Getting to 90-90-90 in Asia and the Pacific

11th Regional Management Meeting,
UNAIDS Regional Support Team for Asia and the Pacific

25 October 2014, Bangkok
Setting the scene:

90-90-90: ambitious treatment targets to help end AIDS in Asia and the Pacific

Dr. Michael Cassell, Regional HIV and TB Advisor, U.S. Agency for International Development, Regional Development Mission Asia
The commitment:
2011 Political Declaration

ZERO NEW HIV INFECTIONS.
ZERO DISCRIMINATION.
ZERO AIDS-RELATED DEATHS.
Treatment saves lives: AIDS-related deaths are declining in Asia and the Pacific

People receiving ART

AIDS-related deaths, Asia and the Pacific, 2001-2013

Getting to zero

New tools, old challenges

Treatment as Prevention (TasP)
Immediate antiretroviral therapy for HIV-positive partner

Medical male circumcision

Tenofur/emtricitabine oral pre-exposure prophylaxis

Pre-Exposure Prophylaxis (PrEP)


Estimated millions of people eligible for ARV in LMIC in 2012

Scenarios of ARV eligibility

ART regardless of CD4 count for:
- Serodiscordant couples
- Pregnant women
- Children < 5 years

Source: WHO 2014

Total ART coverage
Gap

Eastern Europe and Central Asia
Middle East and North Africa
South and South-East Asia
Caribbean
Latin America
Sub-Saharan Africa
A “crystal-clear” roadmap...

90% diagnosed

90% on treatment

90% virally suppressed

...by 2020...

Getting to zero
…and the promise

73% of all people living with HIV will be virally suppressed

…a three-fold increase over current estimates...

…an end to the AIDS epidemic by 2030.
HIV testing is the entry point for treatment, but testing coverage among key populations remains low

HIV testing coverage among key populations
(Asia-Pacific regional median trend*)

HIV testing coverage (%)

* latest available data from UNGASS/ Global AIDS Response Progress Reporting (GARPR) 2010 to 2014

Source: Prepared by www.aidsdatahub.org based on www.aidsinfoonline.org
ART coverage (%) = \( \frac{\text{Number of people receiving ARVs}}{\text{Total number of people living with HIV}} \) \times 100

Trends in antiretroviral therapy coverage 2011-2013

The HIV cascade: assessing and improving public health impact with routine program data

Opportunities for PrEP, other prevention efforts

Opportunities for TasP

Getting to zero

Source: WHO, HIV, UNIVERSAL HEALTH COVERAGE AND THE POST-2015 DEVELOPMENT AGENDA
The HIV cascade in China, 2012

The HIV cascade in Vietnam, 2012

Point of care diagnostics

The role of oral-fluid rapid tests in increasing HIV testing and counseling coverage among men who have sex with men in Wuhan, China

Oral-fluid screening on site
6108 clients screened, 360 (5.9%) reactive

Rapid test in drop-in center
1256 clients screened, 90 (7.2%) reactive

Source: The Bill and Melinda Gates Foundation/WHO
Service coalitions to improve cascade outcomes

Community response

Need approaches and systems to support collaborative action and links

Local coordination body

Community member

HTC or other facility

ART site

Getting to zero
Mobile solutions

Outreach worker engages a client, records data in mobile application

In next engagement, outreach worker sees client progress in app.

Progress from each step is tracked in cloud database

SMS messages are sent to client’s phone, reminding about referral -- until visit is completed

Data

This client is given a referral to a clinic. But this link is not simply dropped:

Referral is sent to clinic’s phone app, providing records on expected arrivals.

When client arrives, clinic marks referral as successful

Getting to zero
“Right-sized” service decentralization

When (and how best) to link clients to ART and other services vs. bringing ART and other services to them?

A New Multidisciplinary Home Care Telemedicine System to Monitor Stable Chronic Human Immunodeficiency Virus-Infected Patients: A Randomized Study

Agathe León¹, César Cáceres², Emma Fernández¹, Paloma Chausa³, Maite Martin³, Carles Codina³, Araceli Rousaud³, Jordi Blanch³, Josep Mallolas¹, Esteban Martinez¹, Jose L. Blanco¹, Montserrat Laguna¹, Maria Larrousse¹, Ana Milinkovic¹, Laura Zamora¹, Neus Canal⁵, Josep M. Miró¹, Josep M. Gatell¹, Enrique J. Gómez², Felipe Garcia¹

1 Infectious Diseases Unit, Hospital Clinic, Institut d’Investigacions Biomèdiques August Pi i Sunyer, University of Barcelona, Barcelona, Spain, 2 Biomedical and Telemedicine Unit, Technical University of Madrid, Madrid, Spain, 3 Pharmacy Service, Hospital Clinic, Institut d’Investigacions Biomèdiques August Pi i Sunyer, University of Barcelona, Barcelona, Spain, 4 Clinical Institute of Psychiatry and Psychology, Hospital Clinic, Institut d’Investigacions Biomèdiques August Pi i Sunyer, University of Barcelona, Barcelona, Spain, 5 Health Economics and Outcomes Research, IMS Health, Inc., Barcelona, Spain

Abstract

Background: Antiretroviral therapy has changed the natural history of human immunodeficiency virus (HIV) infection in developed countries, where it has become a chronic disease. This clinical scenario requires a new approach to simplify follow-up appointments and facilitate access to healthcare professionals.

Methodology: We developed a new internet-based home care system covering the entire management of chronic HIV-infected patients. This was called Virtual Hospital. We report the results of a prospective randomized study performed over two years, comparing standard care received by HIV-infected patients with Virtual Hospital care. HIV-infected patients with access to a computer and broadband were randomized to be monitored either through Virtual Hospital (Arm I) or through standard care at the day hospital (Arm II). After one year of follow up, patients switched their care to the other arm. Virtual Hospital offered four main services: Virtual Consultations, Telepharmacy, Virtual Library and Virtual Community. A technical and clinical evaluation of Virtual Hospital was carried out.

Findings: Of the 83 randomized patients, 42 were monitored during the first year through Virtual Hospital (Arm I) and 41 through standard care (Arm II). Baseline characteristics of patients were similar in the two arms. The level of technical satisfaction with the virtual system was high: 85% of patients considered that Virtual Hospital improved their access to clinical data and they felt comfortable with the videoconference system. Neither clinical parameters [level of CD4+ T lymphocytes, proportion of patients with an undetectable level of viral load (p = 0.21) and compliance levels >90% (p = 0.58)] nor the evaluation of quality of life or psychological questionnaires changed significantly between the two types of care.

Conclusions: Virtual Hospital is a feasible and safe tool for the multidisciplinary home care of chronic HIV patients. Telemedicine should be considered as an appropriate support service for the management of chronic HIV infection.

Trial Registration: Clinical-Trials.gov; NCT011117675.
Country Experiences
Cambodia’s experience in scaling up treatment with focus on innovative approaches along the cascade of continuum of care

Marie-Odile Emond  
Country Director, UNAIDS Cambodia  
25th October 2014
Third decade of national AIDS response

Cambodia 1.0
- First brothel-based prevention projects
- Condom social marketing started

Cambodia 2.0
- Started VCCT scale-up
- Started to scale up VCCT, HBC, ART

Cambodia 3.0
- Finger prick testing

Incident cases
- Mother to child
- Needle sharing
- Male-male sex
- Casual sex
- Wife->husband
- Husband->wife
- Sex work

HIV+ adults

Getting to zero
Targeting KAP at higher risk or unreached by services

<table>
<thead>
<tr>
<th>At risk +</th>
<th>At increased risk ++</th>
<th>At highest risk +++</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex workers</td>
<td>SW with &gt;7 clients/week</td>
<td>Injecting plus many sexual partners (paid and non-paid)</td>
</tr>
<tr>
<td>MSM</td>
<td>Male sex workers, MSM with many partners</td>
<td>and/or very high vulnerability</td>
</tr>
<tr>
<td>TG</td>
<td>TG with many partners (paid and non-paid)</td>
<td></td>
</tr>
<tr>
<td>People who use drugs</td>
<td>PWID</td>
<td></td>
</tr>
</tbody>
</table>

(Source: NCHADS, MOH Cambodia, 2014)
Number of people with HIV in need of ART and on ART aged 15+ (2000-2015)

Ongoing innovations

New technologies: interactive voice response, social media for KAP
Behavioural change communication under branded programme: Smartgirls (SW), Mstyle (MSM), Srey Sros (TG)

Needle & syringe new distribution models

Finger prick testing (by community peer)
Partner tracing/ risk tracing snowball approach
GIS mapping

Integrated active case management
Unique Identifier Code (KAP), mregistry

TrasPr

HBC: new model + HIV sensitive social protection (Health equity fund+, ID poor card access), linkages with other primary health care and health community system

Livelihoods: village & saving loans
Integrated active Case Management to accelerate case detection and maximize retention

- HIV screening (Outreach, finger prick, Point of care)
- HIV Confirmation Test
- Enrol. in care
- Retain pre-ART
- Start ART
- Retain Adher.
- Accelerate enrollment in Pre-ART
- Early/Immediate ART initiation
- Maximize adherence
- Village loan Support/s social protection

CSV = Community Support Volunteer

PMTCT
- Partner Tracing and Testing
- Treatment as Prevention
Community finger prick testing at Karaoke place, Siem Reap, May 2014
Evolution of HTC Procedures

2009-2012

Referral Hospital with VCT/ART
Pre-ART&ART (and Syphilis confirmatory at STD clinic)

Health Center with VCT
HIV 1st Test, Confirmatory Test (and Syphilis rapid test)

Sample referral
1st Test Result
Patient Referral if (+)

Antenatal Care & TB Services at Health Center without VCCT
Offer HTC and Blood Taking

2013 –

Referral Hospital with VCCT/ART
HIV Confirmatory Test at Pre-ART/ART

Client referral if (+)

Every Health Center & Hospital
Drop-in-Center & “Meeting Point” (Karaoke, Massage, Sauna, etc.)
by NGO worker/outreach worker
First HIV Test with Finger Prick

Getting to zero
## Finger Prick Testing Results: October 2013 – September 2014

<table>
<thead>
<tr>
<th>Key Population</th>
<th>Number of Individuals Tested</th>
<th>% HIV reactive</th>
<th>% enrolled in pre-ART/ART</th>
<th>Ave. CD4 count at diagnosis (cells/mm³)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EW</td>
<td>14,705</td>
<td>0.5%</td>
<td>71.0%</td>
<td>403.7</td>
</tr>
<tr>
<td>MSM</td>
<td>5,008</td>
<td>0.5%</td>
<td>77.8%</td>
<td>414.8</td>
</tr>
<tr>
<td>TG</td>
<td>255</td>
<td>2.7%</td>
<td>100%</td>
<td>573.8</td>
</tr>
<tr>
<td>PWID</td>
<td>442</td>
<td>3.4%</td>
<td>100%</td>
<td>437.0</td>
</tr>
<tr>
<td>PWUD</td>
<td>3777</td>
<td>0.5%</td>
<td>88.9%</td>
<td>304.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24,467</strong></td>
<td><strong>0.6%</strong></td>
<td><strong>79.4%</strong></td>
<td><strong>419.3</strong></td>
</tr>
</tbody>
</table>

- Performed by 760 trainer lay counsellor (SW), monitored by 51 trainees
- Lower prevalence – focusing on right places and people? Duplication?
- Earlier detection at higher CD4 count
Findings of Documentation on Finger Prick Testing

- **Good acceptance.** An effective approach in normalizing HIV and increasing demand for and uptake of HTC among key populations.

- An effective **entry point into the continuum of care**, increasing the efficacy of utilizing Treatment as Prevention.

**Challenges:**
- confidentiality
- low capacity of lay counsellors + high rotation affect quality of testing and counselling
- Duplication? how much?
- Unable to reach highest risk individuals through venue-based outreach approach
- Lost-to-follow up for confirmatory testing and enrolment in pre-ART/ART due to migration, stigma in health setting.
New Community-based prevention, care and support model: from NGO to PLHIV/community delivery

Social protection schemes targeting poor PLHIV: eg. ID Poor, New Community-based prevention, care and support model: from NGO to PLHIV/community delivery
Some lessons learned with innovations

- Procurement: e.g., test kits at right place and right time!
- Who implements? Trusted implementer with links with community and health services
- Confidentiality and human rights issues
- Systematic links with PLHIV and KAP community for trust, buy in and demand creation
- Human resources intensive – need, funding, capacity and stability + dedicated long term TA support
- Translate concepts into operations
- Data to monitor (gaps and use?) and adapt – better do it well that too quick
- Phase introduction: pilot -> review -> adapt -> train -> scale up
- Funding visibility, availability and flexibility for piloting+ scaling up – risk of low marginal direct cost/benefit but other potential returns.
- Sustainability?
- New buzz words: focus, streamline, integrate

*Paradox of Cambodia as an excellent incubator of innovations but still low capacity, need continued technical and financial partners support!*
Community perspective on access to treatment services
COMMUNITY SCIENCE AT WORK

Community Access to Treatment, Care, and Support Study (CAT-S) (Regional consolidation)

Omar Syarif, APN+
Background

- APN+ initiate to establish a pool of strategic information dedicated for PLHIV movement in Asia and The Pacific
- Implemented as part of APN+ Multi Country Proposal GF R 10 grants implementation in 2011
- Phase I completed by Sep 2013
What's in the name:

- Regional Information Portal on Treatment Access (RIPTA) - Monitoring Access to Treatment in Asia (MATA)
- Research on Access to treatment (RAT) - Community access to treatment (CAT)
Study Objectives

- To assess the HIV treatment-related issues such as access to pre-ART care, ART, ART adherence, treatment literacy, high risk behaviors, health seeking behaviors, etc.

- To develop baseline to monitor changes in the key issues in community access to treatment, care and support services

- Pre ART care
- Early diagnosis
- Access to CD4 and Viral Load
- Disclosure and stigma
- Reproductive health
- HIV risk behavior
- Cost of treatment
- Treatment of Hepatitis C
- Treatment Literacy
- ART adherence
<table>
<thead>
<tr>
<th>Framework/Method</th>
<th>Bangladesh</th>
<th>Lao PDR</th>
<th>Nepal</th>
<th>Pakistan</th>
<th>Philippines</th>
<th>Vietnam</th>
<th>Indonesia</th>
<th>Consolidated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td>600</td>
<td>530</td>
<td>1,598</td>
<td>525</td>
<td>1,320</td>
<td>1,615</td>
<td>1,655</td>
<td>7,843</td>
</tr>
<tr>
<td>Number of data collectors</td>
<td>15</td>
<td>11</td>
<td>14</td>
<td>11</td>
<td>14</td>
<td>15</td>
<td>18</td>
<td>98</td>
</tr>
<tr>
<td>Ethical approval</td>
<td>Medical Research Council (BMRC)</td>
<td>Center for HIV/AIDS and STI (CHAS)</td>
<td>Nepal Health Research Council (NHRC)</td>
<td>Bridge Consultants Foundation</td>
<td>DOH Ethics Committee (DREC)</td>
<td>Ha Noi School of Public Health</td>
<td>Atmajaya University</td>
<td></td>
</tr>
<tr>
<td>Start interview date</td>
<td>26-Nov-12</td>
<td>4-Jan-13</td>
<td>1-Oct-12</td>
<td>21-Nov-12</td>
<td>6-Nov-12</td>
<td>4-Dec-12</td>
<td>17-Nov-12</td>
<td>1-Oct-12</td>
</tr>
<tr>
<td>Average time to complete question in minutes</td>
<td>71</td>
<td>69</td>
<td>64</td>
<td>77</td>
<td>57</td>
<td>69</td>
<td>53</td>
<td>64</td>
</tr>
</tbody>
</table>
Respondents - Place of enrollment (%)
Respondents - Gender (%)
Respondents - Risk classifications (%)
Reasons for HIV test (%)

- Overseas working
- Spouse/partner/children get sick/death due to HIV infection
- Risky behavior
- Refer by a doctor
- Want to know
- Never choose, got result from a doctor

Countries: Bangladesh, Indonesia, Lao PDR, Nepal, Pakistan, Philippines, Vietnam, Consolidated
Place of initial HIV test (%)
Duration HIV diagnosis (years) &
Average of baseline CD4 count

<table>
<thead>
<tr>
<th>Duration of HIV diagnosis</th>
<th>Bangladesh</th>
<th>Indonesia</th>
<th>Lao PDR</th>
<th>Nepal</th>
<th>Pakistan</th>
<th>Philippines</th>
<th>Vietnam</th>
<th>Consolidation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 year</td>
<td>268</td>
<td>278</td>
<td>204</td>
<td>335</td>
<td>324</td>
<td>216</td>
<td>408</td>
<td>258</td>
</tr>
<tr>
<td>1-2 years</td>
<td>256</td>
<td>252</td>
<td>243</td>
<td>407</td>
<td>341</td>
<td>319</td>
<td>399</td>
<td>312</td>
</tr>
<tr>
<td>2-3 years</td>
<td>291</td>
<td>259</td>
<td>177</td>
<td>378</td>
<td>351</td>
<td>317</td>
<td>346</td>
<td>309</td>
</tr>
<tr>
<td>3 years or more</td>
<td>288</td>
<td>257</td>
<td>171</td>
<td>352</td>
<td>379</td>
<td>293</td>
<td>273</td>
<td>290</td>
</tr>
<tr>
<td>Total</td>
<td>281</td>
<td>259</td>
<td>181</td>
<td>361</td>
<td>367</td>
<td>281</td>
<td>292</td>
<td>292</td>
</tr>
</tbody>
</table>
Percentage of respondents who never had viral load test (%)
Never had viral load test VS Ever changed ART regimen (%)
Cost of health care

Sick Past 6 months (%)

Required Hospitalization (%)

Bangladesh
Indonesia
Lao PDR
Nepal
Pakistan
Philippines
Vietnam
Consolidated

Associated cost (USD)/ Episode
Average income (monthly) USD

Self reported average monthly income
## Access* to HIV prevention services

<table>
<thead>
<tr>
<th>Countries</th>
<th>% condoms (all respondents)</th>
<th>% clean needles and syringes (PWID)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>59.2</td>
<td>44.6</td>
</tr>
<tr>
<td>Indonesia</td>
<td>66.1</td>
<td>12.6</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>88.7</td>
<td>-</td>
</tr>
<tr>
<td>Nepal</td>
<td>51.3</td>
<td>5.9</td>
</tr>
<tr>
<td>Pakistan</td>
<td>63.6</td>
<td>15.0</td>
</tr>
<tr>
<td>Philippines</td>
<td>48.1</td>
<td>14.5</td>
</tr>
<tr>
<td>Vietnam</td>
<td>49.4</td>
<td>7.5</td>
</tr>
<tr>
<td>Total</td>
<td>57.4</td>
<td>10.6</td>
</tr>
</tbody>
</table>

* Available- every time when needed
## Self-reported ART Adherence

<table>
<thead>
<tr>
<th>Countries</th>
<th>% with &gt; 95% adherence</th>
<th>% never missed a dose</th>
<th>% missed an appointment of HCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>99.6</td>
<td>78.8</td>
<td>2.6</td>
</tr>
<tr>
<td>Indonesia</td>
<td>78.5</td>
<td>48.2</td>
<td>11.4</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>49.3</td>
<td>83.7</td>
<td>9.1</td>
</tr>
<tr>
<td>Nepal</td>
<td>72.7</td>
<td>70.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Pakistan</td>
<td>83.3</td>
<td>63.6</td>
<td>18.1</td>
</tr>
<tr>
<td>Philippines</td>
<td>88.2</td>
<td>58.2</td>
<td>9.9</td>
</tr>
<tr>
<td>Vietnam</td>
<td>70.1</td>
<td>60.3</td>
<td>12.7</td>
</tr>
<tr>
<td>Consolidated</td>
<td>76.3</td>
<td>62.9</td>
<td>9.7</td>
</tr>
</tbody>
</table>
Conclusions- Findings

- Indication of late diagnosis, Low CD4 at diagnosis
- Poor access to viral load counts – Monitoring of viral load is almost non-accessible in 7 countries
- Absence of VL count as part of ART program will reduce treatment effectiveness, and may increase risk of PLHIV morbidity and mortality rates
- Despite large scale funding for treatment - out of pocket costs of care is still a burden
Conclusions-Findings

- Access to prevention services need to be improved (Condoms, Needle and Syringes)
- Self-reported adherence is lower than 80% in 4 out of seven countries.

Visit http://apnmata.org for more data and stories
Ways forward

- Use of data from CAT-S in refining existing service deliveries as well as new programmatic approach (incl. funding allocation), especially during country’s NFM proposal development process;
- Continue expanding database, recognize and include human stories of PLHIV community as part of on-going community documentations; and
- APN+ continue to facilitate a community platform to interact, share and learn.
Encourage PLHIV National Network to develop country’s specific data analysis in partnership with key stakeholders (MoH, NAC, UNAIDS) to feed on new strategies towards new UNAIDS 90-90-90 target;

Initiate an innovative approach in addressing barriers to access HIV test service (i.e. community led testing)

Strengthening country’s Health System and infrastructure as in-country preparedness to implement full treatment cascade (including access to VL monitor, ARV drugs SCM, health financing approach for PLHIV)
Acknowledgement

- Asar Alo Society, Bangladesh
- National Association of People Living with HIV, Nepal
- Pinoy Plus, Philippines
- Association of People Living with HIV, Pakistan
- Lao Network of People Living with HIV, Lao PDR
- Vietnam Network of People Living with HIV, Vietnam
- GWL- INA, Indonesia

Full report and presentation can be downloaded at www.apnmata.org

For questions, comments etc get in touch at

sushil@apnmata.org
aor@apnmata.org

Thank you!
Young people and access to HIV services
What young people living with HIV in Asia Pacific are facing with?
• Knowing our HIV status..........

&

• Navigating healthcare systems......
Can we access HIV testing?

NO!

We face policy and legal barriers:

– Consent for minors to access HIV testing

– Punitive laws on homosexuality, transgressed expression, sex work.
Get lost in healthcare system

- Long queues
- Lack of linkages between ARV and other needed services - e.g., Interaction between HIV treatment and hormones therapy
- Lack of confidential services (service centers are publically known as HIV clinic, fear of disclosure if seen)
- No flexible operation hours
- Judgmental and discriminatory healthcare providers
What needs to be done to reach 90-90-90?

• Holistic, age-appropriate, confidential, nonjudgmental and nondiscriminatory health services are must!

• Adolescents and young people living with HIV have right to best possible treatment and related care, accessible, affordable, optimal and uninterrupted ARVs; and regular access to diagnostics and monitoring tests for HIV

• Peer support services to address treatment adherence and education, as well as mental health; sexual and reproductive health services have to be introduced

• PrEP should be included in the comprehensive package of services as per WHO Consolidated Guidelines recommendation
Closing the gaps in the HIV cascade
Cascade of HIV testing, care and treatment services in Asia: Closing the gaps

Yu Dongbao
WHO Regional Office for the South-East Asia
25 Oct., 2014
Metrics for monitoring the cascade of HIV testing, care and treatment services in Asia and the Pacific

- Developed & published by WHO WPRO/SEARO, CDC, USAID together with partners

- Objectives:
  - To assess and improve the effectiveness of HIV testing, linkages, and retention along the cascade of HIV, TB/HIV and PMTCT services at national and subnational levels;
  - To assist country program in prioritizing key indicators to monitor the cascade of HIV services from HIV testing to linkages to care and treatment.
What to measure?

**Cascade Indicators:**
- Aware of HIV status
- Uptake of HIV testing by: TB patients; pregnant women
- Ratio of newly enrolled to newly diagnosed
- Retention in pre-ART care
- Coverage of ART (overall, TB/HIV and PMTCT)
- Retention on ART
- Viral load suppression
- HIV+% infants

**Programme Indicators:**
- Uptake of HIV testing by KP (SW, MSM, PWID); partners; EID
- CD4 count at enrolment
- Timely initiation of ART
- On-time drug pick-up
- ARV stock out
How?

Analyse
Take
Triangulate
Action
Data

Identify
Gaps
Country example 1: HIV cascade in Indonesia, 2013

Key findings:
- ART coverage is low
- Data gap for unique identifier to report No. diagnosed, and viral test data

Source: GARPR, 2014
Key findings:
- Data complete
- High ANC coverage but low HIV testing among pregnant women
- Low PMTCT coverage
- Caveats about the national aggregated data and interpretation

Data source: GARPR 2014
Country example 1: TB/HIV services in Indonesia, 2009-2012

Key findings:
- TB incidence increasing
- TB/ART treatment increasing

Source: UNAIDS, aidsinfoonline.org. Data reported from WHO TB programme.
Country example 2: HIV cascade Myanmar, 2013

Key findings:
- Data gaps on HIV diagnosis, care and viral test.
- ART coverage is around one third.

Source: UNAIDS, WHO. GARPR, 2014
Country example 2: PMTCT in Myanmar, 2013

Key findings:
- HIV testing covers around 1/3 of the pregnant women
- PMTCT coverage for mother is good, but for infants not adequate or with data gaps.

Source: UNAIDS, WHO. GARPR. 2014
Country example 2: TB/HIV services in Myanmar, 2009-12

Key findings:
- TB incidence is increasing
- Sudden increase of HIV + rate in 2012, so was the number of ART/TB treatment.

Source: UNAIDS, aidsinfoonline.org. 2014
Viral Load scale-up in many public programs is starting

- Considering plans for public scale-up
- Feasibility analysis on VL. Funding secured in some cases
- Guidelines updated and funding secured. Piloting VL or recently rolled out a VL program
- Well established VL program. Scale-up to improve access

Countries: Lesotho, Uganda, Mali, India, Tanzania, Mozambique, Zimbabwe, Swaziland, Vietnam, Indonesia, Ethiopia, Zambia, Malawi, Kenya, Cambodia, China, Rwanda, South Africa, Brazil, Thailand, Botswana, India, Tanzania, Mozambique, Zimbabwe, Swaziland, Vietnam, Indonesia, Ethiopia, Zambia, Malawi, Kenya, Cambodia, China, Rwanda, South Africa, Brazil, Thailand, Botswana.

Source: CHAI, June 2014
However scale-up rates are too slow even with old targets – better strategies to deploy viral load are needed

To reach universal viral load access, smarter implementation is needed

Source: CHAI, 2014
Multiple levels of innovation are needed

**POLICY**
- Expanding Test and Treat to all PLHIV (not just <5yrs)
- Integrate HIV testing into other diseases/programs

**PROGRAM**
- Decentralize treatment to all places where testing is provided
- Community Education around importance of seeking care after testing
- Reinforce and strengthen mechanisms of referral between testing and treatment

**TECHNOLOGY**
- Technology solutions to improving the quality of rapid test services
- POC EID or CD4 to provide while-you-wait results and reduce LTFU
- Reducing turnaround time for centralized testing

**DATA SYSTEMS**
- Standardize and prioritize data management systems to improve program visibility and management

Source: CHAI, 2014
Conclusions and suggestions

● Significant gaps in both HIV services and data in most countries. Scaling up services (including VL test) and strengthening data needed.

● The cascade analysis useful for analysing gaps in HIV services and data.

● It provides snapshots of services and gaps when using cross-sectional aggregated national data.

● It may be more valuable if cohort data is available; it is more useful for subnational analysis, such as at site and district level.

● For M&E purpose, lack of Unique Identifier Code (UIC) is the one of the biggest barriers for most countries.

● Can be adapted by countries according to country context.
Thanks!