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| This version of the draft Integrated Regional Action Plan for viral hepatitis, HIV and sexually transmitted infections in the South-East Asia Region, 2022–2026, is dated 27 May 2022.  This is a revised draft following consultation with national programme managers, partners, civil society and community consultations.  Please also note that the draft will undergo professional editing, and hence review and feedback may please be prioritized on substantive and technical aspects for consideration in the revised draft. |

Integrated Regional Action Plan for viral hepatitis, HIV and sexually transmitted infections in South-East Asia, 2022–2026

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# Glossary

|  |  |
| --- | --- |
| Affected populations | Those members of the community living with the particular infection or disease |
| Community-based organization | A public or private non-profit organization that is representative of a community or significant segments of a community and provides educational or related health services to individuals in the community |
| Community health worker (CHW) | CHWs are health-care providers who live in the community they serve. They receive lower levels of formal education and training than professional health-care workers such as nurses and doctors. |
| Community-based monitoring (CBM) | Community-based or community-led monitoring refers to service users assessing the effectiveness, quality, accessibility and impact of health programmes and services which they receive. |
| Disability | Disability is an umbrella term for impairments of bodily function or structure, activity limitations or participation restrictions. This can be physical, intellectual or psychological. |
| Integration | In the context of this action plan, integration refers to the combining of health interventions and health programmes to provide people-centred care, regardless of the disease category experienced by the individual. |
| Key population | Key populations are defined groups who, due to specific higher-risk behaviour, are at increased risk of HIV, irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviour that increase their vulnerability to viral hepatitis, HIV or STIs. |
| Social contracting | The process by which government resources are used to fund entities which are not part of government (herein called civil society organizations) to provide health services which the government has a responsibility to provide, to assure the health of its citizenry. |

# Abbreviations

AMR antimicrobial resistance

ANC antenatal care

ART antiretroviral therapy

BD birth dose

CBM community-based monitoring

CBO community-based organization

CHW community health worker

CPAD compact pre-filled auto-disable injection device

CSO civil society organization

DAA direct-acting antiviral

EMTCT elimination of mother-to-child transmission

GHSS Global Health Sector Strategies

GRSH Global Reporting System for Hepatitis

HAV hepatitis A virus

HB Ig hepatitis B immunoglobulin

HBsAg hepatitis B surface antigen

HBV hepatitis B virus

HCC hepatocellular cancer

HCV hepatitis C virus

HepB-BD birth dose of hepatitis B vaccine

HepB3 third dose of hepatitis B vaccine

HEV hepatitis E virus

HIV human immunodeficiency virus

HPV human papillomavirus

IPC infection prevention and control

IRAP Integrated Regional Action Plan

LDSS low dead-space syringe

M&E monitoring and evaluation

MSM men who have sex with men

MTCT mother-to-child transmission

NCD noncommunicable disease

NGO nongovernmental organization

NSP national strategic plan

OST opioid substitution therapy

PEP post-exposure prophylaxis

PHC primary health care

PLHIV people living with HIV

PMTCT prevention of mother-to-child transmission

PrEP pre-exposure prophylaxis

PWID people who inject drugs

PWUD persons who use drugs

RAP Regional Action Plan

RDT rapid diagnostic test

SDGs Sustainable Development Goals

SE South-East

STI sexually transmitted infection

SW sex worker

TB tuberculosis

TWG technical working group

UHC universal health coverage

UNAIDS Joint United Nations Programme on HIV/AIDS

UNDP United Nations Development Programme

VPD vaccine preventable disease

WHO World Health Organization

WUENIC WHO/UNICEF Estimates of National Immunization Coverage

# Global and regional integrated elimination agenda

The world has made substantial progress on the elimination goal for viral hepatitis, human immunodeficiency virus (HIV) and some sexually transmitted infections (STIs) as public health threats by 2030 following the global agreement through a resolution at the World Health Assembly in 2016. The global HIV epidemic has now been transformed with the large-scale expansion of antiretroviral therapy (ART), reducing global HIV-related deaths to their lowest since 1994. Global hepatitis B-birth dose (hepB-BD) coverage has expanded greatly and the number of people receiving treatment for chronic hepatitis C virus infection has increased almost 10-fold from 2015, reducing hepatitis C-related mortality. A number of countries and regions have now embraced the triple elimination agenda for eliminating mother-to-child transmission (MTCT) of HIV, syphilis and hepatitis B.

The achievements to date, both global and in the Region, have demonstrated that a strong leadership coupled with innovative technologies and practices, financial investment and community engagement can reduce disease transmission, improve treatment outcomes and save lives. The COVID-19 pandemic interrupted progress during the period 2020–2022, and a refocus is necessary to consolidate the gains achieved. Strategic and innovative shifts are needed to protect the progress to date and to bring the Region closer to the goal of ending the epidemics of AIDS, viral hepatitis and STIs.

Acknowledging the commonalities, differences and potential synergies across these disease areas, the new Global Health Sector Strategies (GHSS) 2022–2030 on viral hepatitis, HIV and STIs have brought together multiple diseases under a common framework, embedded in universal health coverage (UHC) and actioned through primary health care (PHC).

The 2022–2026 WHO Regional Action Plan for South-East (SE) Asia provides an operational framework for the Region aligned with the global strategies, to implement key actions and combine shared and disease-specific approaches. Those affected are placed at the centre of an integrated health sector response including time-bound actions for shared and individual programmes within a UHC framework to achieve elimination.

Reflecting the complex interaction of health issues associated with viral hepatitis, HIV and STIs, this Regional Action Plan is aligned with other global and regional health strategies and plans that address a wide range of related diseases and health concerns.

## Integrated global action to end epidemics

Viral hepatitis, HIV and STIs collectively cause 2.3 million deaths and 1.2 million cases of cancer each year,[[1]](#footnote-2) and continue to impose a major public health burden worldwide. More than 1 million people are newly infected with STIs each day, and 4.5 million with HIV, hepatitis B and hepatitis C (combined together) each year. Although progress has been made in all three disease areas, the global response is off-track and most global health targets for 2020 were missed, including hepatitis B incidence, diagnosis coverage targets for most diseases and treatment targets for both hepatitis B and C. The multiple epidemics of STIs continue to cause a significant disease burden and the global response has lagged severely, resulting from a lack of visibility, funding and implementation support. The full benefits of available tools and technologies are not being realized, many populations are left behind, and structural, systemic and financial barriers to accelerating progress persist. The COVID-19 pandemic has further hampered progress and accelerated action is needed to end these epidemics.

Building on the achievements and lessons learnt under the 2016–2021 GHSS,1-3 the 2022–2030 GHSS on viral hepatitis, HIV and STIs guide the health sector in implementing strategically focused responses to achieve the goals of ending AIDS, viral hepatitis B and C and STIs by 2030.[[2]](#footnote-3)

The strategies recommend shared and disease-specific country actions for the next eight years, supported by actions by World Health Organization (WHO) and partners. Implementation is grounded in delivery through PHCs and the utilization of existing forms of care including TB, HIV and medical diseases under the context of UHC.

The 2022–2030 strategies underline the critical role of the health sector in ending these epidemics, acknowledging that a multisectoral “health in all policies” approach is required to remove structural and systemic barriers to accelerating progress.4 The strategies call for a more precise focus to reach the people most affected and at risk for each disease and to address inequities. They promote synergies under a UHC and primary health-care framework and contribute to achieving the goals of the 2030 Agenda for Sustainable Development.5

## Regional situation and response in SE Asia

The epidemics of viral hepatitis, HIV and STIs and responses thereto are at different stages across the Region.

### Progress in HIV

WHO South-East (SE) Asia Region is committed to achieving the 2030 Sustainable Development Goal (SDG) target of ending the AIDS epidemic as a public health threat. Nevertheless, the Region did not reach the 2020 targets and is currently not on track to end AIDS by 2030.6 Decades of evidence suggests that inequalities have prevented us from achieving the targets.

At the end of 2020, there were an estimated 3.7 [2.8–4.4] million people living with HIV (PLHIV) in the SE Asia Region, including 1.5 million (41%) women aged over 15 years. There were an estimated 100 000 [71 000–130 000] new HIV infections and 82 000 [55 000–130 000] AIDS-related deaths in 2020. The Region has a concentrated HIV epidemic, with a low HIV prevalence of 0.2% among adults (15–49 years). HIV incidence was 0.05 new HIV infections per 1000 uninfected population in 2020.6

The key features of the epidemiology of HIV in the Region are that the overwhelming majority of the estimated PLHIV infections are geographically concentrated in five countries – India, Indonesia, Myanmar, Nepal and Thailand. In addition, almost all new infections occur in key populations and their partners, meaning that the epidemic in SE Asia is highly concentrated.

Despite significant progress in the AIDS response in the Region between 2010 and 2020, the 2020 targets have not been achieved. Epidemiological trends show that new HIV infections declined by 46% from 190 000 in 2010 to 100 000 in 2020 (Regional Action Plan [RAP] 2017–2021 target: 50 000). Similarly, HIV-related deaths declined by 64% from 230 000 in 2010 to 82 000 in 2020 (RAP 2017–2021 target: 45 000). Tuberculosis (TB) related deaths among PLHIV have also declined substantially by 72% between 2010 and 2020 against the target of 75%.6

At the end of 2020, 2.8 million (75%) PLHIV knew their status, 2.2 million (61%) were on ART and 2.1 million (58%) were virally suppressed. The Region fell short of the 90-90-90 target that translates into 90-81-73 along the care cascade. ART coverage in 2010 was only 17% for the Region. This has increased 3.6 times to 61% in 2020 against the target of 81%. Looking at the 90-90-90, only 75% PLHIV knew their status and 81% of them started treatment. Nearly 1.5 million PLHIV received viral load testing, of whom 96% were virally suppressed. Also, despite many positive changes in the legal environment, the laws and policies that perpetuate stigma, discrimination, violence and other rights violations, especially for PLHIV and key populations, still remain across the Region. We need to highlight the serious shortage in achieving the first 90, i.e. the gap between the estimated population and those who were tested.6

HIV incidence is highest among key populations, adolescents and young adults. Country-level data showed that the coverage of HIV prevention programmes among sex workers, people who inject drugs (PWID), men who have sex with men (MSM) and transgender persons remained below 80% in all countries except in India. Despite mature condom programmes in many countries, condom usage among PWID has remained low (22–66%). Also, the testing coverage among key populations is below 60% on an average and there are wide variations between countries (Figs. 1 and 2).

Fig. 1. New HIV infections and AIDS-related deaths trends in SE Asia Region, 2010–20206

Chart

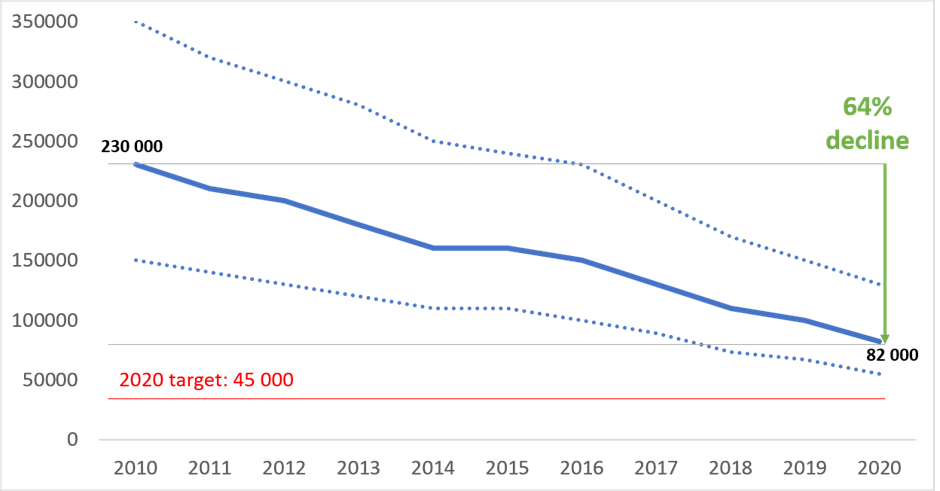
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Fig. 2. Progress towards 90-90-90 along the care continuum, 2020, by age and sex 6

Chart, bar chart

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### Progress in viral hepatitis

Viral hepatitis is a serious public health problem that can cause chronic and potentially fatal complications including liver cancer. Among the estimated 1.38 million people dying globally due to hepatitis every year, 28% are from countries in the WHO SE Asia Region.7 The SE Asia Region has an estimated 39 million people with chronic hepatitis B [29–77 million] and an estimated 14 million [8–18 million] with hepatitis C. Of the estimated 391 000 deaths due to viral hepatitis each year in the Region, 77% are attributable to the chronic complications of hepatitis B and C.7 Unlike other communicable diseases such as HIV and TB, hepatitis-related mortality has not declined, despite the existence of high-impact tools for prevention and treatment.

Most Member States of the SE Asia Region have an intermediate-to-low prevalence of hepatitis B in the

general population. For hepatitis C, most have a prevalence in the range of 0.28–0.75% except Indonesia, Myanmar and Thailand, where it is more than 2%. The prevalence of hepatitis B is slightly higher in PWID, while for hepatitis C the prevalence is manifold higher with a number of countries having a prevalence of over 50% of PWID living with hepatitis C, as illustrated in Fig. 3.

Fig. 3. Prevalence of HBV and HCV in PWID in comparison to the general population in Member States of the SE Asia Region (all values are in percentages)7



70

63.50

60

50

40

30

56.00

58.86

51.48

40.89

27.48

20

10

0

0.72

0.49

2.03

2.65

0.38

5.57

0.23

2.28

HCV Prevalence % in General Population HCV Prevalence % in PWID

16

14.0

14

12

10

8

6 5.5

4

7.1

6.2

7.3

6.5

5.1

3.6

3.5

2 0.9

0

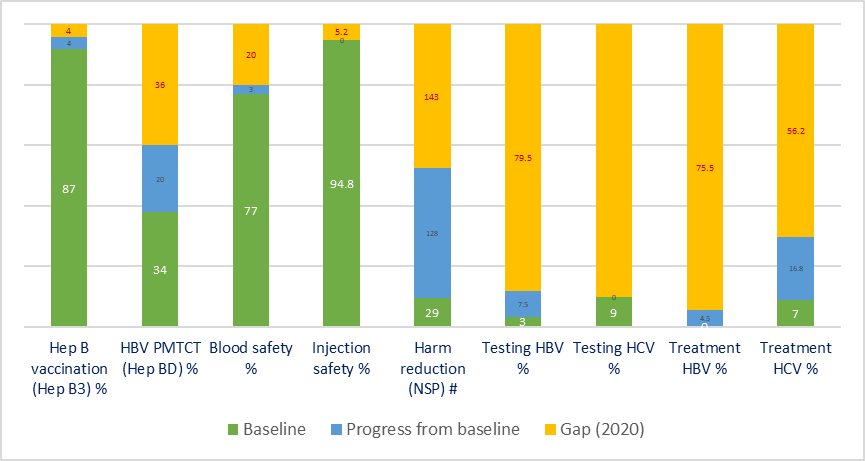
Bangladesh Indonesia Myanmar Nepal Thailand

HBV Prevalence % in General Population HBV Prevalence % in PWID

HBV – hepatitis B virus; HCV – hepatitis C virus

Since 2017, Member States in the Region have been implementing the Regional Action Plan for Viral Hepatitis in SE Asia. The Action Plan focuses on eliminating viral hepatitis as a public health threat by 2030 by achieving the global targets of 30% and 10% reduction in incidence and mortality, respectively by 2020; and a 90% and 65% reduction for chronic hepatitis B and C, respectively by 2030. The plan provides an actionable framework for evidence-based, prioritized actions along five core interventions on prevention, diagnosis and treatment (Fig. 4).

Figure 4 - Progress on key hepatitis indicators against the Global and RAP 2017 - 2021 indicators



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Fig. 4. Gap analysis of progress in hepatitis B and C prevention, testing and treatment in SE Asia, 2020

Commendably, almost all countries are now implementing national strategic plans that provide guidance on key prevention interventions as well as hepatitis testing and treatment. The Region has achieved 91% coverage of three doses of the hepatitis B vaccine. Bangladesh, Bhutan, Nepal and Thailand have already achieved the 2020 hepatitis B control target. Eight countries now provide the hepatitis B birth dose (hepB-BD). During 2016–2019, the regional hepB-BD coverage increased from 34% to 54%. Direct-acting antiviral drugs, which can cure 85–95% of hepatitis C infections, are becoming more affordable in several of the Region’s Member States. Nevertheless, diagnosis and treatment progress is well below that necessary to reach elimination, with only 10.5% of an estimated 60 million with chronic hepatitis B knowing their status and just 4.5% on treatment at the end of 2018. Similarly, only 6.9% of the estimated population of 11 million with hepatitis C knew their status and 23% of those (1.5% of estimated population) had received treatment by end-2018.8

### Progress in STIs

Untreated STIs can lead to long-term and potentially fatal outcomes including chronic pelvic pain, ectopic pregnancies, infertility, adverse pregnancy outcomes and neonatal death. STIs are also associated with greater risk of HIV transmission, with ulcerative STIs being associated with the highest risk. Most cervical cancers and a high proportion of some other anogenital and oropharyngeal cancers are caused by infection with human papillomaviruses. STIs have historically been a serious public health problem in SE Asia, and while the proportion of new infections has declined from a third of the total global estimate in the 1990s to 16% in 2019 (from 118 million to 60 million), the epidemiology of STIs in the Region is highly heterogeneous. Insufficient data on STIs from many countries limits both epidemiological assessment and control efforts (Fig. 5).9

Fig. 5. WHO global estimates of four curable STIs: proportion from the SE Asia Region



SEAR – SE Asia Region

Data on syphilis are more available and reliable than for other STIs and can be used as markers of STI trends in general. Evidence of declining syphilis, as well as progress in eliminating MTCT in some countries, supports the feasibility of regional elimination of syphilis as a public health problem.9 However, congenital syphilis remains an important cause of adverse birth outcomes across the Region. In 2019 (using 2016 data), WHO estimated that in SE Asia, 78 000 pregnant women were infected with syphilis and there were 53 000 congenital syphilis cases including 28 000 adverse birth outcomes, making an estimated rate of 145 cases per 100 000 live births.10 Recent increases in syphilis among MSM in several countries also emphasises the importance of routinely screening key populations for syphilis and monitoring prevalence trends.

The current programme response to STIs varies greatly between countries of the Region. For example, Thailand and Sri Lanka have maintained strong commitment and funding for STI control over many years and have documented high levels of control, while many other countries face challenges in scaling up outreach to key populations, supporting clinical services and conducting basic STI surveillance. A key target in the previous Regional Action Plan for HIV in SE Asia (2017–2021) was the elimination of MTCT of HIV and syphilis,11 and three of 11 countries in the Region, i.e. Thailand, Sri Lanka and Maldives have achieved this.6 However, many countries face challenges in scaling up outreach to key populations, supporting clinical services and conducting basic STI surveillance.

The challenges include a lack of resourcing and trained staff specific to STI programmes with national strategies largely oriented towards HIV, commodity gaps, lack of sustainable funding for community organizations, variable clinical services and contact tracing. Legal and policy barriers to key populations having equitable access to health care, along with stigma and discrimination remain key concerns. Both domestic and external funding has declined for community organizations at the grass roots level over the past few years, and many have ceased to function due to lack of core funding support.

STI screening coverage among key populations and in pregnant women is low. Between 2009 and 2016, only three countries of the Region reported over 90% antenatal clinic syphilis screening in any one year, three others reported almost no antenatal clinic screening and the remaining five countries reported a screening coverage of between 10% and 70%.

Highly effective prevention initiatives including human papillomavirus (HPV) vaccines are available, but access and coverage remains a challenge. The last-dose coverage for HPV vaccination in the Region is 2% as against a global coverage of 15%. Many countries are yet to introduce HPV vaccination in their national programmes.12

## An Integrated Regional Action Plan to accelerate response towards elimination in the SE Asia Region

### Rationale for integrating viral hepatitis, HIV and STIs efforts

Viral hepatitis, HIV and STIs continue to be significant public health problems in WHO SE Asia Region. The Seventy-fourth Session of the WHO Regional Committee adopted a decision to develop an integrated regional action plan for viral hepatitis, HIV and STIs for the period 2022–2026. This integrated regional action plan builds on the previous RAPs on viral hepatitis (2016–2021)13 and HIV (2017–2021)11 and has synergy with the regional flagship priorities on UHC and elimination of diseases. This action plan operationalizes the GHSS 2022–2030 and is aligned with a number of other global and regional initiatives including the United Nations General Assembly (UNGA) High-Level Meeting on HIV/AIDS in June 2021 that adopted the “Political declaration on HIV and AIDS: ending inequalities and getting on track to end AIDS by 2030”. The SDG target for ending the AIDS epidemic and combating viral hepatitis is also 2030.

Viral hepatitis, HIV and STIs are all silent epidemics which do not present as a single outbreak wave. A large number of people are endemic, disseminating through society by taking advantage of the vulnerabilities, inequalities and lack of access to standard health care. HIV became highly visible in the Region during the decade 2001–2010, but later fell in priority with the success of the ART programmes in reducing mortality and new infections. Hepatitis B and C affect a larger number of people than HIV and with a higher mortality rate, but do not get noticed as a priority area of intervention. The opportunity to cure the majority of patients with hepatitis C is not being fully utilized.

STIs also have a large morbidity, albeit less mortality, but they have similar epidemiological characteristics to HIV. During the initial years of HIV response, STIs were also regarded as coinfections and treated under the same programme. Later, as the HIV programmes became too large to respond to the growing epidemic burden, STIs lost importance.

Bringing the three areas together for joint action through a common document was visualized by WHO while formulating the GHSS on HIV, viral hepatitis and STIs for 2022–2030. The RAP should therefore align with the GHSS for various components such as target setting, implementation and monitoring and evaluation (M&E).

For the first time, the RAP will combine three important communicable disease areas, instead of individual ones that was followed until 2021. The need for such an integrated approach has been felt over several years. Moreover, each of them has separately failed to reach the 2020 targets and fully engage political and programmatic attention from Member States. While translating to national action plans, the rationale for integration as well as the process of integration unique to a given country context will need to be clearly articulated. Accordingly, the RAP must offer flexibility within the integrated framework, so that the required focus on specific aspects of the response can be ensured, considering the unique issues in each, as well as the different stages of maturity of the disease programmes in Member States.

Integration also refers to integrating efforts within these three diseases into the existing health infrastructure and health system of the country, including integrated strategies for prevention, testing and treatment across the health system to improve efficiencies and avoid duplication.

Identifying areas of convergence and presenting an integrated model for delivery of services will be the central focus of the new RAP. As programmes for the three disease areas are conducted under different verticals in most countries, issues of governance and integrated programme delivery will assume key importance. Accordingly, the RAP will identify key areas that can be integrated or synergized to bring in efficiency in a client-friendly manner and to ensure availability of services closer to where people need them. The HIV model can be successfully used for integration and decentralization. For example, the opportunity to cure a majority of people living with chronic hepatitis C, which is not being fully utilized currently, could be better utilized by leveraging the infrastructure and social capital of existing HIV programmes through integrated approaches.

### People-centred action

Viral hepatitis, HIV and STIs share overlapping modes of transmission and are addressed together through common interventions. They are also shaped in similar ways by social and structural determinants of health, such that communities facing poorer socioeconomic conditions or discrimination (including discrimination experienced by key populations) experience greater vulnerability to infection and worse health outcomes.

The Integrated RAP takes a people-centred approach. Promoting integrated service delivery that can benefit people with multiple health needs not only benefits the individuals but also the health systems. Services will be better sustainable on a longer term by reducing structural silos to enable efficiency gains and bring cost savings to clients and the system. This will also focus on seamless and comprehensive continuum of services across prevention, testing and treatment as well as expanding and strengthening services through primary health care approach and intervention-specific community-based services.

People-centred care is an approach to care that consciously adopts the perspectives of individuals, carers, families and communities as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences.14 People-centred care is broader than patient and person-centred care or disease-centred care and encompasses not only clinical encounters but also attention to the health of people in their communities and their crucial role in shaping health policy and health services through community-led and community-based monitoring.

Putting people at the centre of rights-based health system responses is the key to ending these epidemics.

Integrated health services are health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services coordinated across the different levels and sites of care within and beyond the health sector and according to their needs, throughout the life course.

The RAP is an integrated approach to operationalizing those interventions necessary to best cater to the health needs of those affected, noting that the burden and distribution of viral hepatitis, HIV and STIs vary between and within countries, and that health sector responses of both the public and private sector need to be adapted to different epidemiological and health system contexts.

### Impact of COVID-19 and lessons for HIV, hepatitis and STI action

The responses to viral hepatitis, HIV and STIs are evolving in an increasingly complex environment. The COVID-19 pandemic has altered the landscape of global health by shifting resources, drawing attention to the gaps in health systems and exposing and exacerbating the disparities and inequalities that make some populations more vulnerable to disease, including key populations which face pre-existing barriers to services. This has drawn attention to the importance of integrating a rights-based public health response to mitigate the COVID-19 impact on public health and social measures, and the need for a strong and well-supported health workforce to maintain service continuity.

The pandemic has demonstrated the vital role of communities in meeting people’s needs during crises and has highlighted inequalities in the burden of this care in the community. It has also catalysed innovations in health and community systems, such as the rapid development and deployment of new vaccines and technologies and the expanded use of integrated diagnostics systems and platforms, health information systems, digital health solutions and self-care approaches.

The challenges and potential opportunities emanating from the COVID-19 pandemic impact and response at the regional level have been detailed in the *COVID-19 and measures to ‘build back better’ essential health services to achieve UHC and the health-related SDGs* discussion paper and include a sustained focus on achieving UHC and responding to and preparing for health emergencies in order to maintain essential health services.15

Many important lessons from the COVID-19 pandemic will inform future responses to infectious diseases. Further, challenges such as demographic shifts, the growing burden of noncommunicable diseases (NCDs), climate change, population displacement and economic insecurity are also currently shaping the health and development context at the regional level.

## The Regional Action Plan development process

The Integrated Regional Action Plan (IRAP) 2022–2026 will be the first of its kind in the WHO SE Asia Region advocating an integrated response to HIV, hepatitis and STIs. This will entail a major policy shift for Member countries and UN agencies led by WHO. The latter has taken the lead in developing a global strategy (GHSS) for an integrated response within an overall UHC framework. While developing the RAP, the Regional Office for SE Asia has ensured that:

* the RAP is broadly in alignment with the GHSS, and other global instruments related to SDG 3;
* ownership for integration is built-in in the countries, both at political and technical levels;
* communities living with, and affected by, the three diseases see merit in an integrated response as one which will address access issues for vulnerable populations by building in community system strengthening as an important deliverable;
* while broadly indicating the resource requirements for the 5-year period, the RAP encourages countries to develop fully-costed national strategic plans (NSPs) with clear targets identifying the requirement of resources (both domestic and external) for implementation, to realize such national targets;
* a critical requirement for integration would be to evolve a unified M&E strategy by integrating the existing M&E systems for the three diseases which presently exist in parallel.

The development of the Integrated RAP started right after the Seventy-fourth Session of the WHO Regional Committee in September 2021 and is following a systematic approach as briefly described below.

* The Regional Office prepared an outline and concept paper for the RAP that was shared and discussed during the extended meeting of the Strategic and Technical Advisory Group (STAG) on viral hepatitis in November 2021.
* An online questionnaire has been widely circulated to all stakeholders and also put on the website and disseminated through social media for inviting inputs.
* A community dialogue organized in conjunction with the World AIDS Day virtual event on 1 December 2021 provided the opportunity for interaction with representatives of community-based organizations (CBOs) of key populations and people living with or survivors of the infections as well as civil society organizations (CSOs) and get their preliminary inputs. Their feedback on the present stage of response in respect of all three diseases and their suggestions for an integrated response were received.
* A technical working group (TWG) has been constituted with experts drawn from all the three disease streams to provide technical inputs for development of the concept paper and preparation of the RAP document. Two meetings of the TWG have been held, in December 2021 and February 2022, respectively. The inputs from the TWG on the concept paper and the outline has led to the development of this draft. Further, TWG members will also participate in the virtual consultation with national programme managers and other stakeholders on 18–19 April 2022.
* The Regional consultation on 18–19 April 2022 will include national programme managers of the three diseases from all Member States in the Region, health ministry officials, regional community-based and CSOs and partners including Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF, UNODC, UNDP, UNFPA, etc. and WHO country office focal points.
* The Member States and partners had also provided their region-specific inputs during the bi-regional meeting for inputs into GHSS on 15–16 June 2021.
* The revised draft of the RAP will be put on the website for further inputs (May 2022).
* A separate community interaction with a wider group of CBOs of key populations and affected populations will be held to ascertain detailed views over and above what have been discussed in preliminary dialogues and online consultations (5 May 2022).
* The revised version of the RAP will be ready for review by the Regional Director in June 2022. The RAP will get the concurrence of the delegates of the High-level Preparatory (HLP) Meeting for the Regional Committee in July 2022.
* Adoption of the RAP by Member States at the Seventy-fifth Session of the Regional Committee (September 2022).

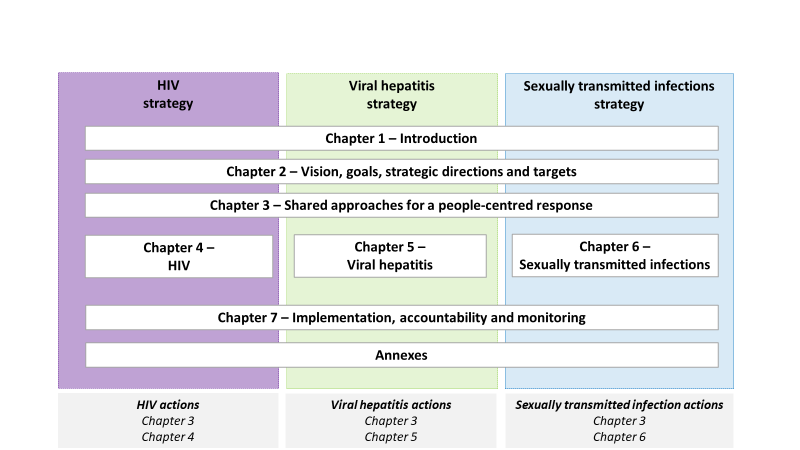
## Structure of this document

The 2022–2026 draft WHO IRAP for viral hepatitis, HIV and STIs in SE Asia is a single document that includes both shared and disease-specific content. Following this chapter, the document is organized as follows (Fig. 6):

* Chapter 2 presents the shared actions necessary for a people-centred tailored response to viral hepatitis, HIV and STIs in SE Asia and the common actions across the strategic directions, including the concrete example of triple elimination – the integrated elimination of MTCT of HIV, syphilis and hepatitis B.
* Chapters 3, 4 and 5 define the actions required across viral hepatitis, HIV and STIs, respectively to deliver the coverage targets and therefore reach the impact targets for the three disease areas by 2025 under a UHC and PHC framework.
* Chapter 6 details the key principles for implementation of this first IRAP across 10 key domains.
* Chapter 7 provides the M&E framework for the RAP aligned with the global framework and existing WHO validation guidance for monitoring and measuring progress towards, and validation of, the elimination of these communicable diseases.
* Chapter 8 provides WHO actions to support Member States in maintaining progress towards elimination through the full implementation of this IRAP.
* Chapter 9 provides an analysis of the financing required to support the IRAP from 2022 to 2026 in SE Asia.
* The annexes provide a consolidated list of all actions, the measurement framework and a glossary.

**Placeholder for figure of document structure**

Fig. 6. Structure of the IRAP for viral hepatitis, HIV, and STIs 2022–2026



## Vision, goals, strategic directions and targets

This section presents the global vision, goals and strategic directions of the IRAP. It also presents the main impact targets.

**Vision:** The 2022–2026 WHO IRAP for SE Asia will have a common vision to end epidemics of viral hepatitis, HIV and STIs under the umbrella of UHC and focus on PHC as well as meaningful engagement of communities.

**Goal**: To end epidemics of viral hepatitis, HIV and STIs as public health threats by 2030 in line with SDGs and aligned to GHSS and Global AIDS Strategy.

The Regional Action Plan for viral hepatitis, HIV and STIs is based on the Draft GHSS on viral hepatitis, HIV and STIs for the period 2022 to 2030, the structure of which is illustrated in Fig. 7.

|  |
| --- |
| *Fig. 7. Vision, goals and strategic directions of the draft GHSS on HIV, viral hepatitis and STIs, 2022–2030*   Strategic directions Five strategic directions oriented around service delivery, health systems, strategic information, community empowerment and innovations provide the overall guiding framework for country actions to implement the strategies:   * **Strategic Direction 1: deliver high-quality, evidence-based people-centred services**. Use evidence-informed guidance and service delivery innovations to accelerate access to and the uptake of a continuum of high-quality essential services for viral hepatitis, HIV and STIs and other related health services, tailored to meet the needs of people in diverse populations and settings, ensuring that no one is left behind. * **Strategic Direction 2: optimize systems, sectors and partnerships for impact**. Take a systems-oriented approach that promotes synergies with PHC, health governance, financing, workforce, commodities and service delivery while also fostering multisectoral responses to social and structural determinants of health. Align and collaborate with partners including funders, academic and research institutions, professional bodies and private sector entities for maximum impact. * **Strategic Direction 3: generate and use data to drive decisions for action.** Gather, analyse and use evidence and data, with disaggregation by sex, age and other relevant population characteristics to monitor and evaluate progress and guide action, innovation and research and development and promote data transparency and accountability. * **Strategic Direction 4: engage empowered communities and civil society.** Engage communities and civil society, including key and affected populations and support their self-empowerment and pivotal role in advocacy, service delivery and policy-making. They should also ensure that services are culturally appropriate and responsive to community needs, address stigma and discrimination and tackle social and structural barriers. * Strategic Direction 5: foster innovations for impact. In collaboration with partners, contribute to defining and implementing national, regional and global research and innovation agendas that give priority to developing new technologies, service delivery models and health system practices. These will overcome key barriers to achieving progress against HIV, viral hepatitis and STIs.  Impact of achieving the IRAP targets The impact of achieving the IRAP targets are given in Figs. 8, 9, 10, 11 and 12. |

#### *Fig. 8. HIV incidence and mortality from new actions implemented under the IRAP 2020–2026 vs no new actions, projected to 2030*

Chart, line chart

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#### *Fig. 9. Hepatitis B & C incidence and mortality trends from new actions implemented under the IRAP 2020–2026 vs no new actions, projected to 2030*

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Fig. 10. Incidence and mortality of hepatitis B, WHO SE Asia Region 2020–2030

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Fig. 11. Incidence and mortality of hepatitis C, WHO SE Asia Region 2020–2030

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#### *Fig. 12. Incidence of four curable STIs and syphilis from new actions implemented under the IRAP 2020–2026 vs no new action, projected to 2030*

PENDING FIGURE

The regional targets, based on the global targets, provide a guide for national targets and should be adapted to each country context. Equitable progress toward the targets is required across all populations, and the IRAP encourages disaggregated analyses of data by sex, age and other relevant population characteristics to track inequities and ensure that most affected and at-risk populations are not left behind.

## Achieving elimination through tailored national action

The Regional Action Plan for viral hepatitis, HIV and STIs provides a comprehensive regional framework of shared and disease-specific actions to guide countries and partners in their efforts to achieve the goals of ending these epidemics. One size does not fit all, and individual countries are encouraged to select, set priorities for, and adapt these actions in relation to local epidemiological and health system contexts, while upholding fundamental human rights, including the cross-cutting principle of equality and non-discrimination in the availability, accessibility, acceptability and quality of health services, products, approaches and interventions. The optimal selection of actions and service delivery models should be aligned with broader national strategies within a UHC framework and be responsive to the needs of individuals and local communities.

# Shared actions for a people-centred tailored response

This chapter presents shared interventions and service delivery models across viral hepatitis, HIV and STIs under a UHC and primary health-care framework.All actions in this chapter should be considered in conjunction with disease-specific country actions presented in Chapters 4 (HIV), 5 (viral hepatitis) and 6 (STIs).

Health systems encompass the public health sector as well as key non-state actors such as private sector health-care providers, civil society and CBOs that design and deliver health services.

Health sector decisions regarding the integration of services across multiple disease areas should be considered in context and be informed by the status of national epidemics, health system priorities and consultation with service providers, individuals and communities. Integration efforts should not have unintended negative consequences. The progress achieved by disease-specific responses must be sustained, especially for the most affected and at-risk populations.

**Priority populations across HIV, viral hepatitis and STIs**

The following populations are at a higher risk of acquiring or having complications from HIV, viral hepatitis or STIs and should be considered priority populations for prevention, diagnosis and treatment:

* people exposed through sexual transmission including young people and adolescents, MSM, sex workers and their clients, transgender persons, people in prisons and closed settings, people whose sexual behaviour is mediated by drug or alcohol use and persons at risk of engaging in high-risk behaviour;
* people exposed through unsafe blood supplies and unsafe medical injections and procedures;
* people who inject and use drugs, especially those who are female;
* children exposed through vertical (mother-to-child) transmission or early childhood infection;
* pregnant and breastfeeding women;
* women and girls, including adolescent girls and young women who face risks associated with gender inequalities and exposure to violence, in conjunction with increased biological risks on the basis of sex;
* young people, including young key populations;
* people of all ages who are less likely to use health services frequently;
* haemodialysis patients;
* migrants and mobile populations and people affected by conflict and civil unrest;
* indigenous peoples; and
* persons with disabilities.

Each country should define the specific populations that are most affected and at-risk for viral hepatitis, HIV and STIs within the local context.

Countries are encouraged to select, set priorities for and adapt the proposed country actions in relation to local epidemiological and health system contexts while upholding fundamental human rights, equitable access to health, and evidence-based practice.

## Priority areas addressed through the IRAP

Integrated regional and national action to address viral hepatitis, HIV and STIs is dependent on strong governance at the national, provincial and local levels. As such, a cross-cutting priority area must be political advocacy and commitmentfrom Member States resulting in stronger governance to support the integrated model of service delivery at national and subnational levels.

Integration of three national programmes will give rise to a number of challenges that will need to be addressed. Given the multitude of potential actions across such a large health space, the IRAP sets the following priorities in policy directives, implementation strategies, finding critical resources and developing monitoring indicators for the integrated response.

|  |  |
| --- | --- |
| Priority | Areas of action for SE Asia |
|  | **Populations that are most affected by and at risk of viral hepatitis, HIV and STIs.** Such populations may overlap across all the three disease areas. They also experience many forms of discrimination and marginalization. These groups may vary from country to country and may include special groups like indigenous peoples, hence context-specific populations should be identified and included. |
|  | **Reduction in incidence of all three diseases through preventing transmission.** Countries, and the Region as a whole have missed the incidence targets for 2020 set in the last regional plans. Concrete actions are needed to reduce the number of new infections to achieve 2025 targets. |
|  | **Scale up substantially the access to testing and treatment.** This has to be done across the three disease areas. Efforts should be made to maximize the number of people initiated on effective treatment following a diagnosis through improved coverage and coordination across the continuum of prevention, testing and treatment services. |
|  | **Elimination of MTCT of HIV and syphilis and movement towards triple elimination.** All countries should prioritize elimination of MTCT interventions in their national plans, with special efforts to address at-home births and births in the private sector, which account for up to a third of all deliveries in some countries of the Region. Triple elimination frameworks emphasizing elimination of MTCT of HIV, syphilis and hepatitis B must be a priority. |
|  | **Effective and inclusive governance structures.** This isa critical determinant for the success of integration efforts. NSPs should prioritize, ab initio, the governance reform process for bringing the three national programmes under a single umbrella of governance. As such, NSPs must explicitly operationalize the process of integration at all levels. Integrated structures should be inclusive and participatory with collaboration across the sector including CSOs, the private sector and communities. Community systems strengthening and community-led monitoring systems should be integrated into governance structures. |
|  | **Adequate and sustained financing for the integrated programme for viral hepatitis, HIV and STIs.** Adequate financing is challenging and requires priority attention. Currently, viral hepatitis, HIV and STIs programmes have separated budget lines utilized and monitored by the different programmes. In the integrated mode, the NSP will reflect a single budget line for all the three diseases with separate funding streams for integrated actions and for individual interventions. Careful articulation to allow equitable distribution based on need and impact will be required by countries. |
|  | **Building the health workforce capacity.** This will be a critical challenge for countries during integration of the three national programmes. Capacity-building of existing staff in increase of skill sets across areas beyond regular work will have to form a fundamental part of health system strengthening. |
|  | **Community health workers.** They play a key role at the grass roots level and are resilient to working across various programmes. Their capacity should be strengthened through training programmes. Major gaps in service provision require expansion of community capacity to provide services to unreached populations. Adequate regulatory measures should be adopted to regulate their services as is done for formalized health-care workers. They should be adequately compensated, and protective equipment should be provided for infection control and maintenance of hygiene standards equivalent to formally qualified health workers. |
|  | **Fostering innovations and operationalizing new technologies.** This should be an area of priority for governments. In the last decade, several new technologies have been brought into the programmes, such as pre-exposure prophylaxis (PrEP) for HIV, self-testing for HIV and viral hepatitis and use of digital technologies in implementation and monitoring of programmes. A technical sub-plan should become a part of the NSP identifying such emerging technologies with timebound operationalization. In addition, operational research should accompany the implementation of new initiatives to allow real-world evaluation. |

## Key targets across HIV, viral hepatitis and STIs

Tables 1 and 2 present the shared and disease-specific impact indicators and targets across HIV, viral hepatitis and STIs.Additional disease-specific indicators and targets are presented in Chapter 4 (viral hepatitis), Chapter 5 (HIV) and Chapter 6 (STIs), respectively.

*Table 1. Impact indicators and targets for HIV, viral hepatitis and STIs, by 2025 and 2030*

| **Disease area** | **Impact indicator** | **Baseline 2020** | **2025 target** | **2030 target** |
| --- | --- | --- | --- | --- |

Insert from below chapter when confirmed

*Table 2. Regional Integration indicators and targets for HIV, viral hepatitis and STIs, by 2025 & 2030*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Integration indicator** | **Baseline 2020** | **2025 target** | **2030 target** |
| **Regional integration targets** | Number of countries that have taken a political decision to integrate the three national programmes of HIV, hepatitis and STIs | 2 | 11 | 11 |
| Countries which have prepared fully costed NSPs for the integrated response and identified finances for funding the NSPs | 0 | 11 | 11 |
| Countries where the three programmes have been brought under a common umbrella of governance | 4 | 11 | 11 |
| Countries where the health workforce of the three programmes have been retrained to work across all the three programmes | 0 | 11 | 11 |
| Countries where the community health workers (CHWs) have been given legal status and recognition at par with government health workers | 1 | 11 | 11 |

## Strategic Direction 1: deliver high-quality, evidence-based, people-centred services

This section describes shared country actions across HIV, viral hepatitis and STIs and other related health areas that can be integrated or are replicable across multiple disease areas for a more effective people-centred response. Actions in this section should be implemented by countries in conjunction with disease-specific country actions with a specific focus to include key populations.

### Integrated actions across HIV, viral hepatitis and STIs

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| --- | --- | --- |
| **#** | **Areas of implementation** | **Country actions** |
| **1** | Primary prevention in sexual and reproductive health | Primary prevention interventions are scaled up to eliminate sexual transmission of viral hepatitis, HIV and STIs.   * The minimum set of necessary prevention interventions includes:   + providing family planning services;   + correct and consistent use of male and female condoms and lubricants with innovative programming;   + addressing the harmful use of alcohol and drugs in the context of transmission risk behaviour, including opioid substitution therapy (OST) and effective substance use treatment;   + vaccination of vaccine preventable diseases (VPDs), human papillomavirus and hepatitis B, with a focus on key and affected populations;   + promotion of sexual and reproductive health and well-being, with a focused approach for specific high-risk populations, including MSM, transgender persons and people who use drugs (PWUD);   + antiretrovirals as PrEP and PEP. * Primary prevention includes comprehensive education and information about sexual and reproductive health and HIV prevention16 consistent with WHO technical guidance17 and evidence based. |
| **2** | Harm reduction | The national policy includes a comprehensive package of accessible harm reduction services as part of a comprehensive package of interventions for the prevention, treatment and care of HIV and viral hepatitis among PWID and for people who use stimulant drugs.   * The minimum harm reduction component package[[3]](#footnote-4) includes:   + provision of sterile injecting equipment through needle and syringe programmes, including low dead space syringes (LDSSs);   + OST for people dependent on opioids;   + community distribution of opioid antagonist medication (naloxone) for the acute management of opioid overdose;   + targeted information and communication with a focus on key populations;   + testing, diagnosis and management of HIV, hepatitis B and C virus, STIs and other common infections, including for partners and catered to women who use drugs. * Harm reduction interventions should be at a low threshold with minimal impact on the general community to promote acceptability, including take-home dosing, flexible timing, task sharing, satellite OST centres in the community and secondary distribution of needles and syringes at community sites with trained collection of used NS by community members. |
| **3** | Integrated testing | Integrated testing is more efficient, people centred and encourages integrated treatment for HIV, hepatitis B virus, hepatitis C virus, STIs, TB and other diseases.   * National programmes should implement integrated testing for HIV, viral hepatitis, STIs, TB and other relevant communicable diseases as appropriate for patient care. * Integrated testing should be promoted through:   + use of multiplex diagnostic tools to streamline the collection and screening of biological specimens;   + rapid point-of-care multiplex tests for HIV, hepatitis B and C to assist in integrated testing and screening;   + community-based and self-administered integrated testing services;   + the use of common laboratory systems and networks;   + linking, through technological systems, different laboratory networks to promote national integration. * Include implementation of human rights-based and gender-sensitive strategies for voluntary partner notification, including partners of key populations. |
| **4** | Integrated treatment | National programmes should enhance opportunities for integrated viral hepatitis, HIV and STI care and treatment. This should include micro elimination efforts in specific populations. Some points are:   * universal testing for viral hepatitis among HIV-infected individuals with referral to care and treatment * micro elimination of hepatitis C infection among PLHIV; * ensuring that all individuals with hepatitis B–HIV coinfection are receiving care and treatment for both infections; * initiating screening programmes in key populations for STIs, especially those affected or living with viral hepatitis or HIV; * operationalizing integrated treatments with shared prescriptions and dosing, including substance use pharmacotherapy programmes. |
| **5** | Stigma and discrimination in health-care settings | National programmes should work to eliminate stigma and discrimination in health-care settings and strengthen accountability for discrimination-free health care, with particular focus on the stigma and discrimination experienced by affected people including key populations, or on the basis of sex, gender, sexual orientation, drug use, sex work or other factors.  National programmes should include:   * regular training for all health-care staff to increase their knowledge of these diseases, address misconceptions and underlying fears and raise awareness about the harmful consequences of stigma and discrimination, including delayed health service utilization and health inequalities; * development and monitoring of standards for health-care workers to ensure that all patients are treated with respect, dignity and compassion; * health-care workers should be educated about patients’ rights as well as their own, and about how to sensitively provide care to all patients, especially key and most-affected populations; * increased efforts to address stigma and discrimination towards health-care workers among the community, including those who may themselves be living with HIV, viral hepatitis or STIs; * consideration of referral in the case of discrimination for those seeking redress, including access to legal and mental health services. |
|  |  |  |

### Linking integrated HIV, hepatitis and STI action to other health areas

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| --- | --- | --- |
| **#** | **Areas of implementation** | **Country actions** |
| **6** | National Inter-programmatic linkage strengthening | The national programme should include structural linkages to other disease-specific programmes to promote a people-centred approach to prevention, diagnosis, care and treatment of HIV, viral hepatitis and STIs to enhance integrated management and early diagnosis and treatment of coinfections.   * Implement national health workforce literacy in prevention, diagnosis and treatment of HIV, viral hepatitis and STIs across the health sector to promote coordinated care and management across health systems. * Linkages should be provided to national or state-based social welfare programmes.   Key health programmes to be linked are as below.   * **Communicable and noncommunicable diseases**   + individuals with chronic viral hepatitis and long-term HIV are linked to care for other NCDs including cardiovascular disease, diabetes, chronic lung disease, hypertension, etc.;   + integration between viral hepatitis and cancer programmes as well as strengthened surveillance;   + cervical cancer among women living with HIV. * **Vaccine preventable disease programmes** including HBV, HPV and COVID-19 * **Vector borne disease programmes**, including malaria * **Tuberculosis**   + prevention, diagnosis and treatment for TB in HIV and viral hepatitis-affected communities and the reverse, given shared population links;   co-management of treatment where there is coinfection to improve outcomes and reduce adverse clinical events during treatment.  **Sexual and reproductive health services** integrated with or having programmatic linkages to HIV, viral hepatitis and STI services, including provision of integrated services   * **Mental health services**   + Screening and integrated care for mental health disorders at primary health-care services for prevention and care services for HIV, viral hepatitis and STIs. * **Substance use treatment** services, including OST, treatment for stimulant and alcohol use disorders as well as rehabilitation programmes * **Integrated surveillance systems** including relevant linked communicable and noncommunicable diseases, e.g. viral hepatitis, cirrhosis and liver cancer; HPV and cervical cancer. |
| **7** | Principles of service delivery across HIV, viral hepatitis and STI | Particular attention should be paid to the needs of individuals with disability and those affected by violence and gender equality across all areas of service delivery.  To achieve these aims, national programmes should include aspects as detailed below.   * **Promote disability-inclusive programming** and ensure that HIV, viral hepatitis and STI services are accessible to people with disabilities through:   + the active participation and engagement of people with disabilities in planning and decision-making; and   + the availability of disability-friendly service, including ease of accessibility. * **Prevent and respond to all forms of gender-based violence**, including sexual violence, through:   + implementation of the four pillars of action specified in the WHO global plan of action on health systems response to violence18 including:     - preventing all forms of gender-based violence;     - implementing policies to guide prevention of and responses to violence;     - provision of comprehensive health services for survivors;19     - establishment and maintenance of evidence and data including through health information systems.   + Implementation of these evidence-based interventions should be guided by the WHO and UN package on *RESPECTING women: preventing violence against women* for policy-makers, which has been endorsed by 12 other UN, bilateral and multilateral agencies.20 * **Promote gender equality by integrating its promotion across all actions** through:   + addressing key issues resulting in inequalities that generate risk of infection, including female genital mutilation, child marriage and lack of sexual and reproductive decision-making autonomy;   + collection of epidemiological data disaggregated by gender;   + disaggregation of programmatic data of prevention, diagnosis and treatment services by gender;   + implementing national policies on HIV, viral hepatitis and STIs that include specific references to addressing the gender needs of those living with or at risk for these communicable diseases, including transgender persons, through gender-affirming care;   + provision of gender sensitive and accessible services for prevention, diagnosis and treatment for women. * **Promote a human rights-based approach** to implementing integrated action across the three diseases, including within the context of human rights obligations in law and practice. Implement through:   + availability of voluntary and accessible testing and treatment;   + evidence of confidentiality and privacy in disease status and treatment;   + evidence of absence of legal discrimination (for employment status, access to education, housing and social benefits);   + documentation of stigma-free access to health care and treatment for HBV and HCV in policy and practice;   + evidence that PLHIV, hepatitis or STIs are informed of their status and educated on their medical care;   + evidence of the absence of drug use, sexual orientation status, incarceration experience, immigration status or profession as a criterion for exclusion from testing and especially treatment;   + evidence of the possibility of health-care access without disclosure of or discrimination against key population status;   + decriminalization of populations at risk or most affected by viral hepatitis, including PWUD, sex workers and MSM. |

## Strategic Direction 2: optimize systems, sectors and partnerships for impact

This section describes UHC and PHC framing integrated actions to strengthen health service delivery and optimize health system functioning in collaboration with partners.

The actions in this section should be implemented in conjunction with disease-specific actions.

|  |  |  |
| --- | --- | --- |
| **#** | **Areas of implementation** | **Country actions** |
| **8** | Universal health coverage | Essential viral hepatitis, HIV and STI services are included as part of UHC. (These essential services are included in national priority health benefit packages, supported by adequate financing, resulting in access without financial hardship). |
| **9** | Primary health care and decentralization | Incorporation of HIV, viral hepatitis and STI services into PHC systems is critical to decentralizing the essential components of prevention, diagnosis and treatment packages. This will optimize the health system’s ability to implement action towards elimination.   * Integrated viral hepatitis, HIV and STI services and their key coinfections and comorbidities are incorporated into PHC platforms. * Viral hepatitis, HIV and STI services are decentralized and accessible through community-based service delivery, including laboratory services. * PHC workforce capacity supports integration of these services and maintenance of service quality and the confidence of service users. * Develop simplified testing and treatment protocols to support task shifting between health-care professions. * Develop hub and spoke models from tertiary and specialized services to support shared care and supported models at lower levels of the health system, including through internet-based systems. This includes the aspect of telemedicine. |
| **10** | Health care Infection prevention and control | Infection prevention and control initiatives seeks to prevent disease transmission, especially HIV and viral hepatitis, in formal and informal health-care settings and other service settings.   * National health systems must be able to:   + guarantee safe medical injections and blood supplies;   + follow standard precautions, especially relating to hand hygiene, blood screening, personal protective equipment and waste management;   + airborne infection control measures should be considered for the prevention of diseases such as TB and COVID-19. * National health systems should reduce transmission risk by:   + eliminating unnecessary injections with the use of oral agents where possible;   + providing safety-engineered syringes for all medical injections;   + using established WHO-aligned protocols for the decontamination of medical devices;   + providing universal and comprehensive screening of blood products so that sources of potentially unsafe blood products are eliminated. * Outside of health facilities, interventions and national regulations are implemented to prevent unsafe injections and transmission through contact with bodily fluids in the informal health sector and in services such as tattooing, piercing and beauty care. |
| **11** | Use of digital technology and telemedicine | * Implement telemedicine within the health system for service delivery. * Use innovative methods to better understand the health needs of target populations, including virtual mapping and online surveys. * Enhance the use of targeted client communication, such as towards young people or individuals who may avoid in-person gatherings because of concerns about stigma and discrimination. * Provide linkages across the digital health architecture of the national health system to enhance efficiencies and communication. * Implement opportunities to access digital services for people who may not have access to digital technologies.   (Differentiated service delivery is implemented by leveraging technology- and community-based approaches and delivering high-quality people-centred services) |
| **12** | Equitable access in closed, humanitarian and other emergency settings | * Access to HIV, viral hepatitis and STI services should be ensured for mobile and displaced populations, or for those dislocated from regular services. * Ensure continued access for affected persons in emergencies and in humanitarian settings when health service delivery is disrupted. * Health-care services in prisons and other closed settings, such as detention centres, should be equivalent to those available to the broader community, in accordance with the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).21 * Continuity of these services should be ensured when people move within and between these settings and the broader community. |
| **13** | Sustained and targeted national financing[[4]](#footnote-5) | National financing for HIV, viral hepatitis and STIs should avoid fragmented funding, maximize the efficient use of resources and minimize overall catastrophic health expenditures for households.  The following actions can optimize financing towards elimination:   * health budget should include optimized domestic funding, complemented, where necessary, by external sources; * aligning of domestic funding for HIV, viral hepatitis and STI packages with essential interventions for each area; * budgeting for HIV, viral hepatitis, and STIs should be reflected in the costing planning and budgeting of essential health services including in the health insurance benefit packages; * financing efficiencies are be integrated into health service financing, including pooling funds from multiple financing sources; * price reduction strategies are to be implemented with a focus on diagnostics and medicines, including use of pooled purchasing mechanisms and participation of the private sector. |
| **14** | Essential health commodities | National health systems require availability of essential health commodities for HIV, viral hepatitis and STIs. The national programming should support the availability.  The following actions support this goal:   * expediting a national registration mechanism for new products, where recommended; * supporting generic domestic markets in commodities, including medicines; * promoting voluntary technology sharing on mutually agreed terms and addressing intellectual property-related barriers by leveraging the use of Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities; * engaging in direct price negotiations with manufacturers and the sharing of product prices; * supporting the recovery of supply chain issues for commodities following the COVID-19 pandemic and drawing lessons learnt from this experience; * implementing integrated supply chain management and logistics information systems to ensure timely and accurate data regarding commodity needs and consumption for decision-making and accountability. |
| **15** | Health system strengthening | National systems require the availability of health workers with the required competencies and training at all levels of care to deliver people-centred prevention, clinical and supportive services across the continuum of care, tailored to the epidemic and country context.  The following actions support this goal:   * comprehensive national health workforce plans should optimize the utilization of the existing workforce including CHWs, and advance multi-disciplinary team-based care; * disease-specific needs should be quantified and balanced against the need for generalist health service provision, ensuring the quality of care; * national capacity-building, ongoing training and supportive supervision for health workers, including initial and postgraduate training of facility-based and community health workers at all levels on sexual health and the needs of people affected by HIV, viral hepatitis and STIs; * provide continuing professional development to the health workforce on HIV, viral hepatitis and STI consistent with up-to-date clinical practice guidelines (including e-learning opportunities) and enhance supportive supervision systems. |
| **16** | Legal, regulatory and policy reform | An enabling legal and regulatory environment is critical to enabling implementation of policies that will allow disease elimination.  The following actions will help to achieve such an enabling environment:   * Undertake review and reform of any restrictive legal and policy frameworks in order to enable equitable access to health services for HIV, viral hepatitis and STIs, especially to the most affected and at-risk populations. * Undertake legal, regulatory and policy reform and provide alternatives to coercive sanctions for PWID, sex workers and people in same-sex relationships seeking care, including harm reduction services. * Create an enabling, safe environment for key populations by reorienting towards evidence-based legal frameworks and policies that promote human rights, harm minimization and discourage stigmatization and discrimination. * Provide mechanisms and support for legal redress for individuals living with viral hepatitis, HIV or STIs when it impacts prevention diagnosis and treatment access or quality. * New initiatives should be implemented through supportive legislation that uphold the implementation of evidence-based interventions, promote and protect human rights and gender equality and reduce stigma and discrimination. These initiatives should support the provision of legal aid for people in need. |

## Strategic Direction 3: generate and use data to drive decisions for action

This section describes shared approaches to strengthen health information systems for better data availability, use and accountability, including person-centred monitoring. The actions in this section should be implemented in conjunction with disease-specific actions.

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| **#** | **Areas of implementation** | **Country actions** |
| **17** | Strategic information and other data | * Regular reporting on prevention, testing and treatment across the three diseases, financing and performance and impact at the national level including in decentralized systems * HIV, viral hepatitis and STI surveillance data is disaggregated by sex, disability, age and other relevant population characteristics, supplemented by information from community-led monitoring. * Active capacity-building of health workers to analyse and use available data to improve the quality-of-service delivery * Utilization of standardized reporting or data tools where possible * Work towards the use of digital data reporting systems to facilitate integration. * Strengthen the interoperability of data systems to take advantage of recent club will developments in health information exchange, using integrated advanced analytics technologies and software systems. * Ensure that data collection efforts cause no harm and collected information is actively used in improving clinical care, laboratory and public health. * Work to integrate or link population-level data with clinical data management platforms and/or facility-based reports. * Strengthen public–private partnerships in data to expand access to services through the private sector, ensure harmonized service quality standards and promote data sharing in compliance with security and data protection standards. * Develop linkages from data to evidence-based programme planning. * Promote systems to maintain data confidentiality and security across systems. * Develop adequate information dissemination systems such that data from the three disease areas can be made available outside national systems and to the public to drive advocacy. |
| **18** | Community-led monitoring (CLM) | Community led or community-based monitoring is any type of monitoring led by communities. CLM is an accountability mechanism for viral hepatitis, HIV and STI services and the health system in general to provide civil society participation in reporting as a key quality feedback mechanism for programmes.22 This may include:   * programme monitoring * community scorecards * patient satisfaction surveys, compliant and other feedback mechanisms from the end-user groups * treatment observations and social audits * engagement of patient groups or peer educators.   These community led or community-based feedback systems should be:   * headed by someone from the community and community led, including and ensuring diversity within the community groups; * focus on action and accountability; * independent, empowering and sustainable; * collaborative – promoting good partnerships; * routine, systematic and standardized; * show results.   The objective of CLM is to provide an opportunity for community-led solutions to address programme implementation bottlenecks, quality and performance. |

## Strategic Direction 4: engage empowered communities and civil society

This section describes approaches to engage and support the empowerment of communities, CSOs and affected populations in advocacy, service delivery and policy-making and initiatives to enhance service delivery and tackle social and structural barriers.

Civil society and community-based organizations have played a leading role in HIV-related advocacy, service delivery and accountability since the early stages of the HIV response. More recently, they have also successfully advocated for stronger responses to viral hepatitis and STIs. The COVID-19 pandemic spurred CBOs worldwide to step up their innovative efforts to bring services closer to people in need within an environment of trust.

The meaningful participation of PLHIV, viral hepatitis or STIs and their families and communities is of critical importance in determining, developing and implementing national and subnational policies for affected communities and should be actively promoted.

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| **#** | **Areas of implementation** | **Country actions** |
| **19** | **Foster community and civil society leadership** | Full engagement with communities and civil society is necessary for elimination goals to be realized.   * Ensure meaningful involvement of key populations, community organizations and people, including women living with HIV and hepatitis in advocacy, service delivery, policy-making, M&E and initiatives to address social and structural barriers to services. * Ensure affected community representation in the national HIV, viral hepatitis and STI taskforce or equivalent. * Drawing on community engagement and empowerment strategies in the HIV field, health systems should elevate the role of communities and community-based service providers as partners in promoting sexual health. * National programmes should include peer-led or peer navigation interventions for key populations who are not reached effectively through traditional approaches, including rural and marginalized populations. * Make domestic resources available to support, build capacity and ensure sustainability of CBOs. * Ensure that the community-based health workforce operates within an environment of adequate regulation, training, supervision and support and is strongly linked to formal health services. * Learn from innovative approaches introduced as part of care during the COVID-19 pandemic to simplify service delivery and meet the needs of communities. * Include social contacting as a mechanism for engaging communities and delivering services to affected communities. |

## Strategic Direction 5: foster innovations for impact

This section describes shared approaches to foster and disseminate innovations for accelerated impact. The points in this section should be implemented in conjunction with disease-specific actions.

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|  | **Areas of implementation** | **Country actions** |
| **20** | Strengthening development and adoption of innovations | * Across viral hepatitis, HIV and STIs, countries should foster the early adoption and inclusion of innovations including:   + new diagnostic technology which enhances screening and testing programmes, including the use of dried blood spots;   + new technologies to improve adherence to treatment of viral hepatitis, HIV and STIs, including but not limited to such interventions as web-based refills, remote testing and adherence reminders;   + new preparations of existing treatments, including long-acting formulations;   + innovations in roll out for testing, care and treatment, including the use of telemedicine and other internet-based technologies. * Adopt, evaluate and rapidly scale up innovative testing and treatment technology and approaches which are effective for key populations. * Engage models of social contracting to assist the delivery of services to affected populations, particularly populations with viral hepatitis, HIV and STIs. |
| **21** | Build partnerships to support innovation and research | * National programmes should encourage participation in collaborative research with national and international research partners to drive innovation in therapeutics, vaccines and HIV and HBV cure. * Support operational research/implementation science to make delivery of interventions through health systems more efficient and impactful for countries. * Build partnerships in the domestic and international innovation space across the three disease areas, including with the private sector, to support the roll out of innovations in the Region. |

## HIV, syphilis and hepatitis B triple elimination

Triple elimination refers to the elimination of major communicable diseases associated with MTCT, specifically HIV, syphilis and hepatitis B. WHO has recently brought these together in the Third Edition of the *Global guidance on criteria and processes for validation of elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus* as a package of interventions and metrics to support the integrated management and monitoring of mother-to-child/vertical transmission of these communicable diseases across a wide range of epidemiological and programmatic contexts.

Strengthening the health system to address vertical transmission of HIV, syphilis and HBV serves to improve a broad range of maternal and child health services and outcomes. This achievement directly contributes to SDGs 3, 5 and 10, that aspire to ensure health and well-being for all, achieve gender equality, empower women and girls, as well as reduce inequalities in access to health services and commodities.

Triple elimination targets can be achieved only when access to quality reproductive, maternal and child health-care services is ensured and used by all women, children and their families. Mother-to-child or vertical transmission of HIV, hepatitis B and syphilis can be effectively prevented and eliminated by similar strategies among people of reproductive age, including antenatal screening for HIV, syphilis and HBV, syphilis treatment of mothers and their infected infants, HBV and HIV antiviral treatment or HBV prophylaxis for eligible mothers, and HBV infant prophylaxis (including BD vaccination). The funding and organization of antenatal care (ANC) services and programmes at the national level provides an opportunity for concrete integrated service delivery to optimize programme efficiencies, deliver quality people-centred care and improve outcomes for both mother and child.

The IRAP impact and programme targets for HIV, syphilis and hepatitis B are consistent with those of the global criteria for countries to validate the elimination of MTCT detailed in the recent WHO guidance. The global validation criteria for elimination are listed in Table 3. In all three areas, it is the combination of maternal screening, antenatal screening and treatment, combined with care of the neonate, that results in the elimination of transmission. In addition, for hepatitis B, there also is a safe and effective vaccine that assists in stopping transmission when given within 24 hours of birth.

Table 3. Summary of required impact and process targets for country validation of EMTCT of HIV, syphilis and HBV23

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| **EMTCT impact targets**  • MTCT rate of HIV of <2% in non-breastfeeding populations OR <5% in breastfeeding populations  • a population case rate of new paediatric HIV infections due to MTCT of ≤50 cases per 100 000 live births  • a case rate of Congenital Syphilis of ≤50 per 100 000 live births  • hepatitis B surface antigen (HBsAg) prevalence of ≤0.1% in the ≤5-year-old birth cohort (and older children)i  • in countries that provide targeted and timely HepB-BD, an additional impact target of HBV MTCT rate of ≤2% should be utilized.  **EMTCT PROCESS targets**  (Must be the most recent verified data and must be achieved for two consecutive years)  **Maternal ANC and testing coverage**  • ≥95% ANC coverage (at least one visit) (ANC-1)  • ≥95% coverage of HIV testing of pregnant women  • ≥95% coverage of syphilis testing of pregnant women in ANC  • ≥90% coverage of HBsAg antenatal testing among pregnant women.  **Maternal treatment**  • ≥95% ART coverage of pregnant women living with HIV  • ≥95% adequate treatment of syphilis-seropositive pregnant women  • ≥90% coverage with antivirals for eligible HBsAg-positive pregnant women with high viral loads (plus coverage of HBV-exposed babies with hepatitis B immune globulin [HB Ig], where available).  **Infant HBV vaccination**  • ≥90% coverage with three doses of HBV infant vaccinations (HepB3)ii  • ≥90% HepB timelyiii BD coverage (with universal programme) or infants at riskiv (with targeted and timely HepB-BD).  i Childhood prevalence is a proxy for HBV incidence. The ≤0.1% HBsAg prevalence can be measured among either 5-year-olds, 1-year-olds or those in ages 1–5 years, according to existing country surveillance and data collection practices. For regions and countries with a long history of high hepatitis B vaccination coverage (for example, the WHO Region of the Americas) and those that already conduct school-based serosurveys, there could be flexibility to conduct serosurveys in older children, >5 years of age.  ii Generally for vaccination, a 5-year period of sustainability is required to be able to measure impact via serosurveys (39).  iii Timely birth dose (HepB-BD) is defined as within 24 hours of birth.  iv At-risk infants are neonates of HbsAg-positive mothers. |

EMTCT – elimination of mother-to-child transmission

Provision of the criteria and processes for measuring progress towards and achieving elimination through assessment of impact and programmatic indicators for triple elimination are detailed in the *Global guidance on criteria and processes for validation: global guidance for the elimination of MTCT of HIV, syphilis and hepatitis B virus (Third edition)23* and the Governance guidance for the validation of EMTCT of HIV and syphilis.24

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| **#** | **Areas of implementation** | **Country actions** |
| **22** | Triple elimination of HIV, syphilis and hepatitis B virus and the prevention of new infections among children and adolescents | * National programmes include key essential services to promote triple elimination of HIV, syphilis and hepatitis, specifically:   + rights-based and gender-sensitive family planning;   + testing for HIV, syphilis and hepatitis B virus in ANC;   + prompt and efficacious interventions to treat pregnant women who test positive and to prevent transmission of the infection(s) to their infants;   + counselling for pregnant women and their partners;   + safe delivery;   + follow-up of exposed infants, including timely hepB-BD +/- HB Ig and completion of the 3-dose series of hepatitis B vaccine;   + optimal infant feeding;   + follow-up treatment and care for mothers, children and families. * National action should have the goal of preventing all new infections due to HIV, viral hepatitis and STIs among children. Also, address the longer-term monitoring, treatment and care needs of affected children and adolescents as part of a family-centred approach and regular monitoring and follow-up through adolescent-friendly health services. * National programmes should promote integrated approaches with sexual and reproductive health programmes for HIV prevention and family planning. * Measuring of progress and validation of elimination should be undertaken in line with WHO [Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus](https://www.who.int/publications-detail-redirect/9789240039360).25 |
| **23** | Linkages to maternal and child health programmes | Triple elimination targets can be achieved only when access to quality services for sexual and reproductive health care (SRH) and maternal and child health are assured and all women, children and their families use these services.   * National programmes for HIV, syphilis and hepatitis B should implement concrete linkages towards integration with maternal and child health programmes at all levels of the health system. * Access to these services should be offered to all women of reproductive age before or between pregnancies to reduce transmission of HIV, syphilis and hepatitis B during pregnancy. |

# Viral hepatitis

This chapter presents the aspects of viral hepatitis in the Regional Action Plan 2022–2026. While acknowledging the importance of viral hepatitis A and E,26, 27 both of which cause acute viral hepatitis, the strategy focuses primarily on chronic viral hepatitis B and C, given that these two infections, which may lead to cirrhosis and hepatocellular cancer, account for 96% of all viral hepatitis mortality. Hepatitis D coinfection or superinfection accelerates the progression of chronic liver disease, but only among people living with hepatitis B.

Actions for countries in this chapter should be implemented in conjunction with and in addition to the integrated actions.

## Key areas for urgent attention towards the regional elimination goal

* At the regional level, address the heterogeneity of hepatitis responses between countries
* Promote greater public and political literacy and awareness on the impact of viral hepatitis B and C prevention, testing and treatment
* Urgent scale up of timely hepB-BD and linkage to mother-to-child triple elimination initiatives with HIV and syphilis
* A specific focus on engagement of key populations through addressing structural barriers
* Urgent scale-up of harm reduction (needle and syringe programme and OST) to reach coverage targets
* Substantially increase access to and drive demand for hepatitis B and hepatitis C testing and linkage to care, further driving treatment scale-up
* Implement decentralized and simplified service delivery of hepatitis B and C testing and treatment to lower-level health facilities (primary care level), including task shifting
* Active participation of the community and civil society at all levels of policy and service delivery
* Undertake mathematical modelling for epidemiological and economic impact assessment of national actions, i.e. “investment cases” for viral hepatitis B and C
* Allocate increased financial resources to viral hepatitis B and C including funding of testing and treatment through essential national health benefit packages.

### 3.1.1 Viral hepatitis targets

Table 4 presents the impact and programmatic coverage indicators and targets as well as policy milestones for viral hepatitis.

Table 4. Regional impact and coverage indicators, targets and milestones for viral hepatitis by 2025 & 2030

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|  | **Indicator** | **Baseline –**  **2020i** | **Targets –**  **2025** | **Targets – 2030** |
| **Impact** | HBsAg prevalence among children younger than 5 years of ageii (proxy forincidence) – | 0.94% | 0.5% | 0.1% |
| Number of new hepatitis B infections per year (incidence) | 256 700  13 per 100 000 | 130 000  5 per 100 000 | 42 000   2.5 per 100 000 |
| Number of new hepatitis C infections per year (incidence) | 234 100  12 per 100 000 | 115 000  6 per 100 000 | 80 000  4 per 100 000 |
| Number of new hepatitis C infections among PWID per year | 8 per 100 | 3 per 100 | 2 per 100 |
| Number of people dying from hepatitis B per year | 179 000 deaths  9 per 100 000 | 100 000 deaths  5 per 100 000 | 60 000 deaths  3 per 100 000 |
| Number of people dying from hepatitis C per year | 38 000 deaths  2 per 100 000 | 20 000 deaths  1 per 100 000 | 10 000 deaths  0.5 per 100 000 |
| **Coverage** | Hepatitis B – percentage of people living with hepatitis B diagnosediii/and treated (initiated vs viral load suppression) | 10.5%/4.5% | 60%/50% | 90%/80% |
| Hepatitis C – percentage of people living with hepatitis C diagnosed/cured | 9%/7% | 60%/50% | 90%/80% |
| Percentage of neonates who have benefitted from a timely hepB-BD vaccine and from other interventions to prevent the vertical (mother-to-child) transmission of hepatitis B virusiv | 54% | 70% | 90% |
| Hepatitis B vaccine coverage among children (third dose) in those <1 year of age | 91% | 90% | 90% |
| Number of needles and syringes distributed per PWIDv (common HIV/viral hepatitis indicator) | 157 | 200 | 300 |
| Percentage of opioid-dependent PWID who receive OST | TBD | 40% | 40% |
| Blood safety – proportion of blood units screened for bloodborne diseases | 80% | 100% | 100% |
| Safe injections – proportion of safe health-care injections | 93% | 100% | 100% |
| **Milestones** | **Planning** – number of countries with costed hepatitis elimination plans | 0 | 11 | 11 |
| **Surveillance** – number of countries reporting burden and cascade annually | 11 | 11 | 11 |
| **Elimination of vertical (mother-to-child) transmission** – number of countries validated for the elimination of vertical transmission of either HIV or hepatitis B or syphilis | Confirm | 5 | 11 |
| **Elimination** – number of countries validated for elimination of hepatitis C and/or hepatitis B | 0 | 2 | 11 |
| **Integration** – proportion of PLHIV tested for/and cured from hepatitis C | To be determined | 60%/50% | 90%/80% |

i Latest data for end 2020. Some targets use data from 2019 because of COVID-19 related service disruptions in the data reported for 2020

ii Please note that the targets in this table are based on global targets and should be adapted to set targets for countries in relation to the national context. For example, in some countries a target for HBsAg prevalence among children younger than 5 years may be less than 0.1% or 0.2%, although the overall regional target should be 0.1%.

iii Denominator is estimate number of people living with hepatitis B virus (standardized population estimate)

iv In addition, the proportion of infants younger than 12 months of age who received the third dose of hepatitis B vaccine should also be measured as well as other indicators for preventing vertical transmission such as maternal testing and prophylaxis.

v As part of a comprehensive harm reduction strategy and in line with national priorities.

## Core targets and additional targets

* Increase timely birth dose to 70% of live births
* Reduce HBsAg prevalence in 5-year-olds to 0.5%
* Reduce the number of new HBV infections to 130 000 (7/100 000) and new HCV infections to 115 000 (6/100 000)
* Reduce deaths from HBV to 100 000 (5/100 000) and HCV to 20 000 (1/100 000)
* Increase markedly from baseline, retention in the HBV and HCV cascades of care
* Increase markedly from baseline, coverage of combination harm reduction interventions to PWID and PWUD
* Increase the number of countries validated for the elimination of hepatitis B or C
* Increase – through integration – the proportion of PLHIV tested for/and cured from hepatitis C and those with HBV and HIV on treatment with HBV active regimens.

## Strategic Direction 1: deliver high-quality, evidence-based, people-centred services

This section describes viral hepatitis-specific areas of implementation and necessary country actions along the continuum of viral hepatitis prevention, diagnosis, care and treatment services.

Service delivery must be tailored to the needs of different affected populations and in accordance with different epidemiological contexts.

**Populations at higher risk for viral hepatitis in SE Asia**

* PWID
* People in prisons and other closed settings
* Gay men and other MSM, especially those living with HIV
* Sex workers
* Children of mothers with chronic hepatitis B or hepatitis C infection, especially if living with HIV
* Family members of persons living with hepatitis B
* Mobile and migrant populations from high and intermediate endemic countries
* People with historical health-care exposure through unsafe blood supplies, unsafe medical injections and other health procedures including haemodialysis
* Displaced persons, those without access to safe water, those in conflict and humanitarian emergencies may be at particular risk of outbreak-related hepatitis A and E.

### Delivering the continuum of viral hepatitis services

The continuum of viral hepatitis services provides an organizing framework for implementing essential interventions that comprehensively address people’s needs. Services should be organized in ways that promote early engagement in care, maximize retention and maximize treatment adherence, and in the case of HCV, prevention reinfection. The retention cascade should be monitored to identify areas in which programmatic improvements are needed (Fig. 10)..

Fig. 10.- The service engagement cascade for hepatitis B virus and hepatitis C virus

A picture containing diagram

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| **#** | **Areas of implementation** | **Country actions** |
| **24** | Viral hepatitis intervention packages | National programmes should define the core viral hepatitis intervention package which is aligned with UHC benefits packages and linked with PHC where feasible and relevant.   * National programmes should review data to determine the optimal mix of prevention interventions for different populations and locations. * Core interventions of the viral hepatitis package includes:   + EMTCT for HBV including universal testing of pregnant women, with universal timely birth-dose for their neoborns;   + Low threshold harm reduction (needle and syringe programme including LDSSs, and OST for PWUD/PWID);   + screening for HBV and HCV with polymerase chain reaction (PCR) confirmation for HCV and viral load testing where indicated for HBV;   + Screening for HIV and other STIs as part of viral hepatitis care;   + antivirals for HBV and HCV;   + targeted prevention, including HBV vaccine and programmes for key populations – MSM, transgenders, sex workers and PWUD;   + efforts to build prevention, diagnosis and treatment literacy for hepatitis A, B, C, D and E across the general population, key and other vulnerable populations and health-care workers. |
| **25** | Elimination of viral hepatitis transmission through vaccination (HBV, hepatitis A virus [HAV]) | The elimination of HBV through vaccination, both hepB-BD and B3 schedules, is critical for stopping HBV transmission.  Full implementation of HBV vaccine programming includes the following:   * implementation of universal timely (< 24h) birth dose; * treatment of pregnant women with high viral loads with antivirals (tenofovir) to augment vaccine effectiveness; * implementation of universal hepB3 infant vaccine schedule (a total of four doses, including the birth dose); * targeted HBV catch-up vaccination of key populations, health-care workers, those having frequent medical procedures (blood products, dialysis) and other non-infant populations, where cost effective; * consider rapid (0, 7, 21 days and 1 year) and accelerated (0, 1, 2 months) hepatitis B vaccine schedules for specific populations where necessary to boost HBV vaccine coverage, including for catch-up programmes.   Hepatitis A and E are endemic in many areas of SE Asia.   * HAV vaccine should be offered under the following conditions: * single dose administration in HAV outbreak contexts; * consideration of implementation of single-dose HAV vaccine as part of routine infant vaccination programming in endemic areas, or in areas of transitioning epidemiology; * consideration of approved hepatitis E virus (HEV) vaccine should be made in line with national guidance, where epidemiologically indicated.   There is no vaccine available for HCV. |
| **26** | Viral hepatitis testing | National programmes to include optimal combination of HBV and HCV (+/-HDV where indicated) testing approaches, including through clinical settings, community-based approaches or self-testing. This entails the following:   * develop national policies for HBV and HCV testing appropriate to the epidemiologic context, including for the general population and key populations; * implement public awareness campaigns educating endemic and at-risk populations and health-care workers; * implement simple, standardized and evidence-based viral hepatitis testing algorithms across all levels of the health system including non-specialists to support task sharing and shifting; * expand access to testing through effective people-centred approaches and link people who undergo testing to treatment and care; * offer hepatitis screening for family members of people living with chronic hepatitis; * where epidemiologically indicated, test individuals with HBV for HDV; * implement targeted HBV and HCV testing in key populations, including provider initiated and self-testing with linkages to care and treatment and retesting for PWID (and other high-incidence populations); * laboratory- and clinic-based reflex testing for viral hepatitis, e;g. to establish rapid diagnosis of HCV * include viral hepatitis testing in integrated testing platforms for multi-disease approaches; * ensure a reliable supply of quality-assured (e.g. WHO-prequalified) diagnostics. * implement timely reporting of testing results, centralized where appropriate, with interoperability between test reporting IT systems. |
| **27** | Viral hepatitis treatment | National programme scale-up for hepatitis treatment is urgently required to include treat all those with HCV and those eligible for HBV treatment, especially persons with advanced disease and pregnant mothers with high viral load.  This may include the following actions:   * strengthen linkages across the health sector to drive diagnosed individuals to early initiation of HBV and HCV treatment; * provide access to staging for HBV- and HCV-related liver disease to inform treatment regimens; * implement national guidelines for treatment aligned with WHO guidelines for treating chronic viral hepatitis B and C infection and promote a simplified public health approach; * implement and scale-up targeted treatment for populations with high HCV incidence including PWID to augment prevention measures; * include treatment initiatives to cater for treatment for children (up to 3 years of age) and adolescents in accordance with WHO treatment guidelines, including adolescent-friendly services that also address psychosocial support and management of stigma for children and adolescents with hepatitis B and hepatitis C virus infection; * programmatic focus on the elimination of HCV among PLHIV through a HCV–HIV coinfection micro elimination initiative; * build capacity in PHC level HBV and HCV treatment, including through hub and spoke models of shared care and supervision; * monitor the cascade of treatment and care to identify and address barriers to early linkage and retention in care. |
| **28** | Support for chronic hepatitis comorbidities and advanced liver disease | Liver disease requires special measures to optimize outcomes, including the management of comorbidities.   * Implement screening for common comorbidities in people with chronic hepatitis B or C infection, including for cirrhosis and hepatocellular carcinoma (primary liver cancer) and extrahepatic manifestations including diabetes. * Screen for and offer treatment for medical conditions that exacerbate liver disease such as problematic alcohol use and metabolic syndrome, including obesity and hypertension. * Offer screening for HIV and other hepatidities, including for HDV in those with chronic HBV infection. * Make available more specialized services for individuals with advanced liver disease, including decompensated cirrhosis, transplantation and palliative services for end-of-life care.   Establish strong linkages between viral hepatitis and cancer screening programmes to allow early detection and effective treatment of hepatocellular cancer (HCC). |

### Viral hepatitis interventions to enhance integration and linkages with other health areas

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| **#** | **Areas of implementation** | **Country actions** |
| **19** | Link chronic viral hepatitis and cancer services | Around 80% of primary liver cancer is caused by chronic HBV and HCV. Strong linkages to cancer screening services are necessary and include the following actions:   * implement routine screening for primary liver cancer in individuals with chronic HBV and HCV infection; * implement HBV, HCV and HDV screening for liver cancer patients where the primary cancer source is unknown; * improve hepatitis diagnosis and treatment literacy among cancer services. |

## Strategic Direction 2: optimize systems, sectors and partnerships for impact

This section describes viral hepatitis-specific priority actions to strengthen health service delivery and other health system functions including multisectoral collaboration.

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| **#** | **Areas of implementation** | **Country actions** |
| **30** | Decentralize hepatitis services | Elimination of hepatitis requires widespread decentralization of hepatitis prevention, testing and treatment services to reach the whole population.   * Implement hepatitis services at the PHC level. * Include hepatitis prevention, testing and treatment in prisons and other closed settings. * Build capacity in non-specialists through task-sharing in hepatitis testing and treatment. * Encourage shared care for the management of complex cases, including through telemedicine services. * Maximize the availability of harm reduction interventions to all subnational areas. |
| **31** | Scale up hepatitis financing in national budgets | Elimination targets are dependent on access to and demand for hepatitis services. Adequate domestic financing is critical to maximizing access.   * Undertake a national investment case for hepatitis B and C to press the case for increased national budget allocation and inclusion of interventions in essential health benefit packages. * Ensure national programmes pursue cost efficiencies, including integrating services, reducing costs, improving efficiencies and price reduction strategies for hepatitis services. * Where state or provincial level budget allocation is an important contributor, ensure that such funding is sufficient to meet viral hepatitis service needs for the state or province. |
| **32** | Essential hepatitis commodities | Equitable and reliable access to viral hepatitis commodities is essential to support consistent and effective national action. The following are the key elements:   * make available low-cost rapid diagnostic tests (RDTs) for hepatitis; * consider innovative financing mechanisms to reduce the cost of molecular tests for HBV and HCV; * encourage generic medicine markets, greater market transparency and pooled purchase mechanisms to reduce drug and diagnostic costs; * address excessive supply chain mark-up impacting end-user prices; * advocate for expanded international financing mechanisms for low- and middle-income countries for hepatitis commodities, especially in coinfection. |
| **33** | Health workforce for viral hepatitis | Decentralization of hepatitis services with maintenance of quality and outcome requires a hepatitis-literate workforce. National programmes should implement the following actions to this end:   * Actively build health worker literacy in viral hepatitis risk factors, prevention and management and in essential hepatitis interventions. * The specific focus should be on the primary health-care level of the system with use of mentoring, remote supervision and support from specialist services, including through virtual systems. Implement occupational health and safety programmes, including testing and routine hepatitis B vaccination of health-care workers and testing and treatment for HCV. |

## Strategic Direction 3: generate and use data to drive decisions for action

This section describes viral hepatitis-specific actions to strengthen health information systems for better data availability, use and accountability. The actions in this section should be implemented in conjunction with the relevant integrated actions.

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| **#** | **Areas of implementation** | **Country actions** |
| **34** | Person-centred monitoring and information systems for viral hepatitis | Economies of scale and existing infrastructure should be utilized for viral hepatitis, including national surveillance and HIV surveillance systems.   * Use existing reporting systems to capture aggregated and disaggregated data for hepatitis cascades of care by sex, socioeconomic status (where possible) and geography, made available to monitor both quality and equity and inform decision-making. * Viral hepatitis information systems should be integrated and enable data triangulation for analysis, including with vital statistics, cancer registries and immunization registries. * Prepare data and measurement systems to enable WHO to validate the elimination of viral hepatitis. |

## Strategic Direction 5: foster innovations for impact

This section describes viral hepatitis-specific actions to foster and disseminate innovations for accelerated impact.

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| **#** | **Areas of implementation** | **Country actions** |
| **35** | New diagnostics and testing approaches | Innovations are necessary to expand testing to improve the Region’s hepatitis care cascade. These may include:   * simple, affordable and reliable point-of-care technologies to confirm the presence of viraemic hepatitis C virus infection; * availability and use of RDT HCV core antigen test and RDT e-Ag for HBV where polymerase chain reaction (PCR) is not available; * use of polyvalent or integrated diagnostic platforms that include hepatitis; * self-testing for hepatitis C virus; * implement affordable methods for staging liver disease, including bio-algorithms such as APRI or FIB-4. |
| **36** | Innovative treatment pathways | Simplifying treatment for HBV and HCV will lower costs and increase uptake. National programmes should consider simplifying diagnostic and standardized care and treatment pathways to the minimal time and tests while increasing efficiency including the “one stop shop” model of viral hepatitis prevention, testing, care and treatment for vulnerable populations needing comprehensive care. |

# HIV

This chapter presents the actions for HIV as part of IRAP 2022–2026. It builds on the successes and lessons learnt from the Regional Action Plan for HIV in SE Asia 2017–2021 and details the key actions necessary for the Region to end AIDS as a public health threat by 2030, with priority targets, interventions and innovations. These actions fully align with the Global AIDS Strategy 2021–2026 and other related global strategies.

Actions for countries in this chapter should be implemented in conjunction with and in addition to the integrated actions for countries defined in Chapter 2.

## Key areas for urgent attention towards the regional elimination goal

* The HIV epidemic in the Region continues to predominantly affect the key populations and their partners. Hence, improving coverage of interventions among key populations, including youth, should be a key focus.
* A renewed focus on prevention and education for the youth is needed.
* Elimination of MTCT needs focus, especially following the interruption in progress during the COVID-19 pandemic.
* The major causes of HIV-related deaths need to be addressed, including TB.
* There are wide variations among Member States in their progress towards 2020 targets, necessitating country-specific approaches adapted from standardised tools. Also, inter-country learning and collaboration is needed.
* Stigma and discrimination remain widespread in communities, health-care settings and among affected individuals themselves (self-stigma). Certain laws and policies in some countries institutionalize stigma and discrimination, especially for key populations.
* Stigma and discrimination deter key populations from accessing prevention and treatment services. Community-led service delivery is important to facilitate access for these populations.
* The mental health of PLHIV should be given priority.
* Large data gaps remain in strategic information. Further disaggregated granularity is necessary.

**HIV targets**

Table 5 presents the impact and programmatic coverage indicators and targets and policy milestones for HIV.

Table 5. Impact and coverage indicators, targets and milestones for HIV, by 2025 and 2030

|  | **Indicator** | **Baseline – 2020i** | **Targets –**  **2025** | **Targets –**  **2030** |
| --- | --- | --- | --- | --- |
| **Impact** | Number of people newly infected with HIV per year | 140 000 | 41 000 | 35 000 |
| Number of people newly infected with HIV per 1000 uninfected population per year (SDG 3.3.1) | Calculate | Calculate | Calculate |
| Number of children 0–14 years of age newly infected with HIV per year | TBD | TBD | TBD |
| Number of people dying from HIV/related causes per yearii (including disaggregation by HIV, cryptococcal meningitis, TB and severe bacterial infections) | 94 000 | 32 000 | 30 000 |
| Number of PLHIV dying from TB, hepatitis B and hepatitis Ciii | TBD | TBD | TBD |
| Number of countries validated for the elimination of vertical (mother-to-child) transmission of HIV, hepatitis B, or syphilis | Confirm | 5 | 11 |
| **Coverage** | Percentage of PLHIV who know their HIV statusiv | 77% | 95% | 95% |
| Percentage of people who know their HIV-positive status and are accessing ARTiv | 78% | 95% | 95% |
| Percentage of PLHIV receiving treatment, who have suppressed viral loadsiv | 91% | 95% | 95% |
| Percentage of people at risk of HIV who use combination prevention with a defined service package | Varies by key population. It is <50% on average | 95% | 95% |
| Condom/lubricant use at last sex with a client or non-regular partner | TBD | 90% | 90% |
| Number of needles or syringes distributed per PWIDv – common HIV/viral hepatitis indicator | 157 | 200 | 300 |
| Percentage of PLHIV and people at risk who are linked to integrated health services, including STIs and viral hepatitis | TBD | 95% | 95% |
| **Milestones** | **Stigma and discrimination –** percentage of people living with viral hepatitis, HIV and STIs and priority populations who experience stigma and discrimination | TBD | Less than 10% | Less than 10% |
| **Laws and policies –** percentage of countries which have punitive laws and policies | Varied by population | <1 | <1 |
| **Gender –** prevalence of recent (last 12 months) intimate partner violence among people aged 15–49 years | TBD | 11% | Less than 10% |
| **Integration –** Percentage of people living with viral hepatitis, HIV and STIs linked to other integrated health services | TBD | 95% | 95% |
| **Late-stage disease** – percentage of people starting ART with a CD4 count of less than 200 cells/mm3 (or stage III or IV)vi | 30% | 20% | 10% |
| **Differentiated service delivery –** percentage of countries that have implemented a 6-monthly refill of drugs | TBD | 50% | 80% |

i Latest data for end 2020. Some targets use data from 2019 because of COVID-19 related service disruptions in the data reported for 2020.

ii Disaggregated by disease coinfection

iii 2019 data

iv Achieved in all ages, sexes and focus populations

v As part of a comprehensive harm reduction strategy and in line with national priorities.

vi To achieve all people living with HIV should receive a CD4 test result, and at least 90% by 2025 and 95% by 2030

### Core targets and additional targets

* Reduce new HIV infections by 2025 with a target of 41 000.
* Advance towards 95-95-95 targets for the Region by 2025.
* The combination prevention services package, including self-testing, condoms, clean needles and syringes, OST and PrEP should be made available to 95% of sex workers, PWID, transgender persons and MSM by 2025
* Increase the percentage of PLHIV who are offered preventive therapy for TB with a target of 95%, by 2025.
* Increase the percentage of PLHIV and people at risk who are linked to integrated health services, including STIs and viral hepatitis, with a target of 95%.
* Reduce the number of countries that have punitive laws and policies for key populations by 2025.
* Reduce the proportion of HIV diagnoses with advanced disease.
* Increase the number of Member States where HIV, viral hepatitis and STI services are linked to other integrated health services.

## Strategic Direction 1: deliver high-quality, evidence-based people-centred services

This section describes HIV-specific priority actions for countries along the continuum of HIV prevention, diagnosis, care and treatment services.

The following are priority populations for HIV:

* MSM
* PWID
* People who use other drugs such as stimulants
* Sex workers and their clients
* Transgender persons
* People in prisons and other closed settings
* Adolescents and young adults, including young key populations
* Elderly individuals with HIV.

Other priority populations may include pregnant and breastfeeding women, people with disabilities, indigenous peoples, migrants and mobile populations and people in settings of humanitarian concern including people affected by conflict and civil unrest. In addition, there will be specific geographic areas in countries where there is a disproportionately high prevalence or risk of HIV.

Country-specific strategic information on risk groups according to demographics and behaviour should inform the development of a list of priority populations for national plans.

### Delivering the continuum of HIV services

The continuum of HIV services provides an organizing framework for implementation of essential interventions that comprehensively address people’s needs relating to HIV prevention, testing, treatment and chronic care. Service access may be interrupted at each step as people move along the continuum. Health services must be client-centred rather than service-centred and organized such that individuals can be continuously engaged in care, including through community access points where appropriate, to optimize outcomes across the life course. Stigma must be actively addressed in all HIV services, including through training, community engagement and provision of peer-led services for key populations. The retention cascade should be monitored to identify areas in which programmatic improvements are needed (Fig. 11). Mobilization of key populations, NGOs, CBOs and governments was the key to continuity of services during the COVID-19 pandemic in countries of the Region.

Fig. 11. The HIV service engagement cascade

**Diagram

Description automatically generated**

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| --- | --- | --- |
| **#** | **Areas of implementation** | **Country actions** |
| **37** | **HIV intervention packages** | * National programmes should define the core HIV intervention package which is aligned with UHC benefit packages and linked with PHC, where feasible and relevant. * National programmes should review data to determine the optimal mix of prevention interventions for different populations and locations. * Core interventions of the package include:   + EMTCT for HIV including universal testing, with universal treatment for HIV-infected pregnant women and their neonates, aligned with triple elimination;   + harm reduction (needle and syringe programme, including LDSSs, and OST for PWUD/PWID);   + HIV self-testing, peer-led partner and contact tracing and rapid HIV testing including at non-HIV services;   + screening and treatment for viral hepatitis and STIs at HIV services   + universal male and female condom access;   + Antiretrovirals for both prevention and treatment of HIV;   + comprehensive single-window services for transgender persons including gender-affirming care, hormone replacement and mental health;   + other targeted programmes for key populations, including MSM, transgenders, sex workers and PWUD. * National programmes should take a human rights approach to intervention delivery, considering how to ensure delivery of commodities and services where key populations are criminalized (such as sex work) or access is blocked (such as in prisons). * A sustainable supply of commodities will be required to deliver intervention packages to key populations across the service continuum. |
| **38** | **Comprehensive HIV prevention** | National programmes should make available a strategic combination of biomedical, behavioural and structural interventions. Different prevention interventions may be suited to different populations at different times of life. These include the following:   * offer PrEP as an additional prevention choice for all individuals who request PrEP and make available the same to those who are at substantial risk of acquiring HIV; * promote treatment as prevention and the concept of U=U; * offer PEP to all people who have had a significant exposure to HIV while not taking PrEP. This may include urgent contact tracing with delivery of PEP within 72 hours; * make available and promote male and female condoms and safe injecting equipment; * develop primary prevention initiatives for key populations and implement and evaluate in collaboration with affected populations, community groups and nongovernmental organizations (NGOs).   National programmes should make available comprehensive interventions for HIV prevention for PWUD, including stimulants. These are:   * condoms, lubricants and safer sex programmes; * needle and syringe programmes and other commodities; * HIV testing services; * ART; * evidence-based psychosocial interventions and drug dependence treatments; * prevention, diagnosis and treatment of STIs, hepatitis and TB; * targeted information, education and communication for people who use stimulant drugs and their sexual partners; * risk mitigation including legal risk mitigation, especially in countries which criminalize specific key populations to support access to services. |
| **39** | **Expanded people-centred HIV testing/screening** | National programmes should include an optimal combination of HIV testing approaches, including through clinical settings, community-based approaches or self-testing.  Specific tasks are to:   * expand HIV testing to meet coverage targets at national and subnational levels; * engage in targeted HIV case finding among infants and children to increase HIV diagnosis coverage in these populations; * expand use of point-of-care testing for HIV in all health-care contexts; * train health-care workers to engage with key populations; * offer peer-led or self-testing for key populations where possible; * consider social network strategies to reach persons not routinely tested for HIV. |
| **40** | **Safe, effective and responsive HIV treatment and care** | National HIV treatment should include rapid and effective ART with support to boost adherence, optimize clinical outcomes and minimize resistance.   * Ensure rapid initiation (within seven days of HIV diagnosis) of HIV treatment with WHO-recommended treatment regimens for all PLHIV,[[5]](#footnote-6) using agents with a high barrier to resistance such as integrase inhibitors. * Offer treatment through delivery models that provide people-centred care, monitoring and support for adherence and retention and re-engagement in care, with service differentiation tailored to the country context. * Increase availability of viral load testing through standard means, while also including point-of-care viral load testing and laboratory-based testing for monitoring to promote optimal treatment outcomes. * Expand laboratory capacity to monitor HIV drug resistance. * Consider innovative solutions to address resistance including early or e-consultation referral mechanisms, e.g., e-SACEP[[6]](#footnote-7) for second- and third-line treatment. * Make available tailored adherence support to maximize retention in care including:   + once a day fixed-dose WHO recommended regimens;   + offering patients the option of multi-month dispensing;   + expanding availability of long-acting injectable antiretrovirals initiated through regulatory approval mechanisms. * Optimize adherence in combination with supply chain integrity to ensure uninterrupted availability of test kits, test reagents and drug supplies and minimize the public health impact of HIV treatment resistance. * Implement combination approaches to monitor antiretroviral drug toxicity and promote patient safety. * Make available interventions to trace people who have disengaged from care and support their re-engagement. |
| **41** | **Reduce prevalence and impact of advanced HIV disease** | Late HIV diagnosis is universally associated with poorer clinical outcomes, poorer quality of life and substantially increased mortality. Late diagnoses are often made through other services such as NCD clinics.   * National programmes should include efforts to further improve early identification of HIV infection. * National programmes should design and offer a specific care package for advanced HIV disease including diagnostic workup, treatment and/or prophylaxis for major causes of morbidity and mortality among PLHIV, as also for TB patients. * Laboratory capacity for CD4 monitoring will be required as part of this package. |
| **42** | **Holistic care to improve quality of life in PLHIV** | Well-managed HIV is increasingly a chronic infection and associated with noncommunicable (chronic) disease impacting quality of life over the longer term. Many populations that are affected by HIV also have high levels of mental health disorders. Chronic diseases including HIV can also be associated with poor mental health. Disability in the context of HIV includes physical, cognitive and mental health related disability.  The key areas of focus for national programmes are:   * screening and integrated care for mental health; * the quality of life of adults and children living with HIV should be monitored and their health and well-being needs addressed holistically over their lifetime. * Provide rehabilitation services, including physical, cognitive and emotional, as part of comprehensive HIV services. * Ensure that there are linkages from other medical programmes to HIV services where HIV diagnoses have been made during the provision of non-HIV care. * Integrate rehabilitation services into clinical guidance and protocols for people-centred HIV care for early identification of rehabilitation needs, referrals and delivery of appropriate interventions using multidisciplinary teams. * The provision of palliative care must be included as an essential component of comprehensive clinical management for PLHIV. |
| **43** | **Reduce and eliminate vertical HIV transmission** | * Promote integrated approaches with sexual and reproductive health programmes for HIV prevention and family planning. * Screen all pregnant women for HIV, syphilis and hepatitis B. Incorporate the use of multiplex point-of-care testing where possible. * Link HIV and ANC programmes to ensure treatment continuity between service delivery points for preventing MTCT. * Make available a package of care for HIV-exposed infants including infant testing and prophylaxis. |

## Strategic Direction 2: optimize systems, sectors and partnerships for impact

This section describes HIV-specific priority actions to strengthen health service delivery and other health system functions including multisectoral collaboration.

|  |  |  |
| --- | --- | --- |
| **#** | **Areas of implementation** | **Country actions** |
| **44** | **People centred, decentralized and integrated services** | **Integration with primary care**  The goal of the SE Asia Regional Strategy for PHC 2022–2030 is to achieve UHC, health security and the health-related SDG targets by 2030 through a PHC-oriented health system. This includes actions as below.   * Develop a package of HIV services which can be delivered as part of primary care, including in areas of low HIV prevalence. This could include dual HIV and syphilis point-of-care testing, hepatitis B vaccination and a syndromic approach to STI treatment. * Expand sexual health and HIV education and training of all health-care workers to ensure that all individuals who seek sexual health services can do so in an environment free from stigma and discrimination and receive high quality, acceptable care. * Provide non-stigmatizing, rights-based, high quality HIV services in a range of settings including primary care to improve coverage. * Stigma in health-care settings and communities and self-stigma must be addressed to enable access to care in a range of settings. * Peer-led services for marginalized key populations remain an important component of HIV services.   **Integration of HIV with viral hepatitis and STIs**  Integration of HIV, hepatitis and STIs at a programme level and through integration of services is a core component of planning, noting that in some countries, structures of programmes and services differ. For example, in India, HIV is a vertical programme while hepatitis is rolled out through a health services approach.   * Link prevention and case management for HIV with STI and hepatitis prevention, screening and treatment including in community-based and outreach services for HIV key populations including:   + hepatitis B vaccination for those susceptible;   + HPV vaccination and cervical screening for women living with HIV.   **Other integration considerations**   * Integrated person-centred HIV care also encompasses addressing reproductive health needs including contraception and fertility. * Countries should develop appropriate models for integration and linkage based on their context and health system characteristics. * NCD/communicable disease linkages: Provide linkages for care of people with chronic HIV to NCD services for early diagnosis, care and effective and timely management of these comorbidities. |
| **45** | **HIV and TB** | * Implement systematic screening for TB symptoms among PLHIV and provide TB preventive treatment (particularly with short regimens). * Undertake, with national TB programmes, HIV testing of all people diagnosed or presumed to be having TB. * Implement timely initiation of ART and WHO-recommended chemoprophylaxis for people with TB coinfection. |
| **46** | **Essential HIV health commodities** | * Ensure equitable and reliable access to quality-assured and affordable commodities. This includes:   + medicines for ART including for children;   + PrEP and PEP;   + diagnostic testing supplies;   + other health products including male and female condoms, lubricants, commodities for voluntary medical male circumcision and needles and syringes for harm reduction and opioid substitution treatment. * Expedite the availability of new products such as HIV rapid point-of-care tests and HIV self-tests and new antiretroviral drugs and long-acting preparations, where available. |

### Tuberculosis and HIV

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| TB is the leading cause of death among PLHIV. Although the number of TB deaths among PLHIV in SE Asia has seen a 74% reduction from 76 100 in 2010 to 19 600 in 2019, less than one third of the estimated number of people coinfected with HIV and TB were reported to be receiving both HIV and TB treatment in 2019.28 The global End TB Strategy29 gives priority to collaborative activities to jointly address TB and HIV through integrated people-centred care. This includes systematic screening for TB symptoms among PLHIV, TB preventive treatment, HIV testing of all people diagnosed with or presumed to be having TB, timely initiation of ART for people with TB, WHO-approved chemoprophylaxis and the treatment of drug-susceptible and drug-resistant TB. The Regional Strategic Plan towards ending TB in the WHO SE Asia Region: 2021–2025 is in line with the global targets of the End TB Strategy, which calls upon Member States to achieve an 80% reduction in the TB incidence rate by 2030 (compared with the 2015 baseline), 90% reduction in TB deaths by 2030 (compared with 2015) and 100% TB-affected families protected from facing catastrophic costs due to disease from 2020 onwards.  The Regional TB Strategy has the goal that ≥90% of PLHIV newly enrolled in care will have treatment for latent TB.  There are opportunities for programme collaboration, such as joint planning, surveillance and financing. Common approaches to address the inequalities that drive both HIV and TB are also important to prevent and manage HIV-associated TB. This includes the use of new points of care diagnostics and innovative treatment, e.g., newer short course therapy for tuberculosis preventive treatment (TPT). |

## Strategic Direction 3: generate and use data to drive decisions for action

This section describes HIV-specific actions to strengthen health information systems for individual patient care and national and subnational surveillance, aiming for interoperable, interconnected, electronic real-time reporting systems.

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| **#** | **Areas of implementation** | **Country actions** |
| **47** | **Integrated person- centred monitoring and surveillance** | * Utilize existing infrastructure in HIV monitoring to optimize outcomes, including:   + use of unique identifiers to allow individualized outcome analysis and management and to avoid duplicate entries for individuals;   + availability of these data at the facility level to support informed clinical decision-making. * Enable confidential data sharing across health services to support patient care, including by addressing the legal environment for data sharing. * Strengthening surveillance will require investments in data capacities and strengthening in-country laboratory capacity. * Utilise WHO-developed tools including SCORE data collection tools30 to build on existing national surveillance capacity. * Data should be disaggregated by sex, age, socioeconomic status, geography and other relevant population characteristics and be in alignment with national priorities to monitor equity in access and outcomes. * Undertake population size estimates for key populations (including virtual key populations) to allow estimation of the HIV cascades of care in these groups. * Consider the utilization of HIV surveillance and monitoring systems for other disease categories to drive integration, e.g. expanding STI surveillance and integrating with HIV   reporting systems including integrated behavioural and biological surveys.   * Consider recent infection surveillance to facilitate early identification of outbreaks. * Produce regular information reports. * Institutionalize regular systems of data quality assurance and establish M&E frameworks. |

## Strategic Direction 5: foster innovations for impact

This section describes HIV-specific actions to foster and disseminate innovations for accelerated impact.

|  |  |  |
| --- | --- | --- |
| **#** | **Areas of implementation** | **Country actions** |
| **48** | **New HIV diagnostics technologies and testing approaches** | * Make available polyvalent or integrated diagnostic platforms for the combined diagnosis of HIV and comorbidities such as TB, viral hepatitis and syphilis. * Offer HIV self-testing and rapid point-of-care tests in a range of settings to improve access. |
| **49** | **New options for antiretroviral drug-based prevention** | * Expand access to novel ARV based prevention, i.e. treatment as prevention (TasP) by offering this as an option to all affected persons. * Expand access to PrEP and PEP including long-acting injectable preparations and other new technologies as they become available. |
| **50** | **Optimized use of antiretroviral drugs, HIV vaccines and cure** | * Support research on optimal doses and formulations of emerging antiretroviral and non-antiretroviral drugs to minimize drug–drug interactions and reduce costs. * Support research into improved HIV therapeutics including vaccine and cure through international collaboration. * Support research on implementation technologies to facilitate adherence including web-based refills, remote testing and adherence reminders and offer the same in programmes. |
|  |  |  |

# Sexually transmitted Infections (STIs)

Actions for STIs given in this chapter should be implemented by countries in conjunction with and in addition to the integrated actions.

Key challenges and gaps identified across the Region include:

* national strategies oriented towards HIV with little attention to STI control;
* a general heterogeneity in services available to diagnose and treat STIs across countries of the Region;
* a lack of resources and staff specific to STI programmes;
* commodity gaps including a lack of reliable supply of STI diagnostics and treatment;
* variable clinical service and contact tracing including guidelines, training and supervision to manage cases and contacts;
* inadequate surveillance systems for STIs and antimicrobial resistance (AMR) monitoring;31
* remaining legal and policy barriers to key populations that impede equitable access to health care, along with stigma and discrimination.

With merging of HIV and STI programmes and increasing focus on HIV-specific activities such as access to ART and PrEP, attention to key STI prevention and control activities has been lost. Strategic and operational planning in most countries is dominated by HIV priorities and targets.

## Key shifts required to strengthen STI control in the Region

It is recognized that there is variability in prevalence and impact of STIs across countries of the Region. in addition, there is a wide variety in the access to appropriate diagnostics laboratory services and treatment within and between countries. It should be noted there has not been a regional action plan for STIs to date and as such countries of the Region may be at different stages regarding the implementation of actions suggested in this chapter.

Key shifts to remedy this situation are enumerated below.

* Urgently take steps to reposition STI control as a public health priority for the Region and advocate for resources, staffing and planning independent of HIV programme priorities (recognizing the common ground and potential synergies in STI/HIV control efforts, i.e. offering STI screening/Comprehensive periodic treatment at quarterly PrEP visits).
* Recognize successes in the Region and leverage the considerable experience and expertise from countries such as Sri Lanka and Thailand and from key population community learning sites like Durbar Mahila Samanwaya Committee (DMSC) and Ashodaya Samithi.
* Advocate for and support progress towards STI elimination, continuing with EMTCT and preparing elimination cases for infectious syphilis, chancroid and possibly gonorrhoea, recognizing that there are strong candidate countries for each of these STI elimination targets in the Region.
* Address the considerable STI data gaps and limitations in most countries, advocating for and supporting basic STI surveillance components including routine reporting (syndromic/aetiological), routine prevalence monitoring (ANC and key population syphilis screening) and leveraging regional experience and expertise including for drug resistance patterns, to inform effective case management.
* Develop a flexible toolkit of proven interventions for countries at different stages of STI control, including:
* appropriate mixed models of aetiological and syndromic management and reporting (as in Thailand and Sri Lanka);
* effective community-based models (including microplanning) for high-impact STI control with key populations (DMSC, Ashodaya learning sites);
* asymptomatic treatment strategies in line with WHO guidelines;
* rapid response methods to identify and control STI outbreaks (this is particularly important as countries move towards elimination).

## STI targets

Tables 6 and 7 present impact and coverage targets and policy milestones for STIs in the Region.

Table 6. Impact and coverage indicators, targets and milestones for STIs, by 2025 and 2030

| **Indicator** | **Baseline – 2020i** | **Targets – 2025** | **Targets – 2030** |
| --- | --- | --- | --- |
| Number of new cases of four curable STIs in adults (15–49 years) per year ('000) | 59 677 | 47 742 | 21 273 |
| Number of new cases of syphilis in adults (15–49 years) per year ('000) | 354 | 283 | 35 |
| Number of new cases of gonorrhoea in adults (15–49 years) per year ('000) | 21 059 | 16 847 | 2106 |
| Congenital syphilis cases per 100 000 live births per year | 145 | <200 | <50 |
| Percentage of girls fully vaccinated with HPV vaccine by 15 years of age | 14% | 50% | 90% |
| Percentage of pregnant women attending ANC who were screened for syphilis/percentage treated if positive | 65%/71% | >85%/>90% | >95%/>95% |
| Percentage of priority populationsii screened for syphilis/percentage treated if positive | No data/no data | >80%/>90% | >90%/>95% |
| Percentage of priority populationsii screened for gonorrhoea/percentage treated if positive | No data/no data | >20%/>90% | >90%/>95% |
| Percentage of women screened for cervical cancer using a high-performance test, by the age of 35 and again by 45 | No data/ | >40%/> | >70%/ |
| Number of countries reporting antimicrobial resistance in Neisseria gonorrhoeae to GASP | 36% | >60% | >70% |
| Planning: number of WHO Member States with national STI plans updated within the past 5 years | 50% | >70% | >90% |
| Policies: number of WHO Member States with national STI case management guidelines updated within the past 3 years | 40% | >70% | >90% |
| Surveillance: number of countries with strong STI surveillance systemsiii | No data | >50% | >90% |

GASP – Gonococcal Antimicrobial Surveillance Programme

|  |  |
| --- | --- |
| *Table 7. Syphilis EMTCT targets23* | |
| EMTCT impact target | A case rate of CS of ≤50 per 100 000 live births |
| EMCT process targets | 1. ANC coverage (at least one visit) of ≥95% 2. Coverage of syphilis testing of pregnant women of ≥95% among those who attended at least one ANC visit 3. Adequate syphilis treatment of syphilis-seropositive pregnant women of ≥95% |

i Latest data for end 2020. Some targets use data from 2019 because of COVID-19 related service disruptions in the data reported for 2020.

ii Priority populations are defined by individual countries; for screening include men who have sex with men, sex workers and people living with HIV.

iii A strong surveillance system for sexually transmitted infections incorporates four core competencies: case reporting, regular prevalence assessments among antenatal care, men and priority populations, regular annual reviews of the causation of sexually transmitted infection syndromes and symptomatic data corrected for underreporting, and monitoring of antimicrobial resistance­ for *Neisseria gonorrhoea.*

## Core targets and additional targets

* Reduce incidence and prevalence of the four key curable STIs: syphilis, gonorrhoea, chlamydia and trichomonas in line with global targets
* Eliminate MTCT of syphilis in all countries (<50/100 000 live births)
* Increase HPV vaccination coverage
* Increase proportion of key populations receiving regular medical care including screening for syphilis and gonorrhoea and treatment if positive
* Increase number of Member States with STI surveillance systems
* Increase number of Member States with STI programmes, including M&E mechanisms.

## Strategic Direction 1: deliver people-centred evidence-based services

Priority populations for STIs include sex workers and their clients, MSM, transgender persons, young people, PLHIV and pregnant women and their exposed infants.

Other groups that are especially vulnerable to STIs in many settings include people who have experienced gender-based violence, indigenous peoples, children and young people living on the street, people affected by conflict and civil unrest and people with disabilities.

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| **#** | **Areas of implementation** | **Country actions** |
| **51** | **Expand primary prevention** | Develop, implement and scale up effective primary prevention interventions tailored to different populations and locations, including provision of HPV vaccines and other vaccines as they become available.   * A range of health promotion initiatives for key populations and the general population should be used, including:   + mass media campaigns   + education in schools   + targeted health promotion activities conducted by community groups. * Information and education campaigns should adopt positive approaches to promoting sexual health, normalize discussion of sexual health and teach individuals to recognize symptoms of STIs. * Develop primary prevention initiatives for key populations and implement and evaluate these in collaboration with affected populations, community groups and NGOs. * Freeing access to condoms in a variety of settings to which key populations have access is a key intervention. * Take prevention initiatives for STIs integrated with HIV PrEP and hepatitis prevention through vaccination for key populations. * Build STI literacy in at-risk populations to seek care for symptoms of STIs and prevent reinfection. * Existing primary prevention initiatives for key populations may have been substantially affected by the COVID-19 pandemic. Specific measures to rebuild and ensure future resilience may be needed. * Effective vaccines exist for preventing HPV infections, but coverage is low. Wider provision of these vaccines will drastically reduce new cases of cervical, penile and anal cancers. * Establish the proportion of adolescent girls currently receiving HPV vaccination by 15 years of age. * Develop strategies to increase HPV vaccination coverage for adolescent girls, including addressing barriers to uptake and vaccine hesitancy. * In countries with sufficient resources, HPV vaccine programmes should be expanded to include vaccination of adolescent boys. |
| **51** | **An effective STI service continuum** | Provide a comprehensive continuum of STI services based on the needs of populations (Figs. 12 and 13).   * Each country needs to define a package of essential STI interventions along the service continuum aligned with UHC benefit packages and linked to PHC. * All services must be non-stigmatizing, rights-based, quality services. * Health systems must identify and remove physical and information barriers that hinder vulnerable populations from accessing STI information and services. * Self-care strategies, including self-collection of specimens and telemedicine, can reduce barriers to accessing STI services and should be made available where possible. * Services should utilize evidence-based interventions including same-day treatment, evidence-based guidelines and partner notification. * STI services should be accessible in settings where individuals are more likely to seek care such as at PHCs and community health services.   **Testing and diagnosis**   * Develop national STI policies and guidelines, including screening strategies based on available epidemiological data considering the following:   + all individuals tested for HIV should also be tested for syphilis;   + as technology becomes available, expand screening opportunities for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* with next generation lower cost point-of-care diagnostic tests;   + laboratory capacity should be developed to improve diagnosis of symptomatic and asymptomatic STIs and quality assurance systems should be established.   **Treatment**   * Evidence-based national guidelines on managing STIs should be developed based on WHO guidelines.32 * Guidelines should include consideration of asymptomatic screening and or/treatment based on risk in line with WHO recommendations. * Same-day treatment for curable STIs should be made available. * Hesitancy to IM benzathine penicillin for syphilis should be addressed. * Retention and referral mechanisms for those needing ongoing care should be established.   **Partner notification and contact tracing**   * Strategies for establishing voluntary partner notification and treatment should be developed and implemented, ensuring that services are accessible and confidential. Such strategies are crucial to avert further transmission of STIs and reinfection. * Evidence-based strategies, such as expedited partner treatment and voluntary provider-assisted referral of sexual partners could be adapted to local contexts. * Social network-based approaches developed for HIV testing could be adapted to reach and offer partner management services for the sexual partners of those diagnosed with other STIs. * Innovations in contact tracing for COVID-19 should be explored, including through the use of digital platforms to support partner testing.   **The care cascade**   * The care cascade should be monitored to determine where loss to follow-up is occurring. This needs to be addressed. * Services were disrupted substantially during the COVID-19 pandemic, and some are yet to reach pre-pandemic levels of functioning. Efforts to improve resilience of services and regular monitoring will be required. |

Fig. 12. The STIs service continuum

**Diagram

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*Fig. 13. The STI reinfection service process*

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| **#** | **Areas of implementation** | **Country actions** |
| **52** | **Reduce and eliminate vertical transmission** | Several STIs, including HIV, syphilis, gonorrhoea, chlamydia, herpes simplex virus, and HTLV-1 can be transmitted vertically.  National programmes should reduce vertical transmission of STIswith a focus on triple elimination,through:   * implementation of STI services at the PHC level, taking a syndromic approach to diagnosis and treatment, with secondary and tertiary facilities providing diagnostics-driven treatment; * screening for maternal syphilis early in pregnancy, using recommended point-of-care tests in ANC and prompt treatment of seropositive women (at least four weeks prior to delivery with intramuscular benzathine penicillin G, a long-acting penicillin) cures syphilis in both mother and foetus and prevents congenital syphilis;23 * for syphilis, screening and treatment should ideally be in the first ANC visit; * follow up infants born to untreated mothers with syphilis, or mothers not treated with benzathine penicillin G; * coverage of PMTCT programmes should be prioritized to achieve the objectives of triple elimination of MTCT of HIV, syphilis and hepatitis B; * provide timely identification and treatment of pregnant women, their sexual partners and their exposed infants and young children;23 * assist pregnant women to notify their sexual partners for treatment; * undertake primary prevention of new infections in women and girls of reproductive age and their sexual partners to also support prevention of vertical transmission among pregnant women; * other actions to be considered after triple elimination interventions:   + administer routine prophylaxis for ophthalmia neonatorum where prevalence of chlamydia and gonorrhoea is high and mothers are not routinely screened;   + implement suppressive herpes simplex virus therapy for women with suspected primary genital herpes during the last trimester of pregnancy. |

## Strategic Direction 2: optimize systems, sectors and partnerships

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| **#** | **Areas of implementation** | **Country actions** |
| **53** | **People-centred and decentralized services** | Provide people-centred, decentralized and integrated STI services and improve coverage of services.  **Integration of STIs with HIV and hepatitis**  Integration of HIV, hepatitis and STIs at a programme level and through integration of services is a core component of planning.   * Develop national plans for STIs, with subnational plans where required. * Link prevention and case management for STIs with HIV prevention services, including community-based and outreach services for HIV key populations. * Link prevention and case management for STIs with hepatitis screening and prevention, including vaccination for hepatitis B for those susceptible.   **Integration into primary health care**  Integrating STI services into PHC is essential. This is in line with the goal of the SE Asia Regional Strategy for PHC 2022–2030, to achieve UHC, health security and the health-related SDG targets by 2030 through a PHC-oriented health system.33   * Develop a package of services which can be delivered in primary care, including in areas of low STI prevalence. This could include dual HIV and syphilis point-of-care testing, hepatitis B vaccination and a syndromic approach to STI treatment. * Develop clear pathways and indications for primary-care referral to secondary or tertiary facilities where further services such as chlamydia and gonorrhoea testing may be available. * Expand sexual health education and training of all health-care workers to ensure that all individuals who seek sexual health services can do so in an environment free from stigma and discrimination and receive high quality, acceptable care. * Providing non-stigmatizing, rights-based, high quality STI services in a range of settings including primary care will improve coverage.   **Other areas for integration**   * Countries should develop appropriate models for integration and linkage based on their context and health system characteristics. The HIV service delivery model could be adapted for integration and decentralization of STI services. * Linkages, collaboration and integration between STI services and other health services may include:   + adolescent health services and school health education services   + family planning   + maternal and neonatal care   + immunization   + NCDs, mental health, and health promotion   + strong referral mechanisms with cancer services. * Encourage and work with the private sector, NGOs and community groups to develop innovative approaches and collaborations to scale up the prevention initiatives, access to vaccines, laboratory services, treatment and care.   **Community-centred care for key populations**   * Develop service delivery models to make high-quality non-stigmatizing STI services accessible and acceptable to priority populations. * Decentralization and differentiated service delivery models are fundamental to ensuring equity in service access for key populations and reaching those who are not yet linked to services, such as in rural areas. * Integration of service delivery for key populations should involve representatives of affected communities and be separately addressed with a clear definition of coverage and impact targets. * Services should be delivered within/alongside comprehensive single window services for transgender persons. |
| **54** | **Mobilize funding** | Mobilize additional funding to support the expansion of STI prevention and treatment services.   * Political support and effective advocacy are needed, with the involvement of key populations. * Increase awareness of the public health impact of STIs and secure adequate funding to address this impact. * STI programmes need to be costed and included in the national essential health-care package. * STI services need to be included in the PHC service package funded by governments and health insurance. Key medications need to be included in essential medicines lists. |
| **55** | **Equitable and reliable STI commodities** | Ensure equitable and reliable access to high-quality and affordable medicines, diagnostics, vaccines, condoms and other health products for STIs.   * Leverage integrated procurement and supply chain mechanisms:   + pooled procurement of essential STI medicines including benzathine penicillin, diagnostics, and reagents;   + optimization of technical resources, training and capacity enhancement across HIV, hepatitis and STIs. |

## Strategic Direction 3: generate and use data to drive decisions and action

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| **#** | **Areas of implementation** | **Country actions** |
| **56** | Strengthen STI laboratory capacity | Enhance laboratory capacity to improve case management and surveillance of STIs.   * Improved screening for asymptomatic infections is needed to monitor and control disease, as STIs are often asymptomatic. * While syndromic management strategies are highly effective, targeted antibiotic treatment will become more important in an era of accelerating AMR. * Develop country-specific, risk-based screening strategies targeted at key populations and vulnerable communities, considering laboratory requirements for the different health-care levels, resourcing, staff training and commodities. * Syphilis screening should be prioritized. Gonorrhoea and chlamydia screening should be undertaken where feasible.   Laboratory capacity should be expanded at all levels including laboratory workforce capacity through training and adoption of new technologies This could include building on existing laboratory systems and networks and quality assurance systems to improve client management and surveillance |
| **57** | Antimicrobial resistance monitoring | There iswidespread resistance to most medicines used to treat gonorrhoea in many parts of the world. Other STI pathogens with potential AMR include *Mycoplasma genitalium* and *Trichomonas vaginalis.*  National programmes should monitor the patterns of AMR to inform treatment recommendations and policies.   * Strengthen and expand surveillance and monitoring of treatment failures and participate in building regional networks of laboratories to perform gonococcal culture and antimicrobial susceptibility testing. * Use data obtained through antimicrobial surveillance to regularly update national treatment guidelines and policies. * Strengthening national drug regulations and prescription policies and increasing awareness of the correct and standardized use of antimicrobial agents among health-care providers and consumers, especially in priority populations, are also important. |
| **58** | STI surveillance | Strengthen STI surveillance and monitoring.   * There are four core components of STI surveillance: case reporting, prevalence assessments, assessment of the aetiology of STI syndromes and monitoring of AMR. * In many countries, STI surveillance systems rely on syndromic case reporting. Strengthening surveillance will help ensure that countries have the relevant data to inform decision-making. * Combinations of syndromic and aetiological reporting have been used in several countries and could be adapted elsewhere. * STI surveillance systems should be developed by expanding on and integrating with HIV reporting systems including integrated behavioural and biological surveys (IBBS). * Strengthening surveillance will require investments in data capacity and strengthening in-country laboratory capacity. * In countries where private sector laboratories, pharmacies and clinicians provide a substantial proportion of STI services, it is important to promote regular reporting from these providers. * Data should be disaggregated by sex, age, socioeconomic status, geography and other relevant population characteristics in alignment with national priorities to monitor equity in access and outcomes. * Institute strong domestic coordination systems across different programmes including AMR reporting systems. * Reporting systems should also collect data on other health outcomes related to STIs such as congenital syphilis. * M&E of STI programmes should be established. |

## Strategic Direction 5: foster innovations for impact

This section describes STI-specific actions required to foster and disseminate innovations for accelerated impact. The actions in this section should be implemented in conjunction with the relevant integrated actions.

While countries may be able to support all of the below, collaboration with partners within and outside of the Region will allow early exposure and access to new innovations.

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| **#** | **Areas of implementation** | **Country actions** |
| **59** | Innovations in prevention | Identify, evaluate and scale up best practices in preventing STIs.   * Advances in health promotion and care such as HIV prevention services and dissemination of health information using social media should be assessed for their relevance to STIs and scaled up as appropriate. |
| **60** | Innovations in diagnosis and treatment | Monitor development of and adopt innovations in STI diagnostics and treatment to address local challenges:   * consider implementation of self-sampling, which has been shown to increase testing uptake. This should be considered where possible for diagnostic testing; * use of low-cost, rapid point-of-care diagnostic tests for asymptomatic screening where access to diagnostic laboratory facilities is limited, as well as for new point-of-care and home-based diagnostics; * support rapid multiplex diagnostic platform development; * increase access to molecular diagnostic tests to identify and characterize AMR; * support the accelerated development and clinical testing of treatments and treatment delivery for STIs and their complications and sequelae. |

# Implementing the Integrated Regional Action Plan

Effective implementation of the Regional Action Plan for viral hepatitis, HIV and STIs requires strong leadership, partnerships, solidarity and accountability, including multisectoral action through a whole-of-government and whole-of-society “health in all policies” approach. This chapter presents the key operational considerations for implementation of the Action Plan.

## Political advocacy and commitment

Political commitment is of critical importance for effective implementation of the IRAP. At the national level, this means country ownership on the nature and extent of the problem and the programmatic solutions required to address viral hepatitis, HIV and STIs.

The integrated RAP is aligned with related commitments expressed in other global health strategies and plans, including the United Nations General Assembly’s 2021 Political Declaration on HIV and AIDS, building on the inequalities lens of the UNAIDS Global AIDS Strategy 2021–2026 and the priorities of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

In addition to these, at the regional level the Action Plan will bridge the gap between the 2021 and 2030 SDGs. Each epidemic requires strengthened political commitment and a renewed strategic focus to guide the final push to reach the SDGs. Apart from the political executive, the active participation of affected persons’ representatives at the national and subnational levels will be critical. It will seek to preserve an individualized approach to each disease area, while also emphasizing important synergies to be found in combating HIV, viral hepatitis and STIs collectively to achieve elimination.

## Governance supporting the integrated model of service delivery

Integrated regional and national action to address HIV, viral hepatitis and STIs is dependent on strong governance at the national, provincial and local levels. National task forces responsible for the development and implementation of integrated national action plans must ensure that integration promotes impact, especially for viral hepatitis and STI programmes, which have traditionally attracted less attention and funding. Integration must be defined so that the concept is similarly understood across the health sector and by partners.

The governance of integrated national action should fall under the broader UHC agenda, including through PHC platforms. This includes UHC for key populations. Integration should encompass the national and subnational policy level, the service level and the community impact.

Triple elimination of vertical transmission of HIV, syphilis and hepatitis B infection as detailed in Chapter 2, is a strong example of integration, possessing policy, service, impact and monitoring evaluation with an associated validation mechanism.

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| **#** | **Areas of implementation** | **Country actions** |
| **61** | Effective and inclusive governance | Political commitment to national governance structures and costed strategic plans are necessary to guide integrated national responses to HIV, viral hepatitis and STIs.   * Encourage national approaches to governance through the establishment and maintenance of national taskforces for integrating HIV, viral hepatitis and STI action, implying collaboration across sectors and stakeholders including state or provincial governments, diverse CSOs, the private sector and communities, in a whole-of-government and whole-of-society approach. * Do a structural integration of Ministry of Health organigrams on viral hepatitis, HIV and STIs, including dedication to the inclusion of key populations as a focus across all three disease areas. * Ensure a meaningful engagement of communities and civil society including all key populations in national policy and implementation, promoting synergies with broader health governance structures and plans. * Provide leadership that is representative across the health system and specifically in HIV, hepatitis and STIs including women and people from affected communities. |

The HIV and STI programmes are integrated in a number of countries as most of the populations vulnerable to these infections are common. Almost 90% of new infections of HIV in the Asia–Pacific are among key populations and their partners. It is therefore relatively easier to carry on horizontal integration from the top level of governance to the field service delivery level.

In the case of viral hepatitis, programmes are designed and implemented through the PHC system and national health missions as a part of the general health system. It is noticed that in this process, the genuine needs of key populations get affected, as many of them do not have access to health system-based services such as testing, treatment, vaccination, etc. The level of involvement differs even within hepatitis between hepatitis B and C. In some of the SE Asian countries, hepatitis C treatment is available as a part of health care or national programmes. The same is not the case with hepatitis B.

While attempting an integrated model of governance, it is therefore important to build in adequate flexibility for countries to adopt a model suitable to their needs, which fits into their socio-political context. The answer lies in adopting a client-centred approach rather than a disease-centred one for integration. While hepatitis B and C programmes for general populations can continue to be delivered through the general health-care system, these services for key populations need to be organized with strong involvement and participation of the communities of key populations, integrating these with HIV and STI services.

Keeping these requirements in mind, the following structures of governance are recommended for countries to adopt based on their needs.

**Total integration (for smaller countries)**

The three programmes will be brought under a single senior level functionary as Director of hepatitis, HIV and STI programmes. The three programme lines can be managed through senior level technical deputies under the director. This arrangement will be replicated at the provincial/district level as well. Budgets for the three programmes should be gradually brought under a single budget line. This could be an evolving process stretched out over a year or two. Fund flow to the implementation level should take place through a single budgetary channel.

At the field level, the technical staff working on the three programmes will be retrained and redeployed as composite teams, sharing accommodation and testing services and dispensation of medicines. Their salary levels will be redefined to avoid frustration and demotivation due to redeployment.

This model works out well for smaller countries with a limited number of technical functionaries and technical service facilities at the field level. Running parallel line programmes for all the three diseases will not be cost effective in such countries.

**Partial integration**

In the partial integration model, the political decision to bring the three disease control programmes under a single umbrella of governance would still be necessary, both at the federal and provincial levels. At the senior management level, a senior functionary in the Health Ministry should be designated as the Director General (DG) of the three programmes. The DG would act as the chief coordinating agency for the integrated programme with the assistance of three senior-level functionaries as the directors for each of the three programmes. For the hepatitis programme, a separate functionary should look after linkages to the national health mission (NHM) and health systems for programmes dealing with general populations such as vaccination of children, testing and treatment at the PHC level, blood safety, infection control, etc. For key populations, such services will be coordinated by the second-level functionaries who will ensure involvement of communities of key populations through community-based programmes and also establish linkages with the PHC for providing hepatitis related services (Fig. 14).

Fig. 14. Example organogram for ministries of health implementing Integrated viral hepatitis, HIV and STI programmes, including focused actions to address these among key populations

Diagram

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A similar pattern will be replicated at the provincial level.

In countries like India where autonomous state AIDS control societies are functioning for HIV and STI programmes, a separate functionary for hepatitis should be added to the team to service the needs of key populations and establish linkages with state health systems and the PHC system. General population services for hepatitis will continue to be delivered through the health system.

At the district level, the district medical/health officer responsible for disease control will coordinate the activities of the field level functionaries of all the three programmes through a reporting system established under the integrated programme. A district-level action plan will be prepared to look at the technical needs of the integrated programme and to retrain and redeploy the technical staff.

## Health facility services in the context of integrated national action

Optimal people-centred prevention, diagnosis, care and treatment for HIV, viral hepatitis and STIs are dependent on effective service delivery. In the context of integrated action, this means the appropriate mix of specialist and integrated primary health-care services.

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| **#** | **Areas of implementation** | **Country actions** |
| **62** | Health facility mix | National integrated action across HIV, viral hepatitis and STIs will be a mix of integrated and stand-alone services. Feasibility will be an important criterion for integration and should be country specific. For service integration, the following areas of implementation are essential:   * conduct situational analyses to optimize the delivery of HIV, viral hepatitis and STI services as part of UHC and PHC; * promote integration of HIV, viral hepatitis and STI services under one umbrella as part of the essential health service package. |

## Active participation of communities of key populations in delivery of services

Addressing HIV, viral hepatitis and STIs in key populations in the SE Asia Region is critical to attaining the elimination goals of 2030, particularly regarding the incidence of these infectious diseases. Please also refer to Strategic Direction 4 in shared actions (Chapter 2) and the individual disease chapters.

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| **#** | **Areas of implementation** | **Country actions** |
| **63** | Active participation by key populations | In addition to those activities specified in Strategic Direction 4 across the IRAP:   * national actions should include clear guidance on community system strengthening and the differences among community-led, community-based and community-friendly approaches; * social contracting of CBOs and NGOs for delivery of prevention and treatment services should be actively pursued by respective countries; * the COVID-19 context has impacted programmes in all countries but has also accelerated the use of various innovative approaches to simplify service delivery and meet the needs of people in the context of the pandemic, including with extensive engagement of all communities. |

## Addressing stigmatization of key communities through legal environment reform

There is need to address stigma and discrimination, not only for HIV, but also for viral hepatitis and STIs, so that people are comfortable to speak about the impact of these infections in their daily lives, their families and communities. In the next phase of the response, it is imperative to plan, deliver and monitor actions through an “inequalities lens”, working proactively to limit barriers to equitable service coverage among the most marginalized communities.

Suggested actions to enhance the legal and regulatory environment are detailed in Area of Implementation #16.

## Strategic information – integrated data systems

Strategic information should be positioned as an important cross-cutting area for the three diseases. There is a need to strengthen surveillance and M&E systems for all disease areas and to promote digital systems and data analysis and use at the central and local levels. Drawing on three generations of HIV surveillance, there is a need to strive towards integrated disease surveillance for HIV, viral hepatitis and STIs, with person-centred monitoring supported by a digital-enabled M&E framework through open-source platforms where possible.

The general principles for strategic information across viral hepatitis, HIV and STIs within the IRAP are:

* leverage existing HIV and integrated surveillance systems to include viral hepatitis and STIs;
* identify common metrics and indicators that are feasible to collect and utilize;
* strengthen overall health information and surveillance systems to support integration at subnational and national levels;
* improve reporting on all three disease areas, including strengthening local data availability and granularity by population and location.

Strategic Direction 3 details shared actions and actions by disease category across this document.

## Optimization of technical resources, training and capacity enhancement

Technical and equipment resources available for the three diseases can be optimally used for the integrated delivery of services. Capacity enhancement of technical personnel should be implemented in a phased manner to enable the health workforce to manage testing, treatment and other services in an integrated model.

## Integration and strengthening of laboratory services

Integration of laboratory services for viral hepatitis, HIV and STIs should occur through the effective and efficient use of existing infrastructure. Integration of laboratory services includes the utilization of multiplex and traditional testing modes, both rapid and platform based. It includes the integration of test reporting, reporting of tests to central registries which are themselves integrated, the use of unique identifiers to prevent duplication and allow integration with and linkages to existing reporting systems. This includes integrating with or linking to other disease reporting and surveillance systems to ensure data linkage and optimize patient care while at the same time providing informed health and disease surveillance.

## Procurement and logistics

Economies of scale and resultant price reductions can be secured by pooled procurement of essential medicines, diagnostics and reagents. Countries are encouraged to pool procurement, at least at the subnational level and ideally at the national level and consider exploration of supranational pooled procurement mechanisms.

## Innovations and how they help in strengthening the regional response

Countries are encouraged to take an evidence-based approach to the adoption of new technologies, including regulatory approval reforms to expedite access to affected populations. Technological solutions to improving access, including developments during the COVID-19 pandemic should be utilized to optimize the effective rollout of key interventions and reduce the cost-of-service delivery.

## Risk mitigation strategies for implementation of the Integrated Regional Action Plan

The success of the IRAP depends to a large extent on the extent of political commitment and ownership of governments in the Region to achieve the goals set out in the Plan. Competing demands and priorities (such as those witnessed during the COVID-19 emergency) from other health and developmental issues could continue to divert the attention of the political and administrative leadership away from an organized response to the three diseases. Integration of these, and the new IRAP must also focus on overcoming challenges. This can pertain to general issues such as the need for adequate funding, or overcoming specific programme challenges, e.g. the availability and maintenance of cold-chain infrastructure.

Risk mitigation for the IRAP will be supported by WHO and will include a risk analysis outlining various threats to the realization of the Action Plan targets. This risk analysis should be conducted and incorporated into the Action Plan along with mitigation approaches, to examine the following threats:

* lack of political support for the integrated strategy
* lack of ownership for the integration model at the implementation level – turf issues with existing line managers
* withdrawing of international funding (GF and PEPFAR for HIV)
* continuing criminalization and stigmatization of key populations
* natural and public health emergencies engaging policy-makers’ attention.

# Monitoring and evaluation

Currently, HIV, viral hepatitis and STIs have their own M&E frameworks. In an integrated model, a national unified M&E framework should be developed and operationalized at both the national and provincial levels. This M&E framework should follow recommended guidelines by WHO and other technical agencies, including preparing those monitoring systems and measuring tools required to support progress towards elimination and its validation.

A detailed layout of indicators for viral hepatitis, HIV and STIs, together with disaggregation-specific details and sources of data is located in annexes and depicted in Fig. 15.

*Fig. 15. Indicators for viral hepatitis, HIV and STIs*

**Diagram

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At the regional level, data collection and analysis efforts will be aligned with the Global AIDS Monitoring process led by UNAIDS and partner processes and the Global Hepatitis Reporting System. In all monitoring and reporting activities, WHO will ensure that data are sufficiently disaggregated by sex, age and other population characteristics to track inequalities, identify gaps and give priority to efforts to reach the populations that are being most left behind.

Progress reports will be made to the Regional Committee for SE Asia in 2024 (mid-term review) and a final report following the completion of the plan will be shared in 2026.

The WHO SE Asia Region will also participate in the 2026 mid-term review of the GHSS for HIV, viral hepatitis and STIs.

# WHO Actions to keep the Integrated Regional Action Plan on track

The role of WHO at the regional level in SE Asia will be to maintain regional progress towards elimination across viral hepatitis, HIV and STIs. It is noted that the Region is off track regarding a number of indicators. The impact of the COVID-19 pandemic during 2020–2022 is yet to be fully understood.

The Regional Office will work closely with WHO headquarters to ensure that regional action is fully aligned with the GHSS for viral hepatitis, HIV and STIs for the period 2022–2030, including those systems supporting the measuring of progress towards the elimination goal.

WHO will support all forms of partnership across the Region to maximize synergies and collective momentum to support full implementation of the Integrated Action Plan.

WHO will implement the actions as listed below in support of the country actions outlined in respective chapters.

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| **#** | **Areas of implementation** | **Country actions** |
| **1** | Integration of viral hepatitis, HIV and STIs | At the regional and country levels, WHO will support full integration of efforts to address viral hepatitis, HIV and STIs through:   * leadership * partnership * driving awareness * adding efficacy * maintenance of norms and standards * direct technical assistance * supporting and driving innovation through partnerships * supporting countries in their efforts to measure progress towards ultimate elimination.   WHO will define the key elements of integration at the political level and within health systems and work to obtain buy-in in conjunction with other stakeholders. |
| **2** | Leadership and partnership | WHO will provide regional leadership across viral hepatitis, HIV and STIs, consisting of the following:   * close relations with Member States and programmes; * advocacy for adequate and sustained funding in the international and domestic space through convening of funding agencies to leverage financing; * ensure dedicated expertise and capacity on viral hepatitis, HIV and STIs at the regional and country offices to ensure that support is provided in and for the countries with the highest disease burdens; * lead advocacy on the need to address the disease burden in populations disproportionally affected, such as key populations. |
| **3** | Advocacy and awareness | WHO will strongly advocate for integrated action and building of awareness to address viral hepatitis, HIV and STIs in the Region through all its activities including:   * driving thematic development and partnership for World Hepatitis Day to raise awareness in the affected and general communities; * developing communications toolkits and providing guidance; * partnering with the World Hepatitis Alliance and other agencies to pool messaging resources and maximise reach; * work with partners in strong advocacy to convince governments that legal regulatory reforms are essential for the achievement of elimination; * partner with civil society and community organizations and other stakeholders to eliminate the stigma and discrimination associated with viral hepatitis, HIV and STIs in the Region. |
| **4** | Norms and standards | Through collaboration with WHO offices globally, the WHO Regional Office for SE Asia will:   * contribute to the development of evidence-based normative guidance and other relevant tools and service delivery approaches for viral hepatitis, HIV and STIs, and aid their dissemination to countries in the Region; * support countries to align their national guidance in viral hepatitis, HIV and STIs with recommended WHO norms and standards; * support countries to develop tools and systems for measuring progress towards and the ultimate validation of the elimination of viral hepatitis, HIV and STIs in accordance with global 2030 goals; * support the development of regional laboratory networks and standards to support quality management systems for laboratories. |
| **5** | Innovation | WHO will engage at the highest levels with partners including research institutes to ensure that the Region has access to the most recent innovations in viral hepatitis, HIV and STIs. This includes but is not limited to the following:   * innovations in service delivery, including the use of new tech digital technologies; * innovations in testing including new rapid tests and other means to improve access to screening, especially among key populations; * innovations in treatment including new formulations for hepatitis antivirals, HIV antiretrovirals and the deployment in innovative ways including PrEP; * supporting efforts to ensure that all new innovations are adapted and implemented in a people-centred approach; * supporting the engagement of civil society and communities in the adoption of any new innovation. |
| **6** | Technical support | WHO will continue to provide technical support to Member States in SE Asia to support adoption, adaption and implementation of the IRAP at the country level by the following:   * support tailored technical assistance to individual countries to promote equity and sustained integrated action across viral hepatitis, HIV and STIs; * Identify key gaps in research and support collaboration across the Region; * work within WHO to support inter-programmatic collaboration for countries and other UN agencies with immunization and combating NCDs; * support national programmes to strengthen regulatory and procurement mechanisms to support reductions in cost and maintenance of product quality, including through the WHO prequalification mechanism. |
| **7** | Monitoring, reporting and validation of progress | WHO will set global standards and regional adoption for collecting, analysing and using health data related to HIV, viral hepatitis and STIs, and support countries to build the capacity of national health data platforms to measure progress.   * Support the standardized assessment on the situation and response to viral hepatitis, HIV and STIs including the development of national investment cases and other means of assessing the population-level, epidemiologic and economic impact of national responses. * Work with countries to prepare the tools necessary to measure progress in preparation for the validation of the elimination of viral hepatitis, HIV and STIs by 2030. * WHO Regional Office for SE Asia will report to the Regional Committee on progress in 2025 and at the completion of the Plan in 2027. |

# Financing of the Regional Action Plan

**To be completed: awaiting full regional analysis**

*This will be a new chapter in the RAP which did not figure in the earlier one. While we do not attempt a detailed costing of the NSPs at country level, a broad suggestion about the optimum resources needed to achieve the 2025 targets will be attempted. It will be built on the basis of unit costs of interventions wherever available with countries.*

For a sustainable response, the RAP must be fully funded as part of the broader efforts to increase overall investments in health at the national level. The responses to viral hepatitis, HIV and STIs face different financing challenges, which national financing systems must address. WHO Regional Office for SE Asia supports countries to achieve continued and predictable funding, reduction of catastrophic expenditures on health and affordable access to health commodities.

* Unit costs for service delivery in priority interventions
* Per capita expenditure on the three programmes
* Approximate commitment of resources at the national level for the countries
* International donors and resource availability
* New sources of financing and challenges.

Data will be extracted at the from the following document and further analysis undertaken as necessary: *WHO Global Health Sector Strategies on, respectively, HIV, Viral Hepatitis and Sexually Transmitted Infections, 2022–2030 – Draft Costing Estimates Methods (version as of 20 January 2022).*

<https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/who_ghss_2022-2030_draft-costing-methods-jan2022.pdf?sfvrsn=bc9d365e_7>

# Annexures

## Annex 1: Measurement framework

Tables A1–A5 present the shared and disease-specific impact indicators and targets across HIV, viral hepatitis and STIs and the sources for these data.Additional disease-specific indicators and targets are also presented in Chapter 3 (viral hepatitis), Chapter 4 (HIV) and Chapter 5 (STIs), respectively.

**Impact indicators and targets for HIV, viral hepatitis and STIs by 2025**

Table A1. Regional Integration indicators and targets for HIV, viral hepatitis and STIs for SE Asia by 2025 & 2030

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Integration indicator** | **Baseline 2020** | **2025 target** | **2030 target** | **Source(s)** |
| **Regional integration targets** | Number of countries that have taken a political decision to integrate the three national programmes of HIV, hepatitis and STIs | 2 | 11 | 11 | MoH |
| Countries which have prepared fully-costed NSPs for integrated response and identified finances for funding the same | 0 | 11 | 11 | MoH |
| Countries where the three programmes have been brought under a common umbrella of governance | 4 | 11 | 11 | MoH |
| Countries where the health workforce of the three programmes have been retrained to work across all the three programmes | 0 | 11 | 11 | MoH |
| Countries where the CHWs have been given legal status and recognition at par with government health workers | 1 | 11 | 11 | MoH |

Table A2. Regional Impact and coverage indicators, targets and milestones for viral hepatitis in SE Asia by 2025 & 2030

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Indicator** | **Baseline –**  **2020i** | **Targets –**  **2025** | **Targets – 2030** | **Disaggregation** | **Source(s)** |
| **Impact** | HBsAg prevalence among children younger than 5 years of ageii (proxy forincidence) – | 0.94% | 0.5% | 0.1% | Age, sex, geography | See source details and methodology in WHO Country Guidelines for the validation of the elimination of viral hepatitis25 |
| Number of new hepatitis B infections per year (incidence) | 256 700  13 per 100 000 | 130 000  5 per 100 000 | 42 000   2.5 per 100 000 | Age, sex, geography |  |
| Number of new hepatitis C infections per year (incidence) | 234 100  12 per 100 000 | 115 000  6 per 100 000 | 80 000  4 per 100 000 | Age, sex, geography, priority population |  |
| Number of new hepatitis C infections among PWID per year | 8 per 100 | 3 per 100 | 2 per 100 | Age, sex |  |
| Number of people dying from hepatitis B per year | 179 000 deaths  9 per 100 000 | 100 000 deaths  5 per 100 000 | 60 000 deaths  3 per 100 000 | Age, sex, cirrhosis or cancer status |  |
| Number of people dying from hepatitis C per year | 38 000 deaths  2 per 100 000 | 20 000 deaths  1 per 100 000 | 10 000 deaths  0.5 per 100 000 | Age, sex, cirrhosis or cancer status |  |
| **Coverage** | Hepatitis B – percentage of people living with hepatitis B diagnosediii/and treated (initiated vs viral load suppression) | 10.5%/4.5% | 60%/50% | 90%/80% | Age, sex, priority population | National programme |
| Hepatitis C – percentage of people living with hepatitis C diagnosed/cured | 9%/7% | 60%/50% | 90%/80% | Age, sex, priority population | National programme |
| Percentage of neonates who have benefitted from a timely hepB-BD vaccine and from other interventions to prevent the vertical (mother-to-child) transmission of hepatitis B virusiv | 54% | 70% | 90% | Age, sex, priority population | WUENIC |
| Hepatitis B vaccine coverage among children (third dose) in those <1 year of age | 91% | 90% | 90% | Age, sex, priority population | WUENIC |
| Number of needles and syringes distributed per PWIDv (common HIV/viral hepatitis indicator) | 157 | 200 | 300 | Sex | National programme |
| Percentage of opioid-dependent PWID who receive OST | TBD | 40% | 40% | Age, sex | National programme |
| Blood safety – proportion of blood units screened for bloodborne diseases | 80% | 100% | 100% | Geography | National programme |
| Safe injections – proportion of safe health-care injections | 93% | 100% | 100% | Geography |  |
| **Milestones** | **Planning** – number of countries with costed hepatitis elimination plans | 0 | 11 | 11 | N/A | MoH |
| **Surveillance** – number of countries reporting burden and cascade annually | 11 | 11 | 11 | N/A | MoH |
| **Elimination of vertical (mother-to-child) transmission** – number of countries validated for the elimination of vertical transmission of either HIV or hepatitis B or syphilis | Confirm | 5 | 11 | N/A | MoH |
| **Elimination** – number of countries validated for elimination of hepatitis C and/or hepatitis B | 0 | 2 | 11 | N/A | MoH |
| **Integration** – proportion of PLHIV tested for/and cured from hepatitis C | To be determined | 60%/50% | 90%/80% | N/A | MoH |

i Latest data for end 2020. Some targets use data from 2019 because of COVID-19 related service disruptions in the data reported for 2020

ii Please note that the targets in this table are based on global targets and should be adapted to set targets for countries in relation to the national context. For example, in some countries a target for HBsAg prevalence among children younger than 5 years may be less than 0.1% or 0.2%, although the overall regional target should be 0.1%.

iii Denominator is estimate number of people living with hepatitis B virus (standardized population estimate)

iv In addition, the proportion of infants younger than 12 months of age who received the third dose of hepatitis B vaccine should also be measured as well as other indicators for preventing vertical transmission such as maternal testing and prophylaxis.

v As part of a comprehensive harm reduction strategy and in line with national priorities.

Table A3. Regional impact and coverage indicators, targets and milestones for HIV in SE Asia, by 2025 and 2030

|  | **Indicator** | **Baseline – 2020i** | **Targets –**  **2025** | **Targets –**  **2030** | **Disaggregation** | **Source(s)** |
| --- | --- | --- | --- | --- | --- | --- |
| **Impact** | Number of people newly infected with HIV per year | 140 000 | 41 000 | 35 000 | Age, sex, priority population, province/state | WHO/UNAIDS reporting |
| Number of people newly infected with HIV per 1000 uninfected population per year (SDG 3.3.1) | Calculate | Calculate | Calculate | Age, sex, priority population, province/state | WHO/UNAIDS reporting |
| Number of children 0–14 years of age newly infected with HIV per year | TBD | TBD | TBD | Age, sex, priority population, province/state | WHO/UNAIDS reporting |
| Number of people dying from HIV/related causes per yearii (including disaggregation by HIV, cryptococcal meningitis, TB and severe bacterial infections) | 94 000 | 32 000 | 30 000 | Age, sex, priority population, province/state | WHO/UNAIDS reporting |
| Number of PLHIV dying from TB, hepatitis B and hepatitis Ciii | TBD | TBD | TBD | Age, sex, priority population, province/state | Multiple sources |
| Number of countries validated for the elimination of vertical (mother-to-child) transmission of HIV, hepatitis B, or syphilis | Confirm | 5 | 11 | Age, sex, priority population | WHO |
| **Coverage** | Percentage of PLHIV who know their HIV statusiv | 77% | 95% | 95% | Age, sex, priority population, province/state | National programmes, community-led monitoring |
| Percentage of people who know their HIV-positive status and are accessing ARTiv | 78% | 95% | 95% | Age, sex, priority population, province/state | WHO/UNAIDS reporting |
| Percentage of PLHIV receiving treatment, who have suppressed viral loadsiv | 91% | 95% | 95% | Age, sex, priority population, province/state | WHO/UNAIDS reporting |
| Percentage of people at risk of HIV who use combination prevention with a defined service package | Varies by key population. It is <50% on average | 95% | 95% | Age, sex, priority population, province/state | WHO/UNAIDS reporting |
| Condom/lubricant use at last sex with a client or non-regular partner | TBD | 90% | 90% | Age, sex, priority population | WHO/UNAIDS reporting, community-led monitoring |
| Number of needles or syringes distributed per PWIDv – common HIV/viral hepatitis indicator | 157 | 200 | 300 | Province/state | WHO/UNAIDS reporting |
| Percentage of PLHIV and people at risk who are linked to integrated health services, including STIs and viral hepatitis | TBD | 95% | 95% | Priority population | National programmes |
| **Milestones** | **Stigma and discrimination –** percentage of people living with viral hepatitis, HIV and STIs and priority populations who experience stigma and discrimination | TBD | Less than 10% | Less than 10% | Priority group | MoH, community led monitoring |
| **Laws and policies –** percentage of countries which have punitive laws and policies | Varied by population | <1 | <1 | By law and priority population | Published regulations |
| **Gender –** prevalence of recent (last 12 months) intimate partner violence among people aged 15–49 years | TBD | 11% | Less than 10% | Age, priority population | Survey |
| **Integration –** Percentage of people living with viral hepatitis, HIV and STIs linked to other integrated health services | TBD | 95% | 95% | Age, sex, priority population | National programmes |
| **Late-stage disease** – percentage of people starting ART with a CD4 count of less than 200 cells/mm3 (or stage III or IV)vi | 30% | 20% | 10% | Age, sex, priority population | National programmes |
| **Differentiated service delivery –** percentage of countries that have implemented a 6-monthly refill of drugs | TBD | 50% | 80% |  | National programmes |

i Latest data for end 2020. Some targets use data from 2019 because of COVID-19 related service disruptions in the data reported for 2020.

ii Disaggregated by disease coinfection

iii 2019 data

iv Achieved in all ages, sexes and focus populations

v As part of a comprehensive harm reduction strategy and in line with national priorities.

vi To achieve all people living with HIV should receive a CD4 test result, and at least 90% by 2025 and 95% by 2030

Table A4.. Impact and coverage indicators, targets and milestones for STIs, by 2025 and 2030

| **Indicator** | **Baseline – 2020i** | **Targets – 2025** | **Targets – 2030** | **Disaggregation** | **Source(s)** |
| --- | --- | --- | --- | --- | --- |
| Number of new cases of four curable STIs in adults (15–49 years) per year ('000) | 59 677 | 47 742 | 21 273 | Age, sex, priority population, geography | National programmes |
| Number of new cases of syphilis in adults (15–49 years) per year ('000) | 354 | 283 | 35 | Age, sex, priority population, geography | National programmes |
| Number of new cases of gonorrhoea in adults (15–49 years) per year ('000) | 21 059 | 16 847 | 2106 | Age, sex, priority population, geography | National programmes |
| Congenital syphilis cases per 100 000 live births per year | 145 | <200 | <50 | Age, male partners, priority population, geography | National programmes |
| Percentage of girls fully vaccinated with HPV vaccine by 15 years of age | 14% | 50% | 90% | Priority population, geography | WUENIC |
| Percentage of pregnant women attending ANC who were screened for syphilis/percentage treated if positive | 65%/71% | >85%/>90% | >95%/>95% | Age, sex, priority population, geography (district) | National programmes |
| Percentage of priority populationsii screened for syphilis/percentage treated if positive | No data/no data | >80%/>90% | >90%/>95% | Age, sex, priority population, geography | National programmes, community-led monitoring |
| Percentage of priority populationsii screened for gonorrhoea/percentage treated if positive | No data/no data | >20%/>90% | >90%/>95% | Age, sex, priority population, geography | National programmes, community-led monitoring |
| Percentage of women screened for cervical cancer using a high-performance test, by the age of 35 and again by 45 | No data/ | >40%/> | >70%/ | Age, sex, priority population, geography | National programmes |
| Number of countries reporting antimicrobial resistance in Neisseria gonorrhoeae to GASP | 36% | >60% | >70% | Country | MoH AMR programme |
| Planning: number of WHO Member States with national STI plans updated within the past 5 years | 50% | >70% | >90% | Country | MoH |
| Policies: number of WHO Member States with national STI case management guidelines updated within the past 3 years | 40% | >70% | >90% | Country | MoH |
| Surveillance: number of countries with strong STI surveillance systemsiii | No data | >50% | >90% | Country | MoH |

GASP – Gonococcal Antimicrobial Surveillance Programme

|  |  |  |  |
| --- | --- | --- | --- |
| *Table 7. Syphilis EMTCT targets23* | | **Disaggregation** | **Source(s)** |
| EMTCT impact target | Age, sex, priority population, geography | National programmes | A case rate of CS of ≤50 per 100 000 live births |
| EMCT process targets | 1. Age, sex, priority population, geography | 1. National programmes | 1. ANC coverage (at least one visit) of ≥95% 2. Coverage of syphilis testing of pregnant women of ≥95% among those who attended at least one ANC visit 3. Adequate syphilis treatment of syphilis-seropositive pregnant women of ≥95% |

i Latest data for end 2020. Some targets use data from 2019 because of COVID-19 related service disruptions in the data reported for 2020.

ii Priority populations are defined by individual countries; for screening include men who have sex with men, sex workers and people living with HIV.

iii A strong surveillance system for sexually transmitted infections incorporates four core competencies: case reporting, regular prevalence assessments among antenatal care, men and priority populations, regular annual reviews of the causation of sexually transmitted infection syndromes and symptomatic data corrected for underreporting, and monitoring of antimicrobial resistance­ for *Neisseria gonorrhoea.*

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1. Including hepatocellular carcinoma caused by hepatitis B and C; cervical cancer caused by human papillomavirus, and other types of cancer caused by viral hepatitis and human papillomavirus. [↑](#footnote-ref-2)
2. While acknowledging the importance of viral hepatitis A and E, both of which cause acute viral hepatitis, the GHSS focus primarily on chronic viral hepatitis B and C. These two infections, which may lead to cirrhosis and hepatocellular cancer, account for 96% of all viral hepatitis mortality. Hepatitis D coinfection or superinfection accelerates progression of chronic liver disease but only in people living with hepatitis B. Further details are provided in Chapter 4. [↑](#footnote-ref-3)
3. it is noted that the specific harm reduction requirements may vary depending on the key population. Harm reduction interventions also include those which reduce sexual transmission as detailed in Implementation Area 1 and as well as diagnosis and treatment detailed throughout this document. [↑](#footnote-ref-4)
4. More details available in Chapter 9 “Financing of the Regional Action Plan”. [↑](#footnote-ref-5)
5. Noting target is 95% [↑](#footnote-ref-6)
6. Driven by the COVID-19 pandemic, the e-SACEP (State AIDS Clinical Expert Panel) mechanism in targeted districts caters for e-consultations with tertiary and peripheral antiretroviral treatment (ART) centres. [↑](#footnote-ref-7)