SEARO-WPRO REGIONAL CONSULTATION FOR DEVELOPING 2022-2030 GLOBAL HEALTH SECTOR STRATEGIES ON HIV, VIRAL HEPATITIS AND STI, 15-16 JUNE 2021

RECOMMENDATIONS AND CONCLUSIONS – SEARO REGION

The three interlinked Global Health Sector Strategies (GHSS) on HIV, Viral Hepatitis and Sexually Transmitted Infections 2016-2021, are coming to an end. Following the decision by the 148th Executive Board in January 2021, the 74th World Health Assembly (WHA) in May 2021 requested that WHO undertake a broad consultative process to develop new GHSS on HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030. The process for developing these strategies started in the final quarter of 2020 and is continuing through 2021 with a series of consultations with WHO Member States, communities and other stakeholders. The strategies will be drafted during 2021 and presented for consideration by the 75th WHA in 2022, through the Executive Board at its 150th session.

The new GHSS will bridge the gap between 2021 and the 2030 SDGs. Each epidemic requires strengthened political commitment and a renewed strategic focus to guide the final push to reach the Sustainable Development Goals. The WHO Department of Global HIV, Viral Hepatitis and Sexually Transmitted Infections Programmes (HHS) is working across all three levels of WHO through an integrated approach to developing these strategies, which will seek to preserve an individual approach to each disease area, while also emphasizing important synergies to be found in combatting HIV, viral hepatitis and STIs collectively.

Objectives

A consultation for the WHO regions of South-East Asia and the Western Pacific for the development of the 2022-2030 Global Health Sector Strategies on HIV, Viral Hepatitis and STI was held virtually on 15-16 2021. The objectives of the consultation were:

- to solicit input from Member States, communities and other stakeholders for the development of the 2022-2030 strategies, ensuring broad participation and ownership of the strategies;
- to establish a consensus on the main themes to guide development of the new strategies; and
- to align WHO's strategies with those of partners such as UNAIDS, GFATM and others.

Conclusions

The main discussion points and conclusions from the consultation are summarized below.

Common themes:

- Critical juncture to 2030 goals: The 2016-2021 implementation period of the GHSS on HIV, viral hepatitis and STIs has seen tremendous progress in the SEARO and WPRO regions; yet many gaps and inequalities persist. There has been a lack of focus and funding for viral hepatitis and STIs in the region in particular, despite the high disease burden. These diseases remain high priorities in both regions. There is need to recommit to SDG 2030 goals and accelerate the response by leveraging opportunities offered by integration, simplification and innovation. The health sector can be seen as driving these responses at the centre of a multisectoral approach.
- Integration with broader health systems, UHC and PHC: Integration and linkages of disease-specific programmes and services into wider health systems should take off from 'theory' to 'practice'. There are many examples of integration of disease responses with the broader universal health coverage (UHC) agenda in the regions, including through primary health care (PHC) platforms. On the ground, the litmus test of UHC is access to services for key populations. For integration to be effective, it requires a deliberate policy case and strategic planning, informed by burden of disease and cost analyses. Integration should consider the policy level, service level, and the community level. A good example of integration is triple elimination of vertical transmission of HIV, syphilis and hepatitis B infection. Other entry points for integration include HIV and MNCH, viral hepatitis and cancer, and STIs and antimicrobial resistance. UHC and disease specific goals and approaches are mutually reinforcing and

should be advanced together.

- Simplification and decentralization: Achieving elimination goals will require greater simplification and decentralization of service delivery; taking a public health approach. For patients, it is challenging to initiate diagnosis and treatment, and to adhere to treatment follow up, when there are too many complex models of care and delivery systems to navigate through. Simplification includes streamlining and simplifying guidelines, decentralizing services, finding efficiencies by identifying which situation requires specialist care, providing integrative training for human resources with task sharing. These evolutions will be critical to deliver client-centred care.
- Community engagement: The involvement of communities in design, delivery, advocacy and monitoring are at the core of UHC and critical to achieving health equity. This should be clearly articulated in the new GHSS. There is need for clearer guidance on what is meant by community system strengthening, and the differences among community-led, community-based and community-friendly approaches. There is also need for sustainable financing, formal recognition of community providers as part of the response, referral pathways, and an enabling environment that engages communities in an equal partnership. Communities also play a role in accountability, e.g. with community score cards, and in expanding health literacy in the community.
- COVID-19 context: 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 communities. These approaches present opportunities to amplify progress achieved to date, to reach those who have been left behind, and to "build forward better" in a more equitable and inclusive manner.
- Virtual interventions: The use of various virtual interventions also offers opportunities for wider outreach. Approaches such as telemedicine and the use of social media platforms and tools play an important role in delivering health information and demand generation, reaching people more widely, and improving retention in care, as was witnessed through the outreach activities undertaken by communities in response to the COVID-19 pandemic. This is particularly important to reach and retain young people.
- People-centred approaches: Tailored approaches, with differentiated interventions and delivery models for different population groups, including key and affected populations, are essential to leave no one behind. A focus on young people is also important, for example by providing comprehensive sex education for all young people and access to sexual health services, leveraging the massive expansion in the use of social media expansion that has occurred in recent years.
- Strategic information – 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 data analysis and use at 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 an IT-enabled M&E framework.
- Stigma and discrimination: 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. This requires continued efforts to identify the drivers of discrimination in each country, implement rights-based approaches, and remove the social and structural barriers that prevent people from accessing services.

HIV:

- The HIV response presents a good platform for integration of services through its many approaches, including multisectoral partnerships, the engagement of affected communities including key populations, the emphasis on decentralization of services, the importance of strategic information and the robust governance structures.
- HIV prevention targets are lagging behind. It is time to use innovation and advances in service delivery, such as community-based testing, self-testing and other self-management and care approaches. HIV programme targets should cover not only clinical interventions, but also include clear targets for prevention interventions.
- Service delivery can be simplified to address HIV and comorbidities, for example, by simplifying HIV/HCV treatment initiation, using multi-month dispensing, physical co-location of services.
- In the next phase of the HIV response, it is imperative to plan, deliver and monitor through an 'inequalities lens', and working proactively to limit barriers to equitable service coverage among the most marginalized communities
- The engagement of the private sector with reporting to national authorities must be emphasized.

- There is a need to clarify the phrasing of “end HIV” or “end AIDS” as a public health issue. The use of the phrase “end HIV” should be defined with engagement of people living with HIV.

Viral hepatitis:
- There has been major progress in addressing hepatitis B and C in the region, in particular in providing the hepatitis B birth dose vaccination to newborns.
- The tools required to eliminate hepatitis B and C as major public health concerns are largely already available, and addressing viral hepatitis can be seen as a “low hanging fruit” in the region. There is a need for simplification and for moving away from the complex care models that have been used high-income countries.
- There is need for stronger political commitment and funding to address viral hepatitis in the regions, as well as to advocate for social and public policy reform and ensure that viral hepatitis is treated as a health issue within a broader social context.
- The opportunity provided by the GHSS 2016-2021 has not been fully leveraged and adopted so far.
- There has been a lack of investment in community organisations for the hepatitis response. The new strategies should clearly articulate the importance of partnerships and the engagement of people living with viral hepatitis, drawing on lessons learned from the HIV response.
- There is a need to call out why some countries are still having to pay prohibitively high costs for hepatitis C treatment despite these medicines being affordable. Further, in some countries, prescribers are also selling the medicines, potentially leading to a conflict of interest.

STIs:
- There has not been enough focus on STIs in the past decade and the link between STIs and HIV has been lost. Strong political commitment, greater public attention and evidence-informed policy making are critical.
- STI services need to be included in the primary health care service package funded by the government, health insurance, essential medicine list, standard health education curriculum, integrated laboratory network, and integrated health promotion interventions.
- A combination prevention approach can be applied for STIs, drawing on lessons learned from HIV. Further, HIV screening and referral systems, partner notification and social network approaches, and outreach, can be used as platforms for the delivery of services for other STIs.
- The introduction of one-stop shops for STI services at point of care, including prevention, testing, referral, treatment and care, is an important approach to expand access.
- Stigma and conservative social beliefs and values are an impediment to comprehensive sexuality education in schools in many countries, and this issue should also be explicitly addressed in the new GHSS.
- Mathematical modeling can project disease trends and provide intervention scenarios with estimated impact to inform evidence-based decision making and strategy development for the STIs.
- Pilot projects with intensive intervention can generate a success model for STI service delivery in a local context, that can be replicated to other sub-national areas or countries.
- The STI GHSS should include reference to strategies to manage antimicrobial resistance (AMR), and growing awareness on AMR could be leveraged to catalyze support for STI interventions.

Additional points raised specific to the SEARO region:
- Several opportunities for linkages and integration of service delivery in the region were highlighted during the group work:
  - Integrated primary prevention of sexual transmission of HIV, viral hepatitis and STIs, with interventions such as male and female condoms and lubricants, comprehensive sexuality education etc.
  - A comprehensive package of harm reduction services for people who use drugs to prevent the transmission and acquisition of HIV and viral hepatitis A, B and C, as well as other blood-borne infections.
  - Prevention of vertical transmission of HIV, hepatitis B, and syphilis
  - Differentiated service delivery models that simplify and adapt service provision to the diverse needs and preferences of beneficiary populations.
  - Community-led and community-based services, particularly among key populations, as an integral part of effective primary health care, and an essential complement to facility-based services.
- There is a need to improve and enhance the certification and accreditation of community-led providers as a part of the national health system.

- There is a need to ensure that impact indicators are feasible for countries to monitor.
- Financing is an important priority for the region. There is need to expand fiscal space and also to find cost efficiencies without losing focus on essential disease-specific needs.
- A regional action plan that accompanies the GHSS is useful for providing more detailed and operational guidance for Member States.

Recommendations for Member States

1. Leverage UHC, PHC and health systems by strengthening the national public health platform, referral mechanisms, public-private partnerships, and multisectoral action across the health sector and beyond. Conduct situational analyses to optimize the delivery of HIV, viral hepatitis and STI services as part of UHC and PHC.
2. Promote integration of HIV, viral hepatitis and STI services under one umbrella as part of the essential health service package, with a common strategy across the diseases, and integrated service provision rather than vertical approaches.
3. Promote awareness and demand creation and reduce stigma, by building health literacy among marginalized or vulnerable groups, such that people are comfortable to speak about the impact of these infections in their daily lives, their families and communities.
4. Strengthen health information and surveillance systems, integrate them at sub-national and national levels, and improve reporting on all three disease areas; including strengthening local data availability and granularity by population and location.
5. Allocate greater resources to community-led interventions and support the sustainability of community networks and organisations.
6. Implement patient centered service delivery models that are differentiated to the needs of populations and settings, that apply task sharing and decentralized approaches, and integrate services as feasible and relevant.
7. Apply the inequalities lens to prioritization, programming and monitoring to ensure access for all, including key and affected populations, homeless people, migrant populations, prisoners, orphans and children.
8. Ensure the protection of human rights for service providers and beneficiaries.
9. Develop country-specific guidelines for the management of viral hepatitis that support the extension of services to the primary healthcare level, with tertiary care to manage difficult cases; as a means to achieve equity and access.
10. Demonstrate micro-elimination among subpopulations based on risk factors, higher prevalence, and simplification of guidelines.
11. Promote a multisectoral approach in the health sector (e.g. including HIV, Viral Hepatitis, TB, Cancer, MCH, reproductive health, dermatology, blood safety, etc.) and beyond the health sector (social welfare, labor, school education, workplace, prison).

Recommendations for WHO Secretariat

1. Provide guidance to Member States for operationalizing the new GHSS 2022-2030 at national level.
2. Provide operational guidance for community system strengthening that clearly define community-led, community-based and community-friendly approaches, and include the role of communities in decision-making.
3. Provide operational guidance for the provision of integrated services, including the service delivery unit cost, and an integrated M&E framework.
4. Provide guidance on innovations, including virtual innovations, and on the use of new evidence and tools, such as PrEP, self-testing, etc.
5. Provide support to Member States to integrate HIV, viral hepatitis and STI services in the context of UHC, PHC and health systems.
6. Provide support to Member States to advocate at higher levels (including different ministries) to leverage additional funding and commitment, in particular to raise the profile of viral hepatitis and STIs and bring them

under national UHC initiatives.

7. Leverage existing HIV and integrated surveillance systems to include viral hepatitis and STIs, and identify indicators that are feasible to collect and use. Provide guidance for strengthening local outcome measurement for HIV, viral hepatitis and STIs for tracking as well as assessing local resource needs.
8. Provide guidance for a comprehensive strategy elimination of stigma and discrimination.
9. Simplify guidelines for care and treatment as much as possible, identifying and removing interventions (e.g. related to testing and patient monitoring) that are not critical, and expanded use of point-of-care testing and decentralized service delivery in communities and through mobile clinics (e.g. allowing for hepatitis treatment prescription by registered nurses).
10. Encourage full participation of private sector players and civil society in service delivery, including promoting better engagement to provide quality services at each level. This includes involving clinical societies and associations and health-related policy makers.
11. Work closely with governments and partners such as GAVI to promote wider access to the HPV vaccine.
12. Ensure that the new GHSS not only provide strategic direction, but are also documents that can drive motivation and be used for advocacy.

Annex 1: Agenda

PROVISIONAL AGENDA

WHO Joint Regional Consultation
Western Pacific and South-East Asia Regions
Global Health Sector Strategies for
HIV, Viral Hepatitis and Sexually Transmitted Infections
15-16 June 2021

Time (CEST)	**Item**	**Presenter**
Day 1 15 June 2021 Moderator: Dr Mukta Sharma		
06:00-06:15	Introduction • *Welcome and opening remarks* • *Review of meeting objectives and agenda*	Dr Huong Tran Dr Meg Doherty
06:15-07:00	Review of existing strategies *The meeting will begin with a quick recap of the existing strategies and their implementation* • *Implementation and achievement of targets* • *Perspectives from national stakeholders (5 min each)* - *SEARO: Indonesia* - *WPRO: Malaysia* • *Perspectives from community and civil society representatives (5 min each)* - *APCOM* - *CEVHAP* • *Discussion*	Dr Meg Doherty National representatives (MOH) Community and civil society representatives
07:00-07:45	Panel discussion: key issues in the regions *The panel will discuss strategic issues, challenges and bottlenecks for HIV, viral hepatitis and STIs across the two regions* • *Accelerating the UHC journey of HIV, Hepatitis and STI elimination (5 min)* • *Key issues in HIV (5 min)* • *Key issues in viral hepatitis (5 min)* • *Key issues in STIs (5 min)* *Moderated discussions*	Dr Prasada Rao Mr. Eamonn Murphy Dr Margaret Hellard Dr Xiangsheng Chen
07:45-08:00	Break	
08:00-08:45	Proposed 2022-2030 GHSS *WHO HQ will present the proposed structure and content of the 2022-2030 GHSS* *Discussions and Q&A*	Mr Andy Seale, HQ
08.45-8.50	Summary of key discussion points from Day 1	Dr Naoko Ishikawa

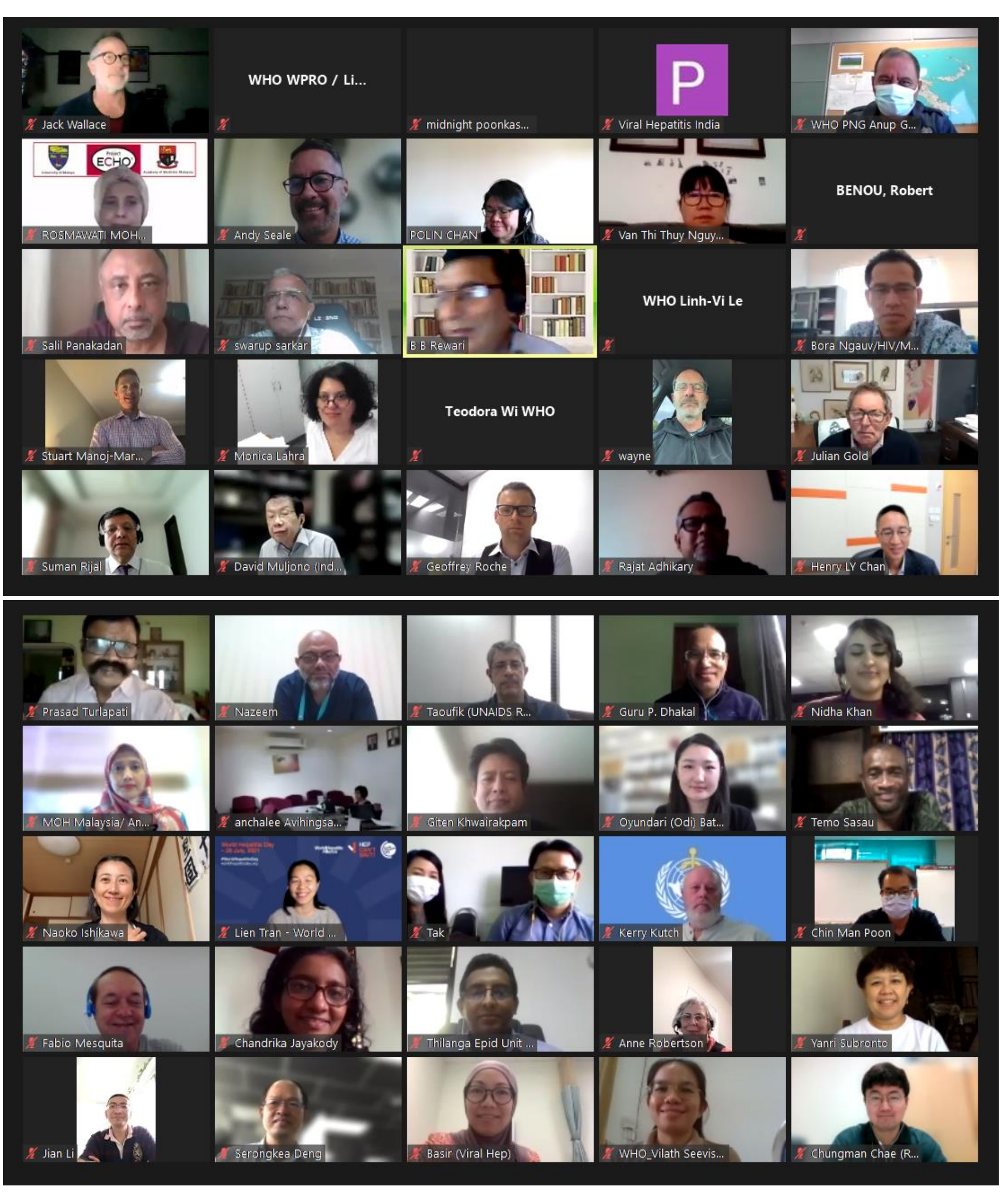
08:50-09:00	Guidelines and instructions for discussion groups • *Briefing for break-out sessions on day 2*	Dr BB Rewari
DAY 2 **16 June 2021** **Moderator: Dr Po-Lin Chan**		
06:00-06:15	Migration to break-out rooms • *Participants will gather in plenary before going to their assigned break-out rooms*	Dr Kerry Kutch
06:15-07:30	Small group discussions *The meeting will reconvene into five break-out groups: one each for HIV, hepatitis and STIs, plus one for each region. This will allow maximum participation within groups for individual participants. Discussion questions will be provided in advance. Facilitators and rapporteurs will be pre-identified for each group.*	Facilitators
07:30-07:45	Break	
07:45-08:30	Plenary – report back from discussion groups *The meeting will reconvene in plenary to hear reports back from the break-out groups. Presentations will be limited to 5 minutes and 10 bullet points. Common themes will be identified by disease area.*	Facilitators
08:30-09:00	Wrap-up and closing • *Closing remarks*	Dr Suman Rijal

Break-out Groups (day 2)

No.	Room	Discussion Area	Facilitators	Notetakers
1	Hanoi	Priorities for HIV	Swarup Sarkar (tbc)	S. Deng
2	Bangkok	Priorities for viral hepatitis	Ben Cowie	V. Nguyen
3	Jakarta	Priorities for STIs	Chen Xiangsheng (T.Wi)	K. Izumi
4	Delhi	Priorities for SEARO	Salil (TBC)	R. Adhikary
5	Manila	Priorities for WPRO	Julian Gold	T. Mahatmi

Annex 2: List of participants

(SEARO-WPRO colleagues to kindly add)



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Fabio Mesquita
Chandrika Jayakody
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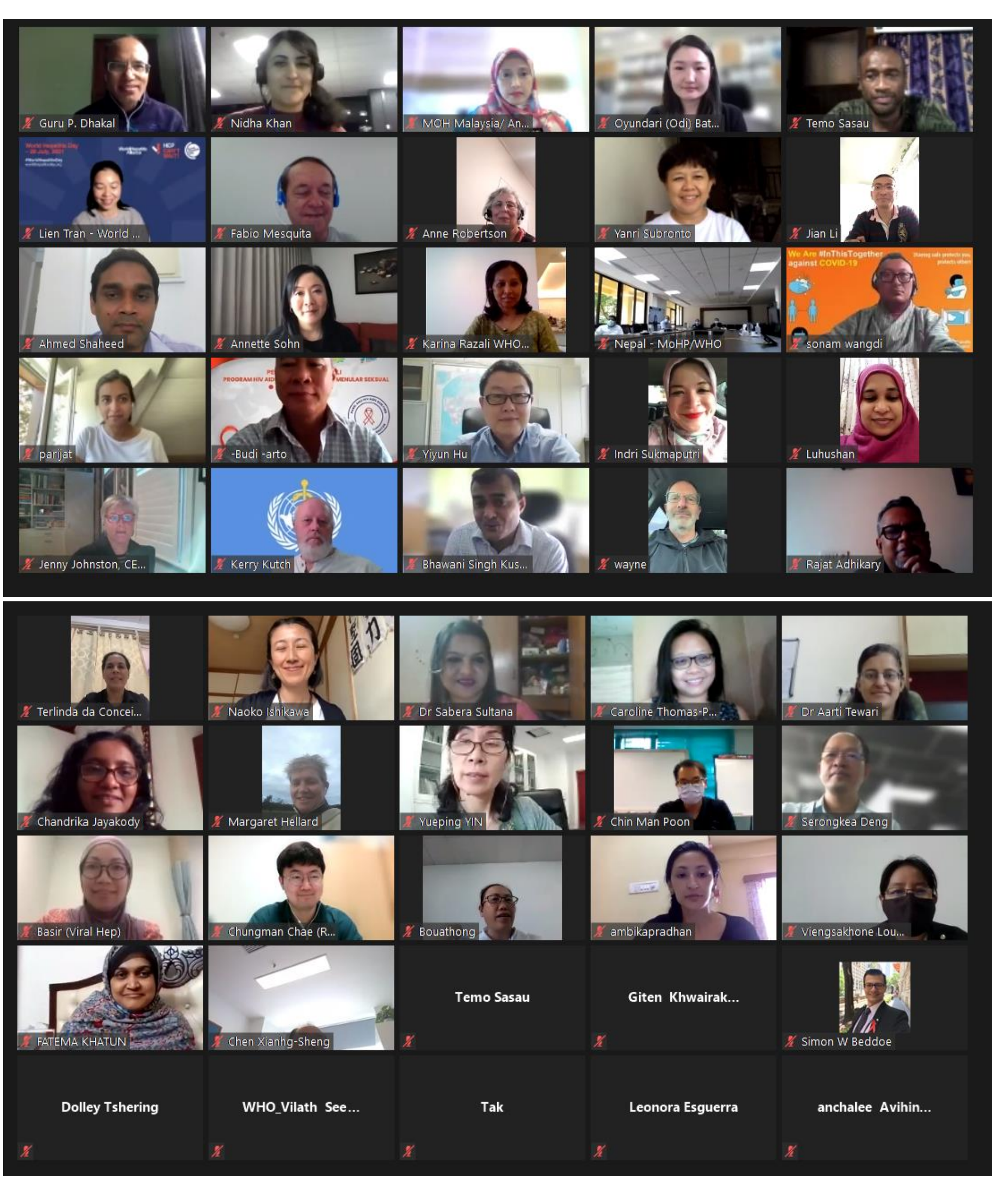
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Naoko Ishikawa
Dr Sabera Sultana
Caroline Thomas-P...
Dr Aarti Tewari
Chandrika Jayakody
Margaret Hellard
Yueping YIN
Chin Man Poon
Serongkea Deng
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Viengsakhone Lou...
FATEMA KHATUN
Chen Xianhg-Sheng
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