HIV in Asia – Transforming the agenda for 2012 and beyond

Report of a joint strategic assessment in ten countries

Final Report

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Clare Dickinson

June 2012

This Assessment was undertaken through collaboration between AusAID, UNAIDS, USAID, WHO, UNFPA, UNODC, UNDP, World Bank, ADB and the Global Fund. This report is the work of independent consultants and does not necessarily represent the views of the collaborating partners.
This Assessment was undertaken through collaboration between the Australian Agency for International Development (AusAID), Joint United Nations Programme on HIV/AIDS (UNAIDS), United States Agency for International Development (USAID), World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), United National Development Programme (UNDP), World Bank, Asian Development Bank (ADB) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). This report is the work of independent consultants and does not necessarily represent the views of the collaborating partners.
We would like to thank all the people we interviewed across the region, and in Geneva, for their gracious acceptance of our intrusion; their wisdom; and their keen interest in what we were doing. We learned much from them. We also appreciate the support we have received from the members of the Reference Group, and their guidance. It is important also to acknowledge the insight and hard work put into the design of the assignment, the detailed thinking that went into the terms of reference, and the support and encouragement we received along the way, from Robyn Biti and her colleagues in AusAID, and Jackie Mundy and her colleagues in the Health Resource Facility.

We especially appreciate the detailed, thoughtful and knowledgeable comments on our draft report we received from members of the Reference Group and their colleagues at country level.

This assignment built on, and we trust has taken forward, the work of UNAIDS in the region, first with the Report of the Commission of AIDS in Asia, and more recently with their Universal Access Stocktaking Report, and their Getting to Zero in Asia and the Pacific publication at the end of 2011. Much of the data and analysis comes from this work; our task was to try to find a useful new perspective on it.

We also need to recognise the courage and fortitude of the people of Asia, faced with the threat of HIV and AIDS. As one HIV positive ex-drug user put it to me: ‘We didn’t give up when we first realised what HIV was; we didn’t give up when there was no treatment; we didn’t give up when drugs were expensive, or difficult to access. Why should we give up?’ It is in the light of this courage and fortitude that we address the partners for who this report is written: do not give up.

‘We are now providing advice to the countries of the region for their programming for 2012; it is important that we give them 2012 advice, not 2006 advice.’

Comment from one Reference Group member, 2 May 2012
Acronyms

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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
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<td>APCASO</td>
<td>Asia-Pacific Coalition of AIDS Service Organisations</td>
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<td>APCOM</td>
<td>Asia Pacific Coalition on Male Sexual Health</td>
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<td>ANPUD</td>
<td>Asian Network of People who Use Drugs</td>
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<td>ART</td>
<td>antiretroviral therapy</td>
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<td>ARV</td>
<td>antiretroviral drugs</td>
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<td>ASAP</td>
<td>(World Bank) AIDS Strategy and Action Plan</td>
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<td>ASEAN</td>
<td>Association of South East Asian Nations</td>
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<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<td>BRICS</td>
<td>Brazil, Russia, India, China and South Africa</td>
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<td>CAA</td>
<td>Commission on AIDS in Asia</td>
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<td>CBO</td>
<td>community-based organisation</td>
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<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
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<td>CSO</td>
<td>civil society organisation</td>
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<td>DALY</td>
<td>disability-adjusted life year</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>ESCAP</td>
<td>Economic and Social Commission for Asia and the Pacific</td>
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<td>European Union</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunisation</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>Global Fund</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>HAARP</td>
<td>(AusAID) HIV/AIDS Asia Regional Program</td>
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<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>HLM</td>
<td>High-level Meeting</td>
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<td>INGO</td>
<td>International Non-Governmental Organisation</td>
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<td>Acronym</td>
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<tr>
<td>IPF</td>
<td>Indonesia Partnership Fund</td>
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<td>LIC</td>
<td>low income countries</td>
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<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>MCH</td>
<td>maternal and child health</td>
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<td>Millennium Development Goals</td>
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<td>middle income countries</td>
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<td>MSM</td>
<td>men who have sex with men</td>
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<td>NAC</td>
<td>National AIDS Commission/Council</td>
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<td>NAP</td>
<td>National AIDS Programme</td>
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<td>NCD</td>
<td>non-communicable diseases</td>
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<td>NGO</td>
<td>non-governmental organisation</td>
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<td>NASA</td>
<td>National AIDS Spending Assessment</td>
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<td>NSP</td>
<td>National Strategic Plan</td>
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<td>OST</td>
<td>Opiate Substitution Therapy</td>
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<td>PAHO</td>
<td>(WHO) Pan-American Health Office</td>
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<td>PEPFAR</td>
<td>The U.S. President’s Emergency Plan for AIDS Relief</td>
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<td>PHC</td>
<td>primary health care</td>
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<td>PMTCT</td>
<td>preventing mother to child transmission</td>
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<td>PWID</td>
<td>people who inject drugs</td>
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<td>RST</td>
<td>(UNAIDS) Regional Support Team</td>
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<td>SEARO</td>
<td>(WHO) South East Asia Regional Office</td>
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<td>SRH</td>
<td>sexual and reproductive health</td>
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<td>STI</td>
<td>sexually transmissible infection</td>
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<td>SW</td>
<td>sex workers</td>
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<td>TA</td>
<td>technical assistance</td>
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<td>TB</td>
<td>tuberculosis</td>
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<td>TOR</td>
<td>terms of reference</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United National Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNITAID</td>
<td>The International Drug Purchase Facility</td>
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<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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US CDC-GAP  United States Centres for Disease Control – Global AIDS Program
USG  United States Government
UNGASS  United Nations General Assembly Special Session
WHO  World Health Organization
WPRO  (WHO) Western Pacific Regional Office
3DF  Three Diseases Fund
Executive Summary

The Report of the Commission on AIDS in Asia of 2008 was a major step forward in identifying the need to shift Asian Human Immunodeficiency Virus (HIV) responses from ‘generalised’ programming to responses that focus increasingly on key populations at higher risk of HIV exposure – that is, men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW) and the clients and intimate partners of these groups (key populations). More recently, the international framework for intensifying action – the ambitious high-level meeting (HLM) targets adopted by the United Nations General Assembly (UN) in June 2011 and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Three Zeros strategy 2011–2015 – has been reaffirmed and adopted by the region. Data released by UNAIDS in 2012 demonstrates, in numeric terms, just how close the region could be to achieving these targets.

There is some evidence that responses are moving in the right direction but the pace of change must accelerate. Many countries are struggling to re-direct resources and focus their programs more strategically, hampered by a legacy of political, programming, funding and architectural issues. Unless responses focus on scaling up public health approaches that target the key populations and shed some of the generalised programming that still consumes significant proportions of HIV funding, the HLM targets will remain out of reach for many countries in the region.

This report represents a collaboration between the Australian Agency for International Development (AusAID), UNAIDS and co-sponsors United National Development Programme (UNDP), World Health Organization (WHO), United Nations Population Fund (UNFPA) and United Nations Office on Drugs and Crime (UNODC), United States Agency for International Development (USAID), the World Bank, the Asian Development Bank (ADB) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). This report is the work of independent consultants Peter Godwin and Clare Dickinson and does not necessarily reflect the views of the collaborating partners.

Findings of the assessment

**HIV continues to present a significant burden of disease in Asia**, particularly among adults. Unlike other communicable diseases, this burden will grow before it starts to reduce due to a large pool of already infected people, and the continuing transmission and spread of HIV. Epidemics in Asia are concentrated, complex and dynamic. Despite the diversity, several epidemiological trends are apparent in the region:

- **Incidence among men who have sex with men is rapidly becoming the largest single driver of the epidemic in the region.** Unless this is addressed, incidence in many countries will sustain significant prevalence levels.
- Incidence among people who inject drugs remains an important, if limited source of infection, exacerbating the overall, largely intractable, public health problem of illicit drug use.

- HIV is likely to remain endemic within the sex industry throughout the region, with significant continuing incidence among sex workers, the clients of the industry, and their sexual partners, again sustaining substantial prevalence levels.

- HIV in ‘closed settings’ (for example, prisons) and among transgender people, are neglected issues; substantial transmission occurs within closed settings, but little is done about it; and while transgender men and women are recognised as highly vulnerable and stigmatised, little is known or done for them.

- In all these situations, HIV is transmitted to intimate partners, who remain a substantial group of infected persons. Apart from limited mother-to-child transmission, however, there tends to be little transmission beyond these partners.

- A significant, long-term, chronic, treatment and care burden exists for the region, that is costly and has the potential to become even more so.

This situation presents a major public health challenge. HIV prevention services need to be at a scale that significantly impacts on new infection rates. Continuing prevalence rates present a significant and growing chronic treatment and care burden and increasing cost to the health sector. This is taking place in a region where the public health sector is chronically underfunded, and weak health systems struggle to deliver a continuum of care that is client-oriented and reaches key populations. HIV programs and services are still largely delivered ‘vertically’, which may deliver short-term results but in the long term are less sustainable and may constrain service linkages and efficiencies.

Global and regional trends are influencing current and future political priority and resources for HIV. The global economic crisis is forcing a more strategic investment approach to spending; there is a policy shift towards health systems strengthening with an attendant ‘push’ for the integration of HIV programs and sustainable public health investments. There are changing global priorities – both within and external to the health sector; particularly important, for example, will be a growing focus on non-communicable diseases (NCD), a significant and growing burden of disease in Asia. There are important economies of scale to be achieved through greater long-term integration of chronic care for HIV into NCD chronic care systems and approaches. The post Millennium Development Goals (MDGs) framework is likely to shift political attention and resources towards a new set of global priorities and shared goals which are unlikely to include a specific global target for HIV. India and China’s role as development actors in the region is growing in significance; their potential prioritisation and engagement in HIV needs further exploration. Sustained growth forecasts across the region may (or may not) result in sustainable financing solutions via increases in levels of domestic funding for HIV.

Substantial external financial investments have been made in HIV over the last decade with external funding accounting for 95 per cent of HIV funding in low income countries (LIC), and a significant proportion in some middle income countries (MIC) including Vietnam, India and
Indonesia. In 2009, the principal sources of external funding were bilateral (40 per cent), Global Fund (36 per cent) and Asian Development Bank (10 per cent). In 2009, Global Fund grants accounted for 5 per cent of HIV funding in Thailand, 41 per cent and 42 per cent in Cambodia and India respectively and 97 per cent of HIV funding in East Timor. External funds have been crucial in funding more politically ‘difficult’ programming areas targeting key populations, for covering treatment costs and much of the program management and architecture costs. Apart from Thailand, China and Indonesia (from 2012), the remaining Assessment countries rely largely on external funds for antiretroviral therapy (ART).

Levels of domestic funding for HIV are variable across the region ranging from 2 per cent in Laos, 10 per cent in Cambodia, 40 per cent in Indonesia to 93 per cent in Thailand. In 2009, the proportion of domestic funds allocated to prevention was: Cambodia, 78 per cent; the Philippines, 54 per cent; and Indonesia, 48 per cent. For care and treatment costs: Thailand, 80 per cent; Indonesia, 29 per cent; and Burma (Myanmar), 20 per cent.

Analysis suggests that substantial volumes of funds are still misdirected to generalised programming and prevention activities for low-risk populations. Where countries are increasing domestic expenditures, funds are largely being used to cover the costs of treatment. Despite high-level rhetoric to focus responses on key populations and, in certain cases, increasing fiscal capacity to pay, there is limited evidence that countries are substantially increasing domestic investments targeting key populations. This situation reinforces the over-dependence on external funding for this area of programming at a time when the trajectory of external HIV funding is one of decline. It also underscores the importance of generating political and social acceptance for policy and programming that targets key populations in the medium and long term, essential for long-term sustainable responses.

The strategic focus and conditions under which external funds are made available is changing. Bilateral donors are considering their future strategic, geographical, absolute levels and funding modalities for the region. The strategic focus of Global Fund grants and the conditions under which funds are made available is also shifting. There is a risk that if countries continue to depend on the Global Fund for un-strategic projects, support to the region will falter. With partners’ help, countries can start to develop forward-looking, focused funding strategies, in which Global Fund grants are used as targeted and effective investments. An ‘investment approach’ is strongly recommended, where all investments (whether financial, technical, or in policy and programming) are specifically directed at results linked to the HLM targets.

The HLM targets adopted by the UN General Assembly in June 2011 and subsequently by the Association of South East Asian Nations (ASEAN) offer a unique opportunity for the region. These are quantified, relatively reachable targets, based upon incidence – the measure of what is actually happening with the epidemic, with global and regional acceptance. Countries and development partners need to consider their roles and contributions in attaining the targets. This will involve regular assessments of the epidemiology and of the financing, policy and programming environments to make sure investments are sound, commensurate with the scale of the epidemics and aligned with the epidemiology. The targets present two opportunities: they are the natural
basis for a results framework for the region; and they have the potential to be used as a road-map for performance-based funding as the basis for continued investment by partners.

The most important threat to the funding situation is countries’ lack of appropriate long term, sustainable funding strategies which are currently resulting in very large financing gaps in many National Strategic Plans (NSPs) with no clear plan of how to fill them (for example, Laos is facing a shortfall of $48.5 million for 2012–2015; UNAIDS estimates $40 million as the average annual funding gap in the years from 2012–2014 in Burma [Myanmar]; Indonesia had less than 50 per cent [$65.6 million] the estimated funding requirement for the NSP in 2010).

Significant investments in HIV are producing important outcomes. Investments in HIV partnerships, policy, programming, architecture and the enabling environment have achieved widespread policy and strategy coherence in the region largely based on global norms; political and policy space in varying degrees which has enabled national HIV programs to be established in every country; the active support, development and involvement of civil society in the advocacy and delivery of HIV services; the establishment of multi-sector governance and coordination mechanisms, largely based on global norms, involving multiple stakeholders and sectors; important pragmatic solutions to overcoming socio-cultural and legal barriers to accessing services; and relatively rapid delivery of critical prevention, treatment and care services to key populations. Important outcomes have been achieved as seen in the stabilisation of the epidemic, falling HIV incidence in many countries and increasing coverage of services for key populations resulting in safer sexual and injecting behaviours (see median values below). There are now over 920,000 people receiving treatment in the region – well over triple the 2006 numbers.

- 83 per cent of people reached with interventions who inject drugs used a sterile needle and syringe at their last injection.
- 200,000 PWID access opioid substitution treatment.
- Pilot models suggest that men who have sex with men interventions can have good outcomes: 61 per cent of men who have sex with men used a condom at last anal sex.
- HIV testing is increasing among key populations: 33 per cent of SWs, 29 per cent of men who have sex with men and 22 per cent of PWID had an HIV test and know their results.
- Preventing mother to child transmission (PMTCT) programs have expanded: 30 per cent of pregnant women in the region received an HIV test in 2010.
- With respect to treatment, 39 per cent of those in need in the region receive ART.

Yet it seems unlikely that the HLM targets will be met. Median program coverage remains substantially below the 80 per cent target required to reduce prevalence. Estimates from UNAIDS suggest that only 17 per cent of PWID, 36.5 per cent of men who have sex with men, 41 per cent of female SWs and 32 per cent of HIV positive pregnant women are covered by appropriate prevention programs. In South Asia and East Asia and the Pacific, only 33 per cent and 48 per cent respectively of people in need, receive ART. Only Cambodia (92 per cent), Philippines (88 per cent), Laos (51 per cent), Thailand (67 per cent) and Papua New Guinea (54 per cent) provide treatment to those in need, and 2.4 million in need of treatment in the region are still not receiving it.
Achieving high levels of coverage with proven successful interventions is the critical challenge. Just as prevalence and incidence seem to have stabilised, so does programming. Key impediments to meeting the HLM targets include:

- **Policy ‘space’ has tended to be limited** to a view of the epidemic as a threat to the general population, or a substantive economic threat. The respect for, protection, and fulfilment of the human rights of key populations has not received the full commitment of human rights duty bearers, severely hindering effective programming for such groups. ‘Enabling environments’ remain largely constrained with respect to PWID, SWs and men who have sex with men. Investment in the enabling environment is still required but in the current funding environment, investments will need to be better focused, linked to pragmatic investments, have clear targets and build on models that have achieved results.

- **Governance and program architecture is outdated and inefficient**, hence the failure in their NSPs to actually prioritise resource allocations according to identified strategy. Vested interests, turf wars between programs, inefficient planning tools, clumsy bureaucracy and weak leadership challenge many programs. Additionally, this architecture is expensive, with management and administration costs accounting for more than 20 per cent of program costs in the Philippines, East Timor, Cambodia, Laos and Indonesia. Some 22 per cent of Global Fund grants and 21 per cent of all UN funding is used for management and administration. Attempts are being made to scale back architecture and/or make it more efficient but changes will take time, have significant political costs, and threaten program achievements. External funding has largely created, supported and is sustaining the architecture, but it is unclear how far development partners themselves recognise the weaknesses or have a vision or sense of responsibility to change it.

- **The picture on alignment and harmonisation of development priorities is mixed.** Overall, Country Reports and informants imply there is considerable alignment of development partner priorities behind national HIV strategies and programs; and harmonisation among partners, at least at national level, is reported to have improved over the last five years. There are examples of multi-partner pooled funding modalities (such as the Three Diseases Fund [3DF] in Burma [Myanmar] and the Indonesia Partnership Fund) that have worked reasonably well. The 3DF is reported to have galvanised development partners around the NSP and has helped bring in smaller partners that may want to commit funds but do not have the resources to set up office. But, there are numerous examples from the region that demonstrate how dependence on partners and multiple, largely vertical funding sources complicates national responses and challenges harmonisation and alignment, leading to high transaction costs, fragmentation of responses, weak comprehensive programming and by-passing of country systems.

- **The provision of timely, transparent and comprehensive information on aid flows** by development partners could be improved. Collecting data for the Assessment highlighted the problems in obtaining clear, coherent, up to date, multi-year (beyond 2013) financial data from development partners that matched government fiscal and reporting cycles. Pooled funding mechanisms such as the 3DF have the potential to increase the predictability of HIV funding from the mobilisation of additional resources and through attracting more risk-averse donors.
National plans are aspirational and resources are frequently misdirected. While there is a fairly widespread recognition that programming needs to respond more effectively to the epidemiological drivers, and resources need to be targeted, most country responses have found this difficult to do in practice. This is not only a fund allocation problem but is also likely to be a function of policy and architecture issues that constrain National Program Managers to make the very significant changes required to their plans and strategies. Deciding ‘how to cut your coat to fit your cloth’ is crucial for the region now. As the primary source of technical support for national strategic planning, UNAIDS must re-fit its approach to strategic planning to help countries be investment-oriented, focused on clear results in their programming and ensure logic chains underpin results frameworks.

Strategic information has improved but is still insufficient and measurement lacks coordination. Weaknesses in the development and effective use of strategic information as a program and resource allocation guide, has emerged as a key finding in this Assessment. Although significant investments in strategic information systems have been made, more data is required concerning key populations, and the growing use of incidence data, and the diversity of models used, needs better coordination and consensus throughout the region. Use of data to determine results and targets and to inform investment approaches and strategic priorities will grow in importance; yet lack of regional coordination and collaboration in the development of measurement, modelling and analysis, particularly of incidence, has a deleterious effect on country level programming.

Vertical HIV funding, programming and service delivery have resulted in rapid scale up, but with mixed impacts on health systems with many basic health system functions such as governance, financing, service delivery, planning, procurement and information systems being developed specifically for HIV, in parallel to those of the general health system. In only a few places has the HIV investment in laboratory services, procurement and supply chain management, quality assurance and community level support for adherence been absorbed into the general health system. Cambodia and Thailand are unusual in this respect and represent important examples for the region.

There is a strong case to balance investments both for specific HIV programs targeting key populations and for health systems strengthening. Investments in health systems in low- and middle-income countries are critical to ensuring that HIV and other health resources achieve their full potential. Likewise, investments in HIV can support the strengthening of health systems to enable sound and effective responses, and to achieve synergies with other health programs, potentially improving wider health outcomes.

Investment in both health systems strengthening and HIV programming is required. In the concentrated epidemics of Asia, where country health systems are too weak to absorb the demands of HIV, and stigma, fear of legal action, and inability to pay still act as barriers to accessing health services, vertical HIV services with ring-fenced budgets and distinct service delivery mechanisms are generally still warranted. Attempting to fully integrate vertical HIV systems, or investing exclusively in health systems strengthening, runs the risk that the gains made to date through vertical programming will be lost. Governments need to strongly commit
to funding prevention, care and treatment services for key populations commensurate to the size and nature of the epidemic, and then determine the most cost-effective way of doing this.

- **Global and regional evidence of the effectiveness of integrated care** compared to partial or non-integration is scarce. Questions remain over how cost-effective integration of HIV into maternal and child health (MCH) settings is, given the very low numbers of women testing HIV positive. Better understanding and technical guidance of what services and strategies can effectively be integrated for different key populations (for example, HIV/sexual and reproductive health/tuberculosis/viral hepatitis services in addition to harm reduction interventions for PWID), at what cost and with what outcomes is important for the region to guide future integration investments. Bi-directional linkages between HIV and NCD services have proved successful in Cambodia (and elsewhere) in reducing HIV related stigma and improving the quality and efficiency of services and should be explored in future.

- **Treatment continues to present a major challenge to the region.** Treatment 2.0 outlines the current normative, technical approach for both expanding access to treatment, and to establishing more sustainable treatment programs. It fails, in many ways, to address the critical programming challenges of scaling up treatment and to the fact that there are, essentially, two groups of clients: general population groups such as spouses of PWID or clients of sex workers, who are likely to access general health services; and the key populations themselves who find accessing general health services more difficult.

- **There is still a very significant treatment gap.** Investment in infrastructure and an accelerated agenda to expand access to HIV testing and counselling and treatment under current guidelines, especially for key populations, will not only make progress towards the HLM treatment targets but will help countries prepare for the ‘take off’ of treatment as prevention. A number of countries are now involved in trials of ‘treatment as prevention’; explicitly improving the nature of care for key populations, for example in Cambodia, which is moving to a new stage of treatment as prevention and integrating PMTCT. Such approaches will undoubtedly increase in importance.

- **Numerous partnerships have developed to respond to HIV in Asia,** but unlike at the country level where the existence of a National Strategic Plan provides the framework and platform for harmonisation and alignment around common agreed strategies and results, no similar comprehensive framework or single platform exists at regional level. Greater clarity of vision and strengthened coordination between partners to address the HLM targets has been identified as a clear need for the region.

- **Considerable external funding has been invested in civil society partnerships** but prospects of replacement through domestic funding sources are weak. A key challenge for the region is ensuring sufficient funds are available in the medium to long term for civil society and that resources are used strategically to refine programming. For civil society organisations (CSOs) to play a greater role in achieving the HLM targets, they need sufficient human resources, finances and management capacity. External funding for CSOs needs to continue but investments must to be guided by a longer-term vision for their future.
It is clear from our findings that the major changes needed in policy and programming must take place at country level. Each country is unique in its HIV situation and response, and needs to adjust to the new agenda in its own way. Yet countries are dependent in many ways on regional and global frameworks, and without the support of those frameworks it is often difficult for a country to manage effectively.

The policy, architecture and programming frameworks in the countries in the region have been highly influenced by such regional and global frameworks. Without significant changes at regional level, therefore, it will be difficult for countries to shift direction. The first priority this Assessment suggests, and the focus of the strategic options (see below), is that the re-shaping of the policy and technical advice that partners provide needs to take place at the regional level first. This is particularly important for the normative partners, such as the UN family; but it is also important for other partners, for whom funding decision making must be contextualised, if not justified, within the new frameworks.

**Strategic options**

From this Assessment, we consider it essential that all stakeholders remain engaged in the region but improve the focus of their investments in policy, programming, advocacy, and approaches to financing HIV. Five sets of strategic options are suggested for consideration.

**Strategic options for country support: Where is investment needed?** Burma (Myanmar), Cambodia, Laos, the Philippines, East Timor, Vietnam and possibly Indonesia, do not have or do not demonstrate the will to make available the domestic fiscal space to fund their HIV programs; continued external support in the medium term to help the country reach their HIV commitments will be required.

**Strategic options for continuing engagement with technical programming: What investment is needed?** A coherent and coordinated consensus on the most effective program interventions required for the region to achieve the HLM targets and how they should be introduced, extended and scaled up, is required. The primary areas of technical and managerial programming where continued external investment include: harm reduction, evidence-based drug treatment approaches and men who have sex with men programming; treatment 2.0, possibly to include treatment as prevention; results-based programming; a coordinated approach to strategic information; the development of a roadmap to more explicitly integrate HIV programs into good public health management through integration of appropriate services for key populations and integrated chronic care programs for ART.

**Strategic options for developing a common strategic vision for the region: Thinking and working together**, aiming to build a shared vision and commitment to a range of investments. Some kind of regional forum for discussing partner investments may be required and could take different forms, for example a Regional Investment Steering Committee, or an Investment Forum or support to UNAIDS Regional Support Team (RST) to explicitly coordinate on behalf of partners, a results-based approach to regional investments. Partners would come together to work on developing a coherent approach to a range of issues, for example future political advocacy, a clear vision for future civil society involvement and how engagement will be sustained; gaining agreement on aspects of the
HIV architecture and what needs to change; how to maximise the effectiveness of Global Fund investments. Partners would need to play a part in strengthening existing regional platforms and institutions to play their part, possibly through funding positions for specific purposes; supporting the network of WHO Collaborating Centres for HIV/AIDS; funding Task Forces or Regional Working Groups to address critical issues.

**Strategic options for financing the future: Investing together.** Addressing significant funding shortages requires evidence-based allocations of existing resources – that is, prioritised investment in services for key populations; switching funds out of program areas with limited impact including those of individual agencies; providing powerful evidence of the value of these investments to national authorities and of the need to increase allocations for health and HIV in the long term.

To ensure that existing and future investments are used more effectively stronger understanding of ‘investment approaches’ and what this means for countries in Asia, backed up with quality data and analytical capacity to provide evidence for decision making, is needed. External partners have a key role to play in this regard. Pursuing this agenda could involve bi-lateral investments to specific countries with possible options of joint funding country level investment; establishing a co-funded mechanism to provide regional oversight monitoring of Global Fund investments; funding dedicated Global Fund-related personnel in UNAIDS offices or Country Coordinating Mechanisms (CCM); establishing and co-funding a civil society grants mechanism; exploring domestic investment opportunities such as health insurance, sustainable funding strategies, transferring costs and functions from National AIDS Programs to Ministries of Health.

**Strategic options for expanding partnerships** and engaging with MIC (India and China) on specific issues such as strengthening their role in ensuring access to high quality and reasonably priced medicines for the region; benefiting from China and India’s technical capabilities; identifying and supporting institutions which could add new blood to the network of WHO Collaborating Centres; encouraging appropriate cross-border work where significant local population movement creates demands for HIV services; and exploring potential south-to-south exchange of technical expertise or triangular cooperation with another ‘dialogue’ partner such as more developed ASEAN members, to support low-income countries in the region.
**1. Introduction**

**Investments in human immunodeficiency virus (HIV) in Asia have achieved significant results.** Asia is home to some of the most effective HIV responses which have pioneered good public health practices; promoting human rights; mobilising communities; contributing to health equity and stronger health systems through integrating chronic care disease management. Region-wide, the number of new infections has declined by 20 per cent since 2001 (UNAIDS, 2011b) and access to antiretroviral therapy (ART) has more than tripled in recent years to 922,000 people on treatment, or 39 per cent in 2010 (WHO, 2011). Recent data released by the Joint United Nations Programme on HIV/AIDS (UNAIDS) (UNAIDS, 2012) demonstrates, in numeric terms, how close the region is to achieving the high-level meeting (HLM) targets of the 2011 Political Declaration on HIV/acquired immunodeficiency syndrome (AIDS) (see Box 13).

The 2008 Report of the Commission on AIDS in Asia (CAA) proved critical in identifying the need to shift responses from ‘one size fits all’ generalised programming to evidence-based responses which focus solidly on key populations at higher risk of HIV exposure (key populations) – that is, men who have sex with men (MSM), people who inject drugs, sex workers and their clients, and the intimate partners of all three groups. Despite the evidence for what needs to be done to make a real impact on the epidemics, many countries are struggling to re-direct resources and focus their programs more strategically. A number of sizeable epidemics are still growing among PWID, transgender people and MSM. Political, programming, funding, legal and health system challenges continue to affect the pace of change and the scale and uptake of services by key populations necessary to impact on the epidemics. Until these challenges are addressed systematically, the region remains vulnerable to continuing small-scale but debilitating HIV epidemics in most countries, with an increasingly serious high-cost, long-term treatment burden.

The international framework for intensifying action – the HLM targets adopted by the United Nations General Assembly (UN) in June 2011 and the UNAIDS Three Zeros strategy 2011–2015 – has already been reaffirmed and adopted by the region (for example, Association of South East Asian Nations (ASEAN)'Declaration of Commitment: Getting to zero new HIV infections, zero discrimination, zero AIDS-related deaths, 2011), see Box 13. The challenge now is for countries and development partners to consider their strategies, roles and contributions in attaining the goals and targets. This will involve regular assessments of the epidemiology and of the financing, policy and programming environments to make sure investments are sound, commensurate with the scale of the epidemics and aligned with the epidemiology.
2. Purpose of the Assessment and Methodology

The purpose of this Assessment is to provide advice, in the form of strategic options, to a set of bi- and multi-lateral partners\(^1\) on priority policy, programming and partnership investments for HIV in the medium term in Asia. The strategic options are evidence-based and informed by an assessment of the current status and future projections of HIV epidemics in Asia, of the changing global and regional socio-economic context, and current and emerging programmatic approaches.

Asia as a region can be defined in many ways. At the request of the partners, this Assessment focused primarily upon ten countries in the region: Burma (Myanmar), Cambodia, China, India, Indonesia, Laos, the Philippines, Thailand, Timor Leste and Vietnam. The purpose of the report was to provide strategic advice to a mixed set of partners with regional perspectives – recognising that this is a pre-requisite to changes at country level. For this reason, the report does not provide specific country advice.

The terms of reference (TOR) for the Strategic Assessment can be found at Annex 1.

The Assessment was undertaken by a team of independent consultants funded by the Australian Agency for International Development\(^2\) between the months of December 2011 and May 2012. The Assessment is underpinned by a conceptual framework (see Figure 1) which looks at investments in the region, the results of these investments, assesses outcomes and impact and suggests strategic options for moving forward.

**Figure 1 Conceptual Framework**

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\(^1\)The development partners for the Strategic Assessment include AusAID, UNAIDS, UNDP, UNODC, UNFPA, WHO, USAID, ADB, the Global Fund for AIDS, TB and Malaria, the World Bank.

\(^2\)Ten independent consultants were contracted to undertake the Country Reports. The overall assignment was undertaken by a small core team comprising Peter Godwin (Team Leader) and Clare Dickinson (Team Member).
The final Work plan provides more detail on the conceptual framework, methodology and timeline, rationale for country visits, guidance for the Country Reports and question guides for the consultation phase. The Final Work plan can be found at Annex 2. The principal phases of the methodology are summarised briefly in Table 1.

A partner Reference Group of technical staff representing the Australian Agency of International Development (AusAID), UNAIDS, United National Development Programme (UNDP), United Nations Office on Drugs and Crime (UNODC), United Nations Population Fund (UNFPA), World Health Organization (WHO), United States Agency for International Development (USAID), Asian Development Bank (ADB), the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) was established in November 2011 to review and provide technical inputs to the Assessment’s outputs and to provide additional information, documents and contacts. The Reference Group met twice: at the start of the assignment (in December 2011) and towards the end of the assignment, to review the draft final report (in May 2012).

Table 1 Principal phases of the methodology of the Strategic Assessment

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<th>When</th>
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<td>December-January 2011</td>
<td>A rapid desk-based HIV situational analysis of the ten countries included in the Strategic Assessment. The final Reports can be found at Annex 3.</td>
<td>To inform the core team and the field work phase. The reports provided a snapshot of the current epidemic status and projections and covered, where possible, epidemiology, programming, funding and budgeting information, challenges and gaps in national responses.</td>
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<td>January-April 2012</td>
<td>A consultation phase including visits to Geneva and seven short (three day) country visits to Cambodia, China, India, Indonesia, the Philippines, Thailand and Vietnam. In Burma (Myanmar), a local consultant conducted and provided feedback on key interviews and issues following the guidance in the Workplan. The full list of people and organisations consulted can be found in Annex 5.</td>
<td>To attend the Economic and Social Commission for Asia and the Pacific (ESCAP) Asia-Pacific High Level Intergovernmental Meeting on HIV/AIDS in Bangkok 6-8 February 2012, meet staff of regional organisations, networks of civil society organisations (CSOs); country visits to discuss the priorities of the Assessment and improve understanding of the national responses with key stakeholders and to validate findings of the Country Reports.</td>
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<tr>
<td>March-May 2012</td>
<td>Analysis, review and drafting phase; A zero draft of the report was circulated to the Reference Group in mid April 2012 and presented for discussion in early May. Comments from the Reference Group, UNAIDS Country Coordinators and Assessment partner organisations were received during May and incorporated into this final report.</td>
<td>To follow-up, identify and discuss emerging findings, brainstorm strategic options, discuss and agree content and structure of the report. To review and respond to comments from the Reference Group and Assessment partner organisations and their country-based representatives to finalise the report.</td>
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3. The Context

Three issues dominate the context of HIV in the region: the need to improve understanding of the epidemiology of HIV in Asia; the existence of a complex but effective set of partnerships; and the need to clearly articulate global and regional priorities to influence a longer-term view of HIV and the necessary response for the region. We discuss each of these in turn.

3.1 Epidemiological assessment and projections

HIV continues to present a significant burden of disease in Asia (see Figure 2), particularly among adults. Unlike other communicable diseases this burden will grow before it starts to reduce. This is due to the large pool of already infected people, for whom there is no current cure, and continuing transmission and spread of HIV, albeit in limited settings.

Figure 2 HIV burden of disease

![Projected contributions to total disability-adjusted life year (DALYs) (%) - Western Pacific Region Baseline](image)
Epidemiologically, the epidemic in Asia is concentrated, but complex and diverse, making it difficult to get a clear picture of HIV in the region. There is no single epidemic pattern that can be addressed with conventional, established policy and program formula. Indeed, few established public health measures are capable of responding to this complexity at present.

For some years it has been recognised that Asia and the Pacific would not experience an HIV epidemic in the general population similar to that in Africa (Godwin et al, 2006 & Chin, 2007). HIV transmission in Asia is largely limited to concentrations of infections in three primary situations: in and around the sex industry, among PWID, and among MSM. This was confirmed by the Report of the AIDS Commission for Asia (2008), and most recently UNAIDS (2011b). These concentrations of infections and transmission are in effect a series of small yet robust and dynamic epidemics throughout the region varying not only between countries, but also within countries.

Although data in a number of areas are still relatively limited in the region, much good work has been done to better understand and interpret what data there are. At a regional level, prevalence (current infections), incidence (new infections) and deaths are levelling off (see Figure 3).

**Figure 3 HIV in Asia and the Pacific 1990-2009**

Source: UNAIDS 2011 HIV in Asia and the Pacific: Getting to Zero
In the absence of a cure, however, the prevalence presents a significant chronic care burden; deaths continue to contribute significantly to catastrophic health expenditures and poverty (Haacker and Claeson, 2009 & Commission on AIDS in Asia, 2008), and the incidence, while falling in some places, is rising in others.

This presents a major public health delivery challenge. HIV prevention services need to be at a scale that will impact on new infection rates and treatment costs are mounting as larger numbers of people living with HIV receive ART. This is taking place in a region where health sectors are chronically underfunded and where weak health systems struggle to deliver a continuum of care that is client-oriented and reaches key populations.

Box 1: Examples of variation in incidence patterns within and between countries

- In India, of the estimated 120,000 new infections in 2009, 41 per cent occurred in low prevalence states suggesting growing epidemics; only 39 per cent occurred in states with ‘established’ epidemics.
- Prevalence is declining in Cambodia, Nepal, Burma (Myanmar) and Thailand; but rising in Indonesia and the Philippines.
- HIV prevalence among sex workers in Indonesia has not changed significantly during 2007–2010, but is increasing in MSM and PWID. The two provinces of Papua and West Papua are experiencing a growing generalised epidemic driven almost completely by unprotected sex.
- In China, more than 80 per cent of all infections are concentrated in six provinces.
- New infections and the number of people living with HIV are increasing in the Philippines in specific urban locations.
- In Vietnam, HIV is concentrated, comprising a number of local epidemics, with very specific dynamics – some growing, some not.
- HIV incidence and prevalence is declining in Thailand but MSM are the main source of new infections potentially accounting for 42 per cent of new infections by 2015, rising to over 50 per cent by 2025 if levels of condom use and risk behaviour remain at 2005 levels.

Sources: UNAIDS (2011a) and UNAIDS (2011b).

In spite of this diversity, the following trends can be identified:

- **Incidence among MSM is rapidly becoming the largest single driver of the epidemic in the region.** Unless this is addressed, incidence in many countries will sustain significant prevalence levels.

- **Incidence among PWID remains an important, if limited source of infection**, exacerbating the overall, largely intractable, public health problem of illicit drug use.

- **HIV is likely to remain endemic within the sex industry throughout the region**, with significant continuing incidence among sex workers (SW), the clients of the industry, and their sexual partners, again sustaining substantial prevalence levels.
HIV in ‘closed settings’ (for example, prisons) and among transgender people, are neglected issues; substantial transmission occurs within closed settings, but little is done about it; and while transgender men and women are recognised as highly vulnerable and stigmatised, little is known or done for them.\(^1\)

In all these situations, HIV is transmitted to intimate partners, who remain a substantial group of infected persons. Apart from limited mother-to-child transmission, however, there tends to be little transmission beyond these partners. They represent, however, an important but very hard to reach population. The Assessment found surprisingly little concern or data regarding this element of incidence in the region.

A significant, long-term, chronic, treatment and care burden exists for the region, that is costly and has the potential to become even more so.

While the HLM targets provide an important roadmap for addressing the epidemiological pattern, the great disparity between the sizes of the epidemics in the countries of the region creates the potential for misleading epidemiological assessment. If either China or India made substantial progress towards the HLM targets, the sheer numbers involved in those two huge countries could mask little or no progress in all the others. The HLM targets must thus be treated with caution at a regional level – translating them into country-specific targets is all-important.

The HLM targets, for the first time, precisely quantified reductions in infections and deaths to be achieved by 2015. Importantly, the HLM prevention targets measure reductions in incidence, rather than prevalence; this has important implications for countries’ and the region’s abilities to measure and calculate incidence as part of precise strategic information management.

### 3.2 Partnerships

Many regional partnerships have developed to respond to HIV in Asia. There are partnerships between governments through existing regional platforms, such as ASEAN and South Asian Association for Regional Cooperation; partnerships between governments and development partners such as UNAIDS, WHO, ADB, ESCAP, USAID, AusAID, Clinton Health Access Initiative (CHAI), Global Fund and so on; partnerships between development partners including Civil Society Organisations (CSOs), such as joint funding of projects; partnerships within civil society, such as Asia-Pacific Coalition of AIDS Service Organisations (APCASO), Asia Pacific Coalition on Male Sexual Health (APCOM), Asian Network of People who Use Drugs (ANPUD), the Seven Sisters; and partnerships between academic institutions, such as the network of WHO Collaborating Centres; partnerships through shared funding modalities such as the Three Diseases Fund (3DF) in Burma (Myanmar) and the Indonesia Partnership Fund (IPF) for HIV. Some of these partnerships are political, some ceremonial, some technical. Details of the main external agency strategic directions and technical areas can be found in Annex 4.

There is an important difference between the partnerships within countries and those between countries at regional level. Within countries there usually exists the National Strategic Plan (NSP), that provides a framework and platform within which all the different partnerships can, to a greater

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\(^1\) Asia-Pacific research, scattered and small-scale, indicates alarming numbers of trans*women are HIV positive, with prevalence rates as high as 49 per cent. There appear to be no data at all on HIV rates among trans*men, an emerging identity group. The number of trans*people of either gender who have died of AIDS, or what proportion they represent of overall AIDS-related deaths, is unknown (Winter, 2012).
or lesser extent, harmonise and align around common strategies and results. Further, within countries many of these partnerships have their own ‘internal’ governance and coordination mechanisms: the UN Joint Team on AIDS, Joint Donor Working Groups or Coordination Forum, Civil Society Coordination Councils, not to mention National AIDS Councils. The Country Coordinating Mechanism (CCM) is an additional intra-country coordination mechanism to bring partnerships and players together.

**No similar comprehensive frameworks or platforms exist at regional level.** While the UN, some bilateral donors and a number of CSOs have regional offices there is no single platform or framework that brings these partnerships together. UNAIDS has attempted, through the establishment of various Task Forces, Technical Working or Reference Groups, and regular regional meetings, to establish frameworks to address some issues. ESCAP provides an inter-governmental forum, with some participation from other partners. But in general, membership of these forums is often ad hoc, and the purpose, nature and scope of participation is often unclear.

Countries have the advantage that ‘ownership’ is accepted as an important feature of the national HIV response (see section 6). There is no equivalent regional ownership; it may be that such a thing is not required, too difficult and complex, too much at variance with how the region operates. Be that as it may, however, lack of leadership in establishing clarity of vision for the region, and in greatly strengthening coordination between the various regional partnerships, was a common complaint heard by the Assessment team.

Partnerships for development are common to all sectors, particularly between governments and development partners.4 The concept that partnerships are not simply pragmatic cooperation, but have an intrinsic value as partnerships, however, has tended to be a major and innovative investment of the global HIV response; particularly with regard to the involvement of civil society (Commission on AIDS in Asia, 2008), and particularly with regard to greater multi-sectoral linkages beyond the health sector. This concept of the inclusive, partnership approach to public health is now reflected in much of the regional consensus (see section 4.1). But this consensus tends to remain superficial in some parts of the region, where ‘health’ is highly ‘medicalised’, with primary focus on curative and facility-based services and little weight attached to ‘community involvement’; and where government accountability tends to be un-transparent and very top-down. In a number of countries, however, the role of civil society in HIV is now established.5

**A critical partnership element in the region nonetheless, has been the large-scale involvement of civil society,** both for advocacy and policy pressure, for capacity building, and for service delivery; both directly and in conjunction with government services. A variety of models, levels of investment and types of civil society engagement can be found in the region (see Box 2).

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4 Viz the Paris Declaration for Aid Effectiveness, which calls for stakeholders to work together for development and specifically refers to the Paris Principles as “Partnership Commitments ... based on the lessons of experience”. The International Health Partnership (IHP) takes this principle even further (see www.internationalhealthpartnership.net).

Box 2: Some civil society models in the region

Advocacy and policy pressure:
- Asia Pacific Network of People Living with HIV/AIDS (APN+) and their country level networks and organisations for the successful introduction and scale up on treatment and care; including current pressure for access to affordable medicines.
- Asian Harm Reduction Network, ANPUD for advocacy for comprehensive prevention and treatment services.
- APCOM, an influential regional community-based MSM advocacy body.
- Human Rights Watch for highlighting compulsory detention centres.
- APCASO and the Seven Sisters for the role and contribution of civil society throughout the region.
- Global Network of Sex Worker Projects for highlighting SW issues throughout the region.

Service delivery:
- The development of home and community-based care models in Cambodia.
- The Avahan project in India for effective prevention with key populations.
- Gates support for men who have sex with men services throughout China.
- Cambodia Network of Positive People for comprehensive continuum of care centres that link people living with HIV with hospitals in co-service provider arrangements in Cambodia.
- Civil society organisations in the Philippines for playing a significant role both as advocates and for service delivery.
- The development of five national networks of key populations receiving office space and operational support from the Indonesian program; national networks of peer educators established.
- Medecins Sans Frontieres (MSF) and the roll out of ART in Myanmar.

Capacity building
- The HIV/Alliance for its capacity building program with Global Fund support throughout India.
- Family Health International (FHI) for capacity building of community-based organisations (CBOs), particularly with key populations in Cambodia, Vietnam and Indonesia.

Development partners have invested hugely in CSOs and their networks at regional and country level.
- AusAID, through various channels, has been the prime funder for the larger regional civil society networks (APCASO, ANPUD, and so on). Perceptions are, however, that is often year-on-year, offering little prospect of long term budgeting and planning for the organisation; funds are often routed through an intermediary which is costly, inefficient and can severely delay the receipt of funds, stalling implementation and having a knock on effect for the following year’s budgets (budgets are sometimes reduced in response to a lack of spend).
- USAID has been the primary funder for CSOs at country level in South East Asia (Thailand, Laos, Cambodia, Vietnam) mainly through international non-governmental organisations (INGOs) such as FHI, RTI and so on, investing in building CBO capacity for service delivery for key populations. In Vietnam, however, the phased withdrawal of USAID funding has forced a major re-evaluation and re-assessment of INGO/civil society models.
• In India, organisations such as the Alliance, working primarily with Global Fund investments, have substantial programs for CSO capacity development. The Government of India has also channelled external (largely World Bank) funding to non-governmental organisations (NGOs) through performance-based contracts to deliver targeted prevention services with peer-based outreach services, an important feature of successful programs.

• The BMGF, through the Avahan project in India has built one of the most successful, if not sustainable, models of civil society service delivery for key populations. There are significant challenges with the ‘transition’ from Gates to government funding for the Avahan model; though the new World Bank credit for India has provided a short-term, if not long-term solution.

• CHAI has been critically important throughout the region, both in helping to scale up treatment and care programs, particularly paediatric care, but also an a channel for AusAID and USAID funding in China, Vietnam and Indonesia.

• Very large Global Fund grants have been made available to civil society in all countries; this is perhaps the most vulnerable of civil society funding. With CCMs largely dominated by governments, it is likely that any future limitations on Global Fund investment will lead to cuts in civil society first. The dependence of civil society funding on Global Fund is well illustrated by the case of China, where the withdrawal of the Global Fund has severely challenged emerging civil society engagement.

But this investment in civil society is externally funded; and the prospect of domestic funding replacing external funding is weak. Although civil society in some countries has a certain amount of indigenous sustainability (for example Thailand, India, the Philippines), to a large extent across the region the role of civil society in HIV remains essentially unsustainable (see section 6.2). A key challenge for the region is thus making sure sufficient funds for CSOs are available in the medium and long term and that resources are used strategically to refine programming; to fund community-based HIV prevention, care and treatment services for key populations; to mobilise demand and uptake of services among these population groups; to advocate for strategic investment of public resources and hold duty bearers accountable. As the technical gains of new ‘technologies’ (such as treatment as prevention, OTC testing) roll out, the role of civil society will also be challenged to adapt – away from general outreach and support towards, for example, more focused adherence support. In addition, as investments in national responses come under scrutiny for political acceptability, value for money and strategic relevance, CSOs will also come under increased pressure to demonstrate and be accountable for their contribution to the national response (Abt Associates Inc., 2011) and to achieving the HLM targets. For CSOs to play a greater role in achieving the HLM targets, they need sufficient human resources, finances and management capacity. External funding for CSOs needs to continue but investments must to be guided by a longer-term vision for their future.

3.3 Emerging global and regional issues

A number of important global and regional issues have emerged from this exercise that have the potential to impact on future political priority and funding for HIV, program directions and partnerships.
The end of AIDS exceptionalism and increasing focus on strengthening health systems

There has been a marked shift within the development community, in many countries, and indeed within UNAIDS itself, in commitment and attitude to HIV, in favour of ending ‘AIDS exceptionalism’ and integrating HIV services into wider health and national development plans and agendas. The huge inflow of resources for HIV over the last decade has presented opportunities and challenges. Without question, major HIV institutions such as UNAIDS, the Global Fund and The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) – with their explicit vertical mandates – have brought about tremendous gains in HIV for many countries. This funding enabled a rapid and scaled up response to the epidemic, especially for treatment access, providing a focus for political support for the goal of universal access and Millennium Development Goal (MDGs) 6. Critically for Asia, it has also enabled better access to HIV services for key populations who either cannot or do not engage with mainstream health services. Equally, however, it has created significant distortions in countries’ health care systems (England, 2007; England, 2008; Dybul et al., 2012). Robust country-level disease burden data are hard to come by, but extrapolations from regional studies (see previous Figure 2) suggest that while HIV disease burdens are significant, they have hardly been proportionally commensurate with the vertical investments – particularly in Asia. This has created inequities in health sector investment and programming that is hard to justify. Equally, the alternative inequity of substantially reducing HIV funding is as unjustifiable– a significant policy conundrum that lies at the heart of this report.

The relatively recent rise of health systems strengthening as a policy and funding priority among HIV funders and technical agencies suggests that a move away from single disease approaches to global health may be occurring as HIV funders and programs have come to recognise the importance of strengthening health systems to their work and for achieving the MDGs (Dickinson and Druce, 2008; Rushton, 2011). History provides examples of vertical and horizontal approaches being used to good effect - Smallpox eradication being one of the most frequently cited successful vertical programs and Alma Ata (1976) ushering in an era of more horizontal interventions. Recent advocates argue that investing more broadly in health systems brings a number of advantages including greater efficiency, improved sustainability and the ability to adapt to the changing nature of health problems (Rushton, 2011).

The primary implications of this policy and funding shift are: i) possible reduced ring-fenced funding for HIV; ii) integrate HIV funding within health sector and health system strengthening funding; and iii) integrate HIV programming itself more comprehensively within health sector programming. In Asia, where HIV-related stigma still presents barriers to prevention, care and treatment, a key challenge for the future is striking the right balance between ring-fencing specific HIV funding and programming for prevention among key populations, particularly in urban areas, whilst integrating some of the functions currently undertaken by national HIV programs into health systems and general health programs (for example blood safety, STI, preventing mother to child transmission (PMTCT) and universal treatment services, health workforce development, procurement, logistics and distribution).
Non-communicable diseases (NCD)

The globalisation of non-communicable diseases – a common health issue that spans countries of all incomes – is likely to inform the post MDG agenda, not just because of its importance for global health but also for the economy, the environment and the global public good. South and South East Asia face an epidemic of chronic NCD, now responsible for 60 per cent of deaths in South East Asia (Dans A et al, 2011). Even with stronger NCD programs, countries can expect an ever-increasing number of people, rich and poor to be affected with chronic disease in the next few decades. For example, between Indonesia and the Philippines alone, there will an estimated 29.2 million people with diabetes by 2030 (Wild S et al, 2004).

A recurring theme throughout our discussions in the region is the need to visualise many aspects of long-term, sustainable HIV care and treatment programs within the context of emerging NCD programming and chronic care management (Rabkin and Nishtar, 2011; Krishna et al., 2011). This is closely linked to the previous point about the need to ‘integrate’ HIV programming more seamlessly into general health care provision systems. Even if HIV incidence were to be eliminated in the region immediately, existing care and treatment programs will remain for the next several decades at least: expensive, long-term, chronic care, sustained alongside rapidly expanding similar programs for NCD. The particular challenges of strengthening ‘continuity care’ that characterise the development of chronic disease management for NCDs suggest that important economies of scale can be achieved by integrating ART care with larger chronic care programs (Rabkin and El-Sadra, 2011). ‘Continuity care’ calls for greater self-management, an expanded role for peer and community groups, increasing rationalisation and efficiency of providers through ‘task-shifting’, simplified diagnostic and treatment protocols, and more robust supply chain management. It would be highly inefficient for significant investment (for example, treatment 2.0 – see Box 9) to be made for HIV alone, with parallel investment being made for NCD systems.

In addition, not only are there strong system parallels between HIV and NCD, but there appears to be an emerging common agenda around investments that are politically acceptable, offer good value and can strengthen health systems over the long term, through more integrated management of chronic conditions. At the same time these investments should aim to ensure equitable access for those in need, including poor and marginalised populations (Lamptey et al., 2011).

The post MDG framework

While there is still a heavy focus on meeting the MDGs at country level, what comes next – the post MDG framework – has been under discussion for some time. Although there is no consensus on its configuration, there is broad agreement that the context in which the post-2015 arrangement will be negotiated is different from the context in which the MDGs emerged.

The Rio+ 20 Conference in June 2012 is probably one of the most influential venues for gaining consensus on the post MDG agenda, the outcomes of which are likely to profoundly shift the focus of country and development partner goals and assistance towards sustainable development. The sustainable development agenda will focus on common global priorities with shared goals for sustainable consumption and production, sustainable agriculture and energy, sustainable water resources and a number of other priorities. Public health currently has a low profile in the draft
outcome document and HIV even less so. Advocates are working to raise this profile but the fact remains it is unlikely that HIV will have a specific global target beyond 2015. This will impact on levels of political priority and resourcing for HIV, underscoring the importance of shifting national responses towards stronger sustainable public health investments.

**Shifts in geopolitical and economic power and attention**

The changing geography of poverty, and recognition that there is an increasingly multi-polar world, are changing thinking on international development. Over the past decade, sustained economic growth has enabled 28 countries to ‘graduate’ from low income countries (LIC) to middle income countries (MIC) (Glassman et al, 2011). The economies of developing Asia are maintaining their growth trajectories (6.9 per cent for Asia in 2012), but poverty and inequality remains high. Despite the region’s rapid growth, the last two decades have witnessed widening income disparities, curbing the poverty impact of economic growth, and even undermining the basis of growth itself (ADB, 2012).

Sixty per cent of the world’s poor now live in five populous middle income countries: Pakistan, India, Nigeria, China and Indonesia. MIC now also have a larger total disease burden than LIC (mainly due to population size but also due to weak public health programs to prevent and control disease), including for HIV (Glassman et al, 2011). Thus there is a poor correlation between the global distribution of people living in poverty and suffering from HIV, tuberculosis (TB) or malaria, with the official income status of countries (McCoy and Kinyua, 2012).

Although there is huge diversity between countries in the grouping in terms of size, socio-economic factors and political systems, a number of broad development issues can be identified that challenge the achievement of the Millennium Development Goals and the HLM targets.

- Inequality
- Social exclusion
- Economic and financial vulnerability (which can cause a country to regress to LIC)
- Weak democratic governance and political institutions
- Weak institutional capacity

MIC income classifications do not always reflect these challenges but they do determine donor actions and the volume and terms of aid and lending to MIC. Pressure on donors to increase the proportion of aid going to LIC by reducing aid to MIC is evident in recent data aid flows⁶ and is based on the idea that MIC have fiscal capacity to spend more on health and disease control priorities. Yet achieving more fiscal space – the ability and willingness to deploy financial resources for priority social actions – on its own is unlikely to be enough to achieve the HLM targets. The Country Reports for this Assessment underscore the point that despite rising levels of wealth in many of the countries in the region, continuing to invest in HIV and health system-related capacity challenges will be important for the medium and long term (see Box 14).

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⁶ As evidenced by the declines in ODA to MIC in favour of LIC over the last decade. For example, between 1998/99 - 2008/9 net disbursements as a percentage of ODA from all DAC donors to MIC declined from 54.9% to 42.2%. During the same period ODA to LIC increased from 45.2% to 57.8%.
The global economic crisis is forcing ‘traditional donors’ to re-examine funding priorities, partnerships and the effectiveness of development assistance. There is a much stronger focus on results frameworks, output-based aid that closely links investments to outcomes in sector plans, and to investment approaches (see Box 16) that require greater understanding of cost effectiveness of sector interventions. Increasing scrutiny of aid budgets as well as a number of other contributory factors (for example the mismanagement/misappropriation of disease specific funds, the reallocation of donor funds to other health-related (and poorer performing) MDGs, and growing policy and funding interest in health systems strengthening) is contributing to change in Geneva and US-based HIV institutions, policies and responses. The Global Fund has embarked on a program of substantial reform and retrenchment in a drive to improve efficiency, effectiveness, value for money and to strike a balance between supply-led and demand-driven funding (see Box 11); UNAIDS is undergoing a functional workforce review to cut costs and strengthen results at country level and target countries and programmatic areas where the biggest impact can be achieved; WHO’s HIV Department is aligning to its current HIV strategy and has been downsizing for some time; PEPFAR’s current phase is working to incorporate health systems strengthening goals into its HIV portfolios. The extent to which these changes are having impact at regional and country level has not been examined in-depth in this Assessment but insights from our country visits suggest that UNAIDS co-sponsor agency organisational capacity in certain areas is currently overstretched and agency technical strategies remain underfunded.

Traditional donors are re-thinking development assistance (Fourth High Level Forum on Aid Effectiveness Busan Partnership for Effective Development Cooperation, 2011); new approaches to how development is funded are becoming increasingly dominant, for example cash on delivery (Birdsall et al., 2010; Pearson, 2011); ‘North-South’ is no longer discussed; there is a move away from absolute poverty reduction to relative poverty, equality, equity and sustainability issues; and emerging donors such as Brazil, Russia, India, China and South Africa (BRICS) are taking a more prominent role in development discussions and are increasingly strategic in the delivery of aid.8

The extent to which BRICS are seen, or wish, to ‘play by the rules’ in conventional North-South terms (that is, adhere to the Paris Declaration on Aid Effectiveness) has been important in negotiating new partnership frameworks, articulated in the Busan Partnership for Effective Development Cooperation (Fourth High Level Forum on Aid Effectiveness Busan Partnership for Effective Development Cooperation, 2011). In this agreement, countries like China and India frame their development in terms of voluntary South-South cooperation.

There is uncertainty over the Busan Partnership. Questions remain over what the Partnership will look like, whether anything concrete will emerge, and what are the potential opportunities, risks and contributions of engaging with BRICS, especially China and India, on specific social issues such as HIV. In the case of China, there are early indications that it would like to collaborate on HIV with the ASEAN countries on its border (in the Greater Mekong Sub Region) in the context of the ASEAN Cities Getting to Zero project. However, assessing whether there is space for the BRICS to develop an interest in supporting HIV, or the potential to establish a platform for South-South and/or triangular exchanges of knowledge and technical expertise with the region, and to encourage

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7 The recent World Economic Forum Global Risk Report places social equality as one of the top three risks to the global economy.
8 For example China recently published white papers on its foreign aid programme, with clear approaches and objectives to aid.
emerging donors to include HIV in their priorities for the region, are areas of work that require further exploration.

**Box 3: What do we know about BRICS and health?**

**Brazil, Russia, India, China and South Africa** are increasingly engaging in global health, scaling up investments in innovation and exploring cooperative mechanisms and commitments to work together, as evidenced by the 2011 Ministers of Health meeting (BRICS Health Ministers Meeting, 2011). A recent report on BRICS in global health and our own observations point to the following:

**Brazil:** Current and potential contributions to global health include: experience of using various methods to ensure cheap access to antiretroviral drugs (ARV); experience of using global leadership to champion South to South cooperation; experience of achieving universal access to ART; conditional cash transfers for child health; contributions to multilaterals including Global Alliance for Vaccines and Immunisation (GAVI), The International Drug Purchase Facility (UNITAID), Pan-American Health Office (WHO/PAHO); non-communicable diseases (tobacco control). Upper limit of development assistance for 2010 was $1.2 billion (no figures for health available) but strong emphasis on partnership, capacity building and health access based on long standing domestic commitment to equity.

**Russia:** Current and potential contributions to global health include vaccine funding; pharmaceutical investments including significant investments in preparing its health care industry for the global market. $500 million a year spent on development assistance, one quarter of which is estimated for health via the Global Fund.

**India:** Arguably the greatest contribution to global health innovation comes from the private sector and pharmaceutical companies producing generics and driving down drug and vaccine prices; innovative approaches to low cost service delivery; telemedicine and e-health. Health assistance is estimated to be $100 million since 2009 spent on development assistance programmed through bi-lateral channels to 20 countries in South and South East Asia and Africa. Funds spent mainly on technical assistance (TA), infrastructure, training, and information technology.

**China:** Greatest contributions to global health include regional public health preparedness; disease surveillance particularly around influenza and emerging infectious diseases; medical teams; malaria support; health infrastructure; family planning; and research and development. Development assistance in total estimated to be $3.9 billion in 2010 (health assistance data not available) channelled through bilateral funds and limited support to multilaterals (although WHO, UNICEF and Global Fund consistently receive support). In addition, China is the world’s primary source of ATI for the pharmaceutical industry, and an important pharmaceutical manufacturer.

**South Africa:** Newest BRIC with smaller volumes of assistance available. Current and potential contributions include globally renowned health research and policy; health and HIV activist community provide inspiration and models for other countries; experience of Test and Treat on large scale; TB diagnostics and vaccine supply; producer of generic ARVs with potential for growth. Development assistance estimated at $143 million in 2010. No data on health but strong South-to-South cooperation and contributions to the Global Fund and GAVI.

There are notable differences between BRICS approach to development assistance from those of traditional development partners: resources are less transparent; there is limited evidence about the quality, impact and value-added of assistance from BRICS; there is limited engagement in development partner coordination mechanisms at country level. For example, in Nepal, where China and India are reported to be important development partners for the health sector, there is no interaction with traditional partners or involvement in the Nepal Sector Wide Approach for health. Lack of engagement is attributed to institutional and technical capacity constraints and most assistance is delivered as project aid, outside program-based approaches.

**Source:** Global Health Strategies Initiative (2012) and Dickinson and Attawell (2011).
4. Investments in Policy, Program Architecture and Programming

Over the last two decades considerable investment has been made in the regional HIV response. As described in the conceptual framework for this Assessment, this section considers the range of investment (in terms of policy, governance and systems, and programs) and the results of these investments.

These investments include what the new UNAIDS Investment Framework Approach calls the ‘critical enablers’: advocacy and development of policy to reduce stigma and protect human rights, monitoring and evaluation (M&E) systems for the equity and quality of program access and results, incentives for program participation, capacity building for development of CBOs, strategic planning, communications, infrastructure, information dissemination, and efforts to improve service integration and linkages (Schwartlander et al., 2011). As we discuss below, these investments may have been good practice at that time – but have created an architecture that needs to be reviewed and largely re-aligned, if not re-designed.

We explore investments in technical gains – new and better technical programming issues. The global HIV response has seen dramatic innovations in prevention interventions, and treatment and care programming over the last decade. The innovations continue – and pose challenges for continued investment.

Finally we consider investment in strengthening health systems, and greater long-term integration of HIV programming into ‘core MoH business’. This may well be the next area where comprehensive, coherent and concerted investment in ‘critical enablers’ is required.

4.1 Policy

Widespread policy coherence has been achieved in the region for HIV largely based on global norms, emphasising the fundamental importance of prevention as the primary tool for addressing the epidemic; of timely, sustained and continuous treatment; and of multi-sectoral/stakeholder engagement in national responses. While this agenda is still relevant, it needs revisiting and updating in the context of concentrated epidemics, the Strategic Investment Framework and new scientific evidence, for example the efficacy of treatment as prevention.

Regional acceptance of global policy norms (for example the UN General Assembly Resolutions of 2001 and 2006) is reflected in the consensus achieved through the CAA Report and the series of ESCAP resolutions, commitments and outcome documents (57/1 of April 2001, 59/1 of September 2003, 60/262 of June 2006, 66/10 of May 2010 and 67/9 of May 2011, 68/13 of March 2012). All countries in the region have some kind of local policy framework reflecting much of the ESCAP consensus; and significant levels of political commitment have been mobilised. Most countries have
an NSP, strongly influenced by UNAIDS’ global guidance, that outline strategic priorities for the country, resource allocations, implementation mechanisms and M&E frameworks. The Report of the Commission on AIDS in Asia, UNAIDS recent stocktaking reports on the epidemiological situation, and more recently the commitments to the HLM targets for the region, have made it clear that the global ‘one size fits all’ consensus on the ‘expanded multi-sectoral response to HIV’ is no longer fully appropriate for the region. The concentrated epidemics of the region require more focused strategies.

**Political and policy space exists in all countries, in varying degrees.** Substantial political commitment has developed in most countries. The days of denial have gone: presidents and prime ministers publicly meet people living with HIV and brandish condoms; they chair National AIDS Councils; ministers flock to regional meetings and consultations; AIDS ambassadors are welcomed everywhere; and both fiscal and policy space have been provided for National AIDS Programmes (NAPs) in varying degrees throughout the region.

A notable policy success has been the commitment by governments to the chronic care burden implied in the roll-out of ART. When WHO launched the ‘3X5’ initiative few countries in the region considered the full-scale provision of ART a viable policy. Within three years this had changed, and ART is now the accepted norm for the region, even for second and third lines of drug regimens.

**But this ‘space’ has tended to be limited to a view of the epidemic as a threat to the general population, or as a substantive economic threat.** The recognition that the epidemic is different in Asia, that it is concentrated, specific, politically unimportant, but manageable and important from a public health and equity perspective needs to be nurtured; and policy space to address this different perspective, developed.

The rights-based approach described by Tarantola et. al. (2008), and referenced in our Workplan, states the need to respect, protect, and fulfil their citizens’ human rights of key populations. This means not only addressing the policy and legal issues that are needed to respect and protect key populations rights, but also specifically the duty of states, and their Ministries of Health, to fulfil key populations’ rights to good quality health care. The respect for, protection, and fulfilment of the human rights of marginalised populations affected by HIV has not received commitment of human rights duty bearers to anything like the same extent, severely hindering effective programming for such groups.

**In terms of respecting and protecting rights, ‘enabling environments’ remain largely constrained with respect to PWID, SW and MSM.** Additionally challenging for working within the sex industry has been the recent regional focus on ‘anti-trafficking’ as this tends to become another source of excessive policing. There are deep-seated cultural, social and political divisions of opinion within the region about the most appropriate legal and socio-cultural responses to illicit drug use, men having sex with men, and sex work. In addition, the CAA also includes poverty, inequality and gender imbalances as part of the enabling environment – also all subject to significant differences of perspective and opinion regionally.

**These divisions of opinion go far beyond their relationship with and impact on HIV;** the struggle to recognise the rights of women, and men, to sex work as legitimate, gainful occupation, the rights of people to use drugs, gender equality, and equity and equality, are still globally constrained as human rights, quite apart from their relationship with the spread of HIV. Indeed, our country visits
revealed several situations where HIV programmers’ perspective on SWs or drug users’ rights related to their need for access to services, for example, were in direct conflict with other donor-supported programs strengthening criminal justice, welfare and governance systems. Many of our respondents felt that such human rights issues had a complexity, an importance, and required attention that went far beyond HIV programming, and that this needed to be made explicit – human rights issues needed to be addressed in the wider context, and not under the umbrella or in the shadow of HIV.

The CAA stressed the critical importance of ‘striking the right balance’ between addressing immediate priorities for access to services, and catalysing long-term actions that address these underlying vulnerabilities. While formal policy, as reflected for instance in the various ESCAP declarations and the policy frameworks of the UN, rightly stresses the fundamental importance of a human rights based approach, and in the longer term this must be the objective of all public health (and other social welfare) programming, perhaps the most pressing HIV priority for the region is finding locally relevant, pragmatic, workable solutions to excessive policing, authority brutality, severe disempowerment, and stigma and discrimination, that deny access to services to key populations. A number of models of this kind of approach have been tried across the region and appear to be highly effective. Many programs have developed pragmatic approaches that achieve results in spite of limitations in the socio-cultural environment. For example, 100% Condom Use Policy, the introduction of opiate substitution therapy (OST) and much policy and CSS work with MSM, for example in India, China and Vietnam.

Box 4: The enabling environment

Investment in the ‘enabling environment’ has been difficult to judge effectively. In spite of extensive investment in the enabling environment over the years, the UNAIDS Stocktaking Report of 2011 noted that laws which obstruct the rights of key affected populations or people living with HIV are in effect in 90 per cent of the countries in the region. More than 29 countries criminalise some aspect of sex work; 20 countries criminalise same-sex sexual relations; many countries enforce compulsory detention for people who use drugs; 11 countries apply the death penalty for drug offences; and 16 countries pose travel restrictions on people living with HIV. In addition, organisations providing support to these key affected populations are criminalised in some countries. There is a continuing tension between public security measures to control drug use and sex work and public health programs that operate within a harm reduction approach.

It is clear that continued investment is needed, but, as the CAA points out, much has been achieved through cost-effective, pragmatic programming, especially working on the one hand primarily with local authorities, and on the other with civil society to ‘provide safe spaces in otherwise unsafe settings’; this type of investment must continue.

Even so, throughout our Assessment many respondents questioned the cost-effectiveness of much longer-term, high-cost investments that attempt to change deep-seated legal and legislative frameworks. Our study found (Table 2, Annex 6) that while on average 1.6 per cent of total funding went to ‘enabling environments’, in some countries as much as 6.7 per cent (Burma/Myanmar), and over 4 per cent (Indonesia and Vietnam), is spent.

Extensive discussion of these issues during the Assessment concluded that while investments in the enabling environment should not be ruled out, in future, they need to be much better focussed, better linked to the ‘pragmatic’ investments, and have clear targets. In addition, many
respondents felt that the HIV community is not the only (nor necessarily the best placed) community to be advocating for human rights and legislative reform. Finally, there is considerable evidence that demonstrating the need for policy change through pragmatic investments, as happens regularly in China, can be very effective.

With respect to the third of Tarantola’s duties of states, the duty to fulfil human rights, far less has been done to make explicit the duty of Ministries of Health to provide equitable access to services for marginalised populations. We consider this a key area for further attention and HIV-specific programming. The provision of ‘user-friendly’, effectively targeted, appropriate services for the key populations among whom HIV spreads need to be established as ‘core MoH business’; although currently as vertical HIV-specific services, but in the future as integrated sexual and reproductive health (SRH), or chronic care, as a long-term, sustained element of equitable health care service provision. Such health care provision should not be HIV specific, but rather key population specific: people who work in the sex industry have a series of specific SRH needs (among them HIV) which MoHs should be providing. People who inject, or use, illicit drugs have specific health needs that should be provided in the fulfilment of their human rights – not simply as HIV prevention.

A final area where policy ‘space’ needs to be expanded is with regard to the role of civil society. Weaknesses in political commitment to the full involvement of civil society threaten many of the achievements of current HIV programs; both directly, as programs dependent upon strong civil society involvement need to go to scale, and indirectly, where such civil society engagement is externally funded. This is discussed in more detail earlier (section 3.2).

Generating greater political support and social acceptance for policy and programming targeting key populations will be critical in the medium term.

4.2 Governance and architecture

Policy has been supported by substantial investment in a variety of governance and accountability frameworks. There are ‘standalone’ multi-sectoral National AIDS Commission/Council (NACs), located outside the health sector, in Cambodia, China and Indonesia; NACs within the health sector, supporting NAPs, in Laos, Vietnam, India, Thailand, Philippines; and there are CCMs in all countries. These governance frameworks were largely established, and continue to be supported financially and with TA by development partners. As NACs they respond to the UNAIDS ‘Three Ones’ principles, the ESCAP consensus and the recommendations of the CAA Report which stressed the critical importance of high-level governance mechanisms. CCMs respond to the requirements of the Global Fund. These mechanisms aim to establish coordination of broad-based, multi-sectoral responses, ensuring multi-stakeholder engagement and coordinated allocation of resources; in addition, they theoretically monitor progress and provide oversight and accountability of Global Fund moneys. There is usually considerable civil society (both local and international), and often private sector and academia participation in these frameworks; most also engage, in some form, with development partners.
This architecture has been very largely ‘donor-driven’. During the first decade of the epidemic in Asia (1980–1990), most Ministries of Health established NAPs, largely as suggested by WHO/GPA. In the following decade, with the establishment of UNAIDS the perception became widespread that the global epidemic was too big, too dangerous, too complex and too urgent to be managed by Ministries of Health alone – the ‘expanded multi-sectoral response’ became the policy consensus.

This consensus took little note of the differing nature of the various epidemics in various different parts of the world – the distinction between ‘concentrated’ and ‘generalised’ epidemics was seen as linear and chronological, rather than exclusive. By the time the CAA established that Asia was never likely to see ‘generalised’ epidemics, the architecture of the ‘expanded multi-sectoral response’ was fully in place in most countries in the region. Cambodia, for example, has a National AIDS Authority comprising 29 different Ministries. While the ‘consensus’ for this kind of architecture may have been the right idea at the time, it is now clearly inappropriate for the region.

**This HIV governance and program architecture is unwieldy and inefficient.** While NSPs might be said to be statements of intent, the NAPs themselves, and the architecture of which they are part, generally fail to support this intent. Analysis, both within the region and globally, has suggested that much of this architecture is ineffective (Commission on AIDS in Asia, 2008; Godwin, 2006; England, 2006; Putzel, 2004; Dickinson, 2006; Dickinson and Druce, 2010), irrespective of epidemic context. During country visits for this Assessment the added value, viability and sustainability of program architecture was repeatedly discussed. Four characteristics of the architecture were commonly mentioned:

- Program structures have been put in place to deliver robust HIV prevention and treatment services that the generally weak health systems of the region would not have been able to achieve.

- The multi-sectoral and multi-stakeholder nature of the architecture does represent a significant step forward for public health programming, that other vertical programs like TB, malaria control, maternal and child health (MCH) have not be able to achieve. But keeping this ‘outside’ the Ministry of Health presents an opportunity cost to the health sector – which ought to be looking to extend this lesson to more of its programming.

- There has been significant political investment in putting this architecture in place, primarily at the demand of development partners; it would be difficult and politically costly to dismantle it; and such dismantling may well threaten program achievements.

- The architecture developed as a ‘child of the years of plenty’ for HIV; much could be attempted and achieved strictly beyond the formal parameters of HIV interventions. With the need to focus more specifically on targeted interventions, a number of constituencies will be disappointed.

In spite of these mixed views, in our judgement NAPs and their surrounding architecture are not fit for purpose: hence the failure in their NSPs to actually prioritise resource allocations according to identified strategy. Vested interests, turf wars between programs, inefficient planning tools, clumsy bureaucracy and weak vision and leadership challenge many programs.
Box 5: NACs and the multi-sectoral response to HIV

The usual justification for NACs to 'coordinate' the multi-sectoral response to HIV has been that the complexity of the responses required, their urgency, the difficult socio-cultural issues involved (sex, drug use, homosexuality, prostitution, and so on), and the resulting necessary advocacy to get these responses, requires very special attention at the very highest levels: 'AIDS exceptionalism'. This position rests on two premises: i) that the challenge of coordinating a multi-sectoral response to HIV is so urgent, so complex and so demanding that Ministries of Health do not have the capacity (political, institutional, managerial and technical) to manage it; and ii) that per se this coordination needs to be outside any one of the mainstream public service delivery sectors. But the ‘multi-sectoral response’ doesn’t really mean things happening in some kind of ‘super-sector’, larger than any one traditional sector – rather that the primarily concerned sector should engage with other sectors to achieve a response larger than its own sector.

The low national incidence and prevalence rates across the region mean, however, that the sectoral impacts of HIV remain relatively small; in general too small to warrant being made major, sector-wide priorities in sectors already grappling with serious problems relating to weak systems, poor coverage, lack of resources, inequity and poverty. Ministries of Health are thus not challenged beyond their capability. In these circumstances the establishment of a NAC creates a significant opportunity cost for the health sector – denying it the space to negotiate multi-sectorality itself.

An additional element in the ‘coordination of the multi-sectoral response’ has concerned increasing involvement of civil society in HIV programs. By their nature, however, civil society organisations tend to be focused on specific issues, within specific sectors, and with specific implementation focus. Far more can be achieved by strengthening the contribution of civil society at sectoral level – where they have credibility, existing partnerships, developed skills, and clear focus (PACT, 2005). This again is a primary role of a Ministry of Health – as part of good, multi-sectoral public health.

Perhaps the best evidence of what doesn't work, however, comes from comparisons with population, nutrition and poverty programs. The great reductions in fertility in the region, some of the fastest reductions the world has seen, were possibly the result of family planning programs, probably largely the result of underlying societal changes, and almost certainly due in no part to Population and Development Councils or coordinating bodies (see Caldwell et al., 2002. Family Planning Programmes in the Twenty-first Century in Studies in Family Planning, Vol 33, No 1, March 2002, special issue based on a Conference of the International Union for the Scientific Study of Population). When presidents, Planning Commissions and populations did pay attention to the ‘population and development’ message it was almost always to strengthen some kind of family planning message or service within sectoral boundaries. It might not be too fanciful to say that the Cairo UN Conference on Population and Development, through the controversies and confrontations it generated, in fact expunged family planning and reproductive health, let alone ‘population’, from the international and many national agendas – as the MDGs show.

In addition, this architecture is expensive. Program management and administration costs a total of $66.7 million annually for nine of the ten priority countries (excluding China) – 11 per cent of all investment in HIV. In the Philippines, East Timor, Cambodia, Indonesia and Laos, management and administration accounts for more than 20 per cent of total program costs (See Table 1, Annex 6). Some 22 per cent of all Global Fund grants are used for management and administration, and 21 per cent of all UN funding. Human resources consume another 3 per cent of the total; 46 per cent coming from Global Fund grants. 16 per cent of all Global Fund investment goes for human resources; as does some 9 per cent of all UN direct investment. In total more than a third of Global Fund investment supports management and administration and human resources.
Box 6: Architectural challenges in Asia

- NACs can add unnecessary layers of bureaucracy and politics on Ministry of Health HIV programs, with little added value. Concentrated epidemics require the selective involvement of a few key sectors (for example drug control, justice, planning, public safety, education). In the experience of Asia’s epidemics, there is little evidence to suggest that NACs provide additional ‘coordination value’; indeed, they tend to be an opportunity cost to Ministries of Health trying to develop such engagement themselves, as part of good, modern public health (World Bank, 2005).

- NACs can also experience mission creep, typically getting involved in program implementation often at the cost of coordination. There may be understandable historical reasons for this. For example, Indonesia’s National AIDS Commission is also a Principal Recipient of a Global Fund grant and is the main implementing body for national prevention work including for harm reduction.

- Vertical HIV programs often develop planning, funding, human resource, logistics and devolution systems separate to standard health care delivery systems. These can be difficult to ‘integrate’ and equally difficult to dismantle.

- HIV programs tend to be structured around the ‘UNAIDS’ Consensus’ of HIV programming: prevention, care and treatment, impact mitigation and management and coordination. This program framework is becoming increasingly inappropriate. The new Investment Framework from UNAIDS, combination prevention, treatment as prevention, the public health approach to integrated SRH, social protection and cash transfers are all alternative frameworks; yet program structures find these difficult to grapple with effectively – program organograms, budgets, planning frameworks, supervision systems all need to be re-aligned.

- Inconsistencies and territorialities between NACS/NAPs and CCMs are tending to create anomalies in accountability, planning, resource mobilisation and programming. Division of labour over major programmatic areas (for example prevention programming for MSM, SW and PWID through the NAC and treatment services through the MOH in Indonesia) is reported by informants to fragment program coherence and has an impact on the continuum of care for people living with HIV.

- As interventions go to scale, the costs of CSO engagement is becoming increasingly unsustainable. Extensive CBO home-based care programs in Burma (Myanmar) and Cambodia are being dismantled. In Vietnam, PEPFAR-funded INGO programs are under serious pressure to reduce the costs of their community level operations. In India, the transition from the Gates-funded Avahan NGO program to Government funding for targeted interventions is highly challenging. Under pressure from Global Fund budget cuts, many CSO are re-assessing their capabilities.

- This architecture is highly dependent upon external funding. If external funding is reduced, program management costs will reduce considerably: external funding is not only supporting interventions, it has been responsible for building and sustaining the architecture.

Source: Information collected for this Assessment including Country Reports and country informant interviews.

This analysis presents a challenge to partners. Throughout the Assessment, when questioned on the architecture, country informants would tell us – but this is what you donors asked us to do; have you now changed your mind? Yet it was unclear during the Assessment how far partners themselves fully recognised the weaknesses of the current architecture, how far they felt empowered to challenge it, how far they accepted their responsibility for dealing with it – and how they might go about it.
4.3 Programming

**Investment in programming has been substantial.** All countries have NAPs in a variety of forms. NAPs are usually vertical within the health sector, either within the communicable disease control sub-sector, or stand-alone, and usually combined with pre-existing sexually transmissible infection (STI) programs. Though many have multi-sectoral linkages fewer have explicit intra-sectoral linkages, even for TB, and are weakly integrated with other health programs, such as MCH, SRH, or primary health care (PHC). Where programming has taken place outside the health sector it has primarily been in education, with limited social welfare programming for orphans and widows and people living with HIV. There has also been growing engagement with the legislative and judicial sectors, police systems, and the narcotic control sector.

**A number of important outcomes have resulted from the investments in the region.** Robust programs around the sex industry (STI care, condom distribution, outreach and empowerment, and so on) have produced significant outcomes in many countries: three-quarters (76 per cent) of paid/sold sex involves condom use (UNAIDS, 2011a). Where harm reduction programs have achieved reasonable levels of coverage, they appear to produce good outcomes. Median values of outcomes in the region include:

- 83 per cent of PWID being reached used a sterile needle and syringe at their last injection (UNAIDS 2010a).\(^9\)
- 200,000 access opioid substitution treatment (UNAIDS, 2011a).
- Pilot models suggest that MSM interventions can have good outcomes: 61 per cent of MSM used a condom at last anal sex (UNAIDS, 2010a).
- HIV testing is increasing among key populations: 33 per cent of SW, 29 per cent of MSM and a 22 per cent of PWID have had an HIV test and know their results (UNAIDS, 2010a).

With respect to treatment, 39 per cent of people with HIV receive ART (WHO, 2011). Around 2.4 million people are estimated to still be in need of ART in the region (UNAIDS, 2011a). Six countries account for over 90 per cent of the HIV burden: India, China, Thailand, Indonesia, Vietnam and Burma (Myanmar).

PMTCT is also being scaled up: HIV testing for pregnant women reached 30 per cent of pregnant women in the region in 2010 (WHO, 2011). The TB impact is mixed: although prevention of TB among people living with HIV is a core component of HIV care and treatment services, implementation of the WHO-recommended ‘Three I’s’ approach has been limited in the region and many national HIV programs are not yet routinely reporting data on TB screening, prophylaxis and treatment.

The impact of these outcomes is seen in the stabilisation of the epidemic (section 3.1). Incidence is estimated to have fallen in most countries in the region and increasing coverage is resulting in safer sexual and injecting behaviours. There are now approximately 922,000 people receiving treatment in the region (WHO, 2011), well over triple the 2006 numbers.

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\(^9\)Data are taken from consolidated data from country UNGASS progress reports. It is important to note that in many countries these data are collected in intervention sites where use of sterile injection equipment is likely to be higher and not necessarily representative of the behaviours among people who inject drugs in non-intervention areas.
Yet as the UNAIDS reports make clear, the pace of scale up of service coverage in the region, compared to other LIC and MIC is slower and very significant coverage increases for prevention programs are necessary if progress towards the HLM targets is to be achieved (UNAIDS, 2011a; UNAIDS, 2012). In 2009, the reported regional median coverage rates for prevention among key populations (among reporting countries in 2010) was substantially below the target (80 per cent) needed to sustainably reverse and control the epidemic:

- People who inject drugs – 17 per cent
- Men who have sex with men – 36.5 per cent
- Female sex workers – 41 per cent
- Male sex workers – 13 per cent
- Needle and syringe programs – 14 per cent
- Number of needles and syringes distributed per user per year – 25 per cent of recommended level
- Opioid Substitution Therapy – only 5 per cent

In addition, there is still a large treatment gap; about 2.4 million people in need of treatment in the region are not receiving it. Cambodia, with 94 per cent coverage, is one of the eight countries worldwide to have reached universal access (more than 80 per cent coverage) under the 2010 WHO treatment guidelines. Lao PDR (67 per cent), Papua New Guinea (52 per cent) and Thailand (61 per cent), are the only other Asia-Pacific countries to provide treatment to over half of those in need. The 2010 revised WHO treatment guidelines, however, recommend earlier initiation of ART for people living with HIV with CD4 counts at or below 350 cells/mm3 and initiation of treatment for all HIV-positive infants under 24 months. As a result, the number of people eligible for ART in the region increased by approximately 50 per cent and the recalculated coverage of ART fell accordingly. Children account for 3.5 per cent of the total treatment burden in the region. An estimated 113,000 children were in need of ART in 2010. The 80 per cent coverage among children in Cambodia, Malaysia and Thailand largely accounts for this.

In spite of the high political focus on PMTCT10, scaling up offers particular challenges. Access to regular antenatal care for at least four visits low in much of the region, below 50 per cent in many countries: and HIV is relatively rare among pregnant women. Only about 0.1 per cent of pregnant women are infected with HIV, an estimated 85,000 positive pregnant women among 69 million pregnancies in 2008 (UNAIDS, 2011a). So reaching these women poses a particular challenge in terms of cost-effectiveness. In addition, as with all health services, key populations have limited access to PMTCT services. Appropriate service delivery models for PMTCT are thus difficult to establish (see also Box 8).

Infections among ‘intimate partners’, as already noted, are an important element in regional incidence. Yet there seem to be few program models that address this effectively. It is important to distinguish between incidence among ‘intimate partners’, who may often be ‘general population’, and transmission within the general population. By their nature, intimate partners of key

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10 Viz the UNAIDS/PEPFR Global Plan towards Elimination of new HIV infections in Children and Keeping their Mothers Alive by 2015
populations are unlikely to be reached effectively with general population channels; yet they are equally unlikely to be reached directly through targeted key population channels. Again, they are a relatively small, yet under-served group.

Investment in national planning processes has also been significant but NSPs remain aspirational, with resources frequently misdirected. While there is a fairly widespread recognition that programming needs to respond more effectively to the epidemiological drivers, and resources need to be targeted, most country responses have found this difficult to do in practice. An analysis by UNAIDS in 2008 of the NSPs of 18 Asian countries found that 15 were not targeted for an effective HIV response: they lacked appropriate prioritisation of populations and sub-regions; did not specify elements of effective interventions for implementation; had no monitoring and evaluation systems built in; and lacked resource estimates, and costed operational plans (UNAIDS-ADB-World Bank-World Bank AIDS Strategy and Action Plan (ASAP)-UNDP, 2008). A follow-up review three years later of a new generation of NSPs found significant improvements in many aspects, though not in actual resource allocations (UNAIDS RST and the regional HIV and AIDS Data Hub, 2011). The Country Reports prepared for this Assessment confirm this – while NSPs say they are strategically focused on key populations, actual resource allocations tend not to support this claim.

This is not only a fund allocation problem. As the previous section has tried to show, policy and architecture are designed for certain kinds of outcomes, and certain kinds of investments and programming decision making. Without changing these, it may well be very difficult for National Program Managers to make the kinds of very significant changes to their plans and strategies that are required – particularly when they require significant funding allocation decisions.

Deciding ‘how to cut your coat to fit your cloth’ is crucial for the region now. As the primary source of technical support for national strategic planning, UNAIDS must seriously review and re-fit its approach (including yielding up agency ‘turf’ where necessary) to help countries be far more investment-oriented, focused on clear results in their programming and ensuring logic chains underpin results frameworks. If MSM are a target group, program interventions need to focus on reaching them effectively; not, as in one country visited, hope to reach them through ‘AIDS in the workplace’ campaigns among garment factory workers, on the premise that some MSM may well work in garment factories. Likewise, HIV investments need to be based on solid evidence rather than investing on perceptions of risk, for example with certain population groups such as migrant workers. Other partners must be prepared to back UNAIDS up.

4.4 Strategic information

Considerable investment had been made in epidemic assessment and strategic information systems. At country level this has been through national M&E systems (United Nations General Assembly Special Session [UNGASS] and other reporting is advanced). At regional level the Data Hub Asia Pacific, established as a joint venture with UNICEF, UNAIDS and ADB, has become the most important repository on data in the region. The region is moving beyond the measurement of prevalence as the foundation of strategic information, towards the measurement and assessment of incidence. This Assessment found progress, demand and keen interest in incidence modelling and measurement throughout the region.
Much of the investment is coalescing around the HLM targets as the vision for the epidemic in the region. This is reflected in the ASEAN Declaration (ASEAN ‘Declaration of Commitment: Getting to Zero new HIV infections, Zero discrimination, Zero AIDS-related deaths’, 2011) adopting the HLM targets as regional targets, and the work of UNAIDS in determining the numerical contribution of the region to the global targets (UNAIDS, 2012). This will be a critically important roadmap for the region (see below).

**But strategic information is still insufficient in certain areas and measurement lacks coordination.**

Weaknesses in the development and effective use of strategic information, as a program and resource allocation guide have emerged as a key finding in this Assessment. Although significant investment in strategic information systems have been made, more is required, particularly data concerning key populations, including population sizes and distributions, behaviour patterns, gender dynamics, vulnerability and risk. There is limited information and tools for costing and cost efficiency assessments of interventions and service delivery models.

In addition, emphasis in the use of strategic information tends to be in ‘monitoring and evaluation’, that is, measuring what has happened rather than determining program results, targets and resource allocations, that is, identifying what needs to happen. This is a critical area where the ‘investment approach’ can be extremely helpful for the region; and where the HLM targets can play a major role.

Incidence measurement and modelling for setting priorities and targets is growing but this Assessment found duplication, confusion and a lack of coordination on this issue throughout the region. Funding for incidence modelling is coming from all currently engaged partners (with most countries involved) but needs to be urgently and effectively coordinated at the regional level, with confidence and credibility on all sides. Investment in understanding and using information for planning and management also remains a major challenge for the medium term – particularly in determining resource allocations, and future investment and accountability frameworks.

**4.5 Technical assistance**

**Technical assistance investments support policy, strategy and programming.** An important element in the investment in the region has been substantial investment by development and national partners in the provision and management of direct TA and for the development of technical support mechanisms. Global and regional providers include UNAIDS (and their UN Joint Teams on AIDS), AusAID, USAID, US-CDC Global AIDS Program, Department for International Development (DFID), ADB, GTZ and, to a lesser extent, the World Bank and the European Union (EU). Regional technical support hubs provide assistance to different audiences, for example the South East Asia Technical Support Facility managed by the International Planned Parenthood Federation, provides advice mainly to NACs and Ministries of Health; International HIV/AIDS Alliance Regional Technical Support Hubs run in Cambodia and India provide support to NGOs, CSOs, and CCMs; WHO collaborating centres and knowledge hubs link many academic institutions. Technical support is also being provided by AusAID’s HIV Consortium partners that have institutional links with counterpart organisations in the region. The Results for Development
Institute is providing technical support to various NAPs. Perhaps the most significant investment in terms of technical quality has been that of the US Government primarily through USAID and US-CDC. All this TA is well recognised and appreciated throughout the region. China, for example, talks of the value of its access to ‘expert science’ from Australian and American academia.

The value and impact of TA investment is rarely calculated, however (West et al., 2012). TA is usually seen as an ‘input’ (quite often with high transaction costs to the recipient) rather than an investment and it is difficult to identify and value. It is useful to consider two aspects of TA as *transactional* (that is assisting organisations to perform their functions without necessarily strengthening their capacity to perform the functions without continued support), and TA as *transformational* (that is essentially building the capacity of organisations to perform their functions without continued support) (DFID, 2006).

Transformational TA has been of very significant import in the region: first in the development of HIV program architecture, second in helping build the capacity of civil society, and third in providing access to academic development. Yet it suffers from the same censure: it may have been a significant investment, but was it to any purpose in today’s context? And what to do about it? Just as considerable TA has gone into helping design NACs and their systems, can similar TA now be available to expunge them? Or, at least, to help them become more relevant? In China and Cambodia, for example, in the last couple of years, partners have funded major management or task analysis reviews of overall program architecture; yet where has the political investment from partners been to help the national programs accept and accommodate these reviews?

**Box 7: Technical assistance as investment**

- United States Centres for Disease Control is primarily a TA agency, rather than a donor agency, and is highly valued throughout the region. It is difficult to obtain figures for CDC investment, but it is notable that even with the withdrawal of bi-lateral assistance, it is one of the few agencies still working in China.
- USAID, while providing very substantial financial investment throughout the region, also provides substantial TA. This is likely to be a major area of re-alignment of USAID funding in the coming years – increasing focus on TA and capacity building. While much of this support has been primarily for civil society, much of it has also been available for government.
- Estimates of UN funding are $35 million per year for the whole region (Annex 6, Table 3). Yet in 2010 there were 286 UN staff members working at least 50 per cent of their time on HIV; at an average cost of $150,000 per person per year, the UN investment in staff time alone comes to nearly $43 million per year – more than doubling the UN investment.
- Very substantial amounts of Global Fund moneys are allocated for capacity building for civil society; this may be direct investments such as the Alliance program in India, or Nadlatul Ulama, Indonesia.

With regard to civil society capacity building, as noted earlier, very considerable TA has been invested. Yet there is less evidence that this has been far-sighted. The rigorous re-structuring that PEPFAR-funded civil society is undergoing in Vietnam is a case in point. Investing in the technical capacity of civil society to design, deliver and refine effective programming and better quality services is warranted.
4.6. Service delivery and health systems

**Investment in health systems, service delivery and integration**

HIV services are mainly delivered through a mix of public health systems and international/national NGOs or CSOs. HIV in Asia has generally been funded and programmed ‘vertically’, bringing about improvements in HIV service coverage for general and key populations. HIV programming, globally, is new to the last three decades. Unlike mature health sector programs like MCH, malaria and TB control, there have been no well-established program principles and systems to follow and build on. This has presented opportunities and challenges: an opportunity to develop a more effective public health model based on greater multi-sectoral and civil society engagement, using a wider variety of strategy and service delivery channels; and the challenge of a model that is increasingly unsustainable and has been slow to find favour with many governments in the region, where former socialist norms tend to perceive, for example, the need for civil society engagement as a sign of state failure, rather than an indication of the potential for state partnership.

Globally, vertical HIV funding, programming and service delivery systems have created positive and negative impacts (often within the same country) on health systems, with many basic health system functions such as governance, financing, service delivery, planning, procurement and information systems being developed specifically for HIV, in parallel to those of the general health system. The scale up of ART has also taken place predominantly through vertical programs. In many countries in Asia, the availability of ART services remains limited to ‘specialised’ hospitals (for example China, India, the Philippines). In only a few places has the HIV investment in laboratory services, procurement and supply chain management, quality assurance and community level support for adherence been absorbed into the general health system. Cambodia and Thailand are unusual in this respect and represent important examples for the region.

There is a strong case to balance investments, both for specific HIV programs (particularly for HIV prevention programming targeting key populations) and for health systems strengthening. Investments in health systems in LIC and MIC are critical to ensuring that HIV and other health resources achieve their full potential. Likewise, investments in HIV can support the strengthening of health systems to enable sound and effective responses, and to achieve synergies with other health programs, potentially improving wider health outcomes. Globally, development partners are investing more in health systems strengthening and there is considerable momentum to ‘normalise’ or integrate HIV into general health services. While strong health systems with integrated HIV services may be a desirable, sustainable, long term goal, the practicalities of actually making it happen are more challenging and require careful consideration (see Box 8), and on their own are unlikely to bring about change on the scale required in the short term to achieve the HLM targets in Asia.

Our fieldwork suggests that investment in both health systems strengthening and HIV programming that still targets key populations is required. In the concentrated epidemics of Asia, where country health systems are too weak to absorb the demands of HIV, and stigma, fear of legal action, and inability to pay still act as barriers to accessing health services, vertical HIV services with
ring-fenced budgets and distinct service delivery mechanisms are generally still warranted. Attempting to fully integrate vertical HIV systems, or investing exclusively in health systems strengthening, runs the risk that the gains made to date through vertical programming will be lost. Governments need to strongly commit to funding prevention, care and treatment services for key populations commensurate to the size and nature of the epidemic – and then determine the most cost-effective way of doing this.

Box 8: Health systems, HIV and integration: Consideration for investment

- Deciding when a country’s HIV services should be integrated and what services make sense to integrate needs to be determined by the concentrated epidemiological context and the associated problems of key populations accessing mainstream services, resource realities of countries in the region (which vary considerably) and ‘system readiness’ to integrate. For example, in Laos, a country with a relatively young HIV epidemic, maintaining or enhancing verticality of HIV programs is considered important to allow greater levels of stewardship, coordination and smoother service implementation (Hanvoravongchai, 2010). Indonesia has chosen to increasingly integrate HIV services into the existing health system and is scaling up the number of public sector hospitals and clinics offering harm reduction services, VCT, ART, PMTCT as part of its drive to develop a sustainable and self-reliant national response. In India, the World Bank is working with the government to consider which functions and programs currently done by the NAP could be taken care of by mainstream health services, for example blood safety, STI services, universal treatment and PMTCT.

- There is still no universally accepted definition of integrated care (see Annex 7), therefore any analysis and comparison of integrated care is methodologically challenging. More generally, evidence on the benefits of vertical or integrated service delivery is mixed and there are no clear conclusions about when vertical programs are desirable (Atun et al., 2008). There is also a paucity of evidence-based technical guidance on integration investments in concentrated epidemic contexts that are critical to strengthening the impacts and sustainability of HIV and other health programs.

- The case of bi-directional SRH/HIV linkages is strong but globally, the predominant model has been integrating HIV services into MCH services. Key questions remain over how cost effective this approach is in concentrated epidemics where many women (intimate partners of MSM, PWID, clients of SW) don’t know they are at risk of HIV. This can result in heavy investment in testing pregnant women in MCH settings where the numbers of women testing HIV positive is low. A stronger focus on understanding the SRH needs of key populations (both male and female sex workers and male and female PWID, MSM, and their intimate partners) and what other services and strategies are effective and necessary to deliver comprehensive services for different key populations (for example, this may include HIV/TB/viral hepatitis integrated services along with NSP, OST, STI and condom programming for PWID) is critical for the region. Investing in studies with robust designs, comparable control and intervention groups, cost analysis and valid outcomes is important to ensure basic human rights and health needs of people living with HIV are met, so SRH and other health needs for key populations becomes ‘core business’ for MOHs in the future, and to guide further integration investments.

- Recommendations to integrate PMTCT programs are widely embedded into global and national policies and strategies for fighting HIV. However, recent studies show the evidence base on the effectiveness of integrated PMTCT compared to partially or non-integrated care is scarce with no clarity on modality of integration and all models failing to achieve target coverage (Tudor Car et al., 2012). A recent study on the cost effectiveness of PMTCT in LMIC suggests that in concentrated epidemics where HIV prevalence in the general population is low, PMTCT strategies based on universal or targeted testing of pregnant women may not compare well against cost-effectiveness benchmarks and offer a low relative value in relation to competing interventions to improve population health. To help ensure PMTCT investments reach their full potential, greater attention needs to be paid to how best to offer these services (Johri and Ako Arrey, 2011). Rigorous research on PMTCT models and integration of PMTCT is urgently needed. Key questions to consider include: which PMTCT strategies are best in a given local context? How best to scale up PMTCT to key populations? How should PMTCT services be organised and delivered?
to strengthen health systems and improve the health of women and children? Which service integration models work best in which epidemic context? What are benefits and costs of linked services including costs and cost-effectiveness?

- Two of the more promising areas for future development are the links between ART and chronic care systems, and ‘treatment as prevention’. Treatment 2.0 (see below) addresses a number of the WHO building blocks for health care systems and is, in effect, a chronic care system, similar to diabetes and other long term NCDs. The expansion of treatment programs could therefore relatively easily be used either as a starting point for developing chronic care NCD systems, which are largely in their infancy in the region (but likely to grow in political priority); or be absorbed into such systems as they develop (Rabkin and Nishtar, 2011). Treatment as prevention is a new and controversial approach.

- Although HIV and NCDs are often thought of as very different challenges and siloed within most health agencies, lessons learned from HIV program expansion can be applied to strengthen models of managing NCDs and can promote bi-directional linkages between HIV and NCDs. Many South East Asian countries such as Burma (Myanmar), Thailand, Cambodia and Vietnam have already established pioneering systems to promote a long term continuum of care for patients on ART, and these systems can be applied for the management of NCDs. In such cases, services were integrated within public health facilities and linked to communities. A key feature was the involvement of affected communities as co-service providers, whereby patients had a central role in promoting self-treatment, treatment adherence and peer support (Poudel et al., 2011). Bi-directional linkages between HIV and NCD could be particularly important in the context of Asian concentrated epidemics for two main reasons: i) to avoid duplication of investment in expensive ‘continuity care’ models of chronic care, and ii) where the incidence of where HIV stigma is perceived to complicate access to integrated services. Although the experience is limited, integrated HIV/NCD services in Cambodia suggest stigma was not a major obstacle to accessing integrated chronic care and chronic care clinics may provide an opportunity to further reduce HIV stigma and discrimination. The experience of Cambodia and Ethiopia demonstrates the feasibility of integrating HIV care with care for other chronic diseases, for example diabetes, with reduced stigma HIV-related, satisfactory outcomes for patients, efficiency gains for services (Janssens et al., 2007), adherence and quality of care improvements (UNAIDS, 2011d).

**Treatment continues to present a major challenge to the region**

Treatment 2.0 outlines the current normative, technical approach for both expanding access to treatment, and to establishing more sustainable treatment programs. It fails, in many ways, to address the critical programming challenges of scaling up treatment.

**Box 9: Treatment 2.0**

Treatment 2.0 promotes a simplified HIV treatment platform built on five inter-connected pillars:

- Optimising drug regimens for simpler and more efficacious protocols with less toxicity
- Providing point-of-care diagnostics for more access to less-expensive treatment monitoring
- Reducing costs for drugs and the non-drug costs of treatment
- Adapting delivery systems to facilitate the continuum of care
- Mobilising communities to improve treatment access and adherence

**Source:** UNAIDS, 2011a: Universal Access in Asia and the Pacific; Regional Stocktaking Report

Treatment 2.0 talks about ‘adapting delivery systems to facilitate the continuum of care’. But this continuum of care essentially applies to two groups of clients: the general population groups such as spouses of PWID, men who have sex with men or of clients of SWs themselves. These groups are more likely to access general health services; the other group are the key populations themselves who find accessing general health services more difficult. Additionally, for key populations, new
‘technologies’ (treatment as prevention, test and treat, over the counter diagnostics and so on) are likely to be particularly effective and acceptable but will be more closely linked to specific SRH programs for key populations.

**Meanwhile, there is still a very significant treatment gap among key populations – they are less likely to be on ART than the rest of the population.** Investment in infrastructure and an accelerated agenda to expand access to HIV testing and counselling and treatment under current guidelines, especially for key populations, will not only help progress towards the HLM treatment targets, but also help countries prepare so that once normative guidance on treatment as prevention is available, countries will be ready to implement. A number of countries are now involved in trials of ‘treatment as prevention’; explicitly improving the nature of care for key populations. Cambodia, for example, is moving to a new stage of treatment as prevention and integrating PMTCT. Such approaches will become increasingly important.

### 4.7 Regional rather than country focus

**It is clear from the analysis above that the major changes needed in policy and programming must take place at country level.** Each country is unique in its HIV situation and response, and needs to adjust to the new agenda in its own way. Yet countries are dependent in many ways on regional and global frameworks, and without the support of those frameworks it is often difficult for a country to manage effectively.

**As we have tried to show, the policy, architecture and programming frameworks in the countries in the region have been highly influenced by such regional and global frameworks.** Without significant changes at regional level, therefore, it will be difficult for countries to shift direction. The first priority this Assessment suggests, and the focus of the strategic options (see below), is that the re-shaping of the policy and technical advice that partners provide needs to take place at the regional level first.

This is particularly important for the normative partners, such as the UN family; but it is also important for other partners, for whom funding decision making must be contextualised, if not justified, within the new frameworks.
Extensive investments have been made in HIV programs over the decade. Good expenditure data are hard to come by, as not all countries report expenditure data fully.\(^{11}\) The calculations in this report are based upon best estimate data from the Data Hub Asia Pacific. The funding position is complex.

### 5.1 Funds and funding sources

Overall, for all of South and South East Asia and China, in 2009 some US$1 billion was spent on HIV, of which $900 million was spent in the ten focus countries of this Assessment; 54 per cent of this was domestic funding, largely accounted for by the very high proportions of domestic funding in Thailand and China. In the other countries domestic funding ranged from 2 per cent in Laos and Vietnam to 40 per cent in Indonesia. Many countries are highly dependent upon external investments for their HIV programs. Among low income countries alone, the figure was 95 per cent. Several MIC such as India, Vietnam, and to a lesser extent Indonesia, are also highly dependent on external funding. The principal sources of external funds in 2009 were bi-lateral (40 per cent), the Global Fund (36 per cent), Asian Development Bank (10 per cent), UN (8 per cent) and others (6 per cent).

**Bilateral funding accounted for 18 per cent of the $900 million**, ranging from under 5 per cent in China, Thailand and the Philippines, through 40 per cent in Cambodia and Indonesia, to 87 per cent in Vietnam. The Global Fund accounted for 16 per cent of total expenditure, ranging from 5 per cent in Thailand, through 37 per cent, 41 per cent and 42 per cent in Cambodia, India and Laos respectively, to 58 per cent in the Philippines and 97 per cent in East Timor. Other international (largely Gates in China and the 3DF in Myanmar) accounted for 6 per cent, followed by World Bank and ADB, 4 per cent, and the UN, 2 per cent (see Table 2, Annex 6).

**Domestic funding is highly mixed.** It is used both for prevention and to cover care and treatment costs (Sharma and Szabo, 2011).\(^{12}\) Cambodia, the Philippines and Indonesia allocate 78 per cent, 54 per cent and 48 per cent respectively of their domestic HIV funding to prevention; Thailand 80 per cent for care and treatment, followed by Indonesia 29 per cent, and the Philippines 29 per cent (see Table 3, Annex 6). Apart from Thailand, China and Indonesia (from 2012), the remaining Assessment countries rely largely on external funds for ART.

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\(^{11}\)Note that full data for China and India are largely missing from the calculations.

\(^{12}\)This study was commissioned by UNAIDS RST for the UNAIDS Universal Access Regional Stocktaking Report published in 2011
External funding tends to cover not only the costs of specific program interventions (Commission on AIDS in Asia, 2008) but also much of the program architecture and management costs (see section 4.3). This is not a situation that is easily changed: reducing external funding is more likely, in many cases, to result in serious declines in program quality, rather than greater program efficiency, through re-allocation of scare funds. In addition, few programs give any consideration to longer-term funding planning and program sustainability.

Within the context of a limited assessment such as this it is difficult to draw firm conclusions about current and future country funding policies, and the reasons for the vast divergence in domestic allocations. But some attempt must be made in order to try to project likely scenarios.

From among our ten countries, based on the Country Papers and our observations, countries can be grouped into three categories:

- Those like China and Thailand, who have made serious political investment in their HIV response, and have fiscal space to support this. The ‘political’ energy of Mechai Veravaidya, and the UNDP study of the economic costs of HIV in Thailand, committed Thailand early on to its indigenous HIV response. The external political costs of the plasma scandal in China, coupled with the SARS and Avian flu outbreaks, committed China in a similar manner.
- Those, like Vietnam, India, Indonesia, who have the fiscal space, but by default or political design chose to fund their HIV response largely from external sources. This may be changing in India and Indonesia.
- Those like Laos, Cambodia, Burma (Myanmar), Timor Leste and the Philippines, who are still highly dependent upon donor funding for much of their development investment, particularly in the social sectors.

As this analysis shows, there is limited evidence of, or room for, change in these scenarios. In the second group, India remains a substantial Global Fund recipient, and has borrowed from the World Bank. In Indonesia, total spending on the HIV response does not show substantial increase since 2007 and in real terms may have slightly decreased. MOH has shown increases in financing a larger share of ART costs but most other HIV budgets have not increased. In the third group, only Cambodia has conducted a credible analysis of fiscal space and projected scenarios for its HIV funding (Godwin, 2012), but the real likelihood of significantly increased domestic spending is limited.

5.2 Funding allocations

In terms of expenditure categories, in 2009, the destinations for all external investments in HIV in Asia Pacific were: 42 per cent prevention; 16 per cent program management and administration; 14 per cent ART; 5 per cent human resources; 4 per cent enabling environment and 2 per cent on research (Sharma and Szabo, 2011) (see Figure 4).

13 Note that India, which is pleased to fund 98% of its general health spending domestically, has been funding only 40% of its HIV spending domestically.
Bilateral and Global Fund grants have been critical for improving state and CSO capacity to plan and deliver services targeting key populations, typically focusing investments in: strategic information; HIV and STI services for MSM, SW, PWID, prisons, high risk men (in specific locations) and migrants; integration of HIV with MCH, malaria, TB and other services; organisational capacity and leadership for CSOs, NAPs and NAC. Limited domestic investment through the regular budget for CSO programs and services has resulted in a high degree of dependency for CSO activities on external funds.

Although the data are limited, they tend to suggest, as we have noted in section 4.2, that resource allocations do not always follow strategic priorities. Spending on key populations tends to be low compared to the substantial levels allocated to prevention activities for lower risk groups.

The calculations are based on UNGASS 2010 Indicator 1 Data Summary. The pie chart excludes data from China and India on funding source and spending categories and therefore existing data should be interpreted with caution.
populations. For example, in Cambodia, the National AIDS Spending Assessment (NASA) for 2009/2010 found that expenditures for 2009 and 2010 specifically targeting key populations were only 9 per cent and 10 per cent respectively of the total. ‘Non-targeted interventions’ (those that cover all beneficiaries) were 41 per cent. External funding contributed 6.7 per cent of Thailand’s total HIV resources in 2009, the majority of which was spent on low-cost, high-impact interventions via the Global Fund, USAID and PEPFAR. In terms of its impact on the epidemic, the external component of Thailand’s HIV budget is of considerable importance; the current service coverage level of 20 per cent for MSM has been achieved entirely through external funding (Lind Van Wijngaarden, 2012).

Furthermore, many NSPs remain unrealistic. The Country Reports for this Assessment show very large financing gaps in many NSPs, at a time when the trajectory of external funding is in decline and domestic financing is still constrained (see section 5.3, box 10). This is particularly worrying in the new NSPs developed within the last year, or being developed now. It is important to distinguish, however, between countries that are highly dependent upon external financial support, but which plan within predictable expectations of such support, and those that simply plan with large budget deficits (for example the Philippines and Vietnam). In addition, there is little scenario planning (in the region, but also globally) partly as a result of the limitations of currently available costing tools (Hester et al., 2010; Bush et al., 2011; Forsythe et al. and UNAIDS, 2010).

Countries urgently need to develop better, long-term funding strategies. The current approach being used in national strategic planning, costing and budgeting is largely based upon aspirational resource needs estimations coupled with ‘resource mobilisation’ hopes. This is a bit like a household budgeting for its children’s education based upon winning the lottery rather than the combined household income!

5.3 Funding prospects

For Asia to reach the HLM targets, UNAIDS estimates that $3 billion more is needed than was available in 2010, to be met through a combination of domestic and external funding (UNAIDS, 2012). However, after a decade of abundance, external funding for HIV is on the decline, globally, and this trend is set to continue (Bärnighausen et al., 2012). It is unclear, however, if the UNAIDS estimate fully takes cognisance of the inefficiencies and inappropriate allocations in HIV funding in the region. The effectiveness of available financial resources in Asia can be improved. Considerable amounts of existing resources (both domestic and external) are being allocated on programs with limited prevention benefit, as our analysis shows. A number of countries in the region have the potential to expand domestic financing for HIV. Assessing and measuring the size of this potential, as well as the feasibility of realising this potential would require further consideration of the adequacy of total national health expenditure; the contribution of other development partners; the potential to reallocate funds from other areas of government spending; and the potential for increasing government revenue systems (McCoy and Kinyua, 2012). Effecting changes to these allocations, however, will be time-consuming, and may have considerable social, political and program costs.
For the major external partners in the region, changes in the immediate future in how funds are made available, rather than the absolute amounts, is likely to be the most important issue. The United States Government (USG) remains fully committed to the region, though absolute funding levels are likely to reduce in most cases (for example, Vietnam, where a 10 per cent reduction year on year is likely). More importantly, USAID is in the process of developing a new regional strategy that may well change the strategic focus of funding. The United States Centres for Disease Control – Global AIDS Program (US CDC-GAP) continues to provide TA in most countries. Smaller donors like DFID and AusAID are re-assessing their support; but it appears that this is more in terms of modalities and geographic focus than substantive funding levels.

With regard to the Global Fund, few countries in the region are directly affected by the cancellation of Round 11. Only Laos, Burma (Myanmar) and the Philippines had expected Global Fund support before 2014. China’s Global Fund support had already in effect ceased; India, Vietnam, Cambodia, East Timor and Indonesia have Global Fund grants running past 2015. According to the latest Global Fund eligibility list for 2012 funding channels, virtually all countries in the region, including India but excluding Malaysia and Thailand or China, are still eligible for 2012 funding.

The strategic focus of Global Fund support, as well as the conditions under which it is made available, is likely to change, however (see Box 11). In a recent presentation, the new General Manager of the Global Fund15 talks of:

- Detailed coordination of Global Fund investments with partners, with a special emphasis on procurement and drug supply.
- Prioritising interventions, with the goal of rapidly expanding new and promising approaches and technologies.
- Sharing of detailed information on grants in-country, with a special emphasis on oversight of risk, overcoming political and technical bottlenecks.
- Tracking of progress and identifying potential areas of re-programming as early as possible.

To reiterate, the most important threat to the funding situation is countries’ lack of appropriate long-term funding strategies. As noted below in Box 10, Vietnam, the Philippines, Indonesia, Burma (Myanmar) and Laos have all developed national strategies with enormous funding gaps and without any clear expectation of how these gaps would be filled.

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15 Presentation by the General Manager, 29 March 2012; “The Global Fund at Ten Years: Reflecting on its Impact and Looking Forward to Challenges Ahead”, Council for Foreign Relations, USA
Box 10: HIV funding changes in the region and funding gaps identified in National Strategic Plans:

- In Vietnam PEPFAR funding is projected to decline steadily from a peak of over $90 million in FY 2010, possibly by some 10-12 per cent per year DFID/World Bank financing of approximately $10 million per year (largely for harm reduction) is expected to end in 2012; ADB funds of $6 million per annum is ending soon; Global Fund funding amounts to approximately $7 million per annum. Grant renewal is in doubt and Round 11 has been postponed. NSP costing shows huge ‘gaps’ in funding.

- In India, over $700 million from Global Fund remains; but AusAID funding will end in 2012; DFID and Gates funding for HIV will disappear within the next two years. A new World Bank credit will help the transition from Gates funding, and GOI expects to make up the shortfall.

- In China, bi-lateral DFID, AusAID and USAID funding for HIV has all ended; an AusAID-supported cross-border project is continuing.

- The Philippines originally budgeted for $160 million for 2011–2016, with a gap of $94 million. It currently faces a $17 million gap for 2012 against a budgeted requirement of $26 million. Government is allocating funding for 2013–2015 as part of its regular health budget but the exact amount from 2013 needs to be confirmed.

- Laos budgeted $54 million for 2011–2015; currently it faces a budget shortfall of 48.5 million for the years 2012–2015.

- In Burma (Myanmar) the 3DF donor consortium committed US$138 million over five years (2007–2012) but this is ending in 2012; allocations for HIV will be far less in the following 3MDGF. UNAIDS estimates $40 million on average annual funding gap for 2012–2014.

- In Indonesia, total resource allocation for HIV (domestic and external funding) in 2010 was $65.6 million, less than half the estimated funding needed for the current national strategic plan.

Source: Information collected for this Strategic Assessment including Country Reports and informant discussions from country visits.

In this context, the continued availability of effective and efficient Global Fund investment is crucial. Countries remain highly dependent on the Global Fund; and they expect to rely on very similar levels of investment from the Global Fund once grant-making resumes in 2014. This after all is the funding pattern that has arisen around the Global Fund. Many countries, especially LIC, started with one or two major bi-lateral donors. These slowly gave way to an ever-increasing share of the total program being supported by the Global Fund. But Global Fund investments have not, by and large, been optimally managed as investments – as the 2011 the Global Fund Board appointed High-Level Independent Review Panel (the High Level Panel) found. Much greater engagement is required from stakeholders to ensure that Global Fund investments support effective programming towards reaching the HLM targets. USG, for example, as the largest donor to the Global Fund, has for some time been seeking to reduce its direct spend, and rather focus on achieving greater efficiency of Global Fund investment at country level.

There is a very real risk that if countries continue to rely on the Global Fund for substantial grants for un-differentiated, un-strategic and badly implemented projects, the Global Fund appetite for supporting the region will falter. If, however, with partners’ help, countries can start to develop forward-looking, focused funding strategies, in which Global Fund monies are used as targeted and effective investments, it is unlikely that continued support from the Global Fund will dry up. Given the concentrated epidemics of Asia, the opportunity to leverage sound, strategic Global Fund investments to achieve HLM targets looks promising.
Box 11: The Global Fund

The Global Fund, which has been the single largest source of funding for HIV over the past decade, is undergoing major financial and organisational reform. This reform is the culmination of a process going on for the last four to five years seeking greater efficiency and effectiveness in response to greater demand for value for money from its donors. Key steps include the Board’s decisions in 2008 for efficiency savings of 10 per cent and 25 per cent for Round 8 grants; the move toward greater strategy-based funding for Global Fund grants with the learning waves of the National Strategy Application modality (NSA); the ‘new architecture’ of grant consolidation, single stream funding, and periodic reviews introduced in 2009 (Godwin, 2010); the designation of ‘General Funding’ and ‘Targeted Funding’ pools; culminating in the High Level Panel review and recommendations in 2011 and the new 2012–2016 Global Fund Strategy. Much of this process has been driven by the recognition that while the Global Fund has been remarkable in making very large amounts of funding available to countries relatively easily, much of the investment has been neither strategic nor efficient; and with the exception of supply of ART, has been difficult to assess for effectiveness (Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, 2011). This recognition was behind some countries’ decisions to withhold contributions pledged to the Global Fund, contributing to the Global Fund Board decision to cancel Round 11, and convert it into a new funding opportunity consistent with the new Global Fund 2012–2016 Strategy, with a view towards funding proposals under the new model beginning in early 2014 (Decision point GF/B25/DP16, 2011).

It would probably be a mistake to assume, however, that Global Fund investments will substantially decrease in the immediate future; though significant adjustment to how Global Fund funding becomes available is very likely (see Press Release from the Global Fund ‘Global Fund Forecasts $1.6 billion in Available Funds for 2012-2014'). It is unclear how far grant architecture will be further adjusted as a result of the current reform process. However there is demand from many stakeholders for Global Fund investments to be more strategic and good value for money. The Global Fund is in the process of formally defining both high impact interventions and high impact countries; and recognises the importance of key populations as particularly disadvantaged and central to the HIV dynamics in concentrated epidemics. The Global Fund is not a normative agency but seeks to ensure that guidance is optimally translated for Global Fund grants by working with key partners. For HIV the Global Fund is aligning with the UNAIDS Investment Framework to help define basic program activities, critical enablers and supportive activities. The Global Fund itself, as part of this Assessment, requested support and assistance in piloting such a transition to more strategic investment, matching the regional realities and epidemiology.

The reprogramming of Global Fund grants is currently taking place in a number of Asian countries (for example in Indonesia and Burma [Myanmar] a 15–20 per cent and 10 per cent reduction respectively in phase two grants in 2012) and more are scheduled in 2012. Over time, and with an increased investment approach, reprogramming should present opportunities and encourage countries refocus priorities. Without such a refocus, the Global Fund and informants for this Assessment have predicted that spending on MSM, PWID and SW would be particularly hard hit by the current efficiency savings, because the needs of such key populations are not typically covered by government programs. In response to the efficiency savings in Indonesia, the MOH has recently publicly committed to funding 100 per cent of ART from domestic sources from 2013. There is not a similar commitment on prevention programs.

There is no doubt that countries in the region are feeling vulnerable. How far countries are starting to think about different ways to reduce their dependence on external financing is still unclear. As yet, evidence of change is quite limited. Despite the high-level rhetoric and the fiscal capacity to pay more, some middle income countries remain well below the minimum spending levels per capita as recommended by the CAA, even with their growing epidemics or large numbers of people living with HIV (UNAIDS, 2011a) (see Annex 8). Where governments are gradually contributing more from domestic resources, funds are largely being used to pay for treatment costs.
Increasing the level of domestic funding for programs focusing on key populations still appears to be a challenge largely due to the political costs of investing in marginalised populations, and of channelling government funding through civil society to reach key populations.

**Box 12: The counterfactual**

During the country visits we asked the question: *What would happen if all external funding disappeared? Would the government simply allow people with HIV to die for lack of treatment? Would the government simply ignore new infections among PWID or MSM?*

The answer was consistently: *No, of course not. But the quality of services would degrade severely; access would become much more difficult; many people would get left out; the response would become much more inefficient and ineffective.*

This is an important perspective. As we seek to show in this Assessment, the commitment to HIV remains real and strong within the region. The simple fact is, however, that most countries still do not, on their own, have the capability to manage an effective response: the HLM targets remain out of reach.

Deng Xiaoping said to World Bank President, Robert McNamara, in 1980, ‘Without the World Bank’s help, China can definitively reach its own goals. With the World Bank’s help, China will be able to develop at a faster pace.’ (The International Bank for Reconstruction and Development/The World Bank: ‘China and the World Bank: A Partnership for Innovation’, 2007).

### 5.4 Aid effectiveness

**Given the breadth and depth of the aid effectiveness agenda, it has not been possible to assess in-depth, the extent to which governments and partners for this Assessment are aligned with the principles of the Paris Declaration on Aid Effectiveness.** Nevertheless a number of important insights emerge from the Country Reports and country informants.

**Country ownership** appears to be relatively strong across the region – helped by stronger economic and policy autonomy in a number of countries and fewer development partners or agencies operating at country level compared to other regions of the world. The Global Fund is credited with supporting broader country ownership through expanded stakeholder participation in the CCM and there are a number of reported well-functioning CCMs in the region, including Indonesia and Burma (Myanmar). However, there are strong perceptions in the region, as elsewhere, that CCMs are largely arms of the state; CSO participation has increased but is still viewed as tokenistic; a rubber stamping exercise (Dickinson and Attawell, 2011).

The picture on **alignment and harmonisation** of development priorities is mixed. Overall, Country Reports and informants imply there is considerable alignment of development partner priorities behind national HIV strategies and programs; and harmonisation among partners, at least at national level, is reported to have improved over the last five years. There are examples of multi-partner pooled funding modalities (such as the 3DF in Burma [Myanmar] and the IPF in Indonesia) that have worked reasonably well. For example, the 3DF is reported to have galvanised development partners around the NSP and has helped bring in smaller partners that may want to commit funds but do not have the resources to set up office. But, there are numerous examples to show that dependence on partners and multiple funding sources complicates national responses and challenges harmonisation and alignment.
East Timor reports that development partners are largely ‘cherry picking’ areas of the NSP to fund according to their priorities; Burma (Myanmar) reports that the strategic directions in the NSP were heavily directed by implementing partners; in Laos, Global Fund grants are considered not aligned with national stated health priorities (MCH). In Indonesia, coordination, harmonisation and alignment are considered insufficient at all levels, leading to high transaction costs; this Assessment found mixed views on the impact of development partner programmatic divisions of labour. Some informants perceived the division of labour to be an efficient and effective way of working which maximised the comparative advantage and expertise of the development partners. Others, however, perceived the division of labour as contributing to ‘disjointedness’, and fragmented initiatives and gaps which weakened comprehensive programming for people living with HIV.

Country systems are increasingly used in some countries for programming of development partner funds but there are still plenty of examples of where country systems are being by-passed, avoided or undermined. For example, development partner funding in Vietnam has been used to establish separate Project Management Units (of which there is a specific indicator to avoid creating dedicated management structures in the Paris Declaration) that work in parallel to government bodies with the mandate to manage and account for project outcomes. Global Fund programs score poorly in this area and in managing for results, primarily due to separate Global Fund-reporting and procurement system requirements which have missed opportunities for strengthening and using national systems; and the use of incentive payments which is undermining the ability of government to retain skilled staff and has weakened health systems in a number of contexts (Indonesia and previously Cambodia).

While NASA exercises are being undertaken in many countries, transparency, accountability and tracking of HIV budgets and expenditures across sectors and at different levels of the health system needs to be stronger. Informants regularly discussed how HIV funding has contributed to the decline of CSOs as policy advocates and watchdogs rooted in civil society in favour of service delivery organisations; CSO lines of accountability are frequently seen as ‘vertical’ – upward to the funding agency or CCM – rather than ‘downward’ to their constituencies. This issue has been observed in other countries with significant off-budget, vertical funds such as Uganda.

The provision of timely, transparent and comprehensive information on aid flows by development partners could be improved. Collecting data for the Country Reports highlighted problems in obtaining clear, coherent and up to date, multi-year (beyond 2013) financial data from development partners that matched government fiscal and reporting cycles. Fluctuating aid flows and rapid scale down of international funding, for example in Vietnam is forcing government to consider how the remaining international donor funds will be integrated in different program areas to ensure continuity of service and to maintain a single standard of quality. Pooled funding mechanisms such as the 3DF have the potential to increase the predictability of HIV funding from the mobilisation of additional resources and through attracting more risk-averse donors.
6. The HLM Targets and an Investment Approach

6.1 The targets

The HLM targets adopted by the UN General Assembly in June 2011 and the UNAIDS Three Zeros strategy 2011–2015 offer a unique opportunity for the region. For the first time there are quantified, relatively reachable targets, based upon incidence – the measure of what is actually happening with the epidemic. These targets have global and regional acceptance. As already noted, the HLM targets have already been reaffirmed and adopted by the region (ASEAN ‘Declaration of Commitment: Getting to zero new HIV infections, zero discrimination, zero AIDS-related deaths’, 2011).

Box 13: HLM targets for the region

- To reduce sexual transmission by 50 per cent, the region will need to have 140,000 fewer HIV infections in 2015 than in 2010.
- To halve the number of new infections among people who inject drugs, 32,000 fewer HIV infections in this population will be required in 2015.
- Achieving elimination of mother-to-child transmission will require the number of new HIV infections among children to decline from 25,000 in 2010 to 2,500 in 2015.
- To contribute towards the global goal of having 15 million people on ART by 2015, the number of people receiving treatment must grow from 920,000 in 2010 to more than 2.3 million in 2015.
- The number of TB deaths among people living with HIV in the region must fall from 69,000 in 2010 to below 35,000 in 2015.


The challenge now is for countries and development partners to consider their roles and contributions in attaining the goals and targets. This will involve regular assessments of the epidemiology and of the financing, policy and programming environments to make sure investments are sound, commensurate with the scale of the epidemics and aligned with the epidemiology.

The targets present two opportunities: they are the natural basis for a results framework for the region; and they have the potential to be used as a roadmap for performance-based funding as the basis for continued investment by partners.
6.2 Will the targets be met?

It seems unlikely that these targets will be met. Coverage by programs remains substantially lower than the 80 per cent target required to reduce prevalence. UNAIDS estimate that only 17 per cent of PWID are reached with appropriate prevention programs\(^\text{16}\), 49 per cent of MSM, 40 per cent of female SWs, 32 per cent for PMTCT. In South Asia only 33 per cent of people in need received ART in 2010. In East Asia and the Pacific, 48 per cent received ART. In 2010, only Cambodia (92 per cent), Laos (51 per cent), Thailand (67 per cent) and Papua New Guinea (54 per cent) provided treatment to more than 50 per cent of those in need (WHO, 2011). Yet achieving high levels of coverage with proven successful interventions is the critical challenge (Haacker and Claeson, 2009). Just as prevalence and incidence seem to have stabilised, so does programming. With very few exceptions, HIV programs in Asia are likely to sustain this stability, but not make significant progress towards reducing it without very significant changes to current programming and architecture.

It is important also to remember that the HLM targets represent only half way towards zero new infections, zero discrimination and zero AIDS-related deaths between now and 2015. There will be a further period from 2015 onwards for the ‘final’ set of targets, and long-term program (if not financial) sustainability, greater integration and so on.

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Box 14: Country Reports Summary: Which countries have potential to meet the HLM targets?

**Cambodia**: significant progress made in meeting MDG6 and universal access to prevention, treatment and care; vertical and independently funded and managed program; highly dependent upon external funding; sustaining present program means Cambodia likely to meet the HLM targets.

**Burma (Myanmar)**: heavy dependence on development partner investment; weak government systems; declining epidemic; with renewed external commitment, potential to achieve HLM targets.

**China**: strong commitment; full domestic funding; strong systems in place; but program management challenges and difficulties in working with civil society may threaten progress in reaching targets.

**India**: program management challenges and difficulties in ‘domesticating’ and scaling up successful civil society models threaten progress towards targets.

**Laos**: low level epidemic; extreme dependency on external funding (Global Fund); resources spread too thin to reach current targets in NSP; with TA and support for policy/program management reform possible to meet HLM targets.

**Philippines**: program management/architecture challenges, difficulties in working with devolved local administration, low coverage, and lack of strategic policy; current limitations in external support threaten progress towards targets.

**Thailand**: lack of strategic prevention focus and ‘war on drugs’ policy threaten progress towards some targets.

**Vietnam**: highly dependent on external funding (USG); program management/architecture challenges; decentralisation, ‘social evils’ policies, and difficulties in working with civil society threaten progress towards targets.

**East Timor**: strong leadership; heavy dependence on development partner investment; incidence increasing outside of key populations; weak technical capacity in policy, programming, training and systems severely threatens progress and East Timor is unlikely to meet the HLM targets.

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\(^{16}\)This is taken from consolidated data from country UNGASS progress reports and again, is data mostly collected from intervention sites in limited geographic areas and is unlikely to reflect the national picture. This UNGASS indicator does not capture coverage of OST which is currently only approximately 6% in Asia.
Indonesia: The HIV response is challenged by issues related to decentralisation and regional disparities that lead to ‘heavy’ program architecture and management; fragmented and weak prevention programming; insufficient funding means Indonesia is off track to meet MDG6, Three Zeros and HLM targets.

Main challenges cited in Country Reports to meeting the targets and achieving better HIV outcomes

- Underfunding and budget sustainability of national responses. A major discordance between estimated cost of the NSP over five years and available resources reported in East Timor, Indonesia, Laos, Burma (Myanmar) the Philippines, Vietnam. But this is largely the result of aspirational budgeting.
- Weak epidemiological data; scarce guidance and costing information on minimum packages of prevention (for example for key populations).
- Not fit-for-purpose program architecture, and concomitant management constraints.
- Lack of political will and service delivery capacity and capability in pursuing both technical gains (harm reduction, treatment 2.0, testing and access to services for key populations and so on) and enabling environments (pragmatic, local level accommodations with police, criminal justice, social development programs, cultural norms, and so on).
- Limited human resources at facility level to maintain continuum of care.
- Inadequate levels of public sector capacity to develop policies, implement plans and deliver services evidenced through constrained testing, STI, ART, PMTCT and services for PWID.
- Nascent, underdeveloped or weak civil society responses in planning and delivery of services targeting key populations. Usually the result of difficulties in getting government funding for civil society.

Source: Country Reports

6.3 Implications

This anticipated slow progress towards the HLM targets has important implications for longer-term outcomes.

First, the longer the presence of HIV continues in key populations, the longer some ‘spill-over’ into other populations remains a risk, with concomitant flare-ups of infections. While this is unlikely to cause ‘generalised epidemics’ anywhere, it means that HIV remains an unacceptable public health threat throughout the region, and the impact intended, of zero new infections and zero AIDS-related deaths, remains out of reach. In addition, reducing incidence (preventing new infections) is generally held to produce a better return on investment than treating infections. In the long term, investment now, in reducing incidence, is the most sensible strategy for value-for-money health spending.

Second, the continuing presence of pools of infection among key populations will tend to exacerbate tensions around human rights and civil society engagement in many countries. While not suggesting that human rights and civil society engagement are not important for the region, the elimination of the significant presence of life-threatening disease as an additional source of concern might help reduce the heat with which these issues are debated, and encourage greater openness on matters.

Finally, even if the rate of new infections is not increasing, the fact that new infections continue means more and more people will be in need of treatment later because of the cumulative effect. For the treatment burden to decrease, the number of new infections must decrease. Thus the longer new infections continue to occur, the larger the burden of, and the more urgent the need for chronic care with ART becomes. World Bank calculations for South Asia suggest that the targeted scale-up of HIV treatment costs would absorb 7 per cent of total public health expenditure in India, and 20 per cent in Nepal. This study notes that such treatment costs could potentially absorb all the
planned increase of public health expenditure in India from 1 per cent to 3 per cent of Gross Domestic Product (GDP) by 2012 (Haacker and Claeson, 2009).17

This analysis suggests that continued external investment (of all kinds) is required for most countries, both in the short term, and longer term.

- Some countries are highly dependent on external support, but are making good progress; with continued support they are likely to substantially reduce their HIV burden.

- Some countries are highly dependent upon external support, but are not making as much progress as they might be; if external support is continued or increased, progress towards reducing their HIV burden can be maintained, if not at the pace required to meet the HLM targets.

- Most countries require continuing external support to achieve the policy and systems developments necessary to make progress towards ensuring their HIV programs are sustainable in the long term.

If external support is withdrawn, it appears likely that countries will not only fail to make progress, but will significantly add to their current HIV burden with increasing new infections, and an increasing treatment and care burden. This will remain a substantial, unsustainable, disease specific, long-term public health problem for the region.

UNAIDS has identified five priority countries for reaching the HLM goals, and recently expanded this to six, on the basis of disease burden. While prioritisation is important, the point made in section 3.1 above must be remembered: if either China or India alone made substantial progress towards the HLM targets, the sheer numbers involved in those two huge countries could mask little or no progress in all the others. The HLM targets must thus be treated with caution at a regional level – translating them into country-specific targets is all-important. The HLM targets are country commitments, not global or regional commitments; elimination of HIV in Cambodia and Thailand, while leaving it endemic in India, Vietnam and Timor Leste does not constitute regional success.

6.4 The investment approach

Trying to use HIV resources effectively is not a new challenge but the noticeable squeeze on external funding is changing the HIV balance sheet, calling for a more strategic approach to spending. This is what is being referred to, increasingly, as an investment approach: where investments are specifically identified to produce a specific set of results. The investment approach is fundamental both to how we conceptualised this Assessment (see Figure 1, p.2), and to the future of the response in Asia.

The investment approach is based on a results framework; where the results to be achieved are clearly identified and the investments needed to achieve those results are made – investments not just in the financial sense, but also investments in policies and programs, in systems, and in governance frameworks.

17A similar study finds the global costs of treatment will rise about 17 times to $67 billion (constant 2009 dollars) a year. To gauge the magnitude of this sum, note first that it is almost three times the total value of all U.S. foreign assistance in 2007, which was about $26 billion, and it is almost two-thirds the total amount of foreign assistance by all donors in 2007, which was $103.5 billion. Ref. Mead Over (2010). Sustaining and Leveraging AIDS Treatment. Center for Global Development Essay.
In this approach, the epidemiological and socio-political and economic conditions of a country will influence the outputs and outcomes required to reach the Three Zeros. Evidence informed strategies and realistic targets, based on a country’s epidemiology should be reflected in the country national strategic plan or equivalent; this in turn must consider the country’s governance frameworks, architecture and implementation systems. This results chain can then be used to identify investments required (in terms of policy, strategy and program, systems, governance architecture, and financing (domestic and external) to contribute to the achievement of those results. This framework explicitly gives full weight to the context and environment in each country, and the region as a whole. It also can help to identify the most appropriate, cost-effective, value for money investments to make.

Current thinking on investment approaches and HIV is captured in the recent UNAIDS Investment Framework (Schwartlander et al., 2011) which claims to offer a radical departure from existing programming and a roadmap to accelerating progress in the global response. Major strengths lie in the fact it is based on best available evidence on what works and it can be adapted as new evidence emerges; it also simplifies the process of determining what program elements are effective or not. Its main weaknesses are that it doesn’t identify the best way to cluster HIV interventions and important evidence on the cost effectiveness of service delivery approaches including community-led delivery of programs, or synergies, is missing. In addition, missing in the UNAIDS approach is emphasis on planning and managing for results that is essential if investments are to have any impact; and the need for a clear, logical results chain.

The Global Fund High Level Panel Report and Global Fund 2012–2016 Strategy also has an investment approach at its core and is working with bilateral partners on a country-by-country basis to coordinate investments and identify areas that require reprogramming.

**Box 15: What is a results framework?**

A logical chain of results

**IMPACT Results:** changes in the *quality of life* of people – the goals of the planning: such things as incidence, prevalence, reductions in HIV-related premature mortality

*produced by a set of*

**OUTCOME Results:** *behavioural and institutional* changes results from the implementation of the plan: such things as prevention, treatment and care services being universally accessible; reductions in the numbers of PWID sharing needles; increased condom use in purchased sex; etc.

*resulting from a set of*

**OUTPUT Results:** *products and services* developed by implementers (in the public, private and civil society sectors), identified and determined by careful analysis as necessary and sufficient to achieve the OUTCOMES desired

*resulting from*

**INPUTS - ACTIVITIES:** conducted by implementers according to their strategic and operational programmes as necessary and sufficient to achieve the OUTPUTS required.
There is considerable discussion in Geneva-based institutions (UNAIDS and the Global Fund) about investment frameworks and investment approaches. There has been less discussion or thinking at country level (such as with CCMs or indeed in some UNAIDS country offices) where it needs to take place although there are indications that this is beginning to change, for example, with UNAIDS Regional Support Team (RST) holding an Asia Pacific Strategic Investment Framework Workshop in June 2012, largely for civil society advocates.

Box 16: How to implement the Investment Framework?

Existing guidance on how to implement an Investment Framework is emerging but is limited in detail, though the point is made that in most countries Investment Frameworks mean changing investments in HIV and a re-programming of HIV efforts. More detailed guidance is needed on how country stakeholders are expected to use the Framework in the context of a concentrated epidemic; how this differs from the existing NSP process; what TA is required; and whether there should be independent oversight to scrutinise the value for money of stakeholder programs are questions that still need to be answered. Some actions required for an Investment Framework have been identified:

- Need for up to date **epidemic assessment**: use of information on HIV incidence and prevalence as well as KAP, the geographic distribution of HIV and determinants of transmission; investing in high-quality data through baseline and progress surveys, data modelling – used to set **SMART targets**.
- Clear identification of the **results and logic chain that investments will achieve**: impact, outcome and output results, with indicators, targets to measure progress towards results.
- Comprehensive understanding of the **scope and coverage of existing and needed HIV programs and their costs**, based on evidence: understanding of cost-effective, high impact interventions and technologies possibly through commissioning of work, data and studies on feasibility, costs and impact; and what is required to bring strategies to scale rapidly.
- Close **regular monitoring and evaluation of investments** focusing on KAPs; staying on top of evidence and using it to adapt strategies at appropriate points in time.
- Consideration and feasibility of **innovative approaches that might deliver stronger results** on investments, for example cash on delivery approaches for HIV prevention; use of external funding for performance-based contracting of NGOs to deliver targeted prevention services.

**Sources:** UNAIDS (2011c) and Global Fund (2011).

In the Asia-Pacific region, where epidemics are concentrated, localised, and relatively small-scale, current funds are still misdirected, and the future prioritisation and funding of HIV is vulnerable, an investment approach is relevant and should be urgently developed and implemented across the region.
7. Strategic Options

The end of HIV in Asia is potentially in sight but very few countries have the political vision, program strategy or implementation capability to shift their responses in ways that will significantly impact on the HLM targets. Without continued development partner support and engagement, HIV will remain endemic in key populations for many decades to come, with increasing political, public health and economic costs to the region.

We consider it essential that all stakeholders remain engaged in the region – but with significant refocus of their investments – across the full spectrum of ‘investment’ – policy, programming, advocacy and approaches to financing.

Current perceptions among stakeholders on what remains to be done fall broadly into three camps:

Those that perceive HIV has been ‘managed’ in the region; that the policies and programs put in place have developed sufficiently; that all that remains to be done is to roll these out and ‘mop up’ remaining pockets of infection. A bit more commitment from governments is still required, but the job of their partners is essentially complete.

Those that fear that the changing understanding of the dynamics of the epidemic and the epidemiological data of falling prevalence and incidence mask serious deficiencies in socio-cultural patterns and norms, political, legal and cultural provisions, and understanding of vulnerabilities and risk. For them, the long term struggle for, for example, the human rights of SW, PWID or the right of civil society to hold governments accountable, is far from over. HIV has provided a ‘bully pulpit’ for these aspirations; much of the gains made could easily be lost if the HIV response does not continue as a high-level social transformation platform.

Thirdly, those that find themselves somewhere in between: it is not over, but the tools, strategies and programs are in place and it is just a matter of ‘tweaking’ and continuing significant investment for the battle to be won.

We find that stakeholders need to articulate a clear fourth position: the end of HIV in Asia is potentially in sight. The policies, strategies and program foundations needed are largely in place, but few, if any countries have the clarity of political vision, program strategy, nor implementation capability to achieve the end of HIV without substantial continuation of development partner investment. Without this support, the needed re-shaping of responses is unlikely to happen and HIV will remain endemic in key populations for many decades to come, with increasing political, public health and economic costs to the region. At this point external technical input and thinking, partnerships and support for HIV in the region are going to change in the immediate future. It behoves all partners to anticipate and help manage these changes.

Such support needs to be designed within a long-term investment framework. In the following section we offer a number of strategic options for how such investment might be achieved in the region by partners. We have described these strategic options in five areas, to emphasise the
different dimensions of continued engagement and investment: which of the ten focus countries still need external investment support; what kinds of things such investment should support; critically, how the partners in the region could work together to maximise these investments; what kind of financing channels investments could go through; and how current partnerships might be expanded.

**We have specifically not provided a single, continuous set of ‘recommendations’ for how any single partner might invest in the region** – that was not requested in our TOR; this was not a scoping or design assignment. Nor have we tried to give a country-by-country situation analysis and investment framework; this again was beyond the scope of our TOR. The fundamental nature of the change we are advocating – a re-orientating of the response in Asia – will necessarily require a process of extended and extensive (political) negotiation between key stakeholders. The aim of this report is to inform that negotiation, not to pre-empt it – thus options are provided, not solutions.

We have thus tried to provide, from several different perspectives (where, what, how), what the five main strategic issues are that need to be addressed for the region as a whole.

The options are obviously linked; since we are addressing a wide range of partners, we have sought to provide a range of possible ways of structuring these options for investment.

### 7.1 Strategic options for country support: Where is investment needed?

Cambodia, Laos, the Philippines, East Timor, Burma (Myanmar) and Vietnam and possibly Indonesia, do not have, or do not demonstrate the will to make available, the domestic fiscal space to fund their HIV programs; substantial continued external support is essential. In addition, many countries still require significant technical, advocacy and policy investment, particularly with regard to program architecture and the ‘micro’ enabling environment.

Below, we identify countries that require continuing external investment; both those likely to reach the HLM targets with current levels of external support, and those for whom additional investment is needed to ensure that progress does not reverse. This section should be read in conjunction with Box 14, to assess the role of external support in how likely the countries are to achieve their HLM targets.

It is important to recognise that the support required here is not short-term, emergency assistance in a period of funding crisis, but rather longer-term commitment to help the country reach its HIV goals.

- **Cambodia** finances most of its HIV program from USAID and the Global Fund, with considerable technical support from PEPFAR and UNAIDS. But there are considerable efficiencies that can be achieved with greater focus of programming and reduced architecture. AusAID and other donors support the health sector SWiM\(^{18}\); greater engagement between this and HIV programming could be very beneficial for the longer-term evolution of HIV and other programming.

\(^{18}\) In Cambodia the MoH has adopted a modified version of sector coordination arrangements, termed sector-wide management (SWiM), which incorporates refined features of the Sector-Wide approach concept.
- **Laos** requires continuing technical support to make the best allocations of its Global Fund monies towards effective programming, and to achieve efficiencies with other existing funding. Given the very low levels of domestic investment, continuing external support is probably needed to help re-focus programming and architecture.

- The **Philippines** is primarily supported by the Global Fund, along with the UN Joint Team and USAID. It urgently needs support to bridge gaps in Global Fund grants and to help re-focus programming and architecture – particularly in the context of its significant devolution of health care provision. But efficiencies can be achieved with existing funding.

- **Burma (Myanmar):** the Australian and British governments both recently announced major increases in aid as part of efforts towards poverty alleviation and development. Other partners may ramp up their support in response to the changing political situation; given the vulnerable national program situation, however, coordination among external partners will be critical.

- **Vietnam** is now primarily funded by USG and the Global Fund; but important support for evidence-based harm reduction for PWIDs is needed, in which USG is constrained.

- **East Timor** is heavily dependent upon the Global Fund. But as the weakest of the countries, and with the most uncertain epidemic, continued technical support for program design and resource allocation is critical.

- **Indonesia** is funded largely through the Global Fund, AusAID and USAID. Domestic resource inputs are reported to be around 42 per cent. Progress has been made in prevention and treatment but it is uneven and coverage remains insufficient.

While decisions about each of these countries lies, in general, with partners’ bi-lateral frameworks, this Assessment strongly suggests that a comprehensive, strategic approach is taken to deciding what to support in each country, how, and by whom. These kinds of options are described in the following sets.

### 7.2 Strategic options for continuing engagement with technical programming: What investment is needed?

Although countries develop and implement their programs on their own, internally, this Assessment has repeatedly observed the benefits of coherent regional consensus – particularly with regard to politically or socio-culturally sensitive issues. Coherent and coordinated consensus on the most effective program interventions required for the region to achieve the HLM targets (see Box 13), and how they should be introduced, extended and scaled up is thus needed – with investment in advocacy, policy, technical quality and implementation for each. Primarily among these are a public health approach to NSP, OST and ART, SRH for SWs, MSM and PWIDs, treatment 2.0 including treatment as prevention, treat and test, provider initiated testing and counselling, over-the-counter diagnostics and so on. WHO and other partners (such as UNDP, UNAIDS, UNODC, US CDC-GAP, USAID) are already developing guidelines in a number of these areas; but these will need consolidation and support at country level to articulate them in their contexts.
In this set of options we identify the **primary areas of technical and managerial programming where continuing external investment is required**. It is important to recognise that in the context of the region’s diverse epidemics (see section 3.1, box 1) HIV programming requires a coherent, evidence-based approach: careful identification of programming gaps in each country is essential.

- **Harm reduction, evidence-based drug treatment approaches**, and **MSM programming**, while proven to be effective, face significant domestic political and implementation challenges (particularly with respect to counterproductive investment by countries in compulsory detention of drug users) if they are to achieve the necessary coverage to meet the HLM targets. Continuing external political, advocacy, technical and financial support is essential to meet these challenges. With specific regard to harm reduction, AusAID has extensive technical experience and credibility in the region, yet currently limited capacity at country level, while USG is politically constrained from the direct purchase of needles and syringes, but can work in all countries where harm reduction is critical. The case for combined programming in this regard is compelling. A good example of such collaboration has been USAID and DFID funding of condom social marketing in Cambodia, where DFID gave part of its contribution to USAID, and used the rest to purchase condoms, which USAID was unable to.

- **Treatment 2.0 possibly to include treatment as prevention**, is the best chance the region has, in the short term, to achieve the HLM targets of 15 by 15 (15 million people on treatment by 2015); but this is a large agenda. WHO, as the duty bearer for global norms in this area, has a crucial role to play in ensuring the necessary adoption and scaling up of treatment 2.0 in the region, but lacks the capability and capacity; it must be strengthened and supported to play this role (see below). The Global Fund is likely, along with domestic funding, to be the major support for the scale-up of treatment 2.0; but effective use of Global Fund monies is necessary.

- **Results-based programming**. Little programming in the region is truly results-based: accountability, both domestic and external, and among partners, remains weak: robust efforts are required to convert the HLM targets to realistic country-level targets, and measure progress towards them. This is not simply a case of ‘better M&E’; but rather a more robust use of result-based planning and management to set and achieve specific targets. External support for this should be a condition for overall continued support. But such an approach requires far better strategic information.

- **A coherent and coordinated approach to strategic information** in the region is urgently needed, with coordinated and shared investments in incidence modelling and measurement, cost-effectiveness assessments, population size estimates, and robust results-based planning methodologies for national and partners’ strategies, with good national and regional target setting. As noted, various approaches and projects in this regard are already being funded by different partners in various countries – these should be brought together: not necessarily as a single model or approach, but ensuring there is no duplication, and that the various strengths and weaknesses of models are appreciated. Particularly important is the use of these models to transform the global and regional HLM targets into a set of explicit country-level targets.
• In the longer-term, HIV programming must become more explicitly integrated into good public health management, through targeted SRH services for specific key populations, and integrated chronic care programs for ART. A clear roadmap for how this is to be achieved in the region is needed urgently, with the full political, scientific and implementation support from all stakeholders – particularly where they are already working with and supporting general health systems. By the same token, some thought should be given to the longer-term implications of post-MDG policy scenarios and frameworks.

7.3 Strategic options for developing and implementing a common, conceptual strategic vision for the region: Thinking and working together

No one donor can address the full needs of the region; the epidemics, the countries and the needs are too diverse. But this Assessment found that there is fairly general agreement about the main issues facing the countries and the region – the variations in thinking tend to be more how to go about addressing them. It would therefore be helpful if partners were to develop a coherent, shared vision for the region; and then develop a shared commitment to a range of key investments, and ensure they are all covered; in effect, a shared strategic conceptual framework of results for the region within which all partners should invest.

Partners need to find ways to work more effectively and efficiently together both to develop this shared vision, and then to maximise their investments and contribution towards achieving these results.

There is currently no common forum at which partners can discuss and coordinate their investments in the region. Various issue-specific fora do exist; but nothing of the comprehensive nature required. The original Commission on AIDS in Asia was such a forum, but it was established with an 18-month mandate, for the purpose of creating its report only. This current Assessment, and the Reference Group it has created, could be a foundation on which to build. There are various possibilities that can be considered; we are not by any means suggesting all of these options, nor any particular one; but some kind of option needs to be considered:

• Establish some kind of Regional Investment Steering Committee, modelled perhaps on the Commission on AIDS in Asia, to provide oversight for such coordination. Considering the transaction costs involved in setting up the original Commission, it may be easiest to adapt and build on it; or even more simply, form an ad hoc group.

• For a more limited forum, continue the current Strategic Assessment Reference Group, with perhaps slightly expanded membership to include civil society and some country representation.

• UNAIDS could convene and service a regular (possibly annual) ‘Investment Forum’ for the region, at which partners could deliberate. This would not need to be particularly formal, and membership could be by invitation; and definitely not a ‘pledging’ session, but rather a review and oversight meeting.

• Partners might fund the UNAIDS Regional Support Team to explicitly and pro-actively coordinate, on behalf of regional partners, a results-based approach to all these various activities.
It is important that any such mechanism should be effective, and not merely another layer of bureaucracy or ‘talking-shop’; that it should not be ‘captured’ by any partner or group of partners for political reasons; and that it should be low on transaction costs. It is also important that it is sufficiently inclusive to ensure its credibility and legitimacy, but not to hamper its efficiency. It is vitally important, however, if the region is to develop its own identify and axis of development cooperation around HIV. It can be argued that this option is part of the core business of UNAIDS; but UNAIDS is, like all parts of the UN system, essentially a ‘consensus body’, with multiple constituencies to service. The mechanism we are suggesting should be more focused, more ‘hard-hitting’, it should not be seen as an alternative or replacement for existing UN-supported fora, such as ESCAP, or ASEAN; rather it should be an additional purpose-driven forum.

To actually then work together, the kinds of things that partners could consider are:

- Developing a coherent and comprehensive strategic results framework for the region. Based (probably) on the HLM targets for the region (both regional and country), a results framework with specific outcomes and annual outputs could be developed that provided a prioritised investment framework for all partners. This would have the benefit of various partners being able to see how they could contribute, based on their track record and comparative advantage; and avoid duplication, or gaps. Ideally, this could be used to contribute to wider health outcomes for the region.

- Ensuring a coherent and coordinated approach to continuing political advocacy in the region. In the face of other competing health priorities in the region and shifting global development agendas, sustaining political interest in HIV and addressing the political determinants of HIV responses will be a key challenge. Strong leadership; innovative political advocacy that reframes HIV in ways that resonate with emerging health and social justice agendas; identifying and engaging with potential HIV champions from a broader constituency and building supportive coalitions; and creating the right political incentives for governments to continue and/or increase resources HIV, will be essential.

- Establishing a coherent and coordinated mechanism to maximise the effectiveness of Global Fund investment in the region. The Global Fund is likely to remain a critical source of external funding for the region; yet as the High Level Panel review found, much of its investments were not well directed or managed. The new General Manager has stated that Global Fund investments must yield a return on investment much higher in terms of lives saved, and be based upon better management of risks in the countries (El Mundo, 2012). As a financing agency, however the Global Fund cannot achieve this without greater assistance from partners. For how this might work, see below.

- Articulating a coherent and coordinated vision of civil society involvement in HIV, with a coherent and coordinated approach to investing in civil society in the region, with predictable, increased, results-based support for regional and country-level civil society organisations and networks. Again, for suggestions as to how this might be done, see below.

- Supporting a cohesive and coordinated position to address aspects of the HIV architecture with a view to improving efficiency and reducing costs, an obvious example being whether to continue to support standalone NACs.
Much of this work is currently being done; in the opinion of this Assessment, however, it tends to be ad hoc, isolated, uncoordinated and sometime duplicative. Far greater vision, coherence, coordination and leadership is required of partners if real progress is to be made.

Partners also need to find ways to strengthen the capacity of existing regional platforms and institutions to play their full part. While UNAIDS has been the focal point globally for developing the global consensus on HIV, within the region UNAIDS requires continuing and committed support from all partners to take this forward; support both for individual co-sponsors of UNAIDS, and for the UNAIDS regional secretariat (the RST). A number of other existing platforms also require support. Some options for such support are:

- **Funding positions for specific purposes** (for example, Global Fund grant support, strategic information, harm reduction) in UN or other agencies, both regionally and at country level – such as ASEAN. A single externally funded (and recruited) staff member specifically to work on Global Fund investments (design, management, review, and so on) in each key country and regional office of UNAIDS would allow much greater accountability for good use of Global Fund grants.

- Supporting the **HIV section of the WHO Western Pacific Regional Office in Manila (WPRO)** to implement the Joint UNAIDS/WHO Operational Plan for the region, developed in 2010. This might include specific funding support for activities within the operational Plan, as well as support for positions to strengthen the capability of this section. The assessment found the potential for supporting the WHO South East Asia Regional Office (SEARO) less compelling.

- Supporting the **Network of WHO Collaborating Centres for HIV and AIDS**; this network represents academic institutions from Australia, New Zealand, China, Singapore, Vietnam, Japan, Malaysia and the Philippines, and while currently not robust, could be a critically important platform for establishing the academic credentials of a new approach.

- Funding, possibly through UNAIDS RST, a set of results-based and carefully and explicitly coordinated **Task Forces or Regional Working Groups** to address critical issues. Some such Working Groups already exist (for example the Regional Thematic Working Group on HIV and Sex Work, the Datahub Steering Committee, the Regional Working Group on Strategic information, and others on Injecting Drug Use and HIV, PMTCT and Treatment); it is not clear how results-focused they currently are, not how well coordinated they are within a single conceptual framework for the region.

- Re-examining the **AusAID-supported HIV Consortium** to see how to link the academic members of the Consortium more explicitly with the network of WHO Collaborating Centres.

### 7.4 Strategic options for financing the future: Investing together

The effectiveness of available financial resources in Asia can be improved – but external pressure and support are needed. Considerable amounts of existing resources (both domestic and external) are being allocated to programs with limited prevention benefit. Addressing significant funding shortages requires evidence based allocations of existing resources, that is, prioritised investment in prevention among key populations; switching funds out of program areas with limited impact
including those of individual agencies; providing powerful evidence of the value of these investments to national authorities and of the need to increase allocations for health and HIV in the long term.

To ensure that existing and future investments are used more effectively (as per the UNAIDS Strategic Investment Framework) stronger understanding of ‘investment approaches’ and what this means for countries in Asia, backed up with quality data and analytical capacity to provide evidence for decision making is needed. External partners have a key role to play in this (Dybul et al., 2012).

In the previous sections we have suggested which countries need continued support, and for what. We have also suggested how partners might work better together to address these needs. In this section we suggest some of the options through which partners might channel their investments in order to achieve mutually accountable results. We suggest options in four areas: for donors supporting specific countries; for getting the best out of Global Fund investments; for ensuring that civil society as a critical element is not lost; and for working with countries to improve their own investments.

**Bi-lateral investments – for donors supporting specific countries**

- Using the Global Fund ‘strategic funding approach’\(^{19}\), partners should ensure that all investments clearly fit within well-designed national strategies, contribute towards appropriate national results frameworks and targets, and can be monitored and reported on within national strategy M&E systems.

- Partners need to investigate joint funding opportunities for both regional and country-level investment; this can be particularly beneficial where one partner has financial management systems in place and can accommodate additional financing from another partner. Some specific examples of where this might work have already been suggested.

- Building on better targets, greater attention to ‘performance-based funding’ and ‘cash on delivery’ approaches may be useful for external support.

**The Global Fund – getting the best out of Global Fund investments**

- Invest in getting Global Fund investments ‘right’. Related to the issue of effective investment, Global Fund reprogramming exercises in the region represent immediate opportunities to adopt an investment approach that will refocus existing resources to areas with most impact. In January 2012, the Global Fund expressed a strong interest in working with partners in the region to support countries in their reprogramming. The feasibility of this approach needs to be explored further, but, in principle, this may be of interest to a number of countries and partners including USAID/PEPFAR which is increasing collaboration with Global Fund and others to align programs and target investments. When the new grant architecture and strategy are announced for the Global Fund this ‘strategic investment approach’ is likely to be increasingly important.

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\(^{19}\)The National Strategy Application (NSA) was a new funding modality piloted to ensure alignment of Global Fund financing with country priorities within the framework of a country’s national disease strategy, and to help strengthen national strategies. The strategic funding approach has been recommended by the Global Fund Board as its preferred modality for the future.
Partners should consider establishing a co-funded mechanism that would provide regional oversight/monitoring of Global Fund investments. This might be based on the WHO Health Observatory model, but would monitor Global Fund grants and their implementation; or an independent group of regional Wise Men, who can provide advice to countries applying for and using Global Fund grants. This is critical; despite speculation, the Global Fund is likely to remain one of the largest sources of external financing for HIV in the region – without a proper handle on how it is being used, other partners’ funding risks being duplicative or irrelevant – or simply an opportunity for rent-seeking. There are significant political and transaction costs likely to be associated with this option but our Assessment found significant appetite for such a mechanism. An additional consideration may be support to dedicated Global Fund-related personnel, based in selected UNAIDS country offices or, as in the case of Indonesia, a USAID-dedicated full time, CCM representative. This would allow much greater accountability and efficient use of grants.

Increase and enhance investments in civil society – ensuring that this critical element is not lost

Partners could establish and co-fund a Civil Society Grants mechanism to support programs developed by both regional and country civil society organisations. Responsive, flexible, direct, recipient-driven grant-making facilities can be highly effective in channelling investments. A number of partners already have substantial experience of such facilities. While transaction costs will be high, significant impact can be achieved with robust design – a number of good parameters for which now exist. Partners need to seriously consider such a facility, specifically directed to civil society in the region. Relatively long-term (five year), predictable funding for civil society, both at regional and country level, would be a powerful investment for the region.

Domestic investment – working with countries to improve their own investments

Partners also need to help countries explore a range of new financing options in order to increase domestic investment and ensure greater financial sustainability for HIV in the region. Some of the key options are:

- Partners can support countries to investigate and test the possibilities of greater health insurance and other third-party health care costs for HIV, particularly treatment costs. This should be part of larger work on financing health care in countries in the region and should build on previous experience of developing these schemes in Thailand, the Philippines, and through technical support provided by DFID, USAID, World Bank and AusAID in Indonesia.

- Partners can support countries to investigate how to transfer, in the longer term, the costs of vertical HIV prevention programs into more integrated, sexual and reproductive health care for key populations programs, thus integrating management costs more evenly into the broader health budget. This is particularly important for countries with largely devolved/devolving health care systems.
• Partners can support countries to **strengthen health systems** to absorb more of the vertical costs of logistics, supply chain management, human resources, M&E into health care systems (health systems strengthening). Partners need to take close note of how far Global Fund investments are being currently used appropriately in this regard.

• Partners should support countries to develop appropriate **long-term funding strategies**, rather than simply ‘resource mobilisation’ strategies. Regardless of UNAIDS’ or other resource need calculations, countries need to tailor their strategic plans more carefully towards available or committed funding. Again, this could be linked to larger work on health care financing. And again, if such work is under way, it is urgent that HIV financing is factored into it. The HIV experience has shown that trying to tackle one disease in isolation has serious deleterious implications for wider sectoral financing issues.

### 7.5 Strategic options for expanding partnerships

China and India are developing new identities and roles in the context of development cooperation in the region. It is essential that all stakeholders recognise this and work towards greater **engagement with China and India** in a new partnership paradigm – with China and India as full development partners rather than ‘recipients’ of development assistance.

It is an unknown whether India or China will provide substantial development assistance specifically for HIV in the immediate future, but there are a number of common issues that require closer working relations. Some of the key options are:

• **Working to better understand and ensure access to high quality, reasonably priced medicines** for the region. China and India are both manufacturing giants in the field of medicines: what happens in the future as far as their respective capabilities and cooperation are concerned largely determines the costs the region (and the rest of the world) will pay for medicines. In addition, counterfeit medicines are a very serious problem for the region (and the world); concerted efforts by China and India and regional partners are essential to deal with this.

• China and India’s **technical capabilities**, in terms of academic and other technical institutions, are now world class. It is essential that these capabilities be more meaningfully engaged in scientific exchange and development for the regional response to HIV.

• Identifying and supporting new institutions in **China and India** (such as the Kunming Institute for Drug Abuse), that have established regional credibility, and which could add new blood and stimulus to the network of WHO Collaborating Centres, and help reflect the new development partnerships the BRICS are seeking.
- Encouraging appropriate **cross-boundary work**, where significant local population movement creates demand for HIV services. Cross-boundary work is needed to address HIV (in all aspects), but the implementation realities around effective inter-government cooperation other than information sharing and coordination meetings can be too big and difficult to have any effect in the short time. There needs to be political will and buy-in. It is questionable the extent to which external donors can facilitate this. The AusAID HIV/AIDS Asia Regional Program (HAARP) has cumulative knowledge and should build on its regional legacy. Key areas are the China-Burma (Myanmar) border, India-Nepal, and India-Bangladesh borders.

- Exploring potential south-to-south exchange of technical expertise or triangular cooperation with another ‘dialogue’ partner such as more developed ASEAN members, to support LIC in the region

It is hoped that the above sets of strategic options present partners with a set of possibilities for consideration as they plan for the future. For some partners, these options should suggest funding opportunities; for others new approaches and ways of working. From the perspective of this Assessment, the single most important finding is the opportunity, indeed imperative, for partners to work more closely together.
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1. The HIV epidemic in the Asia Pacific region

UNAIDS reports that the Asia Pacific HIV epidemic is largely stable. The data shows that the number of people living with HIV remained approximately the same in 2009 as 2005. The number of new infections has declined by 20 per cent since 2001 although remains substantial with 360,000 people newly infected with HIV in 2009.

The number of people receiving antiretroviral treatment in the Asia Pacific region has tripled since 2006 to 740,000 people by 2009. While this is a significant achievement, it represents less than one-third of those who are eligible under WHO guidelines.

The majority of new infections in Asia remain ‘concentrated’ among people who buy and sell sex, people who inject drugs, transgender people and men who have sex with men, a significant proportion of whom are under the age of 25.

- It is estimated that one in six people who inject drugs in Asia is living with HIV.
- The Commission on AIDS in Asia predicted that unless effective prevention services are brought to scale, by 2020 around 46 per cent of new infections in Asia will be among men who have sex with men, up from around 13 per cent in 2008.
- Thirty-five per cent of people living with HIV in the region are women, the majority of whom were infected by their intimate partners. Male clients of sex workers are the single biggest group who transmit HIV to their intimate partners.

Despite the epidemiological data, resources are not being directed to where they will have the greatest impact. Just eight per cent of the total HIV budget in South Asia and 20 per cent in South-East Asia is spent on prevention for key populations while high-cost, low-impact programs (such has blood safety and standard precautions) received at least one third of funding. Despite years of effort, we are still only reaching approximately five per cent of people who inject drugs with sterile needles and syringes and five per cent with methadone maintenance therapy. The median service coverage for men who have sex with men is 49 per cent among the ten reporting countries and falls far short of the 80 per cent needed. While condom use by female sex workers is high the nature of sex work is evolving to include an increasing number of mobile phone- and residence-based sex workers who are significantly more difficult to reach with prevention services.

There is a heavy reliance on funding from external sources in low and middle income countries in the Asia Pacific region with 47 per cent of the total HIV spend coming from foreign donors in 2010. In low-income

21 UNAIDS (2011) HIV in Asia and the Pacific: Getting to zero.
23 About half the countries in the region reported that at least 80% of female sex workers used a condom with their most recent client in 2009.
countries alone, the figure was 95 per cent. Donor funding is becoming less predictable as donors withdraw from the region, the global financial crisis forces budget cuts, funds are reallocated to cater for emerging priorities and more developing countries progress to middle income status. As a result, international funding for the global HIV response decreased slightly in 2010 for the first time, after levelling off the year before\textsuperscript{24}.

In December 2010, the UNAIDS Programme Coordinating Board adopted the UNAIDS 2011-2015 Strategy\textsuperscript{25}. The Strategy sets the long-term global vision for achieving zero new infections, zero AIDS-related deaths and zero discrimination. This, alongside the 2011 Political Declaration on HIV/AIDS sets the framework for reinvigorating efforts to achieve universal access.

The challenge for donors and countries now is to contextualise that vision and consider their roles in supporting the attainment of those goals. Both recipient countries and development partners need to continue to reassess where the epidemic is heading and whether donor and national HIV plans and activities are targeted to the most critical priorities. There is a need to continually assess how effective coordination has been among partners, and consider how partnership building could lead to better outcomes for investments.

Following discussions initiated by AusAID with a number of bilateral and multilateral donors working in the region, it has been agreed that a joint strategic assessment of the current status and future projections of the epidemics and responses in the region be undertaken by AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund to inform future policy and investment priorities in HIV.

2. Objectives of the assignment

The objective of the assignment it to provide advice to donors (particularly AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund), governments and their partners on opportunities and priorities for future policy, programming and partnerships for HIV in Asia. This advice will be informed by a strategic assessment of the current status (and future projections) of HIV epidemics and responses in each priority country, and evidence of best practice and cost-effectiveness. Advice will be contextualised within the broader strategic priorities and mandates of the donor organisations.

3. Scope of the assignment

The assessment will be undertaken in two parts: (a) a desk-based country-by-country situational analysis of the HIV epidemics and projections for the medium term, and (b) identification of priorities, opportunities and partnerships to maximise the value-add of policy, technical and programming investments by AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund.

Countries that will be included in the analysis are: China, Vietnam, Cambodia, Myanmar (Burma), Indonesia, East Timor, Philippines, India, Thailand and Laos.

(A) Country Situation Analysis

The first component of the assignment is a desk-based country-by-country situation analysis of the HIV context in Asia using available information and each undertaken by a consultant with country-specific expertise.

The situation analysis will include both the current status and likely projections into the medium term (over the next 5-10 years), where available, on the following:

i. HIV epidemiology

ii. Mapping of national programming and budgets (from domestic and external sources)

\textsuperscript{24}Kaiser Foundation (2011) \textit{Financing the response to AIDS in low- and middle-income countries: International assistance from donor governments in 2010.}

iii. Mapping of engagement (financial, programming) by major bilateral and multilateral partners, not limited to AusAID, USAID, UNAIDS and UNODC including alignment to principles of aid effectiveness.

iv. Broad assessment of sustainability of national programs and capacity including (but not limited to) human and financial resourcing

v. Identification of priority gaps (including political and bureaucratic leadership, policy, program and operational research gaps). Among the issues to be considered are appropriateness and effectiveness of current programming, and the social, political and structural impediments to successful responses.

(B) Strategic Advice

The second component of the report will provide sound, evidence-informed priority advice to donors, recipient governments and their partners on opportunities and priorities for future policy, programming and partnerships for HIV in Asia that make efficient use of resources (human and financial) and ensure value-add of efforts.

Options will need to be well argued, with a clear rationale that should be based on the situation analysis and other evidence, and include (but not limited to) consideration of the following:

i. The expertise, track record and mandate of AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund (and other partners) in HIV and development in the region

ii. Broader strategic interests of AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund, particularly as they relate to specific bilateral and regional programs

iii. The influence of the political environment, and the challenges this presents, on the HIV response and national commitment

iv. Value-add of AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund’s engagement in the HIV sector

v. Potential risk and benefits to changes in direction of current HIV support with consideration of the predictability of financing

vi. Potential for new and strengthened strategic relationships (with government, community, multilaterals, bilateral donors, local and international non-government organisations and the private sector)

vii. New and innovative modalities that allow AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund to capitalise on their strengths while maximising the potential of partnerships

viii. Approaches to funding are in line with the needs and capacities of countries

ix. Potential for maximising the impact of AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund’s investment in HIV to achieve other health and development objectives. In particular, how HIV funding can be used to lever broader health system improvements and improve broader health outcomes.

x. Capacity constraints within AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund (including country offices, headquarters and/or regional offices) to engage in the HIV sector and manage programs.

The focus of options should not be on advocacy for any one position but based on a rational evidence-based analysis of gaps in the response assessed against the relative risks, and likelihood of impact.

Following finalisation of the report there may also be a potential role of the Team Leader in facilitating discussions among the donor partners, government and other key stakeholders.
4. Reference Group

The Reference Group will be comprised of key technical representatives from AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund to provide input directly to the consultants at key points. The purpose is to provide guidance on the direction of the assignment and ensuring it meets the needs of these partners, and to provide advice and feedback on such areas as: rigour and contestability of the findings and recommendations; accuracy; formulation and articulation of argument; and to provide the consultants with the benefits of additional points of view.

It is expected that the Reference Group will meet with the Team Leader formally (in person or via teleconference) at least twice – at the start of the assignment to ensure clarity of the assignment and after submission of the draft Strategic Advice report.

The Reference Group may also meet following receipt of the final Strategic Advice report to discuss its implications, and possibilities for taking the findings and recommendations of the report forward including ways to monitor progress and achievements.

The Reference Group will also provide written feedback on the draft Country Situation Analyses and the draft Strategic Advice report.

5. Timing, approach and roles

The start date will be as soon as is feasible and will be dependent on the availability of suitable consultants. Consultants will be contracted by AusAID. A list of consultant names is provided at Attachment A.

The Country Situation Analyses will be a desk-based study based on available reports and data. The consultants will be expected to identify and source relevant literature.

The Strategic Advice component will be undertaken through selected in-country visits; email, face-to-face and telephone interviews; and desk-based literature reviews. A researcher will be available to assist the Team Leader and Team Member to identify and source information.

The role of the Team Leader will be to:

i. Plan, guide and develop the overall approach and methodology for the assessment.

ii. Manage and direct activities and team inputs, including guiding and oversight of the Country Situation Analyses to ensure that they are fit for purpose and consistent in content, structure and approach.

iii. Represent the team and lead consultations with development partners and other stakeholders, including the Reference Group.

iv. Be responsible for the delivery of all the deliverables listed under Reporting in these Terms of Reference and ensuring the quality of documents.

The role of the Team Member will be to:

i. Undertake data collection activities and analysis.

ii. As part of the workplan preparation, provide inputs into the guidance for the country analyses and methodological approach.

iii. Provide inputs into the draft and final reports as directed by the team leader, including a focus on modalities for support and engagement of development partners in the region and broader relevant governance and institutional issues.

iv. Contribute to the dialogue and analysis, including the strategic thinking and the development of options for future HIV engagement, and the achievement of the objectives of the assessment.
v. The team leader may, in consultation with the team member, agree to divide the responsibilities and focus of the assessment following the country situation analysis. For instance, by issue or stakeholder group or both.

Consultations should include:

i. AusAID, UNAIDS and cosponsors, USAID, World Bank, ADB and Global Fund, and implementers of their major programs

ii. Other regional and country-based bilateral and multilateral donors, such as PEPFAR, WHO and ADB

iii. Government representatives from appropriate ministries and national coordinating committees

iv. Key regional networks of people living with HIV and key affected populations such as APN+, ANPUD, APNSW, APTN and APCOM

v. Other in-country experts and stakeholders (such as representatives from Global Fund country coordinating mechanisms, Joint UN Teams on HIV, key civil society organisations and service providers)

vi. Other HIV experts

The Team Leader and Team Member will be expected to travel within Asia to meet with key stakeholders and experts and attend Reference Group meetings. Details of the travel plan will be provided by the Team Leader in the Workplan.

The following timetable is indicative and will be finalised and agreed to in the Final Workplan.
<table>
<thead>
<tr>
<th>Date (tbc)</th>
<th>Activity</th>
<th>Team Leader</th>
<th>Team Member (CD)</th>
<th>Team Member (JM)</th>
<th>Country Experts (each)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov</td>
<td>Initial phone briefing</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>21-25 Nov</td>
<td>Prepare draft workplan</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 Nov</td>
<td>Submit draft workplan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Nov</td>
<td>First Reference Group meeting - discuss objectives and approach of assignment, and draft workplan (Bangkok)</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>Guidance to Country Situation Analysis consultants</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-23 Dec</td>
<td>Preparation (identification and sourcing available literature and data) and writing Country Situation Analyses</td>
<td></td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>23 Dec</td>
<td>Submit draft Country Situation Analyses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Dec-21 Jan</td>
<td>Feedback on Country Situation Analyses</td>
<td>7</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>Pre-field preparation and establish initial contact with key informants</td>
<td>7</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>Geneva visit (Global Fund, UNAIDS and so on)</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Jan</td>
<td>Revise and submit final workplan</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22-31 Jan</td>
<td>Revise Country Situation Analyses (incorporating feedback from Reference Group members and Team Leader/Member).</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 Jan</td>
<td>Submit final Country Situation Analyses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>Conduct field work as specified in final workplan (including travel days).</td>
<td>20</td>
<td>11</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>Community consultation meeting Bangkok (tbc)</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mid March</td>
<td>Team meeting London</td>
<td>2</td>
<td>2</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>Strategic Advice report writing</td>
<td>13</td>
<td>10</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>13 April</td>
<td>Submit draft Strategic Advice report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 May</td>
<td>Reference Group meeting to discuss draft report (presentation by Team Leader) (Bangkok)</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>early May</td>
<td>Written feedback from Reference Group members on draft Strategic Advice report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>early-mid May</td>
<td>Revise Strategic Advice report</td>
<td>5</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 May</td>
<td>Submit final Strategic Advice report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tbc</td>
<td>Reference Group meeting to discuss report implications and direction forward</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total (maximum) days excluding travel days</strong></td>
<td></td>
<td>63.5</td>
<td>44.5</td>
<td>5.5</td>
<td>9.5 each</td>
</tr>
</tbody>
</table>
6. Consultants specifications

(A) Country Situation Analysis

One consultant will be engaged for each country analysis (although a consultant may undertake more than one analysis, and the Team Leader and Team Member may also undertake these assignments where there is the appropriate expertise and timing allows).

Consultants will be expected to demonstrate the following skills and knowledge:

i. in-depth and current understanding of the HIV epidemiology, policy, programming and political context in the relevant country

ii. sound skills in HIV epidemiology

iii. excellent research and communication skills, including the ability to analyse complex information and write clearly

iv. thorough understanding of aid management principles

(B) Strategic Advice

The Strategic Advice component of the assignment will be undertaken by two consultants – a Team Leader and the Team Member. A researcher will also be available to assist the team for up to 5 days. Each consultant will be required to demonstrate expertise and knowledge in the following areas:

i. HIV technical, policy and programming issues in the South East Asia region

ii. health system improvement in low and middle income countries

iii. understanding of, and skills in applying, economic analysis of HIV epidemics and responses

iv. the role of bilateral and multilateral donors in low and middle income countries and ability to influence in this context

v. high-level strategic thinking and planning

vi. aid effectiveness principles and practice

vii. significant experience working within a bilateral or multilateral donor agency is strongly preferred

7. Reporting

The consultants will prepare and submit the following documents in electronic (Word) format.

i. Draft workplan to be submitted by 25 November 2011. This document will outline the assignment methodology and key dates including proposed mission(s), list of proposed informants, approach to the literature review including types of documents sought, a draft structure of the final Strategic Advice report and will identify any outstanding issues which need to be addressed and agreed to before work commences.

ii. Draft Country Situation Analyses for each of the ten focus countries to be submitted by 23 December 2011. Each analysis will be no more than ten pages. A detailed bibliography should be provided with footnotes throughout the text to indicate the source of information.

iii. Final workplan to be submitted by 21 January 2012.
iv. Final Country Situation Analyses incorporating feedback from the Team Leader and team Member and the Reference Group to be submitted by 31 January 2012.

i. Draft Strategic Advice report to be submitted by 13 April 2012. The report will include the following requirements:

ii. A two-page Executive Summary.

iii. The body of the report will be no more than 30 pages and will provide options for future HIV engagement, as detailed under Section 3: Scope of the assignment.

iv. A detailed bibliography should be provided with footnotes throughout the text to indicate the source of information.

v. More detailed information may be provided as annexes to the report.

vi. Verbal debriefing to the Reference Group in early May 2012. The format of the debriefing will be at the discretion of the Reference Group and may require a formal PowerPoint presentation (including via videoconferencing with country offices) and/or multiple meeting(s).

vii. A final Strategic Advice report to be submitted by 14 May 2012 which will incorporate instructions and feedback from the Reference Group on the draft report and verbal debriefing.
### AusAID CONTRACTED CONSULTANTS LIST

<table>
<thead>
<tr>
<th>Strategic Assessment</th>
<th>Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Leader</td>
<td>Peter Godwin</td>
</tr>
<tr>
<td>Team Member</td>
<td>Clare Dickinson</td>
</tr>
<tr>
<td>Team Member</td>
<td>Jackie Mundy</td>
</tr>
<tr>
<td><strong>Country Situation Analysis</strong></td>
<td><strong>Consultant</strong></td>
</tr>
<tr>
<td>Laos</td>
<td>Chris Lyttleton</td>
</tr>
<tr>
<td>China</td>
<td>Kim Wheeler</td>
</tr>
<tr>
<td>Philippines</td>
<td>Roderick Poblete</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Linette Collins</td>
</tr>
<tr>
<td>Burma</td>
<td>Clare Murphy</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Virginia Loo</td>
</tr>
<tr>
<td>Thailand</td>
<td>Jan Willem de Lind van Wijngaarden</td>
</tr>
<tr>
<td>East Timor</td>
<td>David Fowler</td>
</tr>
<tr>
<td>India</td>
<td>Suresh Kumar</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Peter Godwin</td>
</tr>
</tbody>
</table>
KEY DONOR PARTNER CONTACTS

AusAID:
- Robyn Biti, HIV Advisor (robyn.biti@ausaid.gov.au)
- Benedict David, Principal Health Advisor (benedict.david@ausaid.gov.au)

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- Geoffrey Manthey, Regional Programme Advisor (mantheyg@unaids.org)

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- Anna Bergenstrom, Coordinator Regional Adviser, HIV/AIDS Prevention and Care (anne.bergenstrom@unodc.org)

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- Aye Aye Thwin, Director Office of Public Health (aathwin@usaid.gov)
- ThuVan Dinh, Regional Technical Advisor for HIV/AIDS (tdinh@usaid.gov)
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- Rikard Elfving, HIV and AIDS Coordination Specialist (relfving@adb.org)
- Emiko Masaki Southeast Asia Department (emasaki@adb.org)

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- Edmund Settle, Policy Specialist HIV, Human Rights and Governance (Edmund.settle@undp.org)

UNFPA
- Julia Cabassi, Regional Advisor HIV/ Most at Risk Populations (MARPs) (cabassi@unfpa.org)

Global Fund to fight AIDS, Tuberculosis and Malaria
- Rifat Atun, Director of the Strategy, Performance and Evaluation Cluster (Rifat.Atun@theglobalfund.org)
- Ade Fakoya, Senior Advisor on HIV (Ade.Fakoya@theglobalfund.org)

World Health Organization
- Dr. Teodora Elvira Wi, Medical Officer, HIV/AIDS and STIs, Western Pacific Regional Office (wit@wpro.who.int)
- Dr Iyanthi Abeyewickreme, Regional Adviser HIV/AIDS/STIs, Regional Office for South-East Asia (abeyewickremei@searo.who.int)

World Bank
- Mariam Claeson, Program Coordinator HIV/AIDS, South Asia Region (mclaeson@worldbank.org)
- Toomas Palu, Sector Manager for Health Nutrition and Population, East Asia and the Pacific (tpalu@worldbank.org)
KEY DOCUMENTS

2. UNAIDS (2011) *HIV in Asia and the Pacific: Getting to zero*
4. UNAIDS/USAID docs and so on
7. AusAID (2009) *Intensifying the response: Halting the spread of HIV. Australia’s international development strategy for HIV.*
8. [AusAID Delivery Strategies for relevant countries]
Annex 2 Work plan
Joint Strategic Assessment and Options to Address HIV Epidemics in Asia

(AusAID, UNAIDS and cosponsors, USAID, ADB Global Fund)

Final Work Plan
Peter Godwin
Clare Dickinson

25 January 2012
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1. **Background**

The Terms of Reference for this assessment set out the challenge: how can resources for HIV be more appropriately and efficiently allocated within Asia and the Pacific?

The report originating from a major multi-party consultation for Asia and the Pacific in March 2011 concluded that, despite the reasonable epidemiological and service delivery data in many countries, resources are not being directed to where they will have greatest impact. While overall the Asia Pacific HIV epidemic is largely stable, a number of significant epidemics continue to grow among people who inject drugs, transgender people and men who have sex with men. Yet, just eight per cent of the total HIV budget in South Asia and 20 per cent in South-East Asia is spent on prevention for these key populations and coverage of targeted service delivery is still very limited. The number of people receiving antiretroviral treatment in the Asia Pacific region has tripled since 2006 to 740,000 people by 2009; yet this represents less than one-third of those who are eligible under WHO guidelines.

Among the resources allocated, there is a heavy reliance on unsustainable funding from external sources in low and middle income countries in the region, with 47 per cent of the total HIV spend coming from foreign donors in 2010; in the low-income countries alone, the figure was 95 per cent. Donor funding is becoming less predictable as donors withdraw from the region, the global financial crisis forces budget cuts, funds are reallocated to cater for emerging priorities and more developing countries progress to middle income status.

In June 2011, the High Level Meeting at the UN General Assembly adopted ambitious targets, based on the UNAIDS 2011-2015 Strategy for achieving zero new infections, zero AIDS-related deaths and zero discrimination.

The challenge for donors and countries is to contextualise that vision and consider their roles in supporting the attainment of those goals – given the weaknesses in current programming outlined above. Countries and their development partners need to continue to reassess the trajectory for the epidemic and how national HIV policies, strategies and plans commit resources to the most critical priorities. There is also a need to continually assess how effective coordination has been among partners, and consider how partnership building and funding modalities could lead to better health outcomes for investments.

Following discussions between AusAID and a number of bilateral and multilateral donors working in the region, this Joint Strategic Assessment of the current status and future projections of the epidemics and responses in the region is being undertaken to inform future policy and investment priorities in HIV.

2. **Objectives and Scope of the Assignment**

The objective of the assignment it to provide advice to donors (particularly AusAID, UNAIDS and cosponsors, USAID, ADB, Global Fund and the World Bank) and their partners on opportunities and priorities for future policy, programming and partnerships for HIV in Asia. This advice will be informed by a strategic assessment of the current status (and future projections) of HIV epidemics and responses in each priority country, and evidence of best practice and cost-effectiveness. Advice will be contextualised within the broader strategic priorities and mandates of the donor organisations.

The assessment will be undertaken in two parts: (a) a desk-based country-by-country situational analysis of the HIV epidemics and projections for the medium term and current responses, and (b) identification of priorities, opportunities and partnerships to maximise the added value of policy, technical and programming investments by AusAID, UNAIDS and cosponsors, USAID, ADB, and the Global Fund.

---

Countries that will be included in the analysis are: China, Vietnam, Cambodia, Myanmar (Burma), Indonesia, East Timor, Philippines, India, Thailand and Laos.

3. Conceptual Framework

Our work plan builds on the new ‘investment framework approach’ being promoted by UNAIDS and its partners as the most appropriate way to achieve maximum impact for given resources. That is, we aim conceptually to identify the investments needed to achieve the results required most effectively within the region. We have developed a simple theory of change that illustrates our thinking and will guide our analysis for this assignment.

The framework above sets out plausible links between context, investments (or inputs), short term (within five years) outputs, medium term outcomes (5-10 years) and impact at country level.

We classify as ‘investments’ (inputs):
- policies, strategies and implementation programmes
- multi-stakeholder governance and accountability frameworks
- service delivery systems and
- financial resources

We classify as ‘results’ (outputs, outcomes, impact):
- country national strategic plan outcome targets
- country and development partners outputs
- the June 2011 HLM impact targets applicable for the region for the shorter term
- the three Zeros (new infections, AIDS-related deaths, and discrimination) of the UNAIDS Strategy in the region as long term impact results

---

Conceptually, the epidemiological and socio-political and economic conditions of the countries will influence the outputs and outcomes required to reach the three zeros’ impact. Evidence informed strategies and realistic targets, based on a country’s epidemiology should be reflected in the country national strategic plan (NSP) or equivalent. This framework can then be used to identify existing and future investments required (in terms of policy, strategy and programme, systems, governance architecture, and financing (domestic and external) to contribute to the achievement of those results. The framework explicitly gives weight to the context and environment in each country, and the region as a whole.

This is particularly important for the region, where, as the Commission on AIDS in Asia notes:

“Although the epidemics [in Asia] vary considerably from country to country, they share important characteristics, namely that they are centred mainly around unprotected paid sex, the sharing of contaminated needles and syringes by injecting drug users, and unprotected sex between men.”

These three behaviours are, throughout the region, explicitly illegal in almost all situations, and widely socially and culturally stigmatized. Addressing this epidemiology is thus highly dependent upon national social and legal patterns.

The next step is to identify the precise implementation strategies and interventions needed to apply these investments effectively and efficiently – bearing in mind the logic analysis that underlies the framework. For this assessment, we then identify the appropriate strategic investments for partners to contribute most effectively to the desired outcomes – whether they be in terms of support for policy or governance, programming, or simply financing. Finally, we suggest options for partners to make these investments most effectively and efficiently, given their own policy, strategy and resource realities. It is important to recognise that our study is essentially a ‘rights-based’ study: analysis must take into account not only the perspectives and demands of duty bearers, but also those of rights holders. For the purposes of our analysis we find particularly useful the typology suggested by Tarantola et al.³:

“Firstly, States must respect human rights, which requires governments to refrain from interfering directly or indirectly with the enjoyment of human rights. Secondly, States also have the obligation to protect human rights, which requires governments to take

measures that prevent non-State actors from interfering with the enjoyment of human rights, and to provide legal and other appropriate forms of redress which are accessible and effective for such infringements. Finally, States have the obligation to fulfill human rights, which requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of human rights, thus creating the conditions in which persons are able to enjoy their rights fully in practice.”

In addition to this approach, we will draw on other analytical frameworks in health and aid effectiveness to help inform our analysis including for example, the Kingdon model of agenda setting which helps make sense of how and why certain health issues rise up or fall off the political agenda.

Organically the framework comprises two main elements: a set of ten country situation analyses which will provide details of both results required and investments available for key countries in the region, and a strategic assessment element which will analyse how these currently are matched, what challenges there are in matching them, and what the possibilities are for maximizing the match.

‘Investment’, as defined, does not necessarily mean only financial support.

The subject matter of this assessment is enormous and much previous work (e.g. the AIDS Commission’s Report and the recent UNAIDS Report) was concerned with very similar issues. This assessment will not simply re-visit or second-guess previous work: rather we will seek to extract some fundamental issues about the balancing of investments with results in the region from this prior work, validate these with the particular perspective of the country situation analyses, and then examine them in terms of development partner options.

4. Methodology

The assessment will be conducted in five phases:

1. Conceptualizing and preparing the work
2. Country situation analysis
3. Field work preparation and implementation
4. Analysis and review
5. Reporting writing

4.1. Phase one: Conceptualizing and preparing for the assignment

This is the fundamental task of deciding how to respond to the Terms of Reference of the assignment. It comprises a number of desk tasks to be conducted primarily by the Team Leader with the support of the Team Member and presented to the Reference Group at the initial meeting. These tasks include:

- Reviewing and understanding the Terms of Reference. As discussed with AusAID at the initial telephone briefing, and reflected in this Work Plan. Two consultants have been recruited by HRF on behalf of AusAID as the Team to conduct the assessment, against
TOR in Annex 3. In addition, 9 further consultants have been recruited to prepare the country situation analyses (see below).

- **Setting up technical coordination and management of the assignment.** As discussed with the HRF and agreed with AusAID. 1) AusAID will send all concerned partners a formal, official statement of partners engagement, responsibilities, roles, and introducing formally the Strategic Assessment Team: who they are speaking on behalf of, to what purpose etc. This may be the finalized, overall TOR of the assessment. 2) The role and responsibilities of facilitation of both Country Papers and Field Visits has been accepted by the UNAIDS Regional Support Team (RST) in Bangkok.

- **Determining the conceptual framework guiding the assignment.** Described in this Work Plan.

- **Preparing the Work Plan.** This is the final Work Plan being submitted to AusAID by 21 January 2012. A draft was prepared by the Team for discussion at the initial Reference Group Meeting. **Outlining the requirements and briefing for the Country Situation Analysis:** see below. The full list of recruited consultants (as at 21 January) is at Annex 2.

- **Scoping key partner and country documentation to be reviewed, and individuals and institutions to be interviewed.** A preliminary list of documents has been suggested in the TOR; this will need to be considerably expanded, particularly with respect to other partners. The UNAIDS RST in Bangkok will facilitate the collection of such documentation. Similarly, lists of individuals and institutions have already been determined in the TOR; these have been supplemented by the Reference Group, and facilitated by UNAIDS. It is expected that useful guidance in this respect could emerge from the country situation analysis reports.

- **Identifying likely needs for field work.** At this stage proposals have been prepared. These are in the following section, but are subject to change and refinement as issues emerge during the assignment.

- **Mapping out the time schedule.** See below.

**The Reference Group**

The Reference Group is comprised of key technical representatives from AusAID, UNAIDS and cosponsors (including WHO), USAID, ADB and the Global Fund and will provide input directly to the team at key points. A crucial first step will be attending the first Reference Group meeting in Bangkok on November 30th. Key objectives of the meeting were (i) to set out and agree the scope and parameters of the assignment with the partners (ii) to agree to this draft Work Plan (iii) to identify priority countries and likely issues for field work (iv) to identify key informants, institutions and the location of influence (HQ, regional, country level) for phase three (v) to identify resources and needs for field work (vi) to map out the time schedule (vi) to map out Reference Group inputs, timelines and methods of interaction with the Team.
4.2. Phase two: Country situational analysis

Ten country situational analyses are to be undertaken by country focused consultants in December 2011. These situation analyses will be the basic evidence base for the whole assessment. The purpose of the situation analyses is to ascertain, as far as possible, the current status and likely projections into the medium term (over the next 5-10 years) of the following: (i) HIV epidemiology (ii) Mapping of national programming and budgets (from domestic and external sources) (iii) Mapping of engagement (financial, programming) by major bilateral and multilateral partners, not limited to AusAID, USAID, UNAIDS and UNODC including alignment to principles of aid effectiveness (iv) Broad assessment of sustainability of national programs and capacity including (but not limited to) human and financial resourcing (v) Identification of priority gaps (including political and bureaucratic leadership, policy, program and operational research gaps). Among the issues to be considered are appropriateness and effectiveness of current programming, and the social, political and structural impediments to successful responses. It is recognised that the countries selected for this assessment differ enormously, particularly with respect to their engagement with HIV, and the engagement of partners.

It is important that these situation analyses are not simply re-sequences of the extensive country and regional situation analyses conducted by UNAIDS for its HIV in Asia and the Pacific: Getting to zero Report earlier this year. They should focus primarily on identifying how far explicit national priorities and strategies (results – see above) respond to the epidemiological realities of the country, how far resource allocations (investments – see above) reflect these priorities, and what the role of development partners in this situation is. It will be critical to get good data on existing ‘investments’ and how they link to expected ‘results’.

The primary methodology for this phase is desk-based data collection and analysis using available information, embellished and verified (where necessary) through email and possibly short telephone interviews with key contacts/informants. The country consultants will report directly to the Team Leader and will be briefed in advance by the Team Leader and/or Team Member in the first week of December. The consultants will be provided guidance to follow (see Annex 1). The reports will be submitted to AusAID via the HRF by the Team by 23rd December 2011, for sharing with the Reference Group; consolidated comments from the Reference Group will be sent to the Team Leader for inclusion in the Team’s review of the reports by 21st January 2012. The reports will be finalised by the consultants and submitted to AusAID via the HRF by 31st January 2012.

4.3. Phase three: Field Work preparation and implementation

As the country reports get underway and the draft reports start to emerge, the Team Leader and Team Member will undertake a preliminary analysis of findings (in January 2012) to help inform the field work phase and the outline/structure for the final report. Priority countries for visits and key informants in those countries will need to be agreed with the Reference Group (but see below). Arrangements, including the timing of visits, facilitated introductions, contact and setting up interviews will be put in place. These visits will take place during the months of February and March 2012 (see schedule/purpose of visits in Annex 4.

A specific visit to Geneva to discuss the assessment and strategic implications with senior staff at the UNAIDS Secretariat, Department of HIV, WHO, and the Global Fund will take place on 19th January 2012, prior to the field work in Asia. A key objective of this visit will be to receive an update from the Global Fund on the use of their proposed Risk Assessment Framework (under design) that will shape future allocations and decision making for countries in the Asia Pacific region.

The essence of Phase three will be an assessment both at desk and field level of development partners’ overall engagement in HIV/AIDS in the region. This will include (i) the expertise, track record and mandate of AusAID, UNAIDS and cosponsors, USAID, ADB, the World Bank and Global Fund (and other partners) in HIV and development in the region (ii) broader strategic
interests of the partners, particularly as they relate to specific bilateral and regional programmes (iii) the added value of the partners’ engagement in the HIV sector (iv) capacity constraints within the partners (including country offices, headquarters and/or regional offices) to engage in the HIV sector and manage programmes (vi) potential for new and/or strengthened relationships and modalities that allow the partners to capitalise on their strengths.

The Team Leader and Team Member will use semi-structured interview guides (targeting different audiences) to be used face-to-face and/or by phone/email. It will be particularly important to conduct face-to-face interviews with those partners that are more difficult to access through phone or email for example government and local civil society partners, as well as development partner staff ‘working at the coal-face’. Example question/discussion guides can be found at Annex 5. These guides cover key areas of the terms of reference and are informed by a preliminary analysis of the findings emerging from the country assessment papers and a preliminary review of key documentation. The team recognises that the choice of questions to be pursued will need to be carefully selected/tailor made according to audience, purpose of the meeting and time available.

**Consultation with Constituencies**

At its initial meeting, the Reference Group stressed that for the strategic assessment to have credibility and validity, it is critically important to have extensive consultation with various concerned and interested constituencies throughout the process. Given the timeframe for the assessment, this will be managed through a series of specific consultation mechanisms:

1. The Team Leader and Team Member will meet with AusAID colleagues in each country, at the start of the country visit. The purpose of the meeting will be to discuss the conclusions of the country assessment paper and have a broader discussion on AusAID priorities, strategic directions, perspectives on partnerships etc in that country. In addition, the Team will “interview” key Canberra-based AusAID staff on their priorities, strategic directions, perspectives on strategic options etc either prior to or during the country visits.

2. In addition to the Reference Group the draft Country Situation Analyses will be shared with selected regional civil society and other constituency groups (e.g. AHRN, ASEAN, WB) for comments, along with all UNAIDS Country Offices.

3. Team consultation (face-to-face, phone and email) will be conducted with various constituency representatives (e.g. Reference Group members, WB, AHRN, APCASO, WHO, DFID, GTZ, etc.)

4. At the invitation of UNAIDS the Team will take the opportunity presented by the ESCAP Asia-Pacific High-Level Intergovernmental Meeting on the Assessment of Progress against Commitments in the Political Declaration on HIV/AIDS and the Millennium Development Goals to be held in Bangkok from 6-8 February 2012 to have consultation with both regional and country civil society representatives and government. This will be facilitated by the UNAIDS Regional Support Team.

5. During country field visits explicit consultation will take place with government and civil society groups, and development partners (see Annex 5 question guides). This is being facilitated by UNAIDS country offices in countries to be visited.

6. The draft Strategic Assessment Report will be shared with selected regional constituency representatives for comments.

Face-to-face meetings with regional institutions (where the complexity of regional realities may make electronic discussion less productive) are also required including the two WHO Regional Offices (Manila and New Delhi), USAID, UNAIDS and regional civil society organisations as the ‘Seven Sisters’ and the Asia Harm Reduction Network (in Thailand) or ASEAN in Jakarta. In addition the field visits may provide an opportunity to hold selected group meetings to validate emerging findings from the strategic assessment and discuss future options.
4.4. Phase four: Analysis and review

During the field work, the team will be conducting continual analysis of the emerging findings which will be consolidated through brainstorming sessions via email and conference calls. By late February and early March, however, the analysis and review of data collected will be in full swing, starting to feed into the report. At this stage, a researcher will be assisting with the consolidation of data, particularly ‘investment’ data into manageable tables and formats and the identification of any important literature required for the final analysis. The Team Leader and the Team Member plan to meet in London on March 8th & 9th 2012 to brainstorm findings and map the final report. A teleconference call with key AusAID personnel in Canberra is scheduled for the 9th March. The purpose of the call is to discuss and receive feedback on the findings from the field work phase and initial ideas on strategic options. The call will also be used to deal with any outstanding issues regarding the focus, length and structure of the final report.

Country and Regional perspectives

Globally, the HIV epidemic is now recognised as comprising a series of multiple epidemics. Each epidemic is country-specific (and may be geographically or demographically specific within countries too) in terms of the underlying vulnerabilities and drivers of the spread of the epidemic, its manifestations, and policy, strategy and programme responses to it. This is particularly so in the context of Asia and the Pacific. There are, however, a set of frameworks/networks, ethnic, cultural, political, ideological, technical, economic and commercial, that overlay the region. These frameworks/networks underpin the response to the epidemic at regional level, and can have significant impact at country level. In undertaking the analysis, the team will be sensitive to the frameworks/networks and need to identify both the beneficial and detrimental implications of the regional perspective.

4.5. Phase five: Report writing

The final report will provide a neutral, evidence-informed strategic options and advice to donors, recipient governments and their partners on future investments in policy, programming and partnerships for HIV in Asia. In doing so, the options will consider the most efficient use of resources (human and financial), ensure value-added and will contribute effectively and efficiently towards the realisation of country and regional results and targets.

Options will present a clear rationale based on the situation analysis and other evidence, and include (but not limited to) consideration of the following:

- The assessment of partners current and future engagement
- Potential risk and benefits to changes in direction of current HIV support with consideration of the predictability of financing
- Potential for new and strengthened strategic relationships (with government, community, multilaterals, bilateral donors, local and international non-government organisations and the private sector)
- New and innovative modalities that allow partners to capitalise on their strengths while maximising the potential of partnerships
- Approaches to funding are in line with the needs and capacities of countries
- Potential for maximising the impact of partner’s investments in HIV to achieve other health and development objectives. In particular, how HIV funding can be used to lever broader health system improvements and improve broader health outcomes.

After submission of the draft final report by 30th March 2012, the Team Leader will meet the Reference Group to present the findings and receive verbal feedback. Written feedback will be consolidated by AusAID and submitted to the team to finalise the report. The team will submit the final report by the 30th April 2012. The Reference Group may also meet (with or without the team – to be determined) following receipt of the final report to discuss its implications and ways forward.
5. Indicative Work Plan

Phase 1
- Preparation, TL TM
- Telephone briefing
- Prepare draft work plan
- Approval of draft work plan

Phase 2
- Reference Group meeting Bangkok
- Briefing country consultants
- Country consultants complete draft country reports
- Draft country reports submitted
- Feedback on country reports and revise reports
- Submit revised country reports
- Revise and submit final work plan

Phase 2 - indicative
- Revision of country reports incorporating feedback
- Submit final country situation analyses
- Conduct field work as per final work plan
- Strategic Advice report writing
- Submit/Draft Strategic Advice Report

Reference Group meeting Bangkok to consider report

Written feedback from Reference Group
- Review final Strategic Advice Report
- Submit final Strategic Advice Report
- Reference Group meeting Bangkok to consider implications and way forward

Key milestones
- Reference Group meetings
6. Outputs

The Team will prepare and submit the following outputs in electronic format.

1. **Draft Work Plan:** to be submitted by **25 November.** This document will outline the assignment methodology and key dates including proposed mission(s), list of proposed informants, proposed approach to the literature review including types of documents sought, a draft structure of the final report and will identify any outstanding issues which need to be addressed and agreed to before work commences.

2. **Draft Country Situation Analyses:** for each of the ten focus countries to be submitted by first week of **23 December.** Each analysis will be no more than ten pages. A detailed bibliography should be provided with footnotes throughout the text to indicate the source of information.

3. **Final Country Situation Analyses:** to be submitted by **31 January 2012.**

4. **Final Work Plan:** to be submitted by **21 January 2012.**

5. **Draft Strategic Advice Report:** to be submitted **30 March 2012.** The report will include the following requirements:
   a. A two-page Executive Summary.
   b. The body of the report will be no more than 30 pages and will provide options for future HIV engagement, as detailed under **Section 3: Scope of the assignment.**
   c. A detailed bibliography should be provided with footnotes throughout the text to indicate the source of information.
   d. More detailed information may be provided as annexes to the report.

6. **Verbal debriefing:** to the Reference Group in early April 2012. The format of the debriefing will be at the discretion of the reference Group and may require a formal PowerPoint presentation (including via videoconferencing with country offices) and/or multiple meeting(s).

7. A final **Strategic Advice Report** to be submitted by **30 April 2012** which will incorporate instructions and feedback from the Reference Group on the draft report and verbal debriefing.
Annex 1: Country Situation Analysis Report Outline

The aim is to capture three main elements of the country situation:

1. What is the current epidemic status and what is the trajectory over the medium term (the next 5-10 years?)
2. What resources are allocated to the national HIV response and how well are they aligned to address the priority areas of the epidemic/national response?
3. What are the key challenges, both to appropriate resource allocation and to implementation, and how can external donors help with these?

These elements need to be captured as succinctly as possible, preferably with a common set of categorizations so that regional commonalities can be identified. Each country situation analysis must be able to tell us (i) country-specific issues to which we need to respond and (ii) how regional responses can help. Where possible, please identify example of good practice and cost effectiveness of strategies/interventions (where information is available). The report length should be no longer than 15 pages. Once finalised, the reports will be stand-alone documents with open access.

The following outline is suggested:

1. **HIV Epidemiology: Where is the epidemic now and where is it going?**
   This needs to be a concise overview of the current epidemic status and its direction of travel. Where possible please include prevalence disaggregated by sex, age, location, risk group, etc; incidence of HIV (if it is available); numbers of those in care and treatment, as a proportion of need? Figures for MTCT; where did the last 1000 new infections occur? In which groups, locations is it increasing/decreasing etc. What are the underlying vulnerabilities and drivers and what is their status (growing, static, declining etc.)?

2. **Mapping of national programming and budgets: Do strategic priorities and resource allocations match these realities?**
   This needs to a concise overview of the status of the National Strategic Plan and its priorities and whether the priorities of the Plan and HIV resources match the status and direction of the epidemic. Please include: info on the National Strategic Plan (NSP), whether it identifies clear strategic priorities for resource allocations and whether these are likely to be effective in targeting the main drivers/high risk groups affected by the epidemic. Are there targets set in line with High Level Meeting commitments? Include details on domestic resource allocations for HIV, current, projected and likelihood of increased domestic financing for HIV? If possible, briefly map existing resources against the results (or goals, objectives, etc.) of the NSP.

3. **Mapping of external engagement (financial and programming): What are external donors doing and how are they doing it?**
   This needs to map major bi- and multi-lateral donor financial and programming engagement in HIV not limited to AusAID, USAID, UNAIDS (including main cosponsors) and GF. As far as possible, detail sources and volume of external resources (on and off budget) and how these resources are being programmed/what modalities are in use (e.g. project funding, pooled funding etc.). What are the short- and long-term commitments and expectations? When Where possible, identify practical examples of donor commitments to improving aid effectiveness through joint funding modalities, partner coordination mechanisms etc.
4. What are the challenges to implementing an effective national response?

This section needs to briefly identify political, structural, policy, programmatic and operational challenges to implementing an effective response for the medium term. Issues to consider could include robustness of strategic and operational planning processes, resource and implementation challenges, political, structural (e.g. legal frameworks) and bureaucratic constraints, donor harmonisation and alignment with national priorities, integration of HIV into national health and development planning and implementation systems?

5. Conclusions/gaps: What is needed to achieve current NSP results and also HLM targets?

This section needs to sum up the appropriateness and effectiveness of current programming and identify what else/priority gap areas required to meet the NSP and HLM targets.
Annex 2: List of Country Situation Analysis consultants

1. China - Kim Wheeler
2. India – M Suresh Kumar
3. Thailand - Jan De Lind Van Wijngaarden
4. Cambodia- Peter Godwin
5. Philippines – Roderick Poblete
6. Burma – Clare Murphy
7. Laos – Chris Lyttleton
8. East Timor – David Fowler
9. Vietnam – Virginia Loo
10. Indonesia - Linette Collins
Annex 3: Team Terms of Reference

The role of the **Team Leader** will be to:

i. Plan, guide and develop the overall approach and methodology for the assessment.

ii. Manage and direct activities and team inputs, including guiding and oversight of the Country Situation Analyses to ensure that they are fit for purpose and consistent in content, structure and approach.

iii. Represent the team and lead consultations with development partners and other stakeholders, including the Reference Group.

iv. Be responsible for the delivery of all the deliverables listed under Reporting in these Terms of Reference and ensuring the quality of documents.

The role of the **Team Member** will be to:

i. Undertake data collection activities and analysis.

ii. As part of the workplan preparation, provide inputs into the guidance for the country analyses and methodological approach.

iii. Provide inputs into the draft and final reports as directed by the team leader, including a focus on modalities for support and engagement of development partners in the region and broader relevant governance and institutional issues.

iv. Contribute to the dialogue and analysis, including the strategic thinking and the development of options for future HIV engagement, and the achievement of the objectives of the assessment.

v. The team leader may, in consultation with the team member, agree to divide the responsibilities and focus of the assessment following the country situation analysis. For instance, by issue or stakeholder group or both.
Annex 4: Key documents (to be completed); suggestions from Reference Group welcome

2. UNAIDS (2011). HIV in Asia and the Pacific: Getting to zero
7. AusAID (2009). Intensifying the response: Halting the spread of HIV. Australia’s international development strategy for HIV.
11. Australia’s international development assistance program budget 2011-2012: an effective plan for Australia: reducing poverty, saving lives and advancing Australia’s national interests
12. AusAID (2011) Keeping our commitment – Australia’s support for the HIV response
14. Saving lives – Australia’s aid for women and children
15. AusAID/World Bank Group Partnership 2011 Saving lives, creating opportunities
19. Asian Development Bank (April 2010). In Focus: Health
20. USG (2011). Seventh Annual Report to Congress on PEPFAR
22. USG (2010). Report to Congress on Costs of Treatment in the President’s Emergency Plan for AIDS Relief (PEPFAR) (July 2010)
32. ASEAN Declaration of Commitment: Getting to zero new infections, zero discrimination, zero AIDS-related deaths
33. ESCAP (2011) Overview of regional implementation of the Political Declaration on HIV/AIDS and the MDGs and efforts to ensure universal access in Asia and the Pacific including regional follow up to the outcome of the 2011 General Assembly High Level meeting on AIDS
35. OECD (2011) The Busan Partnership Agreement
36. OECD (2011) Progress and challenges in aid effectiveness: what can we learn from the health sector?
37. UN General Assembly (2011) Political declaration on HIV/AIDS: Intensifying our efforts to eliminate AIDS
40. UNDP (2011) Regional Issues Brief: Laws and practices relating to criminalisation of PLWH and populations vulnerable to HIV
41. UNDP (2011) Legal environments, human rights and HIV responses among sex workers in Asia and the Pacific
42. UNDP/Global Commission on HIV and the Law (2011) Asia pacific regional dialogue of the Global Commission on HIV and the law
43. UNDP (2011) Towards universal access: examples of municipal HIV programming for MSM and transgender people in six Asian cities (inc in Indonesia, Thailand, China, Vietnam, Philippines)
44. ids2031Results for Development Institute (2010) Costs and choices: financing the long term fight against AIDS
50. Schwartlander B et al (2011) Supplemented material towards an improved investment approach

For each country

1. Current National Strategic Plan (or equivalent)
2. Most recent Annual/Mid-term Review
3. Latest Annual Report
4. Latest epidemiological/surveillance up-date, DHS, AIS, etc
5. Key recent reports, reviews, studies
6. Partners’ Delivery Strategies/Programme Documents & Reports
7. National Development Plan (or equivalent)

Additional AusAID Reports

1. HIV Consortium for Partnerships in Asia and the Pacific - Independent Progress Report, October 2010
2. Scoping exercise: Recommendations for AusAID support for comprehensive approaches to address HIV infection among men who have sex with men in the Asia Pacific Region, June 2009
3. Asia Regional Consultation on MSM HIV/AIDS Care, Support and Treatment, Bangkok, 17-19 November 2009 - Draft Meeting Report
4. Pandemics and Emerging Infectious Diseases Framework 2010–2015 October 2010
<table>
<thead>
<tr>
<th>Country</th>
<th>Income Classification</th>
<th>Funding Pattern</th>
<th>Rationale for Visit</th>
<th>Purpose, organisation &amp; discussions</th>
<th>Who &amp; how Long?</th>
</tr>
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</table>
| Geneva           | N/A                   | N/A             | HQ of GF, UNAIDS and WHO                                                            | GF: How will the new strategy impact on funding for Asia; discuss anticipated levels of continuing support; perspectives on partnerships: what they see these are and how they will change in medium term.  
UNAIDS: Strategy for Asia; role of the RST and how much scope the RST has for strategy formulation, partnerships etc.; progress with Strategic Investment Framework approach and its implications; future of AIDS architecture for Asia?  
WHO: Implementation of the WHO HIV strategy in Asia; role of WHO’s ROs and scope for strategy formulation and partnership development; views on what needs to be done and where external funding should target its support in medium term. | Godwin & Dickinson (1 days: 18 Jan)                                                                                   |
| India (Delhi)    | Upper middle income   | High levels of external funding for HIV | Relatively mature epidemic  
BRIC: Potential to increase domestic funding for AIDS  
POTential donor to low income countries in the region  
Global source of generic medicines  
WHO Regional Office (SEARO)  
Large problem of PWIDs | SEARO: strategic assessment; WHO perceptions; partnerships; long-term ART sustainability  
UNAIDS: India as a source of generic medicines – issues, threats, opportunities  
NACO/GoI: perceptions of BRIC role; partnerships; GF? Gates? PWID?  
USAID: continuing support for India? Future directions? | Godwin (3 days: 15-17 Feb)                                                                                           |
<table>
<thead>
<tr>
<th>Country</th>
<th>Income Level</th>
<th>Key Characteristics</th>
<th>Key Aspects</th>
<th>Meeting Details</th>
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<tbody>
<tr>
<td>Thailand</td>
<td>Upper middle income</td>
<td>93% of AIDS response funded from domestic funding</td>
<td>Mature epidemic, Important regional centre, Well established civil society responses, Strong policy track record for PWID and SW, ESCAP meeting 6-8 Feb</td>
<td><strong>GoT:</strong> How to achieve the NSP, domestic funding prospects; sustaining prevention; enabling environment <strong>UNAIDS &amp; RST:</strong> strategy for Asia; partnership development; opps/risks in relation to GF strategy; aid architecture; future of UN support (amount and focus); perspectives on what needs to be done <strong>USG:</strong> country and regional strategy; partnerships; future directions and perspectives on efficiency gains</td>
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<tr>
<td>Burma</td>
<td>Low income</td>
<td>Low levels of domestic funding for health. High dependency on external funding for HIV.</td>
<td>Strategically important to AusAID, Uncertain political context - possibly unique set of risks &amp; opportunities for investments, Different model of response: primarily CS-managed, Innovative external funding mechanisms</td>
<td><strong>Govt. MoH officials:</strong> NSP II, sustainability and coordination <strong>AusAID, UNAIDS, other donors/USG ?:</strong> Perceptions, prospects and directions of future support, future direction of UN support, 3DF fund manager. <strong>Civil Society:</strong> INGO groups, CBO/FBO: program delivery, opportunities</td>
</tr>
<tr>
<td>Country</td>
<td>Income Level</td>
<td>Notes</td>
<td>Challenges and Opportunities</td>
<td>Agency Questions</td>
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<tr>
<td>Cambodia</td>
<td>Low income</td>
<td>Low levels of domestic funding for HIV (4% of total spend in 2010)</td>
<td>Strongest program in Asia but weak health system</td>
<td>NAA/NCHADS/UNAIDS: latest models and approaches; future funding? Aid effectiveness and architecture issues given volumes of external funding? MoH: sustainability of AIDS response? USAID: continuing support for India? Future directions? Anti-trafficking?</td>
</tr>
<tr>
<td>Philippines</td>
<td>Middle income</td>
<td>High dependency on external funding primarily GF and bilateral</td>
<td>Developing models for Asia on ART delivery, SW and HIV/HS integration</td>
<td>Godwin (3 days: 1-3 Feb)</td>
</tr>
<tr>
<td>China</td>
<td>Upper middle income</td>
<td>84% domestic expenditure on HIV and 16% external funding (GF) for the response but external funding ending or planned end 2012</td>
<td>Challenged with USG-driven anti-trafficking policy</td>
<td>WPRO: strategic assessment; WHO perceptions; partnerships; long-term ART sustainability UNAIDS: likely dynamics of epidemic in Philippines – issues, threats, opportunities; role of GF? ADB: scope and scale of support for AIDS regionally? Future directions? Godwin (3 days: 10 &amp;13-14 Feb)</td>
</tr>
<tr>
<td>Country</td>
<td>Income Level</td>
<td>Funding Structure &amp; Epidemic Status</td>
<td>Key Points</td>
<td>Future Directions</td>
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<tr>
<td>Vietnam</td>
<td>Lower middle income</td>
<td>High percentage of funding for AIDS comes from a large number of external sources</td>
<td>AusAID Regional Office Strategic/political importance? Important for PWID policy—encouraging developments Large number of donors</td>
<td>GoVN: Drug policies – future directions; prospects for greater domestic funding; aid effectiveness issues given dependency on and fragmentation of HIV funding</td>
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<td>GoVN: Drug policies – future directions; prospects for greater domestic funding; aid effectiveness issues given dependency on and fragmentation of HIV funding</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Middle income</td>
<td>42% domestic funding and 58% external funding for AIDS in 2010, GF being largest share. Generalised and concentrated epidemic Track record of AusAID engagement Highly decentralized political/fiscal system Innovative pooled funding approach</td>
<td>GoI: Achieving the NSP, funding prospects; program expansion/sustainability; perceptions on partnerships, funding modalities and aid effectiveness; focus and direction of external funding UNAIDS: Aid effectiveness and coordination issues; future direction of UN support; threats/opps wrt GF; progress on structural interventions Donors: AusAID/USG: new USAID strategy; AusAID/USG collaboration; future directions; perspectives on efficiency gains etc.</td>
<td>Dickinson (3 days: 12-15 Feb)</td>
</tr>
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Annex 6: Draft question/discussion guides for country consultations

Joint Strategic Assessment and Options to address HIV epidemics in Asia

Draft discussion guide for country visits (Consultant introduces assignment, objectives of the interview and refers to the country assessment paper etc.)

A Government Respondents

Resourcing and programming

1. How have the targets for the NSP been set? *(probe: are they derived from the HLM? From incidence modelling?)*

2. How are resources allocated in the NSP in relation to the epidemic and to achieving the HLM targets? *(probe: % of budget on treatment, prevention, and program costs, in line with epidemic projections etc.)*

3. What factors influence resource allocation? *(probe: international, domestic political pressures/incentives, personalities, past allocation patterns etc.)*

4. How will domestic and external financing for HIV change in the next 5 - 7 years? *(probe: are there any plans to increase govt expenditure in short, medium, long term?)*

5. How far are donors aligning their financial support to the NSP? *(probe: cherry picking; predictable and transparent aid; vertical financing/programming issues; channelling of funds e.g. largely through MOH and what are the implications?)*

6. What are the major opportunities and challenges facing the national response? *(probe: financing, policy and programming especially for KAPs)*

7. How does the institutional environment impact on the response? *(probe: centralised or decentralised fiscal, policy and bureaucratic structures; MOH/NAC/CCM relations)*

8. How can the national response be made more efficient and effective? *(probe: e.g. integration of HIV/health systems, if appropriate; use of evidence/best practice from studies inc cost effectiveness studies etc.)*

9. What does the national programme need to do to significantly impact on the epidemic in the next 5-7 years?

10. What should development partners be doing to support the national response over the medium term?

Enabling environment

1. How is the govt strengthening an effective enabling environment, especially for PWID, MSM, SW? What more needs to be done and by whom? How are and external funders supporting this?

Partnerships and aid effectiveness

1. Please describe the partnership environment for health and HIV in your country. Are there examples of innovative policy, financing or programming partnerships between govt, development partners and civil society?

2. How do you see the partnership landscape changing over the medium term? *(probe: potential for new and strengthened relationships with govt, development partners inc non DAC donors, NGO, CSO, private sector)
3 What efforts have been made by development partners to harmonise and align their aid to the national response? What are the main opportunities/constraints to H & A in Indonesia?

**Other**

1 What do you think are the future opportunities and priorities for policy, programming and partnerships for HIV in Asia?

2 Is there anything else you would like me to take note of?

3 Are there any key documents/reports you would like me to see?
Joint Strategic Assessment and Options to address HIV epidemics in Asia

Draft discussion guide for country visits

B  Bilateral / Multilateral Respondents (example being AusAID in Indonesia)

Resourcing and programming

1  Can you outline your HIV strategy in Indonesia for the next 5-7 years?  How does it relate to AusAID global and regional HIV and health strategies?

2  What’s the trajectory of AusAID resources for HIV in Indonesia over the next 5-7 years?  How are these funds likely to be programmed?  (probe: increase/decrease; multi-yr commitments; use of govt systems; pooled funds etc.)

3  How appropriate and effective is the programming of Indonesia’s national response in relation to its NSP and HLM targets?  (probe: is the money being spent on the right things; could the programme be more efficient and effective – how?  Any examples of best practice?)

4  What does Indonesia need to do over the next 5-7 years to significantly impact on the epidemic and make progress towards their targets e.g. in the areas of policy formulation/implementation and an enabling environment for KAPs?

5  To what extent is Indonesia integrating HIV services into health services and with what success?

6  Is Indonesia’s architecture for HIV effective?  What are the opportunities and challenges for reform?  (probe: appropriateness of the MS response; NAC/MOH/CCM inter-relations/power & influence; scope for rationalisation and reduction in programme management costs)

7  How do you see AusAID (and other development partners) supporting the national response over the medium term?  (probe: financing “gap” left by GF; other technical, policy, programming areas; advocacy etc.)

AusAID

1  How is AusAID adding value to health and HIV in Indonesia?  (probe: track record, niche technical areas etc.)?

2  Are there any capacity issues in the country office that might constrain your ability to engage in HIV and/or address new priorities e.g. stronger results focus etc.?

Partnerships/aid effectiveness

1  What partnerships is AusAID involved in?  (probe: with govt, other bi- and multilateral development partners, community, NGO, private sector)

2  Are there any innovative partnerships and/or modalities that capitalise on AusAID and other partners’ strengths?

3  How do you think the partnership landscape will change over the medium term?  (probe: potential for new and strengthened relationships with govt, development partners inc non DAC donors, NGO, CSO, private sector)

4  What efforts have been made by development partners to harmonise and align their aid to the national response?  What are the main opportunities/constraints to H & A in Indonesia?
Other

1. What do you think are the future opportunities and priorities for policy, programming and partnerships for HIV in Asia?
2. Is there anything else you would like me to take note of?
3. Are there any other documents you would like me to see?
Joint Strategic Assessment and Options to address HIV epidemics in Asia

Draft discussion guide for country visits

C National civil society organisations/networks

Resourcing and programming

1. Please can you describe how your organisation is involved in the national response? (probe: service delivery/ GF-PR; advocacy, watchdog/accountability, outreach etc.)

2. What do you think is the trajectory for HIV financing (domestic and external) in country x over the next 5-7 years?

3. What are you views on the appropriateness and effectiveness of the programming of Indonesia's national response in relation to its NSP and HLM targets? (probe: is the money being spent on the right things; could the programme be more efficient and effective; any examples of best practice etc.)

4. What does the national programme need to do over the next 5-7 years to significantly impact on the epidemic? (probe: policy, strategy, finance, programming, architecture, bureaucracy, integration with health systems, enabling environment, political incentives etc.)

5. What opportunities and challenges exist for national civil society organisations and networks to strengthen support to the national response over the medium term?

Civil society organisations

1. How does your organisation/network add value to HIV in country x? (probe: track record, niche technical areas etc.)?

2. How is your organisation funded and to what extent are you dependent on donor (including GF) funding for your operations? What are the implications for your organisation if funding declines?

3. Are there any organisational capacity issues that constrain your ability to engage in HIV policy and programmes and/or address new priorities (e.g. demonstrating impact/stronger focus on development results)?

Partnerships and aid effectiveness

1. What kind of partnerships are your organisations involved in? (probe: with govt, other development partners, community organisations, NGO, private sector)

2. Are there any innovative partnerships that enable civil society organisations/networks to capitalise on their strengths?

3. How do you envisage the partnership landscape changing over the medium term? (probe: potential for new and strengthened relationships with govt, development partners inc non DAC donors, other NGO, private sector)

4. What efforts have been made by civil society organisations to organise and coordinate themselves and their work?

5. What are the opportunities and challenges for your organisation/network to support the aid effectiveness agenda e.g. participation and ownership; transparency and accountability of the HIV response?
Other

1. What do you think are the future opportunities and priorities for policy, programming and partnerships for HIV in Asia?
2. Is there anything else you would like me to take note of?
3. Are there any other documents you would like me to see?
Joint Strategic Assessment and Options to address HIV epidemics in Asia

Draft discussion guide for country visits

D Regional civil society organisations/networks

Resourcing and programming

1 Please can you describe how your organisation is involved in the Asia regional response? (probe: knowledge sharing; advocacy; developing network capacity; representation; awareness raising; policy development, watchdog/accountability etc.)

2 What do you think is the trajectory for HIV financing (domestic and external) in the region over the next 5-7 years?

3 From a regional perspective, what are the main challenges and opportunities facing the region in trying to meet the HLM targets and the goal of three zeros? (probe: is money being spent on the right things; could regional and national responses be more efficient and effective; any examples of best practice from the region etc.)

4 What needs to happen over the next 5-7 years to significantly impact on the HIV epidemic in Asia? (probe: policy, strategy, finance, programming, integration with health systems, enabling environment, architecture etc.)

5 What opportunities and challenges exist for regional civil society organisations and networks to strengthen support to regional and national responses over the medium term?

Regional civil society organisations/networks

1 How does your organisation/network add value to the regional response? (probe: track record, niche technical areas, high level participation in policy forums etc.)?

2 How is your organisation funded and to what extent are you dependent on donor (including GF) funding for your operations? What are the implications for your organisation if funding declines?

3 Are there any organisational capacity issues that constrain your ability to engage in HIV policy and programmes and/or address new priorities (e.g. demonstrating impact/stronger focus on development results)?

Partnerships and aid effectiveness

1 What kind of partnerships is your organisation/network involved in? (probe: with govt, other development partners, community organisations, NGO, private sector)

2 Are there any innovative partnerships that enable civil society organisations/networks to capitalise on their strengths?

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Other

1. What do you think are the future opportunities and priorities for policy, programming and partnerships for HIV in Asia?

2. Is there anything else you would like me to take note of?

3. Are there any other documents you would like me to see?
Annex 7: Final Strategic Advice Report: DRAFT Outline – but very much open for discussion

Executive Summary (4 pages)

1. Introduction and scene setting (1 page)
   - Purpose and timing of the assignment
   - Changing global epidemiological, socio-economic, organizational and political environment for HIV
   - International frameworks driving medium term HIV priorities and programming (Getting to Zero, HLM targets, Busan/HLF4 agreement on aid effectiveness, ‘performance-based funding’, ‘value for money’, ‘cash on delivery’ approaches, etc.)
   - Global investment framework approach for HIV

2. Methodology and purpose of the report (0.5 page, annexes if necessary)

3. Regional summary overview of HIV national programming and needs, and current donor engagement (AusAID, GF, ADB, USG, UNAIDS, World Bank) (2 pages, annexes if necessary)
   - Current focus of epidemic and its response in countries; the balance of investment with results
   - Current donor HIV and health strategies and priorities, main programmes in the region, ways of working including partnerships and funding modalities used, etc.

4. Findings and analysis from consultations (5-7 pages)
   Consider key factors, trends, gaps, obstacles to influencing successful attainment of medium term country and regional HIV goals/targets including:
   - HIV epidemiology
   - National policy, strategy and programmatic focus
   - Political leadership and prioritisation of HIV in the region/countries
   - Structural, bureaucratic and institutional issues for HIV and health at country level
   - Socio-economic conditions of countries in the region and OECD donor countries influencing priority health investments, results focus etc.
   - Aid effectiveness principles and practices
   - Operational research

5. Strategic Options (5-7 pages)
   Based on analysis from evidence, track record, strategic interests, value added, cost-effectiveness (where possible) identify and explain key donor investment areas and strategic options for the medium term e.g. in areas of
   - Policies
   - National strategies
   - Service delivery systems
- Governance/accountability
- Partnerships
- Resourcing

6. Concluding remarks
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Annex 3 Country Reports

Cambodia
India
Burma (Myanmar)
Laos
Thailand
China
Indonesia
Vietnam
Philippines
Timor Leste
Annex 4 Strategic Directions and Technical Areas of Key Partners

<table>
<thead>
<tr>
<th>Australian Agency for International Development (AusAID)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic direction</strong></td>
</tr>
<tr>
<td><strong>Intensify HIV prevention</strong></td>
</tr>
<tr>
<td><strong>Optimise the role of health services within HIV responses</strong></td>
</tr>
<tr>
<td><strong>Strengthen coordination and capacity to scale up HIV responses</strong></td>
</tr>
<tr>
<td><strong>Review legal and policy frameworks to enable effective responses to HIV</strong></td>
</tr>
<tr>
<td><strong>Build the evidence base for an effective HIV response</strong></td>
</tr>
<tr>
<td><strong>Demonstrate and foster leadership on HIV</strong></td>
</tr>
<tr>
<td><strong>Technical areas</strong></td>
</tr>
<tr>
<td><strong>At an international level Australia plays a leadership role through support to:</strong></td>
</tr>
<tr>
<td><strong>At country level Australia’s support includes expanding prevention and treatment services, and developing STI clinics in PNG and supporting HIV prevention and care in Indonesia. Regionally an Australia supported program across Burma (Myanmar), Vietnam, Cambodia, Laos, the Philippines and China, focuses on harm reduction among people who inject drugs. In the Pacific Islands a regional Response Fund provides support to civil society, governments and multilateral organisations.</strong></td>
</tr>
<tr>
<td><strong>Strategy for Asia (where available)</strong></td>
</tr>
</tbody>
</table>
## Strategic direction

The stated goal of ADB’s strategic response to the HIV epidemic is to support developing member countries in achieving Millennium Development Goal 6, Target 7: to have halted and begun to reverse the spread of HIV by 2015. ADB-supported interventions are meant to ensure an effective response by the countries and the region to HIV. Key features ADB’s Strategic Directions on HIV/AIDS 2011-2015 derive from previous ADB-supported HIV initiatives, and take into account existing global and regional health commitments. ADB supports universal access to HIV prevention, treatment, care, and support by addressing the needs of key affected populations, including men and women who participate in unprotected paid sex, inject drugs, and/or share contaminated needles and syringes, as well as men who have unprotected sex with men. Other contributing factors such as gender inequality, poverty, stigma and discrimination, and misinformation will be carefully considered when designing and implementing new initiatives.

## Technical areas

To support the implementation of Strategy 2020, ADB will intervene in areas where it can effectively and significantly add value. ADBs Strategic Directions on HIV focuses on three priority areas: (i) mitigating HIV risks and vulnerabilities along economic corridors; (ii) promoting regional cooperation to control and reverse the spread of HIV, specifically for those most at risk; and (iii) supporting HIV-related impact studies on economics, gender, and poverty in support of evidence-based policy dialogue.

Key programs will include reducing the risks of transmission of HIV as a result of ADB infrastructure projects; support for targeted assistance, including capacity development, to developing member countries that are frequently exposed to internal and/or cross-border migration of key affected populations; and continued policy dialogue and coordination with partners like UNAIDS, in preventing further spread of the virus. This approach complements the HIV strategies of other major development partners, including UNAIDS. It also reinforces commitments laid out in ADB’s operational plans for health and transport, both of which recognise the need to give special attention to HIV.

### ADB is optimising its comparative advantages to scale up its response to stop new infections by:

1. utilising its role as a major investor in the region to engage leaders in key economic sectors, including finance, planning, and infrastructure ministries, to address DMCs’ national HIV strategic policy agenda
2. working as an ‘honest broker’ with other partners to establish and facilitate a platform where effective collaboration can take place among key players involved in HIV prevention
3. generating and disseminating knowledge products, especially those that address issues of economic sustainability and cost effectiveness, to provide evidence for widespread adoption of prevention interventions; leverage additional funding; and support the effectiveness of regional aid spending.

## Strategy for Asia (where available)

### Strategic direction

The HIV response is grounded in the principles of ‘know your epidemic and know your response’. As the HIV challenge varies around the world, so must the response, although in all places it should be based on public health evidence, human rights and the principles of greater involvement of people living with HIV.

The response must address the challenges in varying HIV and TB epidemics, enabled through:

- a step-change in prevention, and a reduction in costs of treatment
- political action on stigma and discrimination and work to reach key populations
- a rights-based approach, based on ‘know your epidemic and response’.

DFID strategic priorities are to:

- significantly reduce new HIV infections, particularly for women, girls, children and key populations, through the scale up of evidence-based approaches, filling gaps in the evidence base for prevention and paying attention to underlying risk factors
- scale up access to HIV and TB diagnosis, treatment care and support, including early infant diagnosis, within integrated services, focusing on sustainability so that treatment for all is achievable
- significantly reduce stigma and discrimination by working for policy change for most at risk populations and to empower women and girls, including with sexual and reproductive health and rights.

### Technical areas

**Evidence-based prevention approaches**, including PMTCT, TB prevention and diagnosis, family planning, harm reduction, and male circumcision, so as to improve understanding of how behaviour can change, how this impacts on HIV and underlying harmful gender norms, gender based violence and poverty can be addressed.

**Cost-effectiveness improvements**, both through sustainable reductions in the costs of high-quality medicines, diagnostics and more efficient supply chains and ways of providing treatment and care – as set out in the UNAIDS/WHO treatment 2.0 initiative.

**Promotion of country leadership** on HIV around integrated responses rooted in knowledge of the local epidemic: donor support harmonisation and alignment with national plans to deliver quality integrated HIV, TB and reproductive health services. Strong leadership is needed at all levels of society – especially in communities which provide care and support and where traditional and religious leaders may challenge harmful gender norms. This is not just a health issue; it is also about stigma, social and structural barriers.

### Strategy for Asia (where available)

Outside Africa, the epidemic is driven amongst key affected populations and these include: sex workers, injecting drug users, men who have sex with men and prisoners. The principal aim is to achieve social and political change to combat stigma and discrimination and to reach these groups with services.

### Source

## European Union

### Strategic direction

In looking at the fight against HIV as an objective in itself, the EU addresses several lines for EC/EU interventions at the country level:

- Through policy dialogue with partner countries, the mainstreaming of HIV in national policies should be promoted as well as the need to help vulnerable groups such as for example, drug addicts and refugees/displaced people.
- A close link with sexual and reproductive health and rights, and the promotion of gender equality and equity.
- The need to strengthen health systems, especially addressing the exceptional human resource crisis of health Providers.
- Strengthen clinical research through the European and Developing Countries Clinical Trials Partnership initiative.
- Make medicines including antiretroviral drugs more affordable for the poor and develop efficient procurement policies for medicines and pharmaceutical products.
- Within the "Education for All" initiative, particular attention must be devoted to the promotion of girls’ education and safety at school including HIV prevention education.

The EU also views HIV as a cross-cutting issue, one where mainstreaming in all development areas is required.

### Technical areas

At country level, capacity building is the focus including on:

- enhancing human resource capacity to mitigate brain-drain and improve the ability of health systems to cope with the additional burden of HIV
- broad-based co-operation between stakeholders
- investing in social services
- surveillance and monitoring of health outcomes
- strengthening of local production capacity of pharmaceutical products.

At global level, the EC has five focus areas:

- affordable pharmaceutical products
- strengthening regulatory capacity in developing countries
- developing new tools and interventions (such as vaccines and microbicides)
- strengthening partnerships with multilateral agencies and other institutions and
- maintaining a strong European voice in the context of the G8 and EU summits and support for the Global Fund.

### Strategy for Asia (where available)

### Source


EU’s external policies for health on:

### Strategic direction

The strategy is based on the main premise that protecting human rights, mainstreaming HIV as a cross-cutting issue, capacity development, and promoting gender equality all form part of the response to the HIV epidemic.

GIZ bases its activities on the Millennium Development Goals and the German Programme of Action 2015 to:

- **Reduce the number of new HIV infections** through comprehensive prevention programs
- **Strengthen healthcare and treatment**
- **Minimising the social, economic and political repercussions of the epidemic**, in particular stigmatisation and discrimination

Furthering the German government's position, the GIZ supports the efforts of all sectors to combat HIV, in particular multi-sectoral programs in health, rural development, agriculture, education, vocational training, microfinance, private sector promotion, crises, water, governance and transport.

GIZ links its actions to combat HIV to **the strengthening of health systems** and the promotion of women’s health and maternal health. Together with its partners GIZ supports HIV information and education in medical institutions, schools, in the workplace, and among risk groups. The partners are assisted in alleviating the repercussions of HIV in developing countries, enabling persons infected with HIV and their families to lead dignified lives, and enabling economic development. To this end GIZ supports national coordination while promoting more efficient deployment of international funds to combat HIV. A further aim is to strengthen the capacities of non-state actors and private sectors.

### Technical areas

**Cooperation and coordination among the various actors involved:** a push towards donor harmonisation, stronger cooperation between national and international actors and promotion of public-private partnerships

**Prevention:** facilitates various approaches ranging from setting up advice centres offering Voluntary Counselling and Testing to developing teaching materials for schools as well as social marketing initiatives and giving risk-groups access to health services.

**Strengthening health care/treatment:** For example, improving antiretroviral treatment access, promoting their local production and using flexibilities in intellectual property protection rights; providing advisory services to relevant policymakers

**Creating a climate of solidarity and non-discrimination:** For example, supporting self-help groups of sufferers in partner countries; supporting civil society organisations such as NGOs, church organisation and private companies with a focus on supporting families and orphaned children. **HIV interventions at the workplace include:**

- Cooperation through public-private partnerships enabling prevention, medical care and the creation of a non-discriminatory and supportive work environment at the workplace
- Regional project **AIDS Control in Companies in Africa** advises business associations and companies on workplace interventions in Africa

**Quality control: monitoring the effectiveness of responses**

**Access to international funds**

GIZ promotes improved access to the services of the Global Fund and other finance mechanisms, quality assurance during implementation and dissemination of successful anti-HIV measures. The **German BACKUP Initiative** supports accessing and implementing Global Fund grants including through short and long-term seconded experts to provide process and technical consultancy to national, regional, international organisations and networks; capacity development of government and civil society organisations; subsidies for national government and non-government organisations to plan, implement and monitor technical support activities.

### Strategy for Asia (where available)

**Source**

- Federal Ministry for Economic Cooperation and Development
  - [www.giz.de/Themen/en/10973.htm](http://www.giz.de/Themen/en/10973.htm)
- HIV and Health
- Education in the fight against HIV and AIDS
### Strategic direction

The Global Fund contributes one fifth of the international funding against HIV and as a financing instrument (vs. an implementing entity), its strategic objectives are to:

- Invest more strategically in areas with high potential for impact and strong value for money, and fund based on countries’ national strategies.
- Evolve the funding model to provide funding in a more proactive, flexible, predictable and effective way.
- Actively support grant implementation success through more active grant management and better engagement with partners.
- Promote and protect human rights in the context of HIV.
- Sustain the gains, mobilise resources – by increasing the sustainability of supported programs and attracting additional funding from current and new sources.

The funding model of the Global Fund comprises five elements:

1. **The role of the funder**— as a large donor with influence on national governments, the Global Fund can ensure that the most vulnerable can be reached.
2. **Encouraging country-led funding models** helps ensure that programs ownership is achieved.
3. **Promote evidence-based programming** through support for national surveillance and operational research, and through on-going data requirements as part of funding applications.
4. **A rights-based approach** is fostered by linking funding to commitments to universal human rights and commitments to ensuring that people are free from coercion, discrimination and violence.
5. **Performance-based funding** implies funding that is based on measurable program results showing the outcomes and impact relative to baseline need.

### Technical areas

**Prevention:**
- PMTCT: HIV-infected pregnant women to receive ARV prophylaxis and/or treatment
- HIV testing and counselling
- Prevention intervention services delivered for most-at-risk-populations
- Male circumcision

**Treatment:** facilitating access to antiretroviral treatment.

**Monitoring and evaluation:** development of various tools and guidelines including short e-courses to support monitoring and evaluation of Global Fund-funded grants; close tracking of the Global Funds investments in 150 countries through the Grant Portfolio.

**Procurement and supply management:** focuses on policy approach and assistance to countries with policy requirements when procuring products with Global Fund resources for the prevention, treatment and care of HIV.

**Health system strengthening including:**
- investments in human resources supporting both pre-service and in-service training
- supporting task-shifting to maximise current capacity and systems
- promoting the development of informal cadres of health and community workers.

**Risk pooling mechanisms:** such as community-based health insurance to alleviate the high costs the poor pay for health care.

### Strategy for Asia (where available)

<table>
<thead>
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<tr>
<td>Strategy in Relation to Sexual Orientation and Gender Identities</td>
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</table>
The UNAIDS strategy *Getting to Zero* aims to advance global progress in achieving country set targets for universal access to HIV prevention, treatment, care and support and to halt and reverse the spread of HIV as well as contribute to the achievement of the Millennium Development Goals by 2015.

Adopted in December 2010, the strategy works to position the HIV response in the new global environment and intends to:

- **Revolutionise HIV prevention** (*Zero new infections*) through fostering political incentives for commitment and catalysing transformative social movements regarding sexuality, drug use and HIV education for all, led by people living with HIV and affected communities, women and young people.

- **Catalyse the next phase of treatment, care and support** (*Zero AIDS-related deaths*) by promoting greater links between antiretroviral services and primary health, maternal and child health, TB, sexual and reproductive health and thereby reducing cost and increasing efficiencies. Through social and cash transfers and the expansion of social insurance schemes, strengthen nutritional support and social protection services for people living with HIV.

- **Advance human rights and gender equality for the HIV response** (*Zero discrimination*) by realising and protecting HIV-related human rights, including the rights of women and girls; implementing protective legal environments for people living with HIV.

### Technical areas

Targets and commitments in the 2011–2015 strategy are:

- Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work.
- Vertical transmission of HIV eliminated and HIV-related maternal deaths reduced by half
- All new HIV infections prevented among people who use drugs.
- Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment.
- TB deaths among people living with HIV reduced by half.
- People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support.
- Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half.
- HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions.
- HIV-specific needs of women and girls are addressed in at least half of all national HIV responses.
- Zero tolerance for gender-based violence.

### Strategy for Asia (where available)

The strategy in Asia focuses on targeting special groups of HIV infected people such as injecting drug users, men who have sex with men and transgender people, and people who buy and sell sex, with better prevention and treatment services including providing antiretroviral treatment for pregnant HIV positive women and more widespread HIV-tuberculosis services.

In the Asian context with high migration patterns, the focus is to work towards improving access to services for migrants through improved legal frameworks and comprehensive, cross-border strategies.

### Source

- **Getting to Zero 2011–2015 Strategy**
  

- **HIV in Asia and the Pacific: Getting to zero**
  
**United States Agency for International Development (USAID)**

<table>
<thead>
<tr>
<th>Strategic direction</th>
<th>USAID is a key PEPFAR partner. The current focus is moving from an emergency response strategy to promoting sustainable, country-owned programs. The shift in direction focuses on the following goals:</th>
</tr>
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<tbody>
<tr>
<td>- Strengthening the capacity of partner government to lead the response to HIV</td>
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<tr>
<td>- Expanding prevention, care and treatment in both concentrated and generalised epidemics</td>
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<tr>
<td>- Integrating and coordinating HIV programs with broader global health and development programs</td>
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<tr>
<td>- Investing in innovation and operations research to evaluate impact</td>
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<tr>
<td>- Improve service delivery and maximise outcomes</td>
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</table>

At the country-level, USAID works to foster collaboration with multilateral organisations.

USAID enters into unique and robust public-private partnerships and distinct collaborative agreements with businesses and multinational corporations. In many cases, USAID provides staff support to the Global Fund and works with the Fund’s local coordinating committees to improve implementation of programs. USAID staff is participants on the World Health Organization’s global task force dedicated to extensively drug-resistant tuberculosis. Several USAID HIV staff serve as co-chairs on PEPFAR technical working groups, which formulate technical guidance and support PEPFAR implementation in the field.

<table>
<thead>
<tr>
<th>Technical areas</th>
<th><strong>Prevention:</strong> the balanced promotion of ‘ABC’ approach of Abstinence, Being faithful and Correct, Consistent Condom use; safe male circumcision; PMTCT; reduction of HIV-related morbidity and mortality.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care and Support:</strong> covers broad spectrum of clinical, psychological and nutritional services; establishing HIV testing sites; training and supporting counsellors; counselling discordant couples; administering paediatric care and support; routine facility; community and home-based HIV monitoring; diagnosis, prevention and treatment of tuberculosis.</td>
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<tr>
<td><strong>Treatment:</strong> antiretroviral therapy; supply chain management; screening for tuberculosis.</td>
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<tr>
<td><strong>Strategic information:</strong> health management information systems; monitoring and evaluation through HIV seroprevalence studies and surveys; increasing surveillance capacity.</td>
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<tr>
<td><strong>Research:</strong> development of microbicides and vaccines; research in areas like HIV prevention among youth, PMTCT and treatment of paediatric HIV.</td>
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<tr>
<td><strong>Sustainability and health system strengthening:</strong> improving health systems financing; service delivery; institutional capacity building; human resources development; monitoring and evaluation; health information collection and analysis; pharmaceutical management; procurement; health governance; and public private partnerships.</td>
<td></td>
</tr>
<tr>
<td><strong>Multi-sectoral programs:</strong> USAID supports multi-sectoral responses to HIV in many of its programs, including health, education, agriculture, democracy and governance, and economic growth.</td>
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<tr>
<td><strong>International cooperation:</strong> in partnership with PEPFAR, USAID contributes to the Global Fund Technical assistance; cooperation on governance and leadership; financial and grants management; pharmaceuticals and commodities supply management; monitoring and evaluation and reporting.</td>
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<table>
<thead>
<tr>
<th>Strategy for Asia (where available)</th>
<th>The strategy has four major components:</th>
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<tbody>
<tr>
<td>1. Make strategic information available through improved data collection and analysis, for example design and implementation of a plan to collect and analyse indicators.</td>
<td></td>
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<tr>
<td>2. Increase access to comprehensive interventions for MARPS and PLWHA.</td>
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<tr>
<td>3. Increase access to care, support and treatment for PLWHA and their families.</td>
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<tr>
<td>4. Strengthen an ‘enabling environment’ that encourages participation of civil society and promotes supportive policies and regulations.</td>
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<thead>
<tr>
<th>Source</th>
<th><a href="http://www.usaid.gov/our_work/global_health/aids">www.usaid.gov/our_work/global_health/aids</a></th>
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<tr>
<td></td>
<td><a href="http://www.pepfar.gov/strategy">www.pepfar.gov/strategy</a></td>
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</table>
**US Centers for Disease Control (US CDC)**

| Strategic direction | **A key US government agency supporting the implementation of Global Health Initiative and PEPFAR, CDC lends its technical capacity in public health sciences and experience in forging government-to-government partnerships to the implementation of US government’s global health agenda. CDC works with partner governments to build strong, sustainable and country-owned health systems and can respond to the global HIV epidemic.**

CDC’s **Global AIDS Program** plays a key role in implementing legislated priority program areas by providing direct government-to-government technical assistance to Ministries of Health and some technical support to local implementing entities to:

- **Expand quality HIV care and treatment services** and transition these services to local ownership
- **Implement effective HIV prevention programs**, using the most effective combination of evidence-based, behavioural, biomedical, and structural interventions
- **Conduct research on program impact and cost effectiveness**
- **Build sustainable public health information, laboratory and management systems, and local workforce capacity**

The activities strengthen laboratory, epidemiology, surveillance, public health evaluation, and workforce capacity which are all essential components for strong, cohesive, and sustainable public health systems.

| Technical areas | **Health systems strengthening**

- HIV prevention (testing and counselling; PMTCT; medical male circumcision; medical transmission; sexual transmission in special/most at risk populations)
- Care and treatment (capacity building for care and treatment; strengthen TB/HIV programs; PMTCT and paediatric services)
- Laboratory capacity building (incl. laboratory networks and systems integration; quality control and accreditation)
- Human resources for health (HR information systems; pre-service education; training and mentorship such as the Field Epidemiology and Laboratory Training Program; retention and performance)
- Health information systems (for example capacity strengthening of MOH officials to collect and analyse data from multiple sources to make evidence-based decisions; for example identify and promote use of global standards on use of consistent indicators)

**Evidence-based programming**

- Implementation science (for example, evaluating the effectiveness and impact of PEPFAR programs; comparing evidence-based program models in complex health, social and economic contexts)
- Surveillance system strengthening (build in-country capacity to design, implement, and evaluate HIV-related surveillance systems and surveys; and assist and train countries to analyse, disseminate, and use HIV data)
- Monitoring and evaluation (for example, technical assistance on the development and implementation of PEPFAR planning and reporting systems; participates in improvement of PEPFAR indicators and harmonisation of HIV indicators among international partners)

**Partnerships leverage to build capacity**

- of Ministries of Health
- through Collaboration with international organisations (including UNAIDS, Global Fund and WHO)
- public-private partnerships.

| Strategy for Asia (where available) | CDC began providing technical assistance in the region by working with host-country staff to successfully adapt Thai program models to other country national HIV programs. Through technical assistance and cooperative agreements with the World Health Organization (WHO), the CDC Asia Regional Office helps to build host-country capacity for sustainable, country-owned programs with targeted assistance in:

- surveillance
- laboratory capacity
- HIV counselling and testing
- adult and paediatric HIV care and treatment quality improvement
- monitoring and evaluation of PMTCT programs.

| Source | [www.cdc.gov/globalaids](http://www.cdc.gov/globalaids)  
The World Bank provides sustained funding for HIV programs and supports countries to do ‘better for less’ through improved efficiency, effectiveness, and sustainability of national HIV responses using improved evidence related to HIV prevention, including through a multi-sectoral approach (education, transport, energy, and infrastructure). It engages with stakeholders specifically regarding analytical work in six related areas:

1. Allocative efficiency
2. Program/technical efficiency
3. Effectiveness studies
4. Financing and sustainability studies
5. National strategic planning
6. Financing (grants and loans)

The Bank plays a global leadership role in three key areas, consistent with its regional priorities for HIV:

1. **Strategic intelligence and operational planning**: to strengthen evidence for strategic, prioritised and costed national AIDS plans.
2. **Prevention of sexual transmission of HIV**: to reduce sexual transmission of HIV by supporting countries to analyse their HIV epidemics and design HIV prevention strategies appropriate to epidemic contexts; collect better evidence of what works in HIV prevention; and implement more robust HIV prevention programs.
3. **Social protection for people affected by HIV**: to mainstream HIV-sensitive policies into social protection systems and enhance social protection for people affected by HIV.

### Technical areas

**Allocative efficiency**: ensure that scarce resources flow to the programs that are most likely to produce the best results, targeting resources to those at highest risk of transmitting HIV and geographic areas of high transmission, with proven, cost-effective interventions aligned to epidemic context. The Bank supports countries in implementing epidemic, policy and response synthesis and expenditure tracking surveys and analyses. Bank experts also assist countries to conduct bio-behavioural surveys and epidemiological syntheses to inform the design and targeting of HIV projects.

**HIV program efficiency and sustainability**: support countries to understand and improve their HIV service delivery efficiency, institutional efficiency, transactional and administrative efficiency, and information efficiency, as well as HIV funding sustainability.

**HIV prevention response evaluations**: identify and invest in prevention measures that really work to reduce the spread of HIV. The Bank helps countries to understand the efficacy and effectiveness of HIV prevention responses through evaluations and to estimate population level effectiveness.

**Results**: ensure programs are cost-effective and provide the intended return on investment. The Bank helps countries develop tools to conduct HIV cost effectiveness analyses of HIV responses, develop appropriate models for intervention support, and undertake return on investment studies to make economic arguments for investing in HIV responses.

### Strategy for Asia (where available)

**East Asia and the Pacific region**: in a changing, developing region with changing epidemiological profile and a lack of financial sustainability, the Bank has assisted governments in strengthening their HIV portfolios by focusing on allocative efficiencies and improving effectiveness. For example, public expenditure tracking surveys to promote efficient resource management and allocation have been completed in Indonesia and Vietnam.

**South Asia**: given the region’s low HIV prevalence but concentrated epidemics among vulnerable populations, the Bank has adopted a multi-sector approach focusing on the drivers of HIV – unsafe sex and injecting drug use – and works closely with governments and civil society. Supported projects include surveillance, monitoring and evaluation, targeted interventions for high-risk population groups, blood safety, stigma-reduction efforts, and strengthening public and private institutions for a multi-sector response. The Bank supports convergence of treatment for HIV with other health services, integration of HIV and reproductive health services, tuberculosis and other health programs. In partnership with the South Asia Region Development Marketplace (SAR DM) on Tackling HIV/AIDS Stigma and Discrimination, the World Bank supported 26 NGOs from six countries to pilot innovative HIV-related stigma and discrimination reduction interventions.

### Source

- Strategies and technical areas: [http://go.worldbank.org/LCCCQ553X0](http://go.worldbank.org/LCCCQ553X0)
- Regional priorities: [http://go.worldbank.org/EOL81VLA20](http://go.worldbank.org/EOL81VLA20)
- [http://go.worldbank.org/Q6CE5D8J40](http://go.worldbank.org/Q6CE5D8J40)
- [http://go.worldbank.org/7TOYDWQBS0](http://go.worldbank.org/7TOYDWQBS0)
Annex 5 People consulted

Geneva-based organisations

**The Global Fund, Geneva**
- Prof Rifat Atun, Director, Strategy, Performance and Evaluation Cluster
- Dr Jacqueline Bararingaya, Senior Technical Officer, Office of Strategy, Performance and Evaluation Cluster
- Dr Ade Fakoya, Senior HIV/AIDS Adviser

**UNAIDS Geneva**
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- Mr Pradeep Kakkatil, Chief, Aid Effectiveness and Country Capacity Division
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Asia Regional Organisations and Regional Civil Society Networks

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THAILAND

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National Civil Society Organisations and Networks

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LAOS

Government of Laos

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CAMBODIA

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H.E Dr Tia Phalla  Deputy Secretary General, National AIDS Authority; Chairman, CCC
Dr Chiev Bunthy  CCC Secretariat Manager
Dr Saphonn Vonthanak  Vice Director, University of Health Sciences
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Dr Seng Sopheap  NCHADS
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Dr Yolanda Oliveros | Development Assistance Specialist, USAID Philippines  

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**UN, Development and Contracting Partners**

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Mr Prasada Rao</td>
<td>UN Special Envoy for AIDS in Asia Pacific</td>
</tr>
<tr>
<td>Dr Charles Gilks</td>
<td>UCC India</td>
</tr>
<tr>
<td>Ms Nandini Kapoor Dhingra</td>
<td>Senior Programme Coordinator, UNAIDS India</td>
</tr>
<tr>
<td>Ms Nalini Fernandes</td>
<td>Administrative Associate, UNAIDS India</td>
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<tr>
<td>Mr Gopal Menon</td>
<td>Australian High Commission, India</td>
</tr>
<tr>
<td>Ms Mariam Claeson</td>
<td>Regional Program Coordinator – HIV/AIDS South Asia Region, World Bank</td>
</tr>
<tr>
<td>Ms Kerry Pelzman</td>
<td>Director Health Office, USAID India</td>
</tr>
<tr>
<td>Dr Arvind Kumar</td>
<td>Project Management Specialist, HIV/AIDS and Infectious Diseases Division, OPHN, USAID India</td>
</tr>
<tr>
<td>Mr Sampath Kumar</td>
<td>Project Management Specialist, HIV/AIDS and Infectious Diseases Division, OPHN, USAID India</td>
</tr>
<tr>
<td>Ms Sheena Chhabra</td>
<td>Team Leader, Health Systems Development, USAID India</td>
</tr>
<tr>
<td>Ms Sabina Bindra Barnes</td>
<td>DFID India</td>
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<tr>
<td>Ms Aparajita Ramakrishnan</td>
<td>Senior Programme Office, Bill &amp; Melinda Gates Foundation</td>
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<tr>
<td>Mr James Robertson</td>
<td>Country Director, International AIDS Alliance, India</td>
</tr>
<tr>
<td>Dr Iyanthi Abeyewickreme</td>
<td>Regional Adviser HIV/AIDS/STI, WHO-South East Asia Regional Office (SEARO)</td>
</tr>
<tr>
<td>Dr Amaya Maw-Naing</td>
<td>Technical Officer AIDS, WHO-SEARO</td>
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<tr>
<td>Dr Razia Narayan Pendse</td>
<td>Scientist HIV Prevention and Treatment, WHO-SEARO</td>
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**INDONESIA**

**Government**

<table>
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<tr>
<td>Dr Nafsiah Mboi</td>
<td>Secretary, National AIDS Commission</td>
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<tr>
<td>Dr Kemal Siregar</td>
<td>Deputy Secretary of NAC, Program Development</td>
</tr>
<tr>
<td>Dr Tine Tombikan</td>
<td>Executive Secretary, Country Coordinating Mechanism</td>
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**National Civil Society Networks/Organisations**

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<tr>
<td>Dr Adi Sasongko</td>
<td>Director for Health Care, Yayasan Kusuma Buana</td>
</tr>
</tbody>
</table>
Mr Fiyanti Osman  Program Officer, Yayasan Permata Hari Kita
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Dr Nguyen Minh Tam  Head of Harm Reduction Department, VAAC
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Dr Nguyen Viet Nga  Deputy Head of HIV/STI Surveillance and M&E Department, VAAC
Dr Nguyen Van Son  Head of International Cooperation and HIV Research Department, VAAC
Mr Nghia
Staff of International Cooperation and HIV Research Department, VAAC

Civil society
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Vietnam Network of People living with HIV (VNP+)
Mr Ong Van Tung
Bright Futures PLHIV network
Mr Nguyen Tung Vu
Chair of National MSM and HIV Working Group; Youth Dream MSM Club
Mr Bui Duy Tung
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Ms Dao Mai Hoa
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Chief of Party, RTI, USAID Pathways for Participation Project
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Ms Sun Lei
UNESCO
Dr Yasuda Tadashi
UNICEF
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UNODC
Mr Le Van Son
Gender PCG
Ms Duong Hai Nhu
UNODC
Mr Bruce Campbell
UNFPA
Ms Vladanka Andreeva
UNAIDS
Mr Christopher Fontaine
UNAIDS
Mr Eamonn Murphy
UCC
### Table 1 Percentage of funding spent in each intervention area

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<tr>
<th>Country</th>
<th>Prevention</th>
<th>Care &amp; Treatment</th>
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<th>Research</th>
<th>Enabling environment</th>
<th>Social protection</th>
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<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
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</tr>
<tr>
<td>South &amp; East Asia &amp; China</td>
<td>1,079,755,559</td>
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<td>0.00</td>
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</tr>
<tr>
<td>South Asia</td>
<td>726,220,206</td>
<td>0.00</td>
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<td></td>
</tr>
<tr>
<td>South &amp; East Asia 26</td>
<td>313,507,132</td>
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<td>0.00</td>
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<tr>
<td>South East Asia 26</td>
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</tr>
<tr>
<td>South Asia &amp; China</td>
<td>188,383,866</td>
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<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

Source: Data Hub Asia Pacific

All data is from 2009, except for those indicated with *, which are from 2008.

26 Afghanistan, Bangladesh, Cambodia, India, Indonesia, Lao, Malaysia, Myanmar, Nepal, Pakistan, Philippines, Singapore, Sri Lanka, Thailand, Timor Leste, Vietnam
Table 2 HIV Funding by source in Asia and the Pacific: 2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Domestic Funding %</th>
<th>Vietnam</th>
<th>Cambodia*</th>
<th>India</th>
<th>China</th>
<th>Thailand</th>
<th>Timor Leste</th>
<th>Philippines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan, Bangladesh, Cambodia, India, Indonesia, Laos, Malaysia, Myanmar, Nepal, Pakistan, Philippines, Singapore, Sri Lanka, Thailand, Timor Leste, Vietnam</td>
<td>100</td>
<td>46.07%</td>
<td>25.43%</td>
<td>6%</td>
<td>5%</td>
<td>54%</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td>Myanmar</td>
<td>100</td>
<td>30%</td>
<td>66%</td>
<td>19%</td>
<td>8%</td>
<td>5%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Laos</td>
<td>100</td>
<td>48%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Indonesia</td>
<td>100</td>
<td>78%</td>
<td>22%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cambodia</td>
<td>100</td>
<td>76%</td>
<td>0%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>China</td>
<td>100</td>
<td>76%</td>
<td>4%</td>
<td>2%</td>
<td>74%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source</th>
<th>Prevention</th>
<th>Care &amp; Treatment</th>
<th>OVCs</th>
<th>Program, Management, and Administration Strengthening</th>
<th>Human resources</th>
<th>Social Protection &amp; Social Services excluding OVCs</th>
<th>Enabling Environment</th>
<th>Research</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnam</td>
<td>30654413</td>
<td>411384</td>
<td>14</td>
<td>391047</td>
<td>172555</td>
<td>71583</td>
<td>1</td>
<td>35706</td>
<td>24899358</td>
</tr>
<tr>
<td>Cambodia</td>
<td>10934868</td>
<td>2312987</td>
<td>14</td>
<td>3127937</td>
<td>114</td>
<td>16754821</td>
<td>1</td>
<td>13863367</td>
<td>210000</td>
</tr>
<tr>
<td>Thailand</td>
<td>1719873</td>
<td>2312854</td>
<td>1</td>
<td>114</td>
<td>172555</td>
<td>71583</td>
<td>1</td>
<td>35706</td>
<td>24899358</td>
</tr>
<tr>
<td>Philippines</td>
<td>3978640</td>
<td>52615</td>
<td>1</td>
<td>2312854</td>
<td>71583</td>
<td>15924808</td>
<td>1</td>
<td>13863367</td>
<td>210000</td>
</tr>
<tr>
<td>Myanmar</td>
<td>5950748</td>
<td>46687</td>
<td>21</td>
<td>1506239</td>
<td>10069455</td>
<td>15924808</td>
<td>1</td>
<td>13863367</td>
<td>210000</td>
</tr>
</tbody>
</table>

Source: Data Hub Asia Pacific
## Annex 7 Definitions and Examples of Integration

There is a diversity of views and definitions of what integration is, but most suggest integration is positive for health systems: reducing fragmentation or duplication of services; improving patient care outcomes; offering benefits to overall population health; and improving performance of health systems and its programs and services. The analytical framework below defines integration along a spectrum and helps explain ‘linkages’, ‘coordination’ – often used synonymously with integration.

<table>
<thead>
<tr>
<th>Partial integration</th>
<th>Spectrum of integration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No formal interactions between programmes</strong></td>
<td><strong>Linkage:</strong> Unstructured interactions such as referrals and sharing of information but not goal-oriented. Cooperating agreement may be signed or guidelines on who does what and when. Programmes, objectives, structures and functions maintain separation.</td>
</tr>
<tr>
<td><strong>Coordination:</strong> Goal oriented interactions such as common strategies and policies to address related health issues, sharing information in a planned manner, implementing certain activities together and dedicating resources to work together on these tasks. Usually a coordinating committee is established. Programme objectives, structures and functions maintain separation.</td>
<td></td>
</tr>
<tr>
<td><strong>Integration:</strong> Bringing two programmes together (merging) or bringing together a programme’s structures (funds, information systems and human resources) or functions (planning, resource allocation, delivery of certain interventions).</td>
<td></td>
</tr>
</tbody>
</table>

These definitions have been used to rapidly assess the extent to which the Global Fund portfolio is integrated into the disease program and the extent to which the disease programs is integrated into the wider health system in a number of Asian countries. The results demonstrate the varying degrees to which HIV program functions and services are integrated within health systems and across programs and with varying impacts.
For example, Thailand’s HIV services and Global Fund programs are considered to be predominantly integrated and coordinated within the health system demonstrating that in a well-established system, vertical programs can be integrated effectively (Hanvoravongchai, 2010).

In Indonesia, the Global Fund portfolio is considered well integrated into national disease program planning functions at central level but Global Fund monitoring and evaluation functions remain weakly integrated across the board; HIV program functions and services are reported to be partially integrated into the general health system, for example through joint working groups for planning HIV and maternal health with decisions incorporated into the planning documents and clear lines of action. Unintended consequences of vertical Global Fund programming include the payment of incentives to health workers which has resulted in staff shifts to HIV programs, away from other areas such as health promotion (Desai et al., 2010).

In Laos, HIV program functions and service delivery remain vertical and weakly integrated with the general health system. Global Fund programs are generally integrated within the national disease program except for monitoring and evaluation functions; benefits of Global Fund programming include better multi-sectoral governance influencing the health agenda, for example on MSM; extended network of facilities delivering services. Negative effects include costly parallel procurement and management systems and lack of alignment between national stated priorities (including PHC) and Global Fund focus on communicable diseases (Mounier et al., 2010).
### Annex 8 Country income classification, health budget as percentage of GDP and per capita expenditure on HIV

<table>
<thead>
<tr>
<th>Country</th>
<th>Income Classification$^{27}$/number of people living below the poverty line$^{28}$</th>
<th>Health budget as % of GDP$^{29}$</th>
<th>Per Capita/PA expenditure on HIV$^{30}$ compared to Asia AIDS Commission recommendation$^{31}$</th>
<th>On track to meeting MDGs 4,5,6$^{32}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burma (Myanmar)</td>
<td>Low income/ 1.7m</td>
<td>2.0%</td>
<td>$0.7 ($0.975)</td>
<td>MDG 4: off track MDG 5: off track MDG 6: off track</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Low income/ 4.3m</td>
<td>5.9%</td>
<td>$3.7 ($1.72)</td>
<td>MDG 4: on track MDG 5: on track MDG 6: on track</td>
</tr>
<tr>
<td>China</td>
<td>Upper middle income/ 37,5m</td>
<td>4.6%</td>
<td>$0.3 ($0.975)</td>
<td>MDG 4: on track MDG 5: on track MDG 6: off track</td>
</tr>
<tr>
<td>East Timor</td>
<td>Lower middle income/ 560,000</td>
<td>12.3%</td>
<td>$1.6</td>
<td>MDG 4: on track MDG 5: off track MDG 6: off track</td>
</tr>
<tr>
<td>India</td>
<td>Lower middle income/ 435.6m</td>
<td>4.2%</td>
<td>$0.1 ($0.975)</td>
<td>MDG 4: off track MDG 5: off track MDG 6: off track</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Lower middle income/ 31.9m</td>
<td>2.4%</td>
<td>$0.2 ($0.975)</td>
<td>MDG 4: on track MDG 5: off track MDG 6: off track</td>
</tr>
<tr>
<td>Laos</td>
<td>Lower Middle Income/15.7m</td>
<td>4.1%</td>
<td>$1.0 ($0.48)</td>
<td>MDG 4: on track MDG 5: off track MDG 6: off track</td>
</tr>
<tr>
<td>Philippines</td>
<td>Lower Middle Income/ 24.7m</td>
<td>3.8%</td>
<td>$0.1 ($0.48)</td>
<td>MDG 4: on track MDG 5: off track MDG 6: off track</td>
</tr>
<tr>
<td>Thailand</td>
<td>Upper middle income/ 5.6m</td>
<td>4.3%</td>
<td>$3.1 ($1.72)</td>
<td>MDG 4: on track MDG 5: on track MDG 6: on track</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Lower middle income/ 12.6m</td>
<td>7.2%</td>
<td>$1.2 ($0.975)</td>
<td>MDG 4: on track MDG 5: on track MDG 6: off track</td>
</tr>
</tbody>
</table>

---

$^{27}$ Source: World Bank  
$^{28}$ Source: World Bank, most recent figures, on population and percent living under the poverty line  
$^{29}$ Source: World Bank, 2009 figures  
$^{30}$ Source: World Bank for population, UNAIDS for HIV spending 2008-2009 figures  
$^{31}$ Source: Technical annex to the Report of the Commission on AIDS in Africa, 2008. Recommendations are made according to scenarios of the epidemic in 2008 – latent ($0.48), expanding ($0.975), maturing ($2.57) and declining ($1.72). These may have changed now.  
$^{32}$ Source: Most recent MDG country report
(Reports and documents consulted in addition to those referenced in the report)


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