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What will it take to end AIDS in Asia and the Pacific region by 2030?

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Abstract. The 2016 global commitments towards ending the AIDS epidemic by 2030 require the Asia–Pacific region to reach the Fast-Track targets by 2020. Despite early successes, the region is well short of meeting these targets. The overall stalled progress in the HIV response has been further undermined by rising new infections among young key populations and the unprecedented COVID-19 pandemic. This paper examines the HIV situation, assesses the gaps, and analyses what it would take the region to end AIDS by 2030. Political will and commitments for ending AIDS must be reaffirmed and reinforced. Focused regional strategic direction that answers the specific regional context and guides countries to respond to their specific needs must be put in place. The region must harness the power of innovative tools and technology in both prevention and treatment. Community activism and meaningful community engagement across the spectrum of HIV response must be ensured. Punitive laws, stigma, and discrimination that deter key populations and people living with HIV from accessing health services must be effectively tackled. The people-centred public health approach must be fully integrated into national universal health coverage while ensuring domestic resources are available for community-led service delivery. The region must utilise its full potential and draw upon lessons that have been learnt to address common challenges of the HIV and COVID-19 pandemics and achieve the goal of ending AIDS by 2030, in fulfillment of the United Nations' Sustainable Development Goals.

Keywords: Asia, Asia–Pacific region, community interventions, health services, HIV/AIDS, HIV treatment and prevention, key populations, public health, policy.

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Introduction

The 2016 United Nations Political Declaration on Ending AIDS has set the world on an ambitious agenda to end the AIDS epidemic as public health threat by 2030[1] and the governments in Asia and the Pacific region have committed to this agenda. Ending the AIDS epidemic as public health threat by 2030 requires countries to reduce new HIV infections and AIDS-related deaths by 90% between 2010 and 2030. This entails achieving the 95–95–95 HIV treatment targets by 2030 (i.e. 95% of people living with HIV know their status, 95% of people who know their HIV-positive status are on antiretroviral treatment, and 95% of people living with HIV who are on antiretroviral treatment have HIV viral suppression) and zero discrimination.[2,3] AIDS is far from over in Asia and the Pacific and the overall stalled progress in the HIV response has been further undermined by rising and resurging new HIV infections, particularly among young key populations, and the unprecedented COVID-19 pandemic. This paper examines the HIV situation and the response gaps in the region and discusses the critical areas to be addressed so that the region can achieve the ending AIDS targets.

In the past decade, there has been slow progress in the region's HIV response with only a 12% decline in annual new HIV infections and a 29% decline in AIDS-related deaths since 2010.[4] Countries in the region are seeing uneven progress with seven countries having rising or resurging new HIV infections and six countries having increasing annual AIDS deaths.[5] HIV remains largely concentrated among key populations, including gay men and other men who have sex with men, sex workers and their clients, people who inject drugs and transgender people, and their partners. Key populations, due to specific higher-risk behaviours, are at increased risk of HIV exposure and are at the centre of the epidemic's dynamic, and thus they are the key to a successful HIV response. Key populations also encounter a high level of legal and social issues, such as punitive laws, stigma, discrimination, and violence, that create barriers to accessing HIV services.[3,6]

Key populations account for 98% of all new HIV infections in the region.[4] The bulk of new infections (44%) are among men who have sex with men followed by clients of sex workers and partners of key populations, people who inject drugs, sex workers, and transgender people, accounting for 21%, 17%, 9%, 7% of total new infections respectively.[4] It is concerning that in many countries with various epidemic dynamics, rising HIV infections among young men who have sex with men has become a common denominator. For instance, HIV prevalence among young men who have sex with men in Indonesia has quadrupled between 2011 and 2015. Similarly, in Malaysia, it has tripled in two consecutive rounds of 2014 and 2017 surveys according to the UNAIDS key population atlas (https://kpatlas.unaids.org).

A prevention gap: current efforts are unable to attain prevention service coverage that could lead the region to end AIDS

Despite high rates of HIV infection among key populations, they are insufficiently reached by HIV prevention programs and many countries in the region are lagging behind the prevention targets of the ending AIDS commitments.[4,7] Data indicate that only a quarter of men who have sex with men and people who inject drugs receive comprehensive HIV prevention and more than half of transgender people and female sex workers are not reached with prevention interventions.[4] The stalled decline in new HIV infections together with consistently low HIV prevention coverage among key populations underline that the region can no longer continue with conventional prevention and outreach programs. Instead, it needs to swiftly adopt and scale up innovative models and tools, such as key population or community-led service delivery, online peer outreach and linkage to care, pre-exposure prophylaxis (PrEP) of HIV using antiretroviral medicines, HIV self-testing and index testing. These models and tools need to follow a differentiated service delivery (DSD) approach, which is defined as 'a client-centred approach that simplifies and adapts HIV services across the cascade, in ways that both serve the needs of people living with and affected by HIV better and reduce unnecessary burdens on the health system'.[8–14]

Figure 1 shows a snapshot of Asia–Pacific countries' unequal progress and gaps towards achieving 2020 Fast-Track targets. For example, three countries – Cambodia, Thailand and Viet Nam – have less than a 25% gap to reach the 2020 Fast-Track new infection target while Malaysia, Papua New Guinea, Pakistan and Philippines are seeing increasing or resurging epidemics. This uneven progress underscores the differences in these countries' approach in political commitment and in adopting, scaling up and strengthening innovative prevention tools and DSD approaches, including task shifting, decentralised services, and community-led and peer-driven prevention, testing and treatment service delivery models that are responsive, client-centred and tailored to meet the needs of the key populations.[11,16–18] Outstanding examples have been set by Australia, Cambodia, New Zealand, Thailand and Viet Nam with roll out of PrEP and efforts to start scaling up. The evidence indicates that the scaled provision of PrEP in Australia has contributed to steep decline in new HIV infections among men who have sex with men.[4] Similarly, the combination of prevention with innovative service delivery

	New HIV infections		AIDS-related deaths	
	Number	Gap to reach 2020 targets##	Number	Gap to reach 2020 targets##
Cambodia	780		1300	
China*	81 000		35 000	
India	69 000		59 000	
Indonesia**	46 000		38 000	
Malaysia	6300		2700	
Myanmar	10 000		7700	
Pakistan	25 000		6800	
Papua New Guinea	3300		610	
Philippines	16 000		1600	
Thailand	5400		14 000	
Viet Nam	5200		5000	
Asia and the Pacific	300 000		160 000	

DECLINING AND GAP TO TARGET < 25%

DECLINING AND GAP TO TARGET 25–50%

DECLINING AND GAP TO TARGET >50% (or) STABLE TREND

INCREASING TREND

These 11 countries represent the countries with the highest HIV burden, new HIV infections and/or AIDS-related deaths. ##, Fast-Track target is 75% reduction of new HIV infections and AIDS-related deaths in 2020 from 2010 baseline; *, based on country HIV estimates; **, latest available published estimates.

Fig. 1. Select Asia–Pacific countries with new HIV infections, AIDS-related deaths, and the gaps to reach the 2020 Fast-Track targets. Sources: UNAIDS[5] and the National AIDS Control Organisation and National Institute of Medical Statistics.[15]

through community-led and key populations-led HIV services in Cambodia, Thailand and Viet Nam has contributed to a substantial decline in new HIV infections. In contrast, countries with increasing or resurging HIV epidemics have a consistently low level of HIV prevention coverage among key populations and do not adopt and/or scale up new prevention tools and tailored service delivery. For example, in Pakistan, HIV prevention coverage has been low (i.e. less than 5% service coverage) among all key populations.[4] Despite high HIV transmission among people who inject drugs and men who have sex with men, key prevention programs such as opioid substitution therapy (OST) and PrEP are not available. Community-led differentiated services are at limited scale compared with the extent of the epidemic due to political disinterest, conservatism, punitive laws and widespread stigma and discrimination. Similarly, in countries, such as Philippines and Malaysia, with rising or resurging epidemics particularly among men who have sex with men, national roll out and scaled implementation of PrEP programs are still lacking.[19]

Insufficient and uneven progress in reaching Fast-Track treatment targets

Since 2010, the number of people receiving antiretroviral treatment in the region has quadrupled. However, with the current pace, the region will not reach the 2020 Fast-Track treatment targets and currently only 75% of the estimated people living with HIV (PLHIV) know their status, only 60% of all PLHIV are on antiretroviral treatment, and only 55% of all PLHIV in the region have viral suppression.[5] With only 3.2 million people estimated to have viral suppression, the region has a substantial gap of 2.6 million PLHIV with unsuppressed viral load. This means opportunities to save the lives of more than 2 million people, to break the chain of onward transmission and to avoid the occurrence and transmission of HIV drug resistant strains are missing.

Countries across the region have uneven progress and gaps towards Fast-Track treatment targets (Fig. 2). HIV testing is key to improve the first 90 Fast-Track treatment target, but approximately half of key populations in the region do not know their HIV status.[4] This emphasises a major gap in service delivery, particularly the lack of scaled implementation of innovative tools and differentiated approaches, and highlights that countries in the region are still dwelling on traditional facility-based service delivery models that are not sufficiently tailored to the needs of key populations. Evidence in the region shows that countries such as Cambodia and Viet Nam that adopted innovative testing approaches – community-based HIV testing, lay provider/peer-supported testing, online assisted testing and HIV self-testing – have achieved higher HIV testing coverage among key populations. Australia, Cambodia and Thailand have achieved the HIV viral suppression target with more than 73% of all PLHIV with viral suppression. Meanwhile, six other countries in the region still have low treatment coverage (less than 50%) among PLHIV.[5] Different political and programmatic commitments combined with effectiveness and scale of interventions; uptake and implementation of scientific recommendations on HIV testing and treatment; effective use of community-led service delivery and differentiated approaches in care and treatment continuum; and mechanisms set up for treatment retention and adherence support determine the unequal outcomes in countries' treatment programs. For example, Indonesia and Pakistan are among the last countries to endorse a 'treat all' policy[20] in the region and that, among many other reasons, leaves these countries with very low

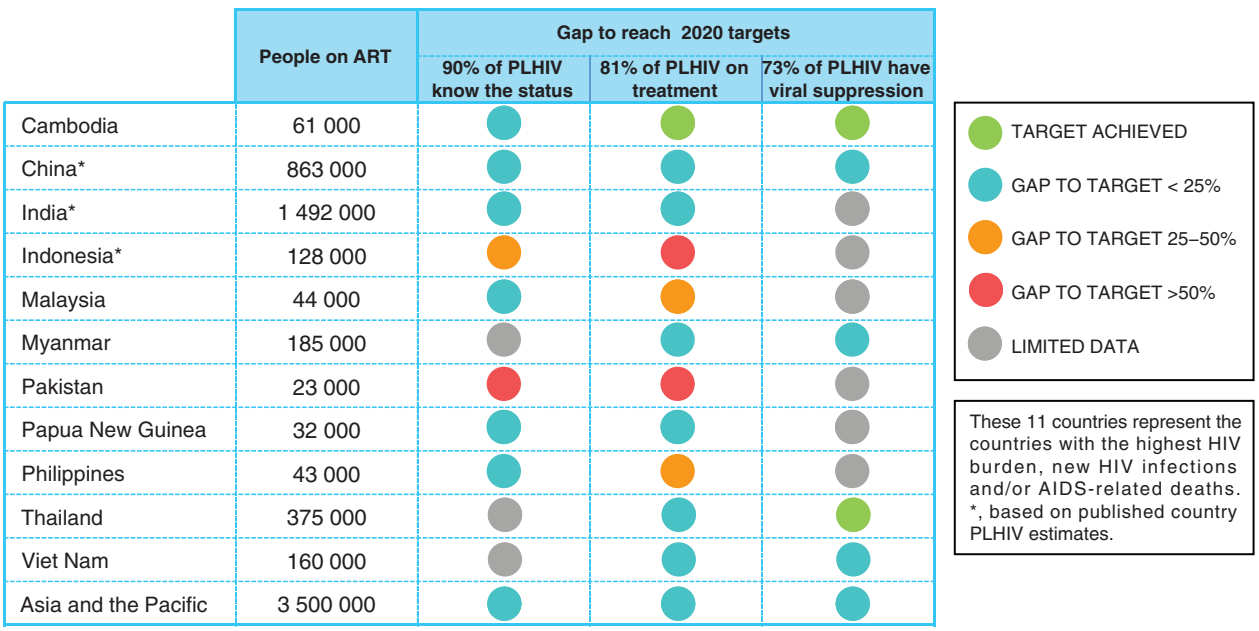

Fig. 2. Select Asia–Pacific countries with people receiving antiretroviral therapy (ART) and the gaps to reach the 2020 Treatment Cascade targets (90–81–73). Sources: UNAIDS[5] and the National AIDS Control Organisation and National Institute of Medical Statistics.[15]

levels of treatment coverage and significant gaps to reach the Fast-Track treatment targets. In contrast, Cambodia and Thailand were early adopters of a 'treat all' policy along with continuous efforts in scaling up treatment through active case finding, using community-led differentiated services, peer outreach and virtual outreach, same-day antiretroviral therapy (ART) initiation, rapid transition to effective new treatment regimens (e.g. dolutegravir (DTG)-based first-line regimens), multi-month ART dispensing (MMD) and differentiated key population-led service delivery, and adherence support and regular viral load monitoring, leading to these countries achieving the HIV viral suppression target.

What will it take to meet the targets for 2025 and 2030?

HIV epidemic patterns and context vary between and within the Asia–Pacific countries. Some countries have declining epidemics and are now running the last mile to end AIDS while others are facing emerging or resurging epidemics with new and recurring challenges, or continuously struggling to catch up with the ever-growing epidemics. There are many lessons to be learnt from within the region. The mix of successes and failures in HIV responses in countries across the region indicate that the solutions to overcome bottlenecks and implement effective interventions do exist within the context and the specificities of the region. Even within a country, there can be both success and failure in different facets of HIV response that others can learn from. For example, Malaysia has demonstrated a successful response in turning around the HIV epidemic among people who inject drugs, but in contrast it is facing resurgence of HIV infection among men who have sex with men.[19] Experience from within the region also tells us that when the response does not evolve with the ever-changing societal and environmental factors that increase vulnerabilities in terms of exposure to risk and HIV, and when policy frameworks and mechanisms of service delivery do not support the scale needed to achieve impact, there will be a threat of resurgent epidemics with the response unable to catch up to prevent infections and save lives. To maintain the current gains and attain epidemic control, countries should not only reinvigorate current response but also revise national AIDS strategies and take advantage of the latest evidence-based approaches for reaching hard-to-reach populations, renew the response infrastructure and functional capacities, and tackle the contextual environment that undermines human rights – punitive laws and policies, stigma and discrimination and gender inequality – in order for the response to be able to reach the goal of ending AIDS.

Reaching the people: key populations are integral to society

The targets for reducing new infections and AIDS deaths will not be achieved without investing in addressing the needs of the Asia–Pacific's marginalised populations. The regional aggregate of program coverage for prevention and testing remains suboptimal, and a large proportion of key populations remain outside the reach of traditional service delivery models. To reach the unreached key populations, it will be necessary for countries to identify and implement appropriate strategies within a multisectoral approach that evolves to find effective solutions for the following:

Find hidden populations: seize the opportunity of digital technology and innovations to complement community- and facility-based health services

Reaching populations at higher risk of infection as early as possible contributes to the prevention of new HIV infections and co-infections, as well as averting more costly treatment that would be incurred with late diagnosis. Current strategies to reach these populations are unable to achieve the service coverage necessary for ending AIDS. With the growing importance of the virtual space and virtual networks, key populations – particularly the young – become harder to reach and more hidden in society. An online survey in Viet Nam found that 66% of surveyed young men who have sex with men were hidden and had multiple sex partners and 77% had never tested for HIV.[21] National responses need to take advantage of proven innovations and new technologies to enhance case finding, initiate immediate treatment and ensure viral suppression. There needs to be more investment to better understand the size and dynamics of key populations in the virtual space and the changing risk and vulnerability dynamics within them at the national and sub-national levels. Technology based and technology supported models for outreach and service delivery need to be scaled up and generalised and move beyond local pilots. To complement the existing community- and facility-based services, health and HIV service providers will need to invest in technology and build capacity to deliver a greater range of services using a variety of channels. For instance, the Key Population-led Health Service delivery (KPLHS) model in Thailand – that utilises key populations' contextual knowledge and social connections to find hard-to-reach key populations – also takes advantage of social media and digital platforms to enhance HIV service uptake and retention.[8] Similarly, the community lay provider HIV testing and self-testing model through online and face-to-face interventions in Viet Nam demonstrates a substantial increase in service uptake among young men who have sex with men who have never had a test.[22] New applications of information and communication technology, especially through the widespread use of smartphones, offer efficiency gains, wider reach, and connectivity as well as more differentiated service options.

Implement integrated and comprehensive package of services

Barriers to services include lack of awareness, financial constraints, time-consuming facility-based processes, and geographical remoteness. Expanded effort in the community can help not only identify hidden pockets at highest risk but also deliver comprehensive services through a people-centred approach that responds to the needs and preferences of the community in holistic ways.[23] Many key populations face overlapping risks for HIV, sexually transmissible infections, tuberculosis, and viral hepatitis. Efforts need to be made to support further differentiation of this people-centred approach that fully adopts the perspectives and knowledge of the

community through their meaningful engagement and participation.[24] It is also important to diversify the entry points of services and provide relevant and comprehensive service packages tailored to the needs of each key or priority population. Engagement with the community can help in understanding newly emerging risk behaviours, such as Chemsex, and address the vulnerabilities emerging from dual risks.

Differentiate HIV services across the cascade

There is a need to build and institutionalise capacities to support implementation of a focused and differentiated approach across the prevention, treatment and care cascade for key populations. Health systems need to be reimagined to enable partnerships with civil society, community-based organisations and the private sector to allow services to be delivered by lay providers and communities. Evidence from the region demonstrates that the countries with a variety of service delivery models achieve the best HIV testing coverage rates among key populations.[8,22] Community organisations are close to key populations and can provide differentiated, personalised and non-judgemental services to these populations whether they are living with or at risk of HIV infection or HIV uninfected. Concurrently, healthcare providers require capacity building to operationalise DSD. An example of DSD practices to be taken to scale include PrEP for high-risk uninfected key populations, MMD and community antiretroviral (ARV) dispensing for less frequent clinical visits to reduce financial and other burdens for PLHIV who have already achieved viral suppression, and for the health sector.

Move from pilots to scale for proven innovations

Achieving impact on the epidemic can only be achieved when effective interventions are implemented on a large scale. Countries need to make use of new approaches to expanding differentiated HIV services, considering opportunities, locations, and settings to reach those not currently being reached, improve yields and enhance treatment initiation and retention. This should include increasing capacity for online and peer-driven recruitment for HIV testing, self-testing, provider-assisted testing, index testing, community-based testing, private clinics and provider-initiated testing. PrEP and HIV self-testing should be rapidly scaled up to an effective level, otherwise the potential impact of these effective interventions will not be achieved. Viet Nam and Thailand are implementing national roll out of PrEP, but the impact of the intervention is yet to be seen because the pace of the scale up is too slow. Other countries have small-scale pilots or demonstration projects that cannot impact on the epidemic. Early diagnosis, same-day ART initiation and MMD significantly improve treatment outcomes and need to be taken to scale. More innovative programs need to be explored to reach people who inject drugs and stimulant drug users, and legal and policy barriers need to be overcome to increase harm-reduction program coverage. Comprehensive health services for transgender people, such as inclusion of hormone affirmation therapy in the service package of HIV care and treatment, will further increase the HIV service uptake among transgender people.

Structures that respond to HIV: putting communities at the heart of the response

Country strategies, systems and institutional capacities need to be revisited with a view to accelerating uptake of HIV services among key populations who are not accessing services. Government leadership is critical. Dynamic partnerships with civil society, the private sector and the community will be needed to accelerate progress. Key populations must be at the heart of the response and engaged in driving policies and programs as well as monitoring results. This will involve:

Improve national program management and coordination capacity at all levels

A systems approach, that is sufficiently flexible, synergistic, and adaptive to respond to people's needs and preferences in all circumstances, and that is optimally inclusive, just, and equitable,[25] is needed for effective coordination of a multisectoral response. It will further improve the ability to implement proven innovations at scale and enhance linkages between services. Civil society and community organisations are key to an effective response with regards to the characteristics of the region's epidemic. Mechanisms should be in place to allow transfer of domestic funding to community and civil society organisations (social contracting). Several models of social contracting have been developed in the region and have proven to be effective.[26] Improved coordination with stakeholders across sectors and at all levels of the health system is needed to achieve greater efficiency and impact.

Expand community and key population-led service delivery

Evidence indicates that the most successful HIV programs in the region are based in, led by, and implemented by communities, with their strong engagement in program design and implementation.[19]

There is evidence that key population community-based organisations are efficient at implementation of key population programs preventing HIV infection, preventing loss to follow up and facilitating earlier treatment initiation and dispensing (e.g. test kits, ARV and PrEP).[8,27] A strategic approach to supporting the expansion of community- and key population-led service delivery is needed to put in place enabling policy, registration procedures, accreditation systems, as well as regulatory reform that enables community-led and key population-led services to access domestic funding sources in order to provide quality health and HIV services as part of or as an extension to the health system.

It is critically important to continue strengthening and sustaining community capacity and its institutionalisation, ensuring technical capacity for community-based and key population-led service provision, putting in place a quality assurance system and including community- and key population-led service delivery, including prevention

services. Extending and professionalising community and lay provider roles, as well as incentivising their contributions to the service cascade, will help to enhance sustainability of a resilient HIV response.

Intensify evidence-driven approaches

Data gaps need to be closed at the national and community level. This means investing in better data gathering processes, quality assurance and analytical capacity. Strategic information is fundamental to putting in place the right combination of interventions and tracking results. Adequate resources, human and financial, need to be in place to support and enhance data management, quality assurance and reporting systems. Health information systems need to be fully operationalised at all levels. There needs to be better sharing of data through information and communication technology and websites. Countries should develop a multi-year research agenda which identifies required research, surveys and evaluations to support an evidence-informed response, and communicate this data with all stakeholders. Community-led monitoring should be reinforced and expanded.

Seize the opportunities of universal health coverage (UHC) to sustain financing and improve investments

The resources available for HIV response in the region have been flatlining in the past 5 years despite a steady increase in domestic investments. In 2019, there was a ~US$1.75 billion resource gap to reach the US$5 billion Fast-Track response annual resource needs.[4] Funding for key populations HIV prevention programs are suboptimal and are heavily dependent on international funding while domestic resources are often prioritising HIV care and treatment programs.[4] Only 2.8% of region's total HIV funding during the period of 2016–2018 were spent on key populations HIV prevention programs.[28]

UHC presents an opportunity for a sustainable HIV response, particularly in the context of the region's inadequate HIV financing. It is crucial for the HIV response to seize the opportunities of UHC and make sure UHC becomes a mechanism for sustainable AIDS financing and enabling systems for health that provide for all, including the most vulnerable and marginalised population groups, with the health services they need. Not just care and treatment services but also HIV prevention and services to reduce and eliminate all forms of gender inequality and human rights abuses should be integrated into essential service packages of UHC.[29]

Contextual environment: working on enablers in a challenging context

The distinctive feature of HIV epidemics in the Asia–Pacific region is that they are mostly affecting key populations and their clients and partners (98% of all new HIV infections).[4] In the region, key populations are subject to punitive legislation, persistent stigma and discrimination, and forms of social, cultural and legal restrictions that prevent them from enjoying their rights to access prevention, testing and treatment services, and that restrict the ability of effective interventions to be implemented to scale, which makes vulnerable populations further marginalised, and more and more hidden, thus, becoming further out of reach of services. Establishing structures capable of responding to HIV and reaching key populations and their partners with effective interventions cannot be achieved without focusing on addressing the contextual environment for the response itself, as well as addressing the barriers that limit the ability and inhibit the potential of these interventions to reach the populations vulnerable to HIV infection.

Establish a supportive policy framework

One of the greatest challenges to the HIV response in the region is a supportive policy framework for an effective HIV response which will facilitate service delivery for populations in need. For example, only 17 out of the 38 countries in the region do not require parental consent for adolescents under 18 to access HIV testing services according to the UNAIDS laws and policies analytics (http://lawsandpolicies.unaids.org/). While efforts to change policies and improve supportive environments should continue, these barriers are best resolved through key population community engagement. Putting policies in place for professionalisation, accreditation and social contracting – as done in China, India, Malaysia, Philippines and Thailand – allows the community-led organisations to have sustainable financing and thus enhance their role in service provision, monitoring and strategy planning in HIV response.[26]

Fast tracking the response starts with rapid adoption of supportive policy based on global normative guidance such as HIV testing policies, same day ART initiation, MMD and other policies governing service delivery. In many countries, the adoption of these policies is delayed for several years leading to missed opportunities to further prevent infections and deaths.

Eliminate stigma and discrimination, protect and promote human rights, and improve equity in society

The shrinking space for community activism and the undermining of the community role in HIV response by growing conservatism, weak political commitment, punitive or discriminative laws and policies present yet another significant challenge to region's HIV response. Almost all countries in the region have some form of punitive laws that restrict basic human rights and the quality of life of people who are at risk of, living with, affected by, and/or vulnerable to HIV. Outstanding examples, however, have been set in the region. The passing of HIV legislation reaffirming human rights approaches in India and the Philippines,[30] the introduction of anti-discrimination and protective laws prohibiting discrimination based on sexual orientation or gender identity in Philippines, Mongolia, Thailand and Nepal,[30] and a new National Drug Control Policy that recognises harm reduction interventions and recommends consideration of decriminalisation of drug use in Myanmar,[30] among others, are all pertinent examples of

positive change, setting the pace for the rest of the region, and need to be replicated.

Lessons learnt from countries that have enabling legal environments must be promoted through regional and sub-regional political events. Coordinated advocacy efforts are needed to enhance law reform and to improve the enabling environment. Legal support mechanisms – such as complaint procedure and accountability mechanisms – and legal services must be established to address discrimination and human rights violations against people living with and affected by HIV. Governments should reform the laws that criminalise key populations and the policies that deter people living with HIV and key populations' access to health services and enact anti-discrimination and protective laws that prohibit discrimination and human rights violations.

Recognise and respond to gender-based violence against key populations

There are very high levels of gender-based violence across the region, and it is one of the key determinants of HIV infections in some parts of region (e.g. Papua New Guinea). A focused approach for addressing the determinants of gender-based violence is needed.

Increased understanding of gender-based violence dynamics must include the reality of sexual violence towards and among key populations. There must be a shift from a binary approach to gender and gender-based violence to one that is inclusive of key populations including lesbian, gay, bisexual, transgender, intersex, and questioning individuals. More research is needed to better understand gender-based violence affecting key populations, to develop prevention programs and enhance access to services.

Adapt to a new normal for HIV response in light of adaptation from COVID-19

Although HIV and COVID-19 are different in many aspects, the two pandemics also have many common traits. Ample experiences that have been learned during the decades-long response to HIV can be of great benefit to the COVID-19 response.[25] Synergies should be effectively utilised to tackle both pandemics. The innovations brought in for HIV programs responding to the impact of COVID-19 and integral elements of the HIV response, such as a people-centred public health approach leaving no one behind – ensuring health services to all who are in need, community-based and -led health responses, use of development synergies, integrated service delivery models, human rights based approaches, and political, legal and social enablers – can be effectively applied to the COVID-19 response,[25] as well as in any possible future health emergency, and must be amplified for the HIV response.

The COVID-19 pandemic has added greater urgency and highlighted the need for and value of community engagement, voluntarism, solidarity among PLHIV and the fundamental importance of PLHIV networks and key populations communities, as well as the benefits of community- and key population-led service delivery models to avoid treatment and service disruption. The societal effects of COVID-19 have led to enhanced recognition of PLHIV vulnerabilities, needs and community potential in responding to local crises among key populations, but also highlighted the great benefits of the HIV response approach and systems as key components for stronger systems for health.

Renew political will for ending AIDS as part of the renewed prioritisation for health security

There is an immense risk that HIV will lose ground in terms of national priorities. However, there are development gains that can be leveraged from the current HIV programming and investment in order to mainstream different health priorities and health system capacity, enabling them to respond to emerging diseases and burdens as they arise.

The region still requires committed political will that places the HIV response high in the political agenda, mobilises resources and addresses the sensitive issues that create more vulnerabilities for PLHIV and those at risk of HIV, such as human rights, inequalities, and social justice. In light of the new UNAIDS global AIDS strategy for HIV response that is being developed, there is an opportunity to reinvigorate commitment to a new regional roadmap that reflects the regional solidarity around the specificity of the epidemic in the region, and guides the countries in making individual and regional collective efforts to end AIDS.

This comes at a time when governments need to find the political wherewithal to control the COVID-19 pandemic and mitigate its serious consequences for the economy and society in general. This will be a big ask for many governments experiencing a decline in revenues, availability of human resources and competing priorities. Accelerating progress towards ending AIDS by 2030 will require a broader constituency that is able to call for resources, engage with people, advocate for rights and justice, and keep HIV high on the political agenda. Mobilisation needs to occur at the sub-regional level, taking advantage of sub-regional bodies and mechanisms such as Economic and Social Commission for Asia and the Pacific (ESCAP), Association of South-east Asian Nations (ASEAN), South Asian Association for Regional Cooperation (SAARC) and the Pacific Islands Community to enhance national efforts and commitment. At the national level, it is political leadership, widespread awareness on national HIV priorities, and activation of civil society and key population communities in partnership with government that is needed to get the job done.

Conclusion

The region was not on track to achieve the 2020 Fast-Track targets even before COVID-19 created additional risks, vulnerabilities and disruptions to HIV service provision, and current business models are unable to attain service coverage that is adequate to end AIDS. Along with insufficient and unequal progress in prevention and treatment, particularly among young key populations, several countries and populations with rising HIV infections could lead the region to a second wave of AIDS epidemics. With the effects of COVID-19 further undermining the overall stagnated progress in the HIV response, the region is in an urgent state to reinvigorate its response on all fronts to end AIDS. A

focused regional strategy that is aligned with the UNAIDS global AIDS strategy and responds to the specificities of the HIV epidemics in Asia and the Pacific as well as the needs required for an effective HIV response must be put up front and restructured in a comprehensive approach that considers learnings from the successes and failures of the past. Political will and commitments towards ending AIDS must be reaffirmed and reinforced through existing regional political platforms while the region's response architecture should be revisited and restructured, making it able to serve the purpose of ending AIDS. The COVID-19 pandemic has highlighted unique opportunities to expand the region's long overdue innovative interventions and service delivery models to leapfrog in finding and providing health services to people where they are. Ample lessons that the HIV response has earned in its decades-long fight to end stigma, discrimination, punitive laws, and policies should be effectively applied to the COVID-19 response and amplified in the HIV response to ensure both pandemic responses are rights-based and people-centred. Meaningful community engagement in all facets of the HIV response can regain the momentum while interlinking and integration between community-led responses and UHC initiatives are key to enable 'systems for health' that provide all people with health services they need.

At the sub-regional level, there are commonalities and differences in the distribution of new HIV infections, the capacity to address HIV and achieving results. Recognising the importance of sub-regional characteristics and cultural commonalities, it may be important to develop more specific sub-regional targets, indicators and strategies in order to better reflect local contexts, garner political ownership and promote opportunities for cross-learning and experience sharing. It will be important to sustain gains in high performance countries in sub-regions while freeing up and refocusing available resources to overcome outstanding gaps in other countries. This may require the development of an Asia–Pacific HIV roadmap with regional targets that are aligned with the UNAIDS global AIDS strategy.

Lastly, the region cannot afford a resurgence of HIV epidemics during and in the aftershock of the COVID-19 pandemic, and it must exploit its full potential and resilience to address common challenges in the HIV and COVID-19 pandemics and achieve the goal of ending AIDS by 2030.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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References

1 UN General Assembly. Political declaration on HIV and AIDS: on the fast track to accelerating the fight against HIV and to ending the AIDS epidemic by 2030. 2016. Available online at: https://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf [verified 19 January 2021].

2 UNAIDS. Fast-track: ending the AIDS epidemic by 2030. 2014. Available online at: https://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf [verified 19 January 2021].

3 UNAIDS. The gap report. 2014. Available online at: https://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf [verified 19 January 2021].

4 UNAIDS. Seizing the moment: tackling entrenched inequalities to end epidemics. 2020. Available at: https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf [verified 19 January 2021].

5 UNAIDS. UNAIDS data 2020. 2020. Available online at: https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf [verified 19 January 2021].

6 UNAIDS. UNAIDS terminology guidelines. 2015. Available online at: https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf [verified 19 January 2021].

7 UNAIDS. Fast-track commitments to end AIDS by 2030. 2016. Available online at: https://www.unaids.org/sites/default/files/media_asset/fast-track-commitments_en.pdf [verified 19 January 2021].

8 Vannakit R, Janyam S, Linjongrat D, Chanlearn P, Sittikarn S, Pengnonyang S, *et al*. Give the community the tools and they will help finish the job: key population-led health services for ending AIDS in Thailand. *J Int AIDS Soc* 2020; 23(6): e25535. doi:10.1002/jia2.25535

9 LINKAGES. Social network outreach – for HIV programs reaching at-risk populations online. 2019. Available online at: https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-social-network-outreach.pdf [verified 19 January 2021].

10 Phanuphak N, Sungsing T, Jantarapakde J, Pengnonyang S, Trachunthong D, Mingkwanrungruang P, *et al*. Princess PrEP program: the first key population-led model to deliver pre-exposure prophylaxis to key populations by key populations in Thailand. *Sex Health* 2018; 15(6): 542–55. doi:10.1071/SH18065

11 Macdonald V, Verster A, Baggaley R. A call for differentiated approaches to delivering HIV services to key populations. *J Int AIDS Soc* 2017; 20: 21658. doi:10.7448/IAS.20.5.21658

12 PATH. Improving access to HIV testing through lay providers and self-testing in Vietnam: bringing testing services closer to the communities that need them most. 2016. Available online at: https://path.azureedge.net/media/documents/ID_hm_hiv_cs.pdf [verified 19 January 2021].

13 Green K. HIV self-testing in Viet Nam: from pilot to program. The IAS Educational Fund Meeting – Overcoming Challenges in HIV with Science, Innovation and Collaborations in Southeast Asia; 4–5 October 2019; Kuala Lumpur, Malaysia. 2019. Available online at: https://www.iasociety.org/Web/WebContent/File/EduFund/Malaysia/08_KGreen.pdf [verified 22 January 2021].

14 Grimsrud A, Bygrave H, Doherty M, Ehrenkranz P, Ellman T, Ferris R, *et al*. Reimagining HIV service delivery: the role of differentiated care from prevention to suppression. *J Int AIDS Soc* 2016; 19(1): 21484. doi:10.7448/IAS.19.1.21484

15 National AIDS Control Organisation, Indian Council of Medical Research National Institute of Medical Statistics. India HIV estimates 2019 report. 2020. Available online at: http://naco.gov.in/sites/default/files/INDIA%20HIV%20ESTIMATES.pdf [verified 11 February 2021].

16 Reza-Paul S, Steen R, Maiya R, Lorway R, Wi TE, Wheeler T, *et al*. Sex worker community-led interventions interrupt sexually transmitted infection/human immunodeficiency virus transmission and improve human immunodeficiency virus cascade outcomes: a program review from South India. *Sex Transm Dis* 2019; 46(8): 556–62. doi:10.1097/OLQ.0000000000001020

17 Thai Red Cross AIDS Research Centre and FHI 360. Differentiated HIV-service delivery along the cascade for men who have sex with men and transgender women in Thailand: lessons learned from LINKAGES project. 2018. Available online at: https://differentiatedservicedelivery.org/Portals/0/adam/Content/ZrutobOVxk-Fze9x6KfQTA/File/1%20Thailand%20-%20Thai%20Red%20Cross%20AIDS%20Research%20Centre.pdf [verified 19 January 2021].

18 Shangani S, Escudero D, Kirwa K, Harrison A, Marshall B, Operario D. Effectiveness of peer-led interventions to increase HIV testing among men who have sex with men: a systematic review and meta-analysis. *AIDS Care* 2017; 29(8): 1003–13. doi:10.1080/09540121.2017.1282105

19 UNAIDS. Communities at the centre: defending rights, breaking barriers, reaching people with HIV services. 2019. Available online at: https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf [verified 19 January 2021].

20 World Health Organization. Consolidated Guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. 2016. Available online at: https://apps.who.int/iris/bitstream/handle/10665/208825/9789241549684_eng.pdf?sequence=1&isAllowed=y [verified 19 January 2021].

21 García M, Duong Q, Mercer L, Meyer S, Ward P. 'Never testing for HIV' among men who have sex with men in Viet Nam: results from an internet-based cross-sectional survey. *BMC Public Health* 2013; 13: 1236. doi:10.1186/1471-2458-13-1236

22 Green KE, Vu BN, Phan HT, Tran MH, Ngo HV, Vo SH, *et al*. From conventional to disruptive: upturning the HIV testing status quo among men who have sex with men in Vietnam. *J Int AIDS Soc* 2018; 21(S5): e25127. doi:10.1002/jia2.25127

23 World Health Organization. WHO global strategy on people-centred and integrated health services-Interim report. 2015. Available online at: https://apps.who.int/iris/bitstream/handle/10665/155002/WHO_HIS_SDS_2015.6_eng.pdf?sequence=1 [verified 19 January 2021].

24 Pantelic M, Stegling C, Shackleton S, Restoy E. Power to participants: a call for person-centred HIV prevention services and research. *J Int AIDS Soc* 2018; 21: e25167. doi:10.1002/jia2.25167

25 UNAIDS. COVID-19 and HIV: 1 moment, 2 epidemics, 3 opportunities – how to seize the moment to learn, leverage and build a new way forward for everyone's health and rights. 2020. Available online at: https://www.unaids.org/sites/default/files/media_asset/20200909_Lessons-HIV-COVID19.pdf [verified 19 January 2021].

26 Vannakit R, Andreeva V, Mills S, Cassell MM, Jones MA, Murphy E, *et al*. Fast-tracking the end of HIV in the Asia Pacific region: domestic funding of key population-led and civil society organisations. *Lancet HIV* 2020; 7(5): e366–72. doi:10.1016/S2352-3018(20)30077-1

27 UNAIDS, Stop AIDS Alliance. Communities deliver: the critical role of communities in reaching global targets to end the AIDS epidemic. 2015. Available online at: https://www.unaids.org/sites/default/files/media_asset/UNAIDS_JC2725_CommunitiesDeliver_en.pdf [verified 19 January 2021].

28 Partnership to Inspire Transform and Connect the HIV response (PITCH), BridgingTheGaps, aidsfonds. Fast-track or off track: how insufficient funding for key populations jeopardises ending AIDS by 2030. 2020. Available online at: https://aidsfonds.org/assets/resource/file/Fast-Track%20or%20Off%20Track%20report-final.pdf [verified 19 January 2021].

29 UNAIDS. HIV and universal health coverage: a guide for civil society. 2019. Available online at: https://www.unaids.org/sites/default/files/media_asset/hiv-uhc-guide-civil-society_en.pdf [verified 19 January 2021].

30 UNAIDS. Legal and policy trends: impacting people living with HIV and key populations in Asia and the Pacific 2014–2019. 2021. Available online at: https://www.unaids.org/sites/default/files/media_asset/legal-and-policy-trends-asia-pacific_en.pdf [verified 22 January 2021].