, diagnostics and vaccines. However, despite the utilization of compulsory licensing of antiretrovirals as permitted by laws dating back to 2004,[18] antiretroviral prices in Indonesia remain some of the highest in the region.

B. Antiretroviral procurement and supply chain issues

Several countries reported that a focus on procurement and supply chain policies has improved antiretroviral access (Bangladesh, Georgia, Russian Federation and Viet Nam).

In **Bangladesh,** integration of antiretroviral procurement and supply within the government health system has increased cost efficiency because the government no longer needs to cover the management costs that were previously allocated to civil society organizations. Within the government system, drug adherence is well maintained and people living with HIV report satisfaction with being able to access services for various health problems from a single muti-disciplinary tertiary hospital, from which antiretroviral treatment is now available.

Georgia reported the use of an innovative mechanism for antiretroviral procurement known as 'WAMBO', the Global Fund for AIDS, Tuberculosis and Malaria's on-line procurement platform for essential medicines. In 2018, Georgia plans to use this new platform for procurement of antiretrovirals using state funds. Georgia is transitioning from the Global Fund financing to state funding support. Georgia previously sustained its antiretroviral programme through using the Global Fund's pooled procurement mechanism to enable access to low price, quality-assured antiretrovirals.

In **Indonesia**, stakeholder consultations addressed the need to reduce antiretroviral prices. As a result of consultations, the National Public Procurement Agency has released official recommendations for the national procurement price range for antiretrovirals in 2018. This is expected to reduce the price of antiretrovirals. Indonesia has also made efforts to simplify the national registration of HIV-related drugs, simplify HIV treatment regimens, and expand the variety of HIV drugs available in Indonesia.

In **Nepal**, consultation meetings have been held on the introduction of new HIV medicines to implement World Health Organization recommendations. To improve access to medicines, antiretroviral treatment services have been decentralized with the provision of dispensing sites. To ensure availability of medicines, the Government of Nepal has commenced procuring antiretrovirals through domestic funds. Previously antiretroviral costs were fully covered through Global Fund grants. The Government of Nepal will procure all antiretrovirals from domestic funds from 2020.

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[18] Presidential Regulation No 83/2004 on Compulsory Licensing of antiretroviral drugs. This was followed by Health Ministerial Regulation No 1190/2004 on the provision of antiretroviral and TB drugs as health programme; and Health Ministerial Regulation No 1237/2004 on the appointment of local pharmaceutical companies to exercise patent of antiretroviral drugs in Indonesia. This was further updated by Presidential regulation No 76/2012 on Compulsory Licensing of Antiretroviral and Hepatitis C drugs.

The **Russian Federation** has held consultations and working meetings on improving availability of antiretrovirals attended by medical specialists, patient organizations, the pharmaceutical industry, and legislative and executive authorities. These meetings have addressed reducing the cost of medicines by measures such as changing patent legislation and localization of production. The Russian Federation has switched to federal purchasing of antiretrovirals, which has led to a significant reduction in costs. Consultations and discussions on antiretroviral availability were also conducted during the international Conferences on HIV/AIDS in Eastern Europe and Central Asia in 2016 and 2018.

Most antiretrovirals registered in the Russian Federation are available as generics and are produced locally. Most antiretrovirals are included in the national Vital and Essential Drugs List, which allows for the limiting of their costs. The Russian Federation has also introduced domestic diagnostic drugs, including molecular-biological methods for diagnosis and monitoring of efficacy and safety of HIV treatment. Clinical guidelines and treatment protocols on HIV testing and treatment are updated on an ongoing basis.

In **Viet Nam**, the Ministry of Health (Viet Nam Administration for HIV/AIDS Control) has successfully organized the process for bidding and procurement of pre-qualified antiretrovirals.

C. HIV testing, PrEP and other prevention methods

Many countries reported innovations in HIV testing and prevention methods, including preparing to pilot and/or rollout PrEP.

Afghanistan has added self-testing as a testing strategy in the diagnostic algorithm and has developed HIV Testing Services Guidelines. Self-testing has been discussed and approved by the national programme task force. There is a well-organized surveillance system in place and Afghanistan is shifting from paper-based surveillance to web-based database and biometric technology.

Australia has made significant steps towards providing equitable access to PrEP for people at medium and high risk of HIV exposure. Access to PrEP combined with high rates of testing and treatment has the potential to considerably advance the HIV response. Tenofovir with emtracitabine was listed for government subsidy on the Pharmaceutical Benefits Scheme for PrEP from 1 April 2018. This medicine was previously only subsidised for the treatment of HIV, but not for prevention. Up to 32,000 people each year will access PrEP via the Scheme. Prior to its listing, PrEP was available through trials. By the end of 2017, approximately 15,351 people who are at higher risk of acquiring HIV were enrolled in PrEP trials. Australia is also providing education for consumers and healthcare professionals on the use and benefits of PrEP.

Cambodia has commenced discussions regarding PrEP and HIV self-testing. Self-testing has been identified as an option to encourage undiagnosed people with HIV to know their HIV status and enrol on treatment. PrEP and self-testing will be piloted in Cambodia from the last quarter of 2018 under the leadership of National Centre for HIV/AIDS, Dermatology and Sexually-Transmitted Diseases with support of UNAIDS and Family Health International 360/LINKAGES.

Indonesia has conducted numerous stakeholder consultations since 2015 to discuss the feasibility of implementing innovations for HIV prevention and

treatment including PrEP and self-testing. Studies have been undertaken to assess acceptability of PrEP and self-testing among select communities. Since 2016, the Global Fund has supported a pilot for community-based rapid HIV testing (Oraquick), and an expanded pilot will be supported from 2018 to 2020. Piloting of PrEP in select communities is proposed at several sites in Indonesia with support from the Global Fund and USAID.

Kiribati provides HIV treatment and there is ongoing consultation on the policy where people who are diagnosed with HIV and identify themselves will also be able to claim other benefits such as monthly cash incentives.

Lao People's Democratic Republic has conducted a series of orientation activities on PrEP for men who have sex with men, transgender people and stakeholders in three target provinces where the international development agency Family Health International 360 has implemented its HIV prevention programme with financial support from USAID. The 2017 National Guidelines on the use of antiretroviral includes the use of PrEP for HIV negative pregnant and breast-feeding women, based on WHO guidelines.

Macao, China provides free HIV tests and treatment for local residents and free rapid HIV tests have been provided to non-residents since 2015. Exemption of treatment fees for non-residents has been discussed, but no consensus has been reached. The outcomes of consultations were (i) the sustained promotion of testing through a Routine HIV Testing Strategy and community-based HIV rapid test network, and (ii) seamless fast and confidential referral systems supported by the establishment of an integrated database of confirmed HIV cases. Compared to 2015, the number of HIV tests increased by 2.5 times in 2016 and 2.2 times in 2017.

In **Pakistan,** national consultations on PrEP have been held with all stakeholders and PrEP has been included in the National Strategy and HIV treatment guidelines. Efforts are underway to mobilize additional resources for initiating PrEP in two cities.

In **Sri Lanka**, prevention and testing innovations have been implemented after stakeholder discussions. Provincial AIDS committees have been established to obtain the support of local stakeholders. Targeted interventions for key populations have been implemented with the support of non-governmental organizations, the Global Fund and other funding agencies. Efforts are being made to reach key populations through programmes targeting prisons, the tourist sector, people who use drugs, migrants and youth. In relation to diagnostics, the process for accreditation of the National Reference Laboratory of the National Sexually-Transmited Diseases/AIDS Control Programme has been initiated to improve the quality of national laboratory services and peripheral Sexually-Transmitted Diseases clinic laboratories. Venereologists have been appointed to 22 clinics to improve diagnosis, prevention and care services including antiretroviral treatment in the nine provinces.

In **Thailand** increasing HIV testing coverage, helping those who test positive initiate and stay on treatment, and providing HIV prevention services to those who test negative are important components of the National Operational Plan for Accelerating Ending AIDS 2015–2019. In 2016, the National AIDS Committee approved the PrEP Policy and the Ministry of Public Health sent letters to hospitals nationwide endorsing PrEP service. In 2017, national treatment and prevention guidelines confirmed PrEP services and it was agreed to include PrEP for men who

have sex with men, serodiscordant partners and other key populations in the universal health care insurance scheme. PrEP is included as part of the HIV combination prevention plan for the 2017–2030 National AIDS Strategy. In 2018, the Food and Drug Administration approved antiretroviral medication for PrEP in the National Essential Drug List for Prevention. The Ministry of Public Health has begun rolling out PrEP for HIV prevention among key higher risk groups in an initial 25 provinces as part of the first phase. Thailand is in the process of including PrEP under the country's universal health coverage by 2020. The Health Intervention and Technology Assessment Programme is working on a cost-effectiveness study of PrEP to include in the HIV prevention benefit package in 2020. A national PrEP implementation guideline is expected by the end of 2018.

A study on cost-effectiveness of PrEP among men who have sex with men in two hospitals in Thailand was conducted and published in 2018. The study found that drug cost accounted for more than 80 per cent of PrEP service cost. Estimated PrEP cost ranged from USD 223-311 per person per year. Modeling found that PrEP would be cost-effective when providing to all men who have sex with men but will be 32 per cent more cost effective if offered to high-risk men who have sex with men compared to all men who have sex with men.

The Thai National AIDS committee endorsed HIV self-testing in 2015. The Ministry of Public Health has been working with Thai Food and Drug Administration to address legal barriers to HIV self-testing. Government collaborated with civil society to form a working committee and is now in the process of drafting the ministerial decree to allow HIV rapid testing by lay persons and other professions.

In **Viet Nam**, the Ministry of Health is promoting access to testing and treatment by issuing a directive on intensifying efforts to reduce stigma and discrimination in health facilities and new policies in HIV testing and treatment to facilitate fast-tracking efforts to achieve the 90-90-90 targets.

3 Pillar 3: HIV investment cases and sustainability plans

In the region, an estimated USD 3.7 billion was spent for the AIDS response in 2017. As countries in Asia and the Pacific are increasingly taking ownership of their national AIDS response and reducing their dependence on external development partners, AIDS spending from domestic resources have doubled over the past decade. However, the decline in international funding has led to a flat annual investment between 2013 and 2017 within the range of USD 3.5 to 3.7 billion, an estimated $1.2 billion shortfall against the estimated $4.9 billion needed to reach established international targets.[19]

With significant funding gaps and the winding down of international financial support for HIV, there is a growing concern that key population HIV prevention programmes essential to the response will fail to reach the number of people needed to reverse increasing infection rates. The recent available national AIDS spending matrix which is part of official Global AIDS Reporting processes indicates that only one third of total prevention spending was spent for key populations HIV prevention programmes, while more than two third of these programmes were funded by international resources.

3.1 Survey findings

[19] UNAIDS, *Global AIDS Update 2018*

The survey requested information about progress in relation to evidence-based national HIV investment cases and sustainability plans, increased coverage of health services, expenditure and efficiency analyses and costing of transition to domestic funding for AIDS responses.

Of the 16 ESCAP members and associate members that completed the survey:

- 8 have conducted studies on costing the transition to domestic funding for AIDS responses (Bangladesh; Georgia; Indonesia; Macao, China; Pakistan; Sri Lanka; Thailand; Viet Nam)
- 13 have conducted national consultations on allocation of funding for AIDS (Australia; Bangladesh; Cambodia; Georgia; Indonesia; Lao People's Democratic Republic; Macao, China; Nepal; Pakistan; Russian Federation; Sri Lanka; Thailand; Viet Nam)
- 14 have made budget provision for domestic funding for AIDS responses (Australia; Afghanistan; Bangladesh; Cambodia; Georgia; Indonesia; Lao People's Democratic Republic; Macao, China; Nepal; Pakistan; Russian Federation; Sri Lanka; Thailand; Viet Nam)
- 12 have implemented monitoring and evaluation measures for assessing impacts of funding (Australia; Afghanistan; Bangladesh; Cambodia; Georgia; Indonesia; Macao, China; Nepal; Pakistan; Russian Federation; Thailand; Viet Nam)

Strategies that have been adopted for managing transition to domestic funding include:

a) Mobilizing resources from private sector and non-traditional donors (Afghanistan)
b) Geographical targeting of resources (Bangladesh)
c) Horizontal integration with mainstream health services (Bangladesh, Afghanistan)
d) Engaging line ministries to include HIV activities in sectoral plans (relating to subjects such as education, and women) (Cambodia)
e) Inclusion of HIV in social health insurance (Lao People's Democratic Republic, Thailand, Viet Nam) or health equity funds (Cambodia).
f) Addressing imbalances of health expenditures between prevention and treatment, and between primary healthcare and specialized hospital care (Indonesia and Viet Nam)
g) Reducing cost of medicines and promoting rational prescribing practices (Viet Nam)
h) Updating HIV Investment Case analyses (Cambodia, Indonesia, Nepal) and National AIDS Spending Assessments (Nepal)
i) National budget co-financing of HIV programmes (Cambodia)
j) Transition plans identifying risks and mitigation strategies (Cambodia, Georgia).

3.2 Pillar 3: themes and priorities

There is increased focus on domestic financing of HIV as more countries gain middle-income status. Domestic resources already comprise 78 per cent of total HIV investments in Asia and the Pacific,[20] and there is increasing urgency for governments to plan transition to domestic funds to ensure sustainability. Many

[20] UNAIDS, *Global AIDS Update 2018.*

countries are experiencing pressure on HIV budgets due to increasing antiretroviral treatment expenditure, competing health priorities, and shrinking donor budgets for HIV.

1. A global shift in donor priorities has contributed to a significant decline in funding for HIV in Asia and the Pacific, yet a 25 per cent increase in resources is needed by 2020 to reach the region's Fast-Track target of USD 4.9 billion.[21]
2. In 2015 it was estimated that external sources funded 95 per cent of prevention interventions targeting men who have sex with men, 94 per cent of prevention interventions targeting sex workers, and for 82 per cent of HIV prevention interventions targeting people who inject drugs in Asia and the Pacific.[22] Prevention programmes for key populations are still largely funded by external partners, with domestic resources focused on general education, treatment and care programmes. Targeted programmes for key populations are vulnerable to being defunded during the funding transition period.
3. The drive to establish universal health coverage is a challenge and an opportunity to HIV responses. Indonesia, Malaysia, Thailand, and the Philippines have established universal health coverage schemes that include some HIV-related services.[23] Integration of services raises new challenges in efforts to address the marginalization and discrimination faced by key populations, including stigma in health care settings. HIV funding also comes under pressure from competing health priorities, particularly due to the increased focus on non-communicable diseases. However, it is increasingly difficult to justify maintaining HIV programmes as siloed interventions as countries move towards integrated primary care as a component of universal health coverage. By integrating HIV-related testing and treatment interventions in universal health coverage coverage, the fiscal space for HIV, the availability of budgetary space for increasing public spending for HIV without jeopardising the country's financial sustainability, is increased.[24]
4. Meeting global HIV targets requires countries to both mobilize and prioritize funding. Diversified sources of domestic funding can help reduce dependence on donors. Some countries have established health funds that pool private sector resources (such as the India Health Fund, Indonesia Health Fund). Health financing strategies can progress toward universal health coverage through establishing health insurance schemes that include insurance for the poorest.
5. Allocations for targeted HIV prevention programmes for key populations in Asia and the Pacific are often low despite the fact that HIV transmission remains concentrated among key populations.[25] Existing funds can therefore be re-allocated for greater impact. Indonesia and Viet Nam have conducted HIV allocative efficiency studies, which model the outcomes of investment choices.[26] These studies examine how best to target the HIV response to the

[21] Ibid.
[22] High-Level Panel on AIDS Funding Landscape in Asia and the Pacific, *Investing for Results: How Asia Pacific countries can invest for ending AIDS* (2015).
[23] Ibid.
[24] SHIFT Project and Australian Federation of AIDS Organisations, *Baseline Evaluation Report of Sustainable HIV Financing in Transition (SHIFT) Project in Indonesia, Malaysia, Philippines and Thailand* (Bangkok, 2017).
[25] United Nations Economic and Social Council for Asia and the Pacific, *Review of the financing of national HIV and AIDS responses in the Asia-Pacific region*, 18 November 2014, (E/ESCAP/HIV/IGM.2/3).
[26] Gray RT, Reyes J, Nadjib M, Harimurti P, Wilson DP. Assessment of the allocation of HIV funding in Indonesia. (Washington, DC: World Bank, 2012); Available from: https://openknowledge.worldbank.org/handle/10986/29500; Zhang L, Pham QD, Do MH, Kerr C, Wilson DP. Returns on investments of HIV prevention in Vietnam (Washington, DC: World Bank, 2013); Available from: https://openknowledge.worldbank.org/handle/10986/29501.

appropriate populations and geographic areas. Allocative efficiency studies assess the benefits of targeting and how to deliver services at the highest possible quality and the lowest feasible cost.[27]

3.3 Pillar 3: Country Specific Actions and Barriers

Afghanistan has conducted a costing exercise as part of developing its 5-year HIV/AIDS Strategic Plan. Resources have been mobilized from government, private sector and development partners that are not traditional donors for HIV. There were initially only two donors for HIV (World Bank and the Global Fund). By 2018, the European Union, Global Fund, World Bank, Canada, Sweden and government of Afghanistan support the programme. However, a large funding gap remains. The HIV programme needs USD54 million for 3 years, but only USD18 million is available. Some donors are departing. The World Bank will not continue funding the HIV programme after 2018.

Afghanistan has undertaken a study of health expenditures and efficiencies of harm reduction and voluntary counselling and testing services to assess the relative benefits of integrated programmes compared to vertical programmes. Integrated programmes were found to have improved operation and programme efficiency. Voluntary counselling and testing centres have been integrated into provincial hospitals. Initially, the centres were stand-alone facilities funded by the Global Fund. Now voluntary counselling and testing is provided in provincial hospitals. If integration had not occurred voluntary counselling and testing would no longer be available.

To support transition to domestic funding, Afghanistan has reduced HIV programme implementation costs by 50 per cent. There has been a 45 per cent increase in operational programme efficiency by using integration, mainstreaming and improved coordination. In the context of shrinking donor support for HIV, this strategy helps to maintain and increase coverage of essential services for key populations.

After active advocacy, the government now funds harm reduction services from domestic resources in seven cities. The coverage of harm reduction services has increased since 2015. Harm reduction services have expanded from 9 provinces to 16, prevention of mother-to-child transmission services have increased from 5 to 10 sites and voluntary counselling and testing services from 9 to 13. Services in prisons have increased from 0 to 5 prisons and drop-in centres from 11 to 16. This increased coverage benefits people who inject drugs, men with high risk behaviours and prisoners.

Providing harm reduction services in prisons and community will support the health of the 10 per cent of all young people who use drugs. This will have further benefits in terms of a more productive work force. There is increased coverage of harm reduction, preventive and treatment services.

Australia's National HIV Strategy 2018-2022 will be released in late 2018 and was informed by extensive consultations. Australia tracks data on HIV incidence,

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See: Stuart R. M. et al. "How should HIV resources be allocated? Lessons learnt from applying Optima HIV in 23 countries", *Journal of the International AIDS Society* 2018, 21:e25097 https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.25097

[27] The World Bank recommends use of the Optima optimization and prioritization tool. See: World Bank, *Checklist for transition planning of national HIV responses*. (Washington, D.C.: World Bank Group, 2018).

prevalence and risk behaviours to identify areas where responses need strengthening. Australia's universal health insurance scheme guarantees all Australians and some overseas visitors access to health services for HIV at little or no cost. The provision of comprehensive treatment, care and support for people with HIV is provided by a range of services. Sexual health and specialist HIV services play a central role. Services are also provided by community general practice clinics and Aboriginal Community Controlled Health Services by specially trained doctors and health workers. Peer-based organizations provide education and support for people with HIV. Other important services include antenatal care, alcohol and other drug programmes, mental health services and treatment programmes, and needle and syringe programmes.

Bangladesh has undertaken an expenditure and efficiency analysis of the national HIV programme. It found that HIV investments have to be geographically focused and that HIV services need to be integrated with other existing health services such as services for tuberculosis, hepatitis and cervical cancer. In some cases, health coverage has increased and in others it has remained stationary. There are some examples where there is a focus to address those most at risk or affected by HIV, however, increased coverage is focused on geographical areas that are high priority. The geographical prioritization is guided by the investment case, and costs have been saved with regard to return on investment.

Cambodia conducted an HIV Investment Case analysis in 2017, under the leadership of the National AIDS Authority and with the support of UNAIDS. The Investment Case identified strategic investment priorities that will contribute to achieving the goal of eliminating HIV as a public health threat by 2030 while strengthening the foundations for a transition to domestic financing for a sustainable response. Harm reduction including needle and syringe programmes and opioid substitution are captured in the investment case. The Ministry of Health costed its Health Strategic Plan 2016-2020 and identified funding gaps by comparing fiscal spaces with costs.

A Transition Readiness Assessment has been conducted for Cambodia, and short term and long-term risks were identified. Based on those identified risks, the Sustainability Roadmap for the national AIDS response was developed which includes mitigating actions for each risk. National budget co-financing of HIV already occurs including for antiretrovirals. With support from USAID, stakeholders were involved in rating elements of the Sustainability Index Dashboard in 2015 and in 2017. The National AIDS Authority and development partners in the Government Donors Joint Technical Working Group on HIV and AIDS chose resource mobilization as a Joint Monitoring Indicator with a commitment to increase domestic funding from USD 8.2 million in 2015 to 12 million in 2018.

The National AIDS Authority engages line ministry members to include HIV and AIDS activities in the sectoral plan. The Ministries of Education, Youth and Sport and Ministry of Women Affairs have integrated HIV and AIDS activities in their national budget plans.

Advocacy and sensitization have occurred with the Ministry of Planning for inclusion of people living with HIV and key populations in the Identification of Poor Households programmes and with the Ministry of Health for inclusion of HIV services in Health Equity Fund benefits packages. There is increased health coverage in 2018 compared to mid-2015 due to expansion of social protection

schemes including the National Social Security Fund and increased coverage of health equity funds. Cambodia is one among seven countries worldwide to have achieved 90-90-90 targets in 2017 (translating to 73 per cent of people living with HIV are viral load suppressed). The focus of national health coverage is mainly on vulnerable populations, including people living with HIV.

Georgia has a Transition and Sustainability Plan for 2017-2019 for transitioning from Global Fund support. In 2018 Georgia updated its HIV/AIDS National Strategic Plan for 2019-2022, which incorporates transition and sustainability activities. Georgia has increased the coverage of health services. Vulnerable people who are at greater risk for HIV have free access to health services.

In **Indonesia**, more people have access to health services now than in mid-2015. In 2015 only 34 per cent people of living with HIV knew their status and 8 per cent received antiretroviral treatment. By December 2017, this increased to 44 per cent knowing their status and 14 per cent receiving antiretroviral treatment. Analysis of the cost of the national HIV programme found 33 per cent of spending is on care and treatment, 16 per cent on prevention and 51 per cent and other expenditure. The national health programme is not sufficiently funded and Indonesia still receives grant funding from international donors. Indonesia conducted an HIV Investment Case review in 2016 to explore health expenditure and efficiencies related to the national antiretroviral treatment programme. Indonesia has also conducted a study on the cost effectiveness of the harm reduction and OST programme. With support from the Government of the United States' President's Emergency Plan for AIDS Relief, the Health Policy Plus project is updating the country HIV investment case to explore health expenditure and efficiencies related to treatment, condoms, harm reduction and OST.

Japan has started an expenditure and efficiency analysis to review the national health programme for men who have sex with men. In Japan, universal health insurance enables universal health coverage and all citizens can access health services.

In **Kiribati**, the World Bank and Ministry of Health and Medical Services are working together to produce the first ever report on the Ministry's financial performance analysis. There is increased health coverage from 2015 to 2017 as indicated by an increase in the number of hospital beds per 1,000 (1.7 to 1.9), the availability of Medical Officers (4.1 to 6.0), population per Medical Officer (2,453 to 1668.7), availability of Nurses (20.2 to 34.8) and population per nurse (495.5 to 287.6).

In **Lao People's Democratic Republic**, the coverage of health services has increased since 2015. People living with HIV have benefited from the new National Health Insurance Scheme that covers consultations, some drugs for opportunistic infections, tests and other treatment cost which are not covered by the Global Fund. The Ministry of Health will do a costing of the national health programme in early 2019. The national health budget is not sufficient, and the impact of floods will result in a reduced health budget in 2019.

Macao, China reported that there were benefits from undertaking expenditure and efficiency analysis such as reduction in expenditure in management and treatment of late diagnosed HIV cases. There has been increased focus on early diagnosis and follow up. No cases of persons lost-to-follow up have been recorded among newly diagnosed resident HIV cases since 2017. New diagnoses are followed up at the outpatient department of the hospital, which provides treatment and support.

In **Nepal,** HIV investment plans have been prepared and are being implemented. A series of consultations informed the investment plans which compute the allocation of funds. Domestic funding is secured through the annual programme and budget of the National Centre for AIDS and Sexually-Transmitted Disease Control. Allocation of funds is decided through consultations with stakeholders and seeking commitments from the Ministry of Health and Population and the Ministry of Finance.

Nepal has national consolidated strategic information guidelines on HIV that describe monitoring and evaluation measures to assess the impacts of the HIV response. HIV expenditure data provide strategic evidence for decision making. To understand HIV spending flows, a National AIDS Spending Assessment is conducted periodically (in 2016 and 2018). This assessment guides budgeting for prioritized investments during the implementation of the National HIV Strategic Plan 2016-2021.

Access to HIV testing and antiretroviral drugs has increased in comparison to 2015. During 2015, antiretroviral coverage was around 30 per cent. In 2018, antiretroviral coverage has improved to 50 per cent of estimated people living with HIV. Coverage of elimination of mother to child transmission services has been expanded. After the adoption of the new national HIV Strategic Plan, innovative approaches such as community-led testing among key populations have also significantly increased.

Pakistan assesses health expenditure through reviews conducted by the Drug Regulatory Authority of Pakistan, which assesses the cost of essential and other necessary pharmacological and diagnostic items, including opioid substitution therapy. The coverage of health services has increased since mid-2015. There has been an increase in key populations registering in HIV treatment centres. Programmatic and financial analyses have been conducted and gaps identified which have been addressed in national and provincial strategies. Efforts are underway to secure increased financial allocations. Currently the funds are insufficient which restricts the impact of programmes.

The **Russian Federation's** transition to domestic funding for AIDS was implemented before 2015. HIV information campaigns conducted in 2016-17 covered a significant part of the population. In 2017, more than 60 per cent of the country's inhabitants were informed. Coverage of HIV testing has increased from 19.4 per cent of the total population in 2015 to 23.1 per cent in 2017. In 2015, over 30 million HIV tests were provided; in 2017 the number of people tested increased to 36,445,059.

The coverage of medical care for HIV has significantly increased compared to 2015. 230,022 patients received antiretroviral treatment in 2015. This increased to 346,132 patients in 2017. Coverage of treatment in 2015 was 28 per cent of the number of registered persons diagnosed with HIV infection, 37 per cent of patients were on antiretroviral treatment among those who were on medical care. Coverage of treatment in 2017 was 35.5 per cent of the number of people diagnosed or 47.8 per cent patients were on antiretroviral treatment among those who were on medical care. The increased coverage includes a focus on those most at risk of or affected by HIV.

Sri Lanka's National Strategic Plan for HIV/Sexually-Transmitted Infection Response will guide the response for 2018-2022. The NSP considers global and

national contextual changes. The Government of Sri Lanka and the United States Agency for International Development have launched a two-year, HIV/AIDS Technical Assistance Partnership to support the goal of ending AIDS by 2025.

Thailand provides HIV diagnostic and monitoring tests and antiretroviral drugs under the national insurance scheme. An evidence-based national HIV investment case has led Thailand to adopt a 'treatment as prevention' strategy. Antiretroviral therapy is included in benefit packages for all state health insurance schemes including Universal Health Coverage, the Social Security Scheme and the Civil Servants scheme. A gap is antiretroviral therapy for irregular migrants. Migrant workers can apply for health insurance in the Social Security Scheme and Migrant Health Insurance Scheme. For stateless or displaced persons, an out-of-pocket payment is required to access health care at public health facilities through the Stateless/Displaced Persons Health Fund under the Ministry of Public Health.

The Government of Thailand is committed to achieve the target of ending the AIDS epidemic in Thailand by 2030. The percentage of people living with HIV who knew their HIV status has increased from 89 per cent in 2015 to 98 per cent in 2017. The coverage of people living with HIV knowing their status who were on antiretroviral treatment has increased from 70 per cent in 2015 to 75 per cent in 2017. The percentage of people living with HIV on antiretroviral treatment who had suppressed viral loads has increased from 82 per cent in 2015 and 84 per cent in 2017.

Thailand foresees financial sustainability, as it relies less on international resources. A National AIDS Spending Assessment conducted in 2016-2017 found:

- Around 70 per cent of total AIDS expenditure was for prevention.
- 90 per cent of total AIDS expenditure was from domestic sources and 74 per cent of this was for treatment.
- Expenditure on the five pillars of combination prevention was 5 per cent of total AIDS expenditure and 57 per cent from domestic resources.

Domestic sources mainly finance medical care and treatments, while international financing is mostly spent on disease prevention, programme management and administration. HIV/AIDS spending in Thailand has increased for ten consecutive years in which care and treatment, in particular antiretroviral therapy, was the majority of expenditure. Financing for HIV/AIDS has been mainly dependent on unpredictable donor funding and has benefited from access to locally produced antiretroviral drugs.

The National Operational Plan for HIV/AIDS focuses on priority interventions in prioritized areas to accelerate ending AIDS. The Operational Plan sets out a framework for service delivery that breaks down the traditional barriers between prevention, treatment and care. It addresses critical gaps in linkages in the system by connecting the five critical components of the prevention and treatment continuum. These are 'Reach', 'Recruit', 'Test', 'Treat', and 'Retain'. It defines service packages for each key population group, and lays out criteria for the intensity with which services should be delivered at the provincial level. The Operational Plan had been costed in collaboration with the community and health service providers, which was used for planning to sustain the response from domestic funding.

Viet Nam conducted an efficiency analysis of the national health programme within the framework of the development of a National Health Financing Strategy till 2025. Factors limiting the efficiency of the health sector include:

(i) Imbalance of health expenditure between preventive care and treatment, between primary healthcare and specialized care in hospitals;

(ii) The grassroots healthcare system is not efficiently used;

(iii) Medicine usage is not safe and appropriate, with low rate of specialised and generic medicines prescriptions, and high rate of antibiotics prescriptions;

(iv) Flawed management of price of medicines and health equipment;

(v) The main mode of payment is still based on fee-for-service; and

(vi) The unintended effects of some health policies such as the hospital autonomy policy, revenue-maximizing motive from socialization through excessive health service prescription.

Social health insurance coverage has increased from 71 per cent in 2015 to 87 per cent in mid-2018. Out-of-pocket payments for healthcare are decreasing as a proportion of total national health expenditures.

Viet Nam has achieved significant progress in transitioning of people on antiretroviral treatment from donor funds to social health insurance. The coverage of social health insurance among people living with HIV has increased from 50 per cent in 2016 to 87 per cent in mid-2018 as the result of the Prime Minister's Decision which mandates local authorities to ensure that 100 per cent of people living with HIV are enrolled in social health insurance. The Prime Minister's Decision provides a strong legal basis to ensure all provinces allocate funds for HIV treatment through the social health insurance premium and antiretroviral co-payment. It is expected that the target of 100 per cent of people living with HIV enrolled in social health insurance will be achieved by 2019.

Recommendations

A. Pillar 1: Legal and policy barriers

1. Countries may consider encouraging dialogue between the health, justice and public security ministries as to the harms to health caused by the existence and/or enforcement of punitive laws which hinder access to essential health services for key populations. This inter-sectoral dialogue is key to building understanding outside of the HIV response to the HIV prevention benefits of non-punitive approaches;
2. Partnerships between health and law enforcement authorities should help to ensure that procedures of personnel working at community level support community-based HIV programming, including outreach services for key populations. Engaging law enforcement bodies is essential to challenging and changing harmful attitudes and practices that tolerate or promote human rights abuses of key populations;
3. Key populations are criminalized, stigmatized and difficult to reach but account for the majority of new HIV infections in most countries. Leadership is therefore key to overcoming political resistance to addressing laws on sensitive issues including sexual orientation, sex work and drug use.

Sensitising political leaders and policy makers about the importance of reaching the most marginalized people facilitates progress towards the global and country fast-track targets (90-90-90 by 2020 and 95-95-95 by 2030);

4. Positive legislative change and the increasing recognition of rights creates an enabling environment and improved HIV programming. Within this environment, it is possible to create people-centred approaches which provide services to the right people in the right place and at the right time.

B. Pillar 2: Medicines, diagnostics and vaccines

1. Ensuring access to affordable medicines, diagnostics and vaccines requires adopting a comprehensive approach. Such an approach covers patent legislation; trade and investment policy; procurement and supply chain issues; community-based access and delivery models; and domestic manufacturing where feasible;
2. Countries may consider engaging and informing ministries responsible for negotiating trade and investment agreements about the importance of TRIPS flexibilities in supporting access to medicines;
3. Many countries in the region have begun piloting PrEP and self-testing as parts of their prevention packages and there are many lessons which can be learned from this experience within the region. Countries may consider engaging with other countries in the region to benefit from their experience in the rollout and scale up of PrEP.

C. Pillar 3: Investment cases and sustainability plans

1. Resource allocations should be guided by programmatic priorities to maximize efficiencies. Countries may consider undertaking allocative efficiency studies prior to making final decisions on budgets and targets of national HIV plans;
2. Incorporating HIV in the design of universal health coverage programmes enables systems for health and can help ensure equity. HIV medicines and diagnostics should be included in social health insurance and health equity funds;
3. Investment cases and transition plans must recognise that HIV-related legal and policy issues create barriers to establishing the enabling environment required to respond to HIV. Transition planning should address these issues within each of the three key dimensions of transition planning:
    a. **Governance** – changes in the institutions/entities responsible for leading and managing the HIV response
    b. **Service delivery** – changes in the service delivery modalities and the scope and level of services provided; and
    c. **Financing** – changes in the source and level of financing available;
4. Equally, transition planning must recognize the essential role of community organizations in the delivery of services to key populations. It is important to address political factors which make it difficult to provide and sustain domestic funding to civil society and community organizations to ensure these populations have access to services when donor support ends.

Annex 1

Survey

Survey on progress against the Asia Pacific Regional Framework for Action on HIV and AIDS beyond 2015

Pillar 1: Continuing national reviews and multisectoral consultations on legal and policy barriers

1. In the context of continuing national reviews and multisectoral consultations on legal and policy barriers faced by key populations,[28] which measures have been carried out in your country? Please respond in all relevant boxes and use the space below to provide additional information and provide links.

Yes/No	Area of Work
	National review of existing legislation to identify legal and policy barriers
	(Inter government) multisectoral consultations on legal and policy barriers
	Legislative or policy reforms to address legal and policy barriers
	Others. Please provide details in the space below

Please provide further details and links to relevant reports, laws or other supporting documents.

Additional questions – Pillar One

2. What was the outcome of the consultations or reviews?

3. To what extent did they lead to changes in policy?

4. Are there any examples or stories that you would like to showcase in the EGM?

Pillar 2: National stakeholder consultations to promote access to affordable medicines, diagnostics and vaccines

1. In the context of improving access to medicines, diagnostics and vaccines, which measures have been carried out in your country? Please respond in all relevant boxes and use the space below to provide additional information and provide links.

Yes / No	Area of Work
	National stakeholder consultations on access to affordable medicines, diagnostics and vaccines
	Review and/or amendment of patent and other relevant laws with impact on access to medicines

[28] Defined per ESCAP resolution 67/9 as sex workers, injecting drug users, men who have sex with men and transgender populations

	Policy or legal measures for addressing cost/prices of medicines, diagnostics and vaccines to ensure accessibility and affordability
	Establish processes to assess the cost effectiveness of essential medicines (e.g. health technology assessment)
	Others. Please provide details in the space below:

Please provide further details and links to relevant reports, laws or other supporting documents**.**

Additional questions – Pillar Two

1. Have you undertaken an investment case review to explore health expenditure and efficiencies? If yes, did the review include harm reduction and opioid substitution as a part of it?

2. What discussions have taken place regarding the impact that innovations (including PREP and/or self testing) might have on planning, budgeting and programming for access to medicines?

3. Are there any stories or examples that you would like to showcase?

Pillar 3: Evidence-based national HIV investment cases and sustainability plans

1. In the context of developing evidence-based national HIV investment cases and sustainability plans, which measures have been carried out in your country? Please respond in all relevant boxes and use the space below to provide additional information and links.

Yes/No	Area of Work
	Studies on costing of transitions to domestic funding for AIDS responses
	National consultations on allocation of funding for AIDS responses
	Budget provisions for domestic funding for AIDS responses
	Monitoring and evaluation measures for assessing impacts of funding

Please provide further details and links to relevant reports, laws or other supporting documents:

2. Have you undertaken an expenditure and efficiency analysis of the national health programme? What were the key findings?

3. Do more people have access to health coverage[29] now than they did in mid-2015?

[29] WHO defines universal health coverage (universal health coverage) as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

4. Does the increased coverage include a focus on those most at risk of or affected by HIV?