NUS National University of Singapore | Saw Swee Hock School of Public Health

REPORT

Ending AIDS in the ASEAN Region through Universal Health Coverage

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Content

Executive Summary

HIV remains a prominent issue in the global health agenda decades after it first emerged in the 1980s. In 2020, 37.7 million were living with HIV globally, and 1.5 million people newly acquired HIV.[i] Even though new HIV infections have fallen dramatically compared to their peak during the mid-1990s, the management of HIV across the world remains a concern due to the significant health burden posed to various health systems. In particular, it is important to understand the extent to which HIV prevention, testing and treatment are incorporated into health systems in terms of financing and service delivery, and what the structural issues are hampering universal access to these services. Examining these issues is important to align with the objectives of universal health coverage (UHC) pledged by many countries, including those in the ASEAN region.

The first chapter of this report depicts the sustained prevalence of HIV in the general population since 1990, and documents the HIV prevalence among five key populations affected by HIV/AIDS. In most countries, people who inject drugs (PWID) showed the highest prevalence as compared to other key populations, even though for some countries, men having sex with men (MSM) outnumbered PWID in recent years. To address the HIV epidemic, all ASEAN Member States (which include Brunei, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand, Viet Nam) have crafted national-level strategies or action plans for HIV/AIDS.

The second chapter delves into the discussion of health system financing mechanisms and examines the extent to which HIV related treatment costs, including costs for HIV prevention intervention, are incorporated into the UHC agenda in each country. The benefits packages for HIV related treatment vary among ASEAN member states. In general, basic HIV treatment such as the first-line antiretroviral treatment (ART) is freely available to patients diagnosed with HIV across ASEAN member states, whether they are directly financed under the national health financing mechanisms or funded by external donors. However, the coverage for additional costs incurred due to ART treatment which include viral load test, HIV drug resistance test, and organ functions tests are more heterogenous, with some countries offering more generous coverage than others. In terms of performance on the HIV testing and treatment cascade, Cambodia, Thailand and Singapore have come closer in reaching the 90-90-90 targets, while more catching-up with these targets are needed for most other countries. Besides, access to pre-exposure prophylaxis (PrEP) for HIV prevention remains limited with no formal discussion on the extension of government subsidies for its coverage in most ASEAN member states, except for Thailand.

The third chapter discusses the roles of community-based organizations (CBOs) and the challenges encountered. In the face of the ongoing Covid-19 pandemic, the roles of CBOs have been heightened. Besides basic service provisions and advocacies, CBOs had to make additional efforts to ramp up their service operations at the height of the pandemic to ensure treatment continuity for people living with HIV. In terms of the challenges encountered, CBOs continue to face barriers in reaching out to people living with HIV and key populations in geographically challenged areas, as well as having to manage longstanding issues of stigma and discrimination faced by key populations affected by HIV in the communities. Furthermore, the pandemic has also put a strain in the operational capacities of CBOs.

This report offers five comparative lessons for ASEAN member states from the legal, financing, and service delivery perspectives. The enactment of the UHC Act and the Philippine HIV and AIDS Policy Act from Philippines demonstrate how legislations and policies can be strengthened to protect the welfare and employment of people living with HIV. Thailand offers insights into the policy process involved in the enhancement of the benefits package for HIV-

related treatment, as well as in the improvement of service delivery using a task-shifting model led by the lay providers. In Philippines, key-population led CBOs offer lessons related to the implementation of interventions and strategies to empower people living with HIV in addressing societal-level stigma and discrimination. In addition, Indonesia, Thailand, Malaysia, Singapore, and Philippines showcase health innovation in HIV service delivery by tapping into digital health technology and expanding telemedicine service to ensure continuity of treatment and service access for people living with HIV during the Covid-19 pandemic.

Finally, the report concludes with seven policy recommendations for the government and five practice implications for the service providers and CBOs. At the country-level, governments should work towards (i) developing concrete task-shifting models for HIV-related services, (ii) enacting and enforcing anti-discrimination laws to protect the welfare of people living with HIV, (iii) improving treatment access and expanding benefits package for HIV to include HIV prevention, (iv) improving digital and telecommunication infrastructures to harness the advantages of telemedicine, (v) upholding the principal of medical neutrality regionally, (vi) improving HIV-related service and treatment access for migrant workers as part of their pledges to achieve UHC, and (vii) establishing social contracting mechanisms for CBOs. These recommendations would necessitate governments to not only focus on country-level efforts, but also facilitate the dynamic transfer of lessons and sharing of experiences across the entire ASEAN region. Furthermore, CBOs, and providers should work hand-in-hand to (i) promote integrated care services for people living with HIV that account for their other physical and mental health co-morbidities, (ii) pilot empowerment-oriented community-based interventions, (iii) expand digital health services for HIV prevention and care support, (iv) embrace data-driven and evidence-based practice in their work, and (v) strengthen operational capacity and build trust.

Chapter 1: HIV/AIDS in the ASEAN Region

Prevalence of HIV in the ASEAN Region

Since the widespread emergence of HIV and AIDS globally in the 1980s, the prevalence of HIV/AIDS has been on a gradual rise. In Southeast Asia, Thailand records the highest prevalence rate among the population ages 15 to 49 among the countries in the region. In 1990, Thailand recorded 0.6 prevalence rate. This number rose to 1.9 in 2000, 1.4 in 2011, before going down to 1 in 2020. All other countries have also seen a gradual rise in HIV/AIDS epidemic among the population ages 15 to 49 between 1990 to 2000, before witnessing a gradual decline or tapering off of the epidemic from 2000 onwards. Among these countries, Cambodia demonstrates remarkable results in bringing down the prevalence rate of the HIV/AIDS epidemic from 1.6 in 2000 to 0.5 in 2020. Table 1 documents the prevalence rate and the trends of HIV/AIDS in the last three decades of the countries in the region.

Table 1: HIV prevalence rate among population ages 15-49 among countries in the ASEAN region

Countries	Prevalence of HIV, total (% of population ages 15-49)[ii]				
	1990	2000	2011	2015	2020
Brunei Darussalam	NA	NA	NA	< 0.1	< 0.1
Cambodia	0.1	1.6	0.8	0.6	0.5
Lao PDR	0.1	0.1	0.3	0.3	0.3
Malaysia	0.1	0.4	0.4	0.4	0.4
Myanmar	< 0.1	0.6	0.8	0.8	0.7[1]
Philippines	0.1	0.1	0.1	0.1	0.2
Singapore	0.1	0.3	0.3	0.3	0.2
Thailand	0.6	1.9	1.4	1.3	1.0
Viet Nam	0.1	0.3	0.4	0.4	0.3
Indonesia	< 0.1	< 0.1	0.3	0.3	0.4

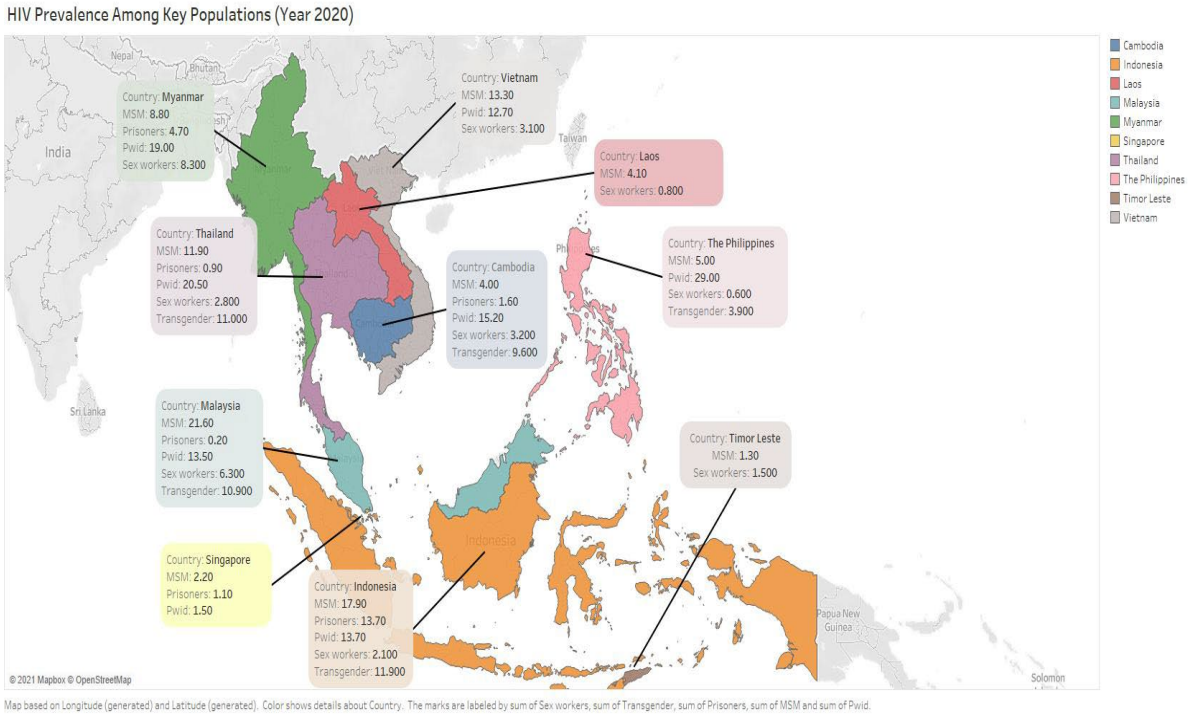
Note: [1] The latest data for Myanmar in the last column is from year 2019.
Data sources: World Development Indicators (The World Bank 2020), HIV & AIDS Estimates: Country Factsheets (UNAIDS 2020).

Key Populations Affected by HIV/AIDS

The HIV epidemic in the ASEAN region is characterized by its concentration in key populations affected by HIV/AIDS, which include people who use drugs (PWUD), sex workers, transgender people, gay, bisexual, and other men who have sex with men (MSM), and people in detention or other closed facilities. In most countries in ASEAN, PWUD remains one of the key populations most affected by HIV/AIDS with the highest HIV prevalence rate as compared to other key populations, with HIV prevalence rates ranging from 1.5% in Singapore, to 29.0 in Philippines based on the most recent data. Sex workers are also another key population affected by HIV/AIDS, with estimated prevalence rates ranging from approximately 1% to 8% in most countries in ASEAN. Similarly, the transgender population recorded a prevalence rate between 3% to 12% in most countries in ASEAN. In addition, the HIV prevalence among MSM is also on the rise in most countries, with the prevalence rate documented to be between 1% to 22% among most ASEAN countries. Another prominent population group that is affected by HIV/AIDS is the people in detention or other closed facilities. Among countries which have

official records, the HIV prevalence among the people in detention or other closed facilities stands between 0.2% to 13.7%.[iii] Figure 1 shows the most recent estimation of HIV prevalence for all the key populations among all ASEAN countries.

Figure 1: Estimates of HIV Prevalence among Key Populations Affected in Ten Southeast Asian countries in 2020



Data source: UNAIDS (2020)

National Strategies/Responses to Control HIV/AIDS

Brunei Darussalam

The Brunei Darussalam AIDS Council (BDAC) was established in 2000 to create awareness and instill education on HIV/AIDS, to ramp up preventive measures, as well as to assist people living with HIV. In Brunei, it is compulsory for all clinicians and national laboratories to report HIV positive cases to the Department of Health Services. As part of the national response, free HIV testing is available in most government health centres and clinic.[iv]

Cambodia

In Cambodia, the National AIDS Authority (NAA) under the Prime Minister Office is the coordinating body of the multi-sectoral national HIV response that leads the strategic direction and coordinate multi-party efforts in HIV response. Every five years since 2001, Cambodia has been launching the National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS. Currently, the fifth National Strategic Plan that runs till 2023 states Cambodia's commitment to end HIV/AIDS as a public health threat by 2025 through the strengthening of the national leadership, improving partnership and increasing domestic investment in HIV/AIDS.[v]

The National Center for HIV/AIDS, Dermatology, and STDs (NCHADS) leads the health sector response and is guided by the Strategic Plan for HIV and STI Prevention and Care in the Health Sector for 2021-2025. NCHADS develops guidance and standard operating procedures for provision of HIV-related services along the HIV treatment cascade.

Since 2014, the Chief of Technical Bureau of the National Centre for HIV/AIDS, Dermatology and STDs undertook a process of capacity building with national leaders, policymakers, civil society and key affected populations to tap into the multi-sector and multi-party collaborative effort in responding to the HIV epidemic. This capacity building effort is planned in line with the dwindling international funding and the need to diversify the domestic funding source in the fight against the HIV/AIDS epidemic (second Regional Report). Through these efforts, coupled by strong support from the government of Cambodia, by 2017 Cambodia is one of the seven countries across the world to have achieved the 90-90-90 targets. These targets are "90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will have viral suppression."[vi]

Indonesia

Under a presidential decree, the National AIDS Commission was established in 1994. Thereafter, a five-year National AIDS strategy was rolled-out with different visions, goals and targets. In 2006, the National AIDS Commission (NAC) was restructured to establish a full-time secretariat to accelerate the HIV programme; and intensify multisectoral response to HIV under the leadership of Coordinating Ministry of People's Welfare that included diverse multisectoral partners from the government sector, private sectors, civil society, community-based organizations, PLHIV and Key Population networks. However, it was dissolved in 2017 due to organizational efficiencies within the government structures. The Coordinating Ministry of Human Development & Culture and the Ministry of Health are now responsible for leading the multisectoral and health sector response to HIV. A Health Sector Strategy on AIDS (RAN) 2020-2024 has been established under the Ministry of Health. A Multisectoral Strategy on AIDS (SRAN) 2021-2025 is being developed with participation from the government sector, private sectors, civil society, community-based organizations, PLHIV and Key Population networks.[vii]

In 2019, in collaboration with the International Labour Organization (ILO), the Ministry of Manpower in Indonesia has launched a program to strengthen non-discriminatory policies and HIV prevention programme in the workplace with potential employers in the private sectors and other key stakeholders from other ministries as key actors in the National AIDS response.[viii]

With 34 Provinces and 514 districts/municipalities, Indonesia has a decentralized system of governance with an explicit division of labour between central, provincial and municipality/district structures. With the introduction of the mandatory minimum standard of service (SPM/MSS) policy on health that includes HIV at cities/district levels, an enabling policy and regulatory environment is required at cities/district levels to accelerate HIV and TB programme implementation and to hold the cities/district leaders accountable for the achievement of local programme targets.[ix]

Lao PDR

Lao PDR has been engaging in systematic and organized efforts in responding to HIV since 1988 after the establishment of the National Committee for the Control of AIDS. In 2006, Lao PDR has launched the first five-year National HIV and AID Strategy and Action Plan (NASP), and is currently moving towards the fourth NASP, covering the period from 2021 to 2025. A national strategy to combat HIV/AIDS was enacted as a law in 2010.[x] The country has set a 95-95-95 target (95 percent of people living with HIV know their status, 95 percent who know their status are receiving treatment, and 95 percent of those on treatment have a suppressed viral load) to be achieved at the end of the current NASP.[xi]

Malaysia

In Malaysia, the Malaysian AIDS Council (MAC) was established in 1992 to serve as an umbrella organization that would coordinate efforts of non-governmental organisations, community-based organisations and other organisations working on the issue of HIV/AIDS in Malaysia. [xii]

Since 2005, the Malaysian government has been launching the National Strategic Plan on HIV/AIDS to provide a framework for Malaysia's response to HIV/AIDS over five years. In 2015, Malaysia launched a National Strategic Plan for HIV/AIDS which commits to "ending AIDS" by 2030 and to achieve four key targets: 95% of key populations tested for HIV and know their results, 95% of people with HIV diagnosis receiving ART, 95% of people on ART achieving viral suppression, and 90% of key populations are reached by combination prevention services. These targets will be achieved via systematic roll-out of four priority programmes under eight guiding principles. The four priority programmes are intensification and expansion of testing and treatment, expanding the capacity of harm-reduction strategies, reduction of sexual transmission via targeted interventions and by tapping into the use of social media messaging, and reducing stigma and discrimination towards people living with HIV.[xiii]

Myanmar

In Myanmar, the National AIDS Program (NAP) was established by the Ministry of Health and Sports (MOHS) since the late-1980s with coordinated national and international support.[xiv] The National Strategic Plan on HIV and AIDS was developed in 2006 for the first time, under the leadership of the MOHS, through a participatory process that involved consultations undertaken with a wide range of stakeholders.[xv] This plan aims to achieve universal access to HIV prevention and care, and to scale up effective interventions through capacity-building. In the National Strategic Plan I launched for the period between 2011 to 2015, HIV has been prioritized as a disease which would be funded heavily by domestic contributions. A total of US$1 million was allocated for methadone maintenance treatment for PWUD, and an additional US$5 million was allocated for ART in 2015.[xvi] In 2020, Myanmar launched the fourth National Strategic Plan (2021-2025) that crafts out five strategic directions aiming at achieving the 95-95-95 prevention and treatment targets in controlling the HIV epidemic. The government also pledged to increase the share of HIV financing and commit at least 20% of the funding to HIV response.[xvii]

Philippines

In Philippines, a national law known as the Philippine AIDS Prevention and Control Act of 1998 RA No.8504 was enacted to serve as a national legal framework in the country's fight against the HIV/AIDS epidemic. This law was later amended to RA11166 in the effort to strengthen the Philippines' Comprehensive Policy on HIV and AIDS Prevention, Treatment, Care, and Support, and, reconstituting the Philippine National Aids Council (PNAC).[xviii] Along with the enactment of law, the Philippines National AIDS Council (PNAC) was established in 1992 to advise the government on the prevention and control of HIV/AIDS, and is a multi-stakeholder taskforce which include actors from the government, non-governmental organsations, members of the HIV/AIDS network, and representatives from community-based organisations supporting people living with HIV.[xix] The PNAC is also mandated to draft the national response or strategy for HIV/AIDS which is also known as the AIDS Medium Term Plan (AMTP). Currently at its sixth iteration, the AMTP that covers a five-year period from 2017 to 2022 has set the elimination of mother-to-children transmission of HIV as one of its key targets.[xx] [xxi]

Singapore

In Singapore, the National Public Health Unit was established in September 2008 as the key public agency that is responsible for managing the National HIV Registry which aims to perform contact tracing and partner notification for all newly diagnosed HIV cases, besides conducting HIV-related research as well as HIV prevention programmes. A high-level ministerial chaired platform known as the National HIV Policy Committee has also been established in 2006 to formulate policies regarding HIV prevention and control, and chart the overarching direction of HIV management in Singapore.[xxii]

Thailand

As the country that has the highest HIV prevalence among ASEAN countries historically, Thailand began to launch the National Strategic Plan on HIV (NSP) since 1992. Developed by a diverse range of actors from multiple sectors and approved by the National AIDS Prevention and Alleviation Committee (NAPAC) chaired by the Prime Minister, the NSP charted the blueprint for HIV prevention and control, as well as delineated collaboration among different government stakeholders.[xxiii] In 2014, the NSP stipulated its ambitious goals to reduce new HIV infection by two-thirds, reduce perinatal transmission to less than 2% of, and cut down AIDS-related death by half, and to gear up towards the ending of AIDS epidemic in Thailand by 2030. In 2017, the Ministry of Public Health of Thailand launched the latest National AIDS Strategy (2017-2030) to lay out a road map stipulating how Thailand plans to end the AIDS epidemic by 2030. In the document, three key goals are stipulated, which include, (i) reduce new HIV infections to fewer than 1,000 cases per year, (ii) reduce AIDS-related death to fewer than 4,000 cases per year, and (iii) reduce HIV and gender related discrimination by 90%.[xxiv]

Viet Nam

Viet Nam has put in place a National Strategy on HIV/AIDS Prevention and Control since 2003. The Prime Minister has approved the National Strategy on HIV/AIDS for 2004-2010 with a Vision to 2020, which is the first national strategy that signifies Viet Nam's response to combating the HIV/AIDS epidemic.[xxv]

Most recently, the Prime Minister has issued a decision approving the National Strategy on putting an end to AIDS in 2030. Specifically, this national strategy targets to strengthen HIV/AIDS prevention and control interventions, reduce newly diagnosed HIV case and AIDS-related deaths, minimize the impacts of HIV/AIDS on the country's socio-economic development, and more importantly, to erase the AIDS epidemic by 2030. Several ambitious goals to control HIV/AIDS have been set out clearly in the national strategy. It is expected by 2030, mother-to-child transmission would be wiped out completely, up to 80% of high-risk population groups would be able to access HIV prevention services, up to 95% of people living with HIV would be aware of their conditions, and up to 95% of people living with HIV would receive ART.[xxvi]

Chapter 2: HIV/AIDS Policy and Practice in the Context of Universal Health Coverage (UHC) in the ASEAN Region

Health Systems and the Extent of UHC in the ASEAN Region

The health financing systems in the ASEAN region are rather heterogenous, with varying arrangements among different countries. While health financing in Indonesia, Philippines and Viet Nam mainly exist in the form of a single-payer national health insurance system with a single pool for revenue collection (*i.e. Jaminan Kesehatan Negara or JKN in Indonesia, Philippine Health Insurance Corporation or PhilHealth in Philippines and Viet Nam Social Security (VSS) in Viet Nam*), multiple pooling systems exist in Singapore, Thailand, Cambodia and Lao PDR, and hybrid systems with a dominant single pool financed by direct/indirect tax and non-tax revenues, alongside other premium payments, are found in Malaysia and Brunei Darussalam. In Myanmar, there is to date no formal arrangement for public health financing within the health system.[xxvii] In the single-payer national health insurance systems of Indonesia, Philippines and Viet Nam, the revenues are derived primarily from individual contributions from formal sector employees, as well as government subsidies for the poor and specific population groups, such as civil servants, army officials, children, ethnic minorities, and other vulnerable populations. In Cambodia and Lao PDR, the revenues for health financing are derived from a combination of social insurance from the formal sector, governments, and external donors through Health Equity Funds. In Cambodia, the Ministry of Health is currently developing a health insurance system to cover those who are still left out from the formal social health insurance system such as the informal sector workers and the dependents of formal sector workers. This new system aims to collect optimal amount of premiums from each socioeconomic group of the society based on per capita disposable income.[xxviii] Singapore's multiple pooling systems are comprised of a hybridized arrangement of their "3M system"—individual medical savings accounts (Medisave), national insurance for citizens and permanent residents (Medishield), and government subsidies for the poor (Medifund). Thailand's financing system is a social health insurance system comprised of three schemes: (i) the civil servants' medical benefit scheme under the finance ministry, covering 5.7 million people; (ii) the social security scheme under the labour ministry, covering 12.3 million people; and (iii) the universal coverage scheme under the public health ministry, covering 47.8 million people or 72% of the population. In Myanmar, only 1% of the population is covered by their national social security system (SSS), which is mainly financed by premium collection.[xxix] [xxx]

In terms of purchasing strategies, most of the health systems are predominantly public while Indonesia, Singapore, Philippines, and Thailand have hybrid systems whereby both public and private providers are dominant players in the healthcare market. Countries in ASEAN employ a variety of provider payment methods. Even within a country, there are two different payment method such as capitation for primary health and DRG for tertiary care in Indonesia.[xxxi] While retrospective payment systems such as fee-for-service or fee schedules are still the main payment method, countries are generally moving towards adopting prospective payment systems such as DRG, capitation, and global budget as they embark on universal health coverage reforms.[xxxii] [xxxiii]Countries vary in terms of the scopes of the benefits package. While most countries cover both essential primary care and high-cost tertiary care, a handful of countries such as Lao PDR, Myanmar, and Philippines only cover essential primary care. The breadth of health coverage among ASEAN countries varies to some extent. As shown in Table 4, Brunei Darussalam, Malaysia, Singapore and Thailand have well achieved UHC, with their citizens covered by government subsidies and/or risk-pooling schemes under the national

health insurance systems. In other countries, there remain gaps in the attainment of UHC. In Indonesia, Philippines, and Viet Nam, UHC attainments are 63%, 76%, and 67% respectively. These figures still fall short of meeting the World Health Organization (WHO)'s target of at least 90% coverage among the population. In Cambodia, Lao PDR, and Myanmar, less than 25% of the population are fully covered.[xxxiv]

Table 2 summarises the mechanisms of health financing in ASEAN in five key areas (sources of revenue, pooling systems, purchasing strategies, provider payment methods, and scopes of benefits package) while Table 3 showcases the key UHC indicators and ART coverage in the ASEAN region.

Table 2: Health Financing Mechanisms in the ASEAN Region

Health Financing Mechanisms	Categories/Domains	Countries and explanations	
Sources of revenues	Direct taxes and Indirect taxes	Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand, Viet Nam	
	Non-tax revenues: natural resource revenue	Brunei	
	Financing from foreign sources through government	Cambodia, Lao PDR, Myanmar	
	Out-of-pocket	Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand, Viet Nam	
Pooling systems	Single pool	Brunei Darussalam, Malaysia	The single pool is based on direct and indirect general taxes and non-tax revenues other than premium payments
		Indonesia, Philippines, Viet Nam	The National Health Insurances' revenues consist of social contribution and government subsidization for the poor people and specific target populations such as minority ethnic groups, children under 6 years, civil servants, and other underprivileged groups.
	Multiple pools	Cambodia, Lao PDR	In Cambodia and Lao PDR, the revenues of the health financing system are obtained from employees and employers through social insurance, as well as from the governments and donors through the Health Equity Funds (HEF).
		Myanmar	There is no proper arrangement for revenue collection in the health sector except for premium collection in the social security system (SSS) which only covers 1% of the population.
		Singapore	In Singapore, the "3M" system (Medisave, MediShield Life, Medifund), a special insurance scheme for the elderly, ElderShield, and a government subsidy are the financing mechanisms. Among these multiple tiers, the government subsidies cover up to 80% of the costs of acute hospital care in the first tier of protection to all citizens.
		Thailand	In Thailand, the tax-financed mechanism for CSMBS, a mandatory tripartite payroll-tax financing mechanism for the Social Health Insurance Scheme, and general taxes financing mechanism for the Universal Coverage Scheme (UCS) are sources of revenue.
Purchasing strategies	Public as dominant providers	Brunei Darussalam, Cambodia, Lao PDR, Malaysia, Myanmar, Viet Nam	
	Hybrid (mix of public and private providers)	Indonesia, Singapore, Philippines, Thailand	
Provider payment methods	Capitation	Cambodia, Indonesia, Lao PDR, Philippines, Thailand, Viet Nam	
	Free-for-service	Malaysia, Myanmar, Philippines, Thailand, Viet Nam	
	DRGs	Indonesia, Thailand, Viet Nam	

	Fee schedules	Indonesia, Lao PDR
	Salary	Myanmar
	Global budget	Brunei Darussalam, Malaysia, Thailand
Scopes of benefits package	Essential health care only	Lao PDR, Myanmar, Philippines
	Essential health care + High-cost tertiary care	Brunei Darussalam, Indonesia, Malaysia, Singapore, Thailand, Viet Nam
	Not defined	Cambodia

Adapted from Myint et al. (2019)

Table 3: Out-of-pocket Expenditure (% of Current Health Expenditure), Current Health Expenditure (% GDP), ART Coverage for Adults and Children (%), UHC Coverage (% of population), and Characteristics of the UHC Schemes in 10 ASEAN countries

Countries	Out-of-pocket expenditure as % of current health expenditure (2018) [a]	Current health expenditure as % of GDP (2018) [a]	ART coverage for adults and children (%) (2020) [b]	UHC coverage (% of population) [c]
Brunei Darussalam	4.86	2.41	51.0*	100 (at present)
Cambodia	57.53	6.03	83.0	31 (2017)
Indonesia	34.85	2.87	26.0	82 (2021)
Lao PDR	48.55	2.25	54.0	75 (2017)
Malaysia	35.12	3.76	51.0	100 (since 1980s)
Myanmar	76.54	4.79	76.0*	No official data published.
Philippines	53.85	4.4	42.0	90 (2017)
Singapore	31.04	4.46	75.0	100 (since 2015)
Thailand	11.01	3.79	79.0	100 (since 2002)
Viet Nam	44.9	5.92	68.0	89 (i2019)

Note: * indicates data in 2019.
Data sources: [a] The World Health Organization Global Health Expenditure Database (2018).[b] UNAIDS [c] A variety of sources including academic sources and governments' official websites.

Financing of HIV/AIDS in the ASEAN Region

In the ASEAN region, most countries are financing HIV treatment and services via a combination of international donors' funding and domestic government spending. In Cambodia, Lao PDR, Philippines, and Myanmar, external donors' funding outweighs government spending for HIV/AIDS.[xxxv] [xxxvi] [xxxvii] [xxxviii]

In Viet Nam, external funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and The President's Emergency Plan for AIDS Relief (PEPFAR) contributed approximately half of the total expenditure for the national HIV response in 2018, but Viet Nam has gradually transited into relying more on domestic funding since then. For instance, 87% of the HIV clinics are now reimbursed by the Viet Nam social health insurance system to date, and the government of Viet Nam has signaled more responsibilities in financing HIV. These include assuming primary financing roles for human resources for health, HIV surveillance, harm reduction programmes, antiretroviral (ARV) treatment, and HIV prevention programmes. The social health insurance system in Viet Nam, for instance, has procured US$5.9 million of ARVs to cover up to 48,000 patients in 2019, and will cover the ARV costs for all people living with HIV in Viet Nam by 2021. [xxxix]

In Malaysia and Thailand, domestic funding from the government constitutes the majority financing source for HIV treatment and services. In Malaysia, 92% of the total expenditure for HIV/AIDS came from the domestic fund in 2020. In Thailand, it was reported that 92% of the total AIDS spending was domestic in 2019. In Singapore, financing for HIV treatment comes from a combination of personal medical savings account and government subsidies. For instance, each patient is allowed to withdraw up to S$550 per month from their medical savings account (known as "Medisave" which is one of the three accounts in the Central Provident Fund account), and financial assistance from the government known as "Medifund" has also been extended to individuals who cannot afford the treatment. In addition, subsidies for ART have also been distributed to lower and lower-middle income patients who are receiving treatment at the public hospitals.[xl]

HIV Testing and Treatment Cascade

Table 4 depicts the performance of three major indicators for the HIV treatment cascade among ten ASEAN member states in 2020. Most ASEAN member states seemed to perform well on the first treatment cascade, with more than 80% of people living with HIV actually know their statuses, with the exception of Indonesia and Philippines. Some countries do not have official data on this. This suggests that community-based health promotion efforts to encourage access to HIV testing have been largely successful in many of the countries in the region.

The second treatment cascade reflects the access to care and services largely. This indicator seemed to be rather heterogenous among different countries, with Cambodia, Thailand and Singapore being some of the best performers among countries in the region. The relatively lower figures in some countries, with barely half or only half of the people living with HIV having access to ART suggest that structural issues such as stigma and discrimination as well as geographical barriers may still deter people living with HIV from seeking necessary care upon knowing their diagnoses.

The third treatment cascade could potentially reflect the extent to which access to HIV care and services are continuous and uninterrupted for people living with HIV. In this respect,

Cambodia outperformed the rest of the countries in the region with 81% people receiving ART demonstrating viral suppression.

Table 4: HIV Treatment Cascade among 10 ASEAN Member States in 2020

Countries	Treatment Cascade (2020)		
	% People living with HIV who know their HIV status	% People living with HIV receiving sustained ART	% People living with HIV who have viral suppression
Brunei Darussalam	NA	NA	NA
Cambodia	84.0	83.0	81.0
Indonesia	66.0	26.0	NA
Lao PDR	NA	54.0	52.0
Malaysia	87.0	51.0	43.0
Myanmar	85.0*	91.0*	94.0*
Philippines	68.0	42.0	NA
Singapore	84.0	75.0	73.0
Thailand	94.0	79.0	77.0
Viet Nam	NA	68.0	63.0*

Note: * indicates data in 2019.
Data source: UNAIDS (2020); Oo et al. (2021)[xli]

Access to Pre-exposure Prophylaxis (PrEP) for HIV Prevention in the ASEAN Region

The World Health Organization (WHO) recommended oral Pre-exposure prophylaxis (PrEP) for people with substantial risk of HIV in 2015. While only Norway and the US drafted national PrEP recommendations in line with the WHO recommendations initially, four years down the road, in 2019, 121 countries already have oral PrEP drafted in their national guidelines. It is projected that 2.1 to 3 million people will be PrEP users by end of 2023, even with the disruptions resulted from the COVID-19 pandemic.[xlii]

In terms of service delivery for PrEP, nurse-led services, telehealth, and key-population led services have been proposed to be the appropriate models of delivery for people at risk of HIV.[xliii] Currently, in most ASEAN Member States, PrEP is still largely financed by international donors, and most governments have yet to signal commitment to assume responsibilities for PrEP financing in the short-term. This is largely due to the fact that most PrEP users are from the key populations, and already other HIV prevention services targeting the key populations are underfunded. In addition, bureaucracy and ministerial gridlocks have been the major contributing factors to this.[xliv]

Most countries in ASEAN have either adopted or are pending adoption of the WHO recommendations on oral PrEP into their national guidelines as of 2019.[xlv] At this point, all countries in countries in ASEAN have begun providing PrEP under different models, ranging from planning of demonstration projects (Lao PDR, Indonesia), initiation of demonstration project (Myanmar), completion of demonstration projects (Malaysia, Philippines), scaling-up phase (Viet Nam, Cambodia) or formal inclusion in universal health coverage (Thailand). [xlvi]

A survey conducted by the Asia and Pacific Coalition on Male Sexual Health (APCOM) in 2016 demonstrated that government and country-level PrEP consultations had been conducted in most parts of Asia (except for China and Mongolia) to explore the use of PrEP in HIV prevention. Nevertheless, public communications in many countries remained as hurdles due to inability of most government-led initiatives to reach high risk populations who are largely hidden under the radar. Hence, the roles of NGOs in reaching out to specific high-risk population groups remain crucial.[xlvii]

Among ASEAN Member States, Thailand appears to be at the forefront in providing PrEP among population groups with substantial risks. Thailand is the first country in ASEAN to launch a national guideline to implement PrEP and since 2014, The Ministry of Public Health has started recommending PrEP to high-risk individuals, including the MSM population.[xlviii] A landmark trial which tested the use of PrEP for HIV prevention among high-risk populations and included a site in Thailand reported a 44% reduction in the incidence of new HIV infections among MSM and transgender populations who received daily oral PrEP as compared to those receiving the placebo.[xlix] In another recent study, it was estimated that MSM population in Thailand, who took daily PrEP and reported using condoms correctly, consistently demonstrated a 92% reduction in HIV infections.[l] Since October 2021, PrEP is formally included in the UHC agenda and is fully insured by social health insurance schemes. Key population-led lay providers have been the key actors providing HIV testing and PrEP delivery in certain geographic areas in the country.[li]

In November 2019, Myanmar published its national PrEP standard operation procedures. A PrEP demonstration project funded by USAID under the President's Emergency Plan for AIDS relief (PEPFAR) was launched in 2020. Tenofovir 300mg and Lamivudine 300 mg were to be prescribed as components of combination prevention for a total 2000 key populations (HIV negative MSM and TGW in Yangon and PWUDs in Kachin).[lii] In Lao PDR, the national strategy and action plan for 2021-2030 has laid out implementation as one of the priority activities in HIV prevention following the WHO's recommendation. [liii] In late 2020, a PrEP pilot implementation involving 250 HIV negative MSM participants was conducted in Vientiane. In Cambodia, a concept note on PrEP with clear provisions on the implementation of PrEP was published in 2019. It was envisioned that the implementation of PrEP will be under the guidance of the National Technical Working Groups (TWG) for HIV Care, Treatment, and Prevention, and the TWG will also include community representation. The TWG will be reviewing the PrEP standard operating procedures as well as monitoring the implementation of PrEP. In terms of delivery mode, both the facility-based approach and community-based approach will be adopted, in which key population-led NGOs are likely to be the brokers or outreach workers for the community-based approach.[liv] In Viet Nam and Philippines, community-based PrEP is the main service delivery model implemented. In Viet Nam, integrated home lab sample collections and HIV self-testing are available to clients through this mode of delivery. During the pandemic, online distribution of HIV self-testing and PrEP are done by courier, coupled with telehealth, to maintain service continuity for clients. In Philippines, client-centered online campaigns were launched to gauge the demand for PrEP, and the successful demonstration project has led to the initiation of a National PrEP network in Philippines.[lv]

Scaling-up the provision of PrEP to a larger segment of the population in a financially sustainable manner remains a work-in-progress. The landscape of PrEP and the readiness and commitment to large-scale implemention varies among countries. In most ASEAN Member States, there remain barriers to large-scale PrEP uptake. At the structural level, punitive laws targeting the key populations, concerns regarding attitudes of healthcare providers, quality assurance, data protection, and cost were presented as barriers to large-scale implementation. At the individual- and societal-levels, no or low risk perceptions among the key populations, poor knowledge about PrEP, doubts about its effectiveness, fear of side effects, and anticipated stigma from the family and societies were presented as major barriers in large-scale PrEP implementation.[lvi] In Indonesia and Myanmar, awareness of PrEP among the MSM and transgender populations remain low.[lvii] However, another study had shown that acceptability towards PrEP among key populations in Myanmar (MSM and transgender populations) was high, especially for those who perceived themselves to be at higher risk of contracting HIV.[lviii]

Case study 1: Thailand

The journey towards achieving UHC in Thailand

Thailand's journey to achieve UHC is often lauded as a successful case among its ASEAN counterparts. Landmark health reform was achieved in 2002 to extend health coverage to the uninsured and poor through the '30 baht for all disease' scheme. This later formally became known as the 'universal coverage scheme' (UCS), and together with the pre-existing Civil Servant Medical Benefit Schemes (CSMBS) and Social Security Scheme (SSS), extended access to subsidized healthcare for all Thai citizens. Backed by strong bureaucratic and technocratic support, and involvement from a broad representation of civil society organisations, UHC in Thailand has brought about remarkable health improvements a decade after it was initiated. The life expectancy at birth has risen from 71.4 to 74.6 between 2003 to 2011, infant mortality has fallen drastically from more 16.2 per 1,000 live births in 2003, to 7.7 per 1,000 live births in 2019.[lix] National household surveys also have found reduced out-of-pocket expenditures for households a decade after the inception of UHC, lower incidence of catastrophic health spending in the poorest and richest quintiles, and increased household savings among previously uninsured households.[lx] [lxi]

Benefits package and financing of HIV/AIDS under the UHC

At the beginning of the UCS implementation, only treatment for opportunistic infections and mother-to-child transmission were covered for people living with HIV. ART was not initially included in the benefits package due to concerns over its high cost, which would have impacted the financial sustainability of the entire UHC programme. However, ART was eventually included in 2006 and became fully integrated into the UHC programme. The National Health Security Board (NHSB) of Thailand approved and adopted Resolution No. 14254B in November 2005 and announced that ARV treatment will be formally included in the UCS benefits package. This landmark reform was to a large extent realised by the government's bold policies to initiate generic drug production, and implement cost negotiation and compulsory licensing for specific ARV drugs, such as efavirenz and lopinavir/ritonavir. The NHSO had also made a strong case to include ART in the benefits package due to the high cost-effectiveness of ART once generic drugs became available. By 2016, the UCS had included a 'test and treat' policy at any CD4 count level in 2016.[lxii] A total of 2,796.2 million Baht health budget was allocated to the NHSO specifically for the management of the provision of a comprehensive continuum of care for 82,000 people living with HIV starting in 2006, which include HIV counselling and testing, viral load tests, ARV resistance tests, as well as drug adherence and coordination with the people living with HIV network for community-level educational interventions.[lxiii]

The UCS in Thailand reimburses service providers using capitation payment. In addition to capitation, the NHSO manages a centralised HIV care budget and management system which was designed as an additional payment to the service providers. Allocated to direct payment for service reimbursement and capacity-building, the HIV care budget serves to streamline healthcare access to align with the government's efforts to improve the access and quality of the services throughout the country. The domestic funding allocated to HIV care in Thailand has increased from about US$165 million in 2007 to US$271 million in 2019 while the number of patients who received ARV had increased from 150,896 to 381,154 during the same period.[lxiv]

Access to HIV testing and treatment

Thailand is on track to achieve the 90-90-90 targets for HIV testing and treatment cascade. Based on the most recent data in 2020, 94% of people living with HIV know their HIV status, 79% of people living with HIV are on ART, and 77% of people living with HIV have suppressed viral loads. National ART coverage includes 79% of adults and 76% of children.[lxv]

Issues of stigma, discrimination and criminalisation of population-at-risks

Thailand has made great strides in improving its laws and policies to protect vulnerable population groups either living with or at-risk for HIV. In the most recent National AIDS Strategy for 2017 to 2030, Thailand's Ministry of Public Health had set a target of reducing HIV-related discrimination in the healthcare settings by 90% by 2030. This is planned to be achieved through a health system-wide response and the implementation of a stigma and discrimination reduction package based on a permanent monitoring system, evidence-informed actions at health facilities, and instructed community engagement at all levels. In addition, the Gender Equality Act was enacted in 2015 to address the issues of stigma and discrimination against the LGBT community. These policy efforts and formal legislation to protect at-risk populations have enabled Thailand to roll-out highly successful HIV advocacies, besides allowing the clinical and research community to move forward faster to implement an effective national-level HIV response.[lxvi]

Challenges within the health system and implications to the HIV/AIDS situation

While the UHC program in Thailand has been lauded as a successful health policy reform in ASEAN, there are ongoing challenges in terms of its inclusion of non-Thai citizens. To date, there is a significant proportion of migrant workers and stateless persons living in Thailand who are not captured by the system due to lapses in the resident registration system despite the presence of the Migrant Workers Health Insurance Scheme. Such missing information may prevent these populations from accessing healthcare and could undermine Thailand's sustained public health efforts in control and containment of communicable diseases, such as HIV, tuberculosis and other neglected tropical diseases.[lxvii]

HIV Prevention

Thailand has been the forerunner in HIV prevention in ASEAN. In 1989, the 100% Condom Use Programme was implemented targeting the sex workers. Collaborations between the local authorities and sex business owners managed to increase condom use among sex workers from 14% in 1989 to more than 90% in the 1990s. Besides scaling-up nationwide, the same programme has also been transported to many other countries in the region such as Cambodia, Lao PDR, Viet Nam, Philippines, and Myanmar, albeit with some variations in programme components.[lxviii]

In addition to condom use, Thailand has also managed to champion for the inclusion of PrEP to be in the UHC agenda. In 2014, Pre-exposure Prophylaxis (PrEP) was successfully included in the prevention chapter of the national guidelines to prevent HIV among persons at risk.[lxix] Since 2018/2019, the Department of Public Health has allowed PrEP to be included in the UHC schemes by setting a quota of 2,000 beneficiaries for each year. Since October 2021, PrEP is fully covered under the UHC schemes. Under the task-shifting model which Thailand has also developed extensively, key population-led lay providers have been the key actors providing HIV testing and PrEP delivery in certain geographic areas in the country.[lxx]

Case study 2: Indonesia

The implementation of National Health Insurance Program and its UHC goal

Indonesia launched its National Health Insurance Program known as Jaminan Kesehatan National (JKN) in 2014 and aspired to achieve the target of UHC by 2019. JKN is an ambitious social health insurance system that consolidates the previously existing social health insurance schemes which were designed to target different population groups into a unifying single payer system. While JKN is largely contribution-based whereby premiums are deducted from the salary from formal sector employees, the national and provincial governments have been subsidizing the premiums for the low-income or unemployed, especially those from the informal sector. [lxxi]

Benefits package and financing of HIV/AIDS under JKN

Relative to many other ASEAN countries, the total health expenditure in Indonesia is relatively low, standing at only 2-3% of the Gross Domestic Product (GDP) historically since 2000.[lxxii] Between 2006 to 2018, government's spending on HIV responses in the country has increased drastically from 26.6% in 2006 to 71.2% in 2018.[lxxiii] Currently most of the HIV treatments are directly subsidised by the national HIV programme, while JKN covers treatment for opportunistic infections. The current financing mechanism for HIV interventions is mixed. While most of the treatment and interventions are reimbursed using capitation payment for primary health centres, donor funding continues to finance some of the HIV prevention programmes and activities. [lxxiv]

Access to HIV testing and treatment

To date, Indonesia still presents a significant gap in achieving the 90-90-90 targets for HIV testing and treatment cascade and continues to lag behind other ASEAN countries. At the end of 2020, approximately 66% of the population living with HIV have been tested and are aware of their statuses, but only 26% are reported to be on ART.[lxxv] Furthermore, the proportion of those who are on ART with viral suppression is estimated to be at only 6%. The lack of consistent viral load monitoring among patients taking ART has been attributed to be the main reason that resulted in the above low estimate. Indonesia's substantial heterogeneity in geography and inequity in terms of the distribution of its health resources across different provinces, coupled with its complicated multi-level governments and bureaucracy have compounded the above issue. [lxxvi]

Issues of stigma, discrimination, and criminalisation of population-at-risks

Besides, Indonesia is also plagued with the issue of stigma, discrimination, and criminalisation of population-at-risks such as the female sex workers, transgender people, and MSM. Sex work remains illegal in Indonesia till now, and the discreet and hidden nature of sex work has resulted in female sex workers become an extremely hard-to-reach population, thus increasing their vulnerability to contracting HIV, besides hindering efforts to effective HIV testing uptake and treatment among them. Similarly, the lesbian, gay, bisexual and transgender (LGBT) community is also facing similar levels of stigma and discrimination, worsened by the increasingly conservative political environment that introduces more stringent laws that further undermine public health outreach and HIV service provisions to the transgender people and MSM populations who are also at-risk. For instance, in Yogyakarta, one of Indonesia's major cities and cultural centre in the populous island of Java, prohibitive cultural perspectives and norms against same-sex relations have worsened HIV treatment access and intervention outreach to the MSM population network, resulted in them concealing their sexual orientations, besides increasing the propensities of unprotected sex amongst

them. The tendency of the MSM population to move on into marriages later on in order to conform to the social norms also contribute to infections among women and children in the general population.[lxxvii]

Challenges within the health system and implications to the HIV/AIDS situation

One of the biggest challenges for JKN is the concern of its financial insolvency in the longer run. Since its inception, JKN has run into operational issues that threaten its financial sustainability such as the inability to collect premiums effectively from populations who can afford them, and the inability of the poor to pay premiums. In addition, the health coverage is still low for children who aged less than nine years, and there is an urgent need to expand HIV treatment for children living with HIV. In addition, HIV infections remain high and are rising among the key affected populations to date. The occasional stockouts of ART drugs and disruption in the supplies of better tolerated and robust RT regimens at the point of care, and the relatively conservative political environment that perpetuate stigma, discrimination and criminalization of the vulnerable populations that are prone to HIV infection, further prevent HIV-related services and interventions to be scaled-up effectively to reach those who need them most.[lxxviii]

HIV Prevention

Indonesia has registered a few milestones in improving HIV prevention throughout the country. However, there has been minimal change, particularly in the consistent condom use indicators and implementation of novel HIV prevention such as PrEP and HIV self-testing.

The inconsistent condom uses are primarily attributable to weaknesses within condom programming more generally. The coordination structures on comprehensive condom programming that integrate HIV prevention and dual protection have not yet been established. In terms of condom support structures, implementation is still weak with an inadequate Monitoring and Evaluations (M&E) system, limited human and financial resources, and limited operational research to inform condom programming.

The implementation of PrEP and HIV self-testing faces challenges and barriers from program managers and communities. A common misunderstanding of the benefit of PrEP is that it is one of the crucial elements attributed to the reduction of a new infection, mainly occurring among program managers at the national and sub-national levels. At the same time, lack of information and false news spread among communities that halted the programs.

Chapter 3: Roles of Community-Based Organizations

Community-based organizations (CBOs) have been a major pillar of support to people living with HIV throughout the history of the HIV epidemic. During the Covid-19 pandemic, the significant roles play by the CBOs have become more pronounced. In some countries, CBOs are indispensable in substituting the mainstream health providers to ensure treatment and service continuity to people living with HIV as the health systems grapple to manage the rising Covid-19 caseloads and escalating hospitalisation demands resulted from infection surges in various phases of the pandemic.

Roles of CBOs in HIV/AIDS Responses

i. Service provisions

CBOs provide a wide range of services from administering HIV testing, to scaling up ART, to promoting a wide range of community-based and structural-level interventions such as condom use, PrEP uptake, targeted psychosocial education programmes, and harm reduction strategies. Outreaching services that target key populations are the key portfolios in many CBOs' initiatives. CBOs in the region has been proactive in providing both tangible and intangible support to people living with HIV and key populations. Tangible support entails encouraging active surveillance through anonymous self-testing among the key populations, enabling access to ART for people living with HIV, and active text messaging to promote behavioural change. Intangible support tends to be more outward looking, focusing on public communications and mass public campaigns to increase the community's knowledge and awareness towards HIV/AIDS.

In countries whereby people living with HIV comprises a substantial number of poor and informal sector population such as Cambodia, CBOs also provide support to people living with HIV through community-based interventions that are aiming at improving their livelihood.[lxxix]

The role of CBOs in service provision is significant especially in countries experiencing high levels of political uncertainty and social instability. In the immediate aftermath of the military coup crisis in Myanmar, there have been concerns on whether ART access will be disrupted. However, community network in Myanmar stepped-up the effort to minimise disruption in treatment provisions by working with the local health authorities to facilitate ART refill during lockdowns or quarantines, and disseminate updated information on service availability to people living with HIV and key populations.[lxxx] In the low- and middle-income countries within the region, CBOs that receive external donor funding have been instrumental in scaling up ART and HIV prevention services, while working closely with the national governments to establish agreement on gradually transitioning HIV financing responsibilities to the national governments using a phased interval approach.[lxxxi]

ii. Advocacy and activism

Advocacy and activism by the CBOs in the region have largely been focused on addressing the long-standing issue of stigma and discrimination against people living with HIV and key populations. In Philippines, engaging celebrities as spokespersons in active social media strategies have been leveraged in mass public awareness campaigns to improve the society's perceptions towards people living with HIV and key populations. In Malaysia, interfaith dialogues and public forums were held as part of CBOs' continuous

efforts to promote better understanding towards the HIV epidemic and structural challenges faced by people living with HIV and key populations, thereby addressing stigma and discrimination that they face daily.[lxxxii]

Apart from advocacy efforts to address stigma and discrimination, CBO-led advocacies have also been relatively successful in reducing prices for ART. In Thailand, the Thai Red Cross has a high bargaining power due to the volume of PLHIV that it serves, and they can command monopsony power to negotiate drug costs directly with the pharmaceutical companies to bring down the generic drug pricing from time to time.[lxxxiii] In Indonesia, the Indonesia AIDS Coalition played an instrumental role to bring down the price of 'fixed-dose combination' drug (tenofovir, lamivudine, efavirenz) by shedding light on an inefficient ARV procurement system in the country. The three-year long advocacy started in 2016 and involved conducting a price assessment that benchmarked the price of similar drugs with other countries, garnering support from domestic and international partners, and publishing a briefing paper that was widely circulated among the public and resulted in several press conferences that garnered the attention of the health minister and Presidential office. This is a successful example of coalition-based advocacy in the region that marked down the life-saving ART price by a significant 48% from the previous price.[lxxxiv]

iii. Ensure treatment and service continuity during the Covid-19 pandemic

While ASEAN countries continue to battle with the Covid-19 pandemic, CBOs are stepping up their efforts to deliver ART and health services to key populations and people living with HIV in situations when health systems become overwhelmed.

In Thailand, the newly established Institute of HIV Research and Innovation (IHRI) has emerged as an alternative avenue that offers ART to clients who need them during the pandemic due to the disruption in drug supply chains and issues related to procurement at the hospital level. In the meantime, established CBOs have been stepping in to provide treatment and testing for people living with HIV and prospective HIV patients while the health system struggles to accommodate and treat Covid-19 patients. Some of the key populations such as the sex workers are also the population group that has been hit the hardest by the Covid-19 pandemic. Since April 2021, some CBOs in Thailand have been providing support to the key populations affected by Covid-19 by facilitating home isolation and community isolation care. They also help to perform contact tracing and deliver medical equipment to patients' homes and isolation facilities, especially for those who need oxygen supplies urgently, in order to lessen the care burden of the hospitals.[lxxxv]

In Philippines, CBOs such as 'Love Yourself' have created their own ride-hailing application to deliver medicines and deploy HIV home-testing kits for people living with HIV during the lock-down periods.[lxxxvi] Similarly, other CBOs and platforms that raise awareness about HIV, improve sexual health and empower the LGBTI communities such as The Red Whistle and TLF Share Collective tapped on their respective volunteer pools to collet ART refills from the treatment hubs and deliver them to clients across the country. Another CBO known as Pinoy Plus Advocacy Pilipinas Inc. established a response centre to provide information on accessible treatment hubs and advice on ART to people living with HIV during the pandemic.[lxxxvii]

In Singapore, Project X, a local non-profit organisation providing social, emotional, and legal support to sex workers, responded to the impact of COVID-19 on sex workers' health and social needs by establishing the Emergency Safety Net Programme. Through this

programme, a total of SGD70,000 (approximately USD50,000) worth of emergency support was disbursed to workers whose financial needs could not be addressed by government aid schemes.[lxxxviii]

Challenges encountered by CBOs

i. Servicing population in geographically challenged areas

Servicing populations residing in remote and geographically challenged areas has been highlighted as one of the notable challenges of CBOs. This is especially true for large and decentralised countries such as Indonesia and Philippines. In remote areas, geographical constraints have limited the outreaching efforts of CBOs. In Indonesia, a vast majority of patients in remote areas are not directly engaged by NGO, nor do they have easy access to the primary healthcare centre nearest to them. Under such circumstances, community health workers become the first line of defense in service provision to facilitate HIV testing and treatment access for people living with HIV or people at-risk of HIV/AIDS.[lxxxix]

ii. Longstanding issues of stigma and discrimination hampering effective service delivery

Stigma and discrimination against people living with HIV and key populations is a rampant and longstanding issue since the beginning of the HIV epidemic in the 1980s. Decades on, there remains community-level barriers that serve as triggering points for structural discrimination to happen. Issues related to privacy and confidentiality of patients' HIV statuses persist in the hospital or clinic settings when health systems are not designed to inculcate sensitivity towards a patient's diagnosis and the need for privacy to be preserved. In close-knit communities whereby referral letter is required from the village/neighbourhood head to receive treatment in the nearest clinic or hospital, patients risk facing stigma from their immediate family members, friends and neighbours when their diagnoses have to be revealed.[xc] Beyond discrimination within the health sector and the community, longstanding stigma and discrimination against people living with HIV is also evident in mechanisms of securing employment which still exist, such as the presence of mandatory HIV testing before hiring, refusing to employ people living with HIV, and unfair dismissal on the ground of an individual's HIV status.[xci] [xcii] Social rejections, devaluation, negative social attitudes and prejudice inherent in various social systems have also known to perpetuate self-stigma. A recent study from Cambodia and Thailand found that the frequency of depressive symptoms among adolescents and young adults with perinatal HIV who experienced HIV-related enacted stigma was nearly twofold higher as compared to those who had not experienced similar stigma.[xciii]

iii. Operational capacity challenge brought about by the Covid-19 pandemic

The ongoing Covid-19 pandemic has posed operational challenges to many CBOs in the region. Notably, funding streams have been affected due to diversion of the state funding to finance health and social protections to cushion the short- and medium-term impacts resulting from the Covid-19 pandemic. This has caused delay in the implementation of large-scale interventions such as the deployment of dolutegravir as the first-line ART regimen and scaling-up of PrEP at the population-level in some countries. Furthermore, postponement of hospitals' appointments for people living with HIV and disruption of ART supplies are also putting a strain on the CBOs as they boost their effort to substitute mainstream health providers to ensure treatment continuity for people living with HIV.[xciv]

iv. Lack of social contracting mechanisms for sustainable financing

The inability of CBOs to be formally registered in some countries and the lack of social contracting mechanisms from the government to fund their operational activities present as another key challenge in sustaining service provisions to people living with HIV and key populations. According to a consultation convened in New York in 2017 by Open Society Foundations, United Nations Development Programme (UNDP) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), social contracting is defined as 'a financing option that could help prevent reductions and disruption in targeted services for key and vulnerable populations and would ideally contribute to more effective HIV responses.'[xcv]

CBOs have made great stride to help countries to reach remarkable progresses in the control and management of HIV, especially among key populations. However, key populations-led CBOs are severely underfunded due to stigma and criminalization. CBOs in countries such as Myanmar, Cambodia, Viet Nam and Lao PDR have always relied heavily on external support from international donor organizations to fund their operational activities. Even in countries where funding has been high like Singapore, criminalization of sex workers and MSM implies that CBOs can only conduct outreaching services instead of direct campaigns to address various issues related to HIV.

The lack of enthusiasm from the governments in the region to establish legal or regulatory frameworks for social contracting for CBOs serving as frontliners in the national AIDS response will hamper the sustainability of their operations. In Thailand, the government has been wary about contracting CBOs due to alleged misappropriation of government-issued funds in the past. Apart from this, the apathy to establish social contracting mechanisms also stems from the lack of a clear performance framework to evaluate the CBO's organizational capacity, effectiveness in service delivery, and accountability in managing funds.[xcvi]

Chapter 4: Best Practices and Comparative Lessons for the ASEAN Region

This chapter discusses and showcases existing legislations, new public policies, and emerging best practices in HIV response and the integration of AIDS financing into the UHC agenda from countries in ASEAN. These examples will serve as useful comparative lessons for countries in ASEAN which are planning or contemplating to implement similar approaches in strengthening the national HIV responses and the inclusion of HIV services into the UHC schemes.

i. Legislations to strengthen HIV responses: Philippines' experiences

In the region, Philippines is the only country that has enacted formal legislation to strengthen HIV treatment and services and to engrave various national-level responses in the country. The Universal Health Care (UHC) Act was enacted as a law in 2019 to guarantee healthcare as a fundamental right for all Filipinos and to prescribe healthcare reforms in Philippines' health system. One of the key provisions is to expand coverage of existing PhilHealth benefits package to HIV services that entail prevention services.[xcvii] In addition, the President of Philippines signed the "Philippine HIV and AIDS Policy Act" in 2018 to institute this legal instrument to strengthen the response towards the rising HIV epidemic in the country, especially among the younger populations. In the process of developing this rights based legislation, Philippines has adopted a participatory approach by engaging the marginalised communities. The law now facilitates easier access to HIV testing among the younger population. For persons aged 15 and above, parental or guardian consent is no longer needed for HIV testing. In addition, the legislation has also formally embedded HIV in the UHC agenda. Phil Health, the agency that executes and operates the National Health Insurance Program, has been tasked to revise the outpatient and inpatient benefit packages to include medications and more diagnostic tests for persons diagnosed with HIV/AIDS. Furthermore, the law formally addresses some of the long-standing structural discrimination issues that exist for people living with HIV. At present, the denial of personal accident, life, and health insurance coverage for people living with HIV would be unlawful under the legislation.[xcviii]

ii. Comprehensive benefits package for HIV related treatment under UHC: Experience from Thailand

Currently, Thailand offers one of the most generous and comprehensive benefits packages for people living with HIV in the region. First-line ART treatment, as well as second-line regimen (when patients fail first-line regimen due to toxicity and drug resistance), are financed by the UHC schemes for Thai citizens. In addition, other HIV-related tests (i.e. CD4 count and viral load tests) are also covered by the UHC schemes. In 2014, Pre-exposure Prophylaxis (PrEP) was successfully included in the prevention chapter of the national guidelines to prevent HIV among persons at risk.[xcix] Thailand has been one of the forerunners in participating in various HIV prevention Phase III efficacy trials, and emerging research has shown that PrEP has been effective in reducing HIV transmission among key populations such as the MSM.[c] As more cost effectiveness data and implementation research data emerged to support the use of PrEP, the Department of Public Health has allowed PrEP to be included in the UHC schemes by setting a quota of 2,000 beneficiaries each year since 2018/2019. Beyond this quota, public donations were mobilised to finance the additional needs for PrEP in the country.[ci] Since October 2021, PrEP is fully covered under the UHC schemes.

iii. Task-shifting: The emergence of lay providers to facilitate HIV-related service delivery in Thailand

Task-shifting which involves the devolution of a physician-led or nurse-led task to lay healthcare providers has been touted as an effective approach to resolve shortages in human resources for health in low- and middle-income countries. A comprehensive review on task shifting in the delivery of ART has concluded that task-shifting is an effective approach for ART delivery in resource-constrained settings and is potentially cost-saving.[cii]

In Thailand, lay providers have been trained to provide HIV-related health services since 2015. Lay providers usually comprise staff working at various CBOs who have been serving HIV affected key populations (MSM, sex workers, transgender people, PWUD) for at least five to ten years. As they already established trust from the key populations they were serving in various geographic areas, they were trained to provide a slew of HIV related services which include HIV testing and the introduction of PrEP. CBOs would nominate their staff to be trained and certified as lay providers. For lay providers to be certified, they will have to undergo both didactic training and practical training. Didactic training involved 15 to 20 hours of training sessions which cover basic HIV knowledge, pre- and post-test counselling, PrEP provision and counselling, operational management, and case management. Upon the completion of didactic training, a theory examination will be administered. The practical training involved direct observation of HIV service provision by shadowing a senior staff. Similarly, a practical examination will be administered at the end of the practical training with passing score set at 80%. While the certification process is led by the IHRI at this point, discussion is underway with the Ministry of Public Health to institutionalise a formal certification from the government. Having a formal certification in place will also legalise the roles of lay providers to perform biological sample collections such as swab tests for HIV and several STI tests, as well as allowing the cost of these service roles to be reimbursed directly by the CBOs as part of UHC. Besides, lay health workers can also deliver the medications (including PrEP, Post-exposure prophylaxis, ART and oral STI medications) directly to the patients based on their online prescriptions issued by the physicians.[ciii]

In Cambodia, community-based ART delivery (CAD) has been experimented as a task-shifting model to facilitate better access to ART for people living HIV across the capital and nine provinces since May 2021. In the CAD intervention, community action workers, who are people living with HIV from the community, were trained on ART dispensing, drug storage, vital sign assessment, HIV education and counselling, ART adherence and measurement, referral systems, as well as issues related to mental health, stigma and discrimination, and sexual and reproductive health. The community action workers will visit ART clinics on a monthly basis to obtain pre-packaged ARV drugs and dispense to people living with in the communities that they are assigned to serve. They will also be conducting group follow up sessions monthly to record vital signs, provide health education and counselling, monitor adherence to ART, and refer those who are unwell to the ART clinics. These records will be compiled and submitted to the ART clinics in their subsequent visits.[civ]

iv. Key-population led CBO interventions to empower people living with HIV to reduce stigma and discrimination: Experience from Philippines

Key-population led CBO interventions have been trending globally as an effective approach to reach out directly to people at risks of developing HIV. In the ASEAN region, CBO-led interventions delivered by key populations, especially the MSM, have shown to be relatively successful in Philippines.

As one of the most successful social advocacy groups and CBOs serving people living with HIV in Philippines, “Love Yourself” has been serving a substantial proportion of people living with HIV and conducts a significant number of HIV testing in Philippines every year since 2011. It currently serves more than half of the newly diagnosed HIV cases in Metro Manila, and close to a quarter of newly diagnosed HIV cases throughout the country. Using a cascade approach for the continuum of care, it currently has 10 community centres that serve people living with HIV directly. The organisation also adopted 16 other CBOs to form community partnerships in its effort to scale up the service coverage to reach out to more people living with HIV. Besides offering HIV related services, it is also an accredited treatment facility for Tuberculosis (TB) certified by the Department of Health. The organisation receives reimbursement from the National Health Insurance Program, PhilHealth directly, for the patients that it serves. Besides treatment and public education, social campaigns to reduce the public’s stigma and discrimination against people living with HIV has also been one of its key interventions in improving services related to HIV. For instance, “Love Yourself” has a track record of leveraging on the power of social media and tapping into the fame of national celebrities and influencers to improve society’s perceptions towards people living with HIV and to champion for anti-discriminatory causes. It has also been successful in mobilising thousands of young volunteers from all walks of lives every year in the organisation of key services and events to help ensure service continuity.[cv]

v. Health innovation leveraging on digital health technology across the ASEAN region

The importance of health innovation in HIV service delivery to ensure continuity of treatment and service access has come to the spotlight amidst the ongoing Covid-19 pandemic. Across Thailand, Malaysia, Singapore, Philippines and Indonesia, telemedicine has been widely practiced. For instance, in-person consultations have been changed to teleconsultations with the physicians as an immediate response to ensure service continuity during city- or national-level lockdowns in various countries, besides adhering to the social distancing measures imposed by the governments during the lockdown periods. Besides, multi-month drug dosing has been widely implemented in which patients are prescribed up to six months of ART each time to reduce physical contact with healthcare providers. The streamlining of the ART service delivery is important for time and economic efficiencies, besides reducing the care burden of the health systems as most ASEAN countries’ health systems continue to grapple with high Covid-19 caseloads and escalated hospital bed occupancies during the pandemic.[cvi]

To further ensure treatment access and continuity for people living with HIV, digital tools such as ride-hailing apps have also been created. In Philippines, riders accredited by CBOs can reach out to prospective patients as frontliners to deliver medicines as well as pharmaceutical kits that could facilitate self-testing at home. In Indonesia, a home-based ART delivery system using ride-based apps and transport courier services known as ‘Jak-Anter’ has been created to ensure continuity of ART treatment to people living with HIV during the pandemic. Online training sessions were provided to the providers to equip them with the standard operating procedures to ensure they abide to appropriate ways of packaging, ensuring informed consent and confidentiality of the recipients, as well as establishing recording and reporting procedures for the purpose of reimbursement.[cvii] In Malaysia, HIV self-testing kits can be ordered online and delivered to the doorsteps of the prospective patients, and results can also be shared real-time by patients should they choose to do so in order to receive support from the CBO staff. Patients will then be supported while navigating the health system and advised on various treatment approaches, including whether to start PrEP.[cviii]

The application of digital health technology such as mobile health (mhealth) for psychoeducation has also been demonstrated in Cambodia. The mhealth has been increasingly utilised as a tool to improve service access to hard-to-reach populations. In a trial reported in 2018, an mhealth intervention targeting female entertainment workers who may engage in direct or indirect sex work was developed as a behavioural tool to impart knowledge and awareness on various health information, including STI symptoms and psychological issues, via text or voice messaging.[cix]

Chapter 5: Policy Recommendations and Implications for Practice

To enable ASEAN countries to move forward collectively in improving service delivery, treatment access, and other psychosocial interventions to improve the health and well-being of people living with HIV, this report proposes six policy recommendations for the governments and relevant authorities as measures to integrate HIV responses into the UHC agenda. It also shed light to four implications for practice for frontline service providers such as CBOs and health workers, highlighting the importance of the roles played by community stakeholders as empowering and enabling forces to fulfil the policy agenda of improving HIV/AIDS treatment access as countries strive to achieve UHC goals.

Policy Recommendations for the Governments

i. Develop task shifting models for HIV-related services

Governments and relevant authorities should allow innovation and flexibility in HIV service delivery which has been proven to be both effective and cost-saving. From a pandemic preparedness perspective, task shifting of physician- or nurse-led interventions such as ART delivery, PrEP delivery, and psychosocial education to lay providers, especially those from the key populations are important to ensure service delivery to key affected populations are not disrupted. The provision of virtual interventions leveraging on digital health technology will be increasingly important in a post-pandemic era.

ii. Enact and enforce anti-discrimination law

For HIV treatment and UHC attainment to be comprehensive as well as meaningful, anti-discrimination law needs to be at the front and centre of the political agenda to overcome barriers in health access, besides reducing discriminatory practices. For a start, countries should consider stipulating soft laws in the form of policy guidelines to directly tackle social barriers to HIV testing and treatment access and discourage all forms of discriminatory practices resulting from a person's HIV status, including the criminalisation of key populations. Over time, these guidelines should be legally binding and engraved into formal legislations. However, legislations will only be meaningful if regulators and public authorities continue to enforce and 're-enforce' them.

iii. Improve treatment access and expand benefits package for HIV/AIDS

While first-line ART is given for free now, access to treatment still presents as an issue in some countries. Besides geographical barriers for some large and decentralised countries such as Indonesia and Philippines, social barriers such as stigma associated with HIV status disclosure should be addressed through continuous efforts to improve access to treatment. Beyond ART and basic HIV-related tests, the presence of mental health conditions as a co-morbidity of HIV has been widely discussed in recent years.[cx] Hence, countries should revisit the composition of HIV benefits package from time to time and consider the inclusion of mental health support which includes psychiatric assessment and treatment as essential components to improve treatment access for people living with HIV. Likewise, HIV prevention services that have proven to be effective should also be included in the benefits package of social health insurance systems.

iv. Improve telecommunication infrastructure to harness the advantages of telemedicine and digital health technology

The role of telemedicine to ensure treatment continuity for patients and to facilitate access to physician and healthcare workers has been elevated during the Covid-19 pandemic. Telemedicine can be harnessed as a powerful digital health tool to widen

health access to more populations and enable health workers to serve populations beyond their geographical reach, especially for non-urgent and non-critical medical consultations and care. In the post Covid-19 'endemic' phase, there is ample room for telemedicine to be expanded not just for HIV service delivery, but also for other types of medical conditions. Besides, the expansion of virtual interventions for HIV prevention through virtual outreach and virtual case management, tapping into the digital health technology such as mhealth, should also be encouraged. Nonetheless, the expansion of telemedicine and mhealth hinges on having well-connected telecommunication infrastructures, legalisation and endorsement from the governments to be formalised as a mode of service delivery, and the ability to design a sustainable financing mechanism to fund its operations. Hence, the optimisation of digital health technology for HIV treatment and prevention needs to go hand in hand with the development of telecommunication infrastructure, including widening broadband access to rural and remote populations.

v. Uphold the principle of medical neutrality as part of the UHC pledge

Access to healthcare needs to be ensured even in the face of armed conflicts and political crisis. While economic sanctions can be imposed by one country to another due to geopolitical reasons or allegation of human rights infringement, the principle of medical neutrality—which entails non-interference with medical services to ensure continuity of treatment access to the population—needs to be championed by ASEAN as a regional pact. For instance, there have been concerns raised regarding ART stockouts for people living with HIV as well as treatment disruption in Myanmar after the military coup crisis took place in February 2021. As a regional pact that promotes social solidarity for all member countries, ASEAN should mobilise its member countries to step up the effort and uphold the notion of **'**access to health as a fundamental human right for every individual' to provide the necessary assistance as well as support to the government and CBOs in Myanmar.[cxi]

vi. Improve HIV related services and treatment access for migrant workers

One of the major health service gaps that the ASEAN region has always been facing is the unequal access to healthcare for migrant workers, especially for international migrant workers. While employment insurance can cover inpatient treatment capped at a certain limit for most migrant workers, many of them are not able to access expensive treatments which require complicated procedures beyond the upper limit. Similarly, for HIV related treatment, it is as important for all member states in ASEAN to consider extending ART and HIV related treatment and diagnostic tests to all migrant workers as a comprehensive measure to reduce HIV transmission and to control the HIV epidemic effectively. For migrant receiving countries in the ASEAN region, notably Thailand, Malaysia, and Singapore, extending more comprehensive health coverage to the migrant workers has risen to the agenda with migrant workers being one of the worst hit populations for Covid-19 infection.[cxii] [cxiii] Integrating migrant workers to either the national health insurance scheme or creating a separate social health insurance scheme specifically for them will be a laudable move to realising the ultimate vision of UHC for all without discrimination of nationality.

vii. Establish social contracting mechanisms for CBOs

A contracting mechanism that establishes agreement and protocol for sustained domestic investment from the governments to these CBOs will enable them to provide essential support to the key populations in both HIV prevention and control. Realising this will require commitment and co-operation from both governments and the CBOs. Governments should see CBOs as equal partners in HIV prevention and control, allocate resources to support their operations, and put in place a clear and strong

accountability mechanism for bidding, contracting, monitoring and evaluation to ensure that public funds allocated to CBOs are spent wisely.[cxiv]

Implications for Practices for CBOs and Healthcare Providers

i. Promote integrated care services for people living with HIV and key populations

Even though efforts and commitments in HIV prevention and control have increased substantially over the years, there remain gaps in HIV service provision in the current health system. Providers of care and support services for people living with HIV need to focus beyond physical and observable symptoms and consider providing a more holistic care service that integrates physical health and mental health interventions as essential health service components for people living with HIV and key populations. Beyond HIV testing and treatment, attention should be given to manage other co-morbidities, particularly their mental health conditions. As such, an integrated care service that combines medical intervention alongside psychosocial and spiritual interventions should be developed over time as part of the continuous initiatives to strengthen service delivery.

ii. Pilot empowerment-oriented community-based interventions

In some low- and middle-income countries, community-based interventions that target marginalised key populations living with HIV to facilitate treatment access need to be aligned with other social agendas such as economic empowerment. A notable example from the region is KHANA Cambodia. One of the goals of KHANA Cambodia at the initial years of its establishment was to implement activities that were directed at income generation as means of economic empowerment for people living with HIV. The organisation directly addressed the socioeconomic impacts of HIV and AIDS by providing small grants to either individuals or households, so that they could start or strengthen small agricultural enterprises to generate sufficient income.[cxv] [cxvi]

iii. Expand digital health services

Digital health technology such as new media technologies and smart phone applications can be harnessed to facilitate health promotion and disease prevention such as HIV treatment for people living with HIV and HIV prevention for people at risk of contracting HIV.[cxvii] Increasingly, smartphone applications such as mhealth and e-health interventions have been created to provide HIV-related psychoeducation and HIV care support through online interactions with case managers or peer educators.[cxviii] Some examples of successful digital health interventions in the ASEAN region include Malaysia's JOM Test and APCOM Foundation's TestBKK campaign in Thailand, where the use of online platforms for the promotion and distribution of HIV testing have seen success among populations at risk of acquiring HIV.[cxix][cxx]

iv. Embrace data-driven and evidence-based advocacy and interventions

CBOs and healthcare providers should embrace data-driven research, and wherever possible, encourage evidence-based research in program evaluation, service improvement, and strategic thinking in their service provisions and advocacy efforts. Evidence-based interventions such as impact evaluations, cost-effectiveness or cost-benefit analyses of interventions are critical to establish grounds for advocacy, including persuading the government to play a bigger role in terms of testing, scaling up PrEP and expanding other HIV related services that would enable a country to reap substantial population-level health benefits.

v. Strengthen operational capacity and build trust

In order to appeal for more domestic investments to fund its operational activities, CBOs need to strengthen their capacity in operations and signal strong management skills, financial accountability, and analytical ability to monitor and evaluate the funds allocated to them by the governments. Beyond effective programme implementation, continuous capacity-building in governance of funds, strategic planning, research and reporting will help to build governments' trust in them to continue serving at the frontline to provide essential services for people living with HIV and key populations. The ongoing Covid-19 pandemic has brought UHC to the front and centre of the governments' agenda. To prepare for future public health emergencies such as this pandemic, health system strengthening must be a key political agenda in the post Covid-19 endemic phase. Almost every government realises the need to strengthen the health system particularly at the primary health level, as far as pandemic prevention and control are concerned. The disruptions that the Covid-19 pandemic has brought to almost every country in the world is a wake-up call to the need to strengthen primary health care and scale-up disease surveillance and prevention at the community-level. The same tenet should be applied to HIV/AIDS prevention and control as well, especially in countries that are still witnessing substantial heterogeneity in health coverage in which access to health services remain challenging for populations living in geographically challenged terrains.

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