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HIV programmes in countries within the Asia-Pacific region

In their Viewpoint in *The Lancet HIV*, Ravipa Vannakit and colleagues[1] provide an overview of challenges and outline priorities for domestically funded programmes delivered by key population and civil society organisations in the Asia-Pacific region. They acknowledge the diversity within countries; however, they do not offer guidance to these vastly diverse individual nations in how to move forwards given some of the unique challenges they face.

In this region, Indonesia is the third most populous and largest island nation and, arguably, the most geographically diverse. Indonesia has a fast-growing HIV epidemic with important context-specific challenges. Although epidemiological similarities exist, such as large increases in infections among men who have sex with men (MSM) and clients of sex workers, women in non-key populations are an increasingly susceptible group in Indonesia.[2–4] The context of the HIV epidemic between nations is diverse, as are structural barriers and HIV transmission dynamics, requiring focused analyses to tailor programmes down to subnational levels. The spillover of risk from key populations to general populations in Indonesia probably accounts for the increasing infections in women and babies being born with HIV. High rates of internal migration among key populations also exists, particularly after HIV diagnosis.[3] These worrying transmission trends require comprehensive efforts to coordinate universal population-based programmes such as up-scaling of routine antenatal HIV testing and services to prevent of mother-to-child transmission and coordinated reporting between provinces.

Basic health-system functioning needs to be addressed before programmes led by key populations can be implemented effectively, sustainably, and at scale. HIV care pathways can be fractured in Indonesia: antiretroviral therapy (ART) procurement is controlled centrally, and non-governmental organisations that offer services to key populations often cannot provide ART because access and administration is protected within government services.[3]

Research is needed to understand drivers of higher incidence of HIV thus enabling prioritisation of interventions that are lacking in Indonesia. This effort would require an enabling environment including legal protections for marginalised populations, health professionals, and researchers. Indonesia's growing conservative political environment undermines public health outreach to key populations.[4] Online spaces to promote HIV education for (for example) MSM need to be safe and secure, which is a challenge because of internet censorship in the country.[1,5]

Further collaboration and analysis of the financial, social, political, and health systems context is needed for countries such as Indonesia where HIV programmes are not prioritised domestically. This effort requires urgent attention. Politics might hinder cross country learning.

Guidance across the Asia Pacific region has restricted scope given the diversity of contexts, disparity of investment, and effectiveness of HIV interventions. Without this recognition, these countries will continue on a poor trajectory even with adequate funding.

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Authors' reply

We thank Keerti Gedela and colleagues for their comments on our Viewpoint.[1] We agree about the need to address context-specific challenges in Indonesia and elsewhere in the Asia-Pacific region. Local remedies

to foster safe, supportive, non-criminalising physical and virtual services, and environments for key populations are necessary.

Investment in programmes led by key populations is a priority to achieve and sustain HIV epidemic control. Although variations exist in the attributable fraction of new infections derived from key populations, there is a growing consensus on the underestimation of key-population contribution to HIV transmission, even in some of the most generalised epidemics.[2,3]

Gedela and colleagues highlight barriers to key-population-led organisations delivering antiretroviral therapy (ART) services and procurement issues. Because ART costs in Indonesia are estimated to be more than four-fold higher than those in other regional countries,[4] we advocate for a combination of investment in efficient key-population-focused or key-population-led services and procurement reforms to make savings in both direct treatment costs and reductions in broader costs associated with HIV-related morbidity and mortality.

Domestic financing for key-population-led programming is a crucial part of a very complex equation. It can send a clear political message regarding institutionalised support for key populations. Investment in key-population-led health services can complement basic health system strengthening addressed in tandem. Community participation in developing health systems is a core principle, not an add-on. In several countries, the community provides essential support to close gaps in access to life-saving HIV treatment and other services. Localised, differentiated solutions are indeed critical, but an essential component of these is investment in key populations.

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