

Meeting Report

Biregional Meeting on the Dissemination and Roll-out of the WHO 2014 Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations



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Manila, Philippines



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**BIREGIONAL MEETING ON THE DISSEMINATION AND ROLL-OUT OF
THE WHO 2014 CONSOLIDATED GUIDELINES ON HIV PREVENTION,
DIAGNOSIS, TREATMENT AND CARE FOR KEY POPULATIONS**

26-27 November 2014

Manila, Philippines

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NOTE

The views expressed in this report are those of the participants who attended the Biregional Meeting on the Dissemination and Roll-Out of the WHO 2014 Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations and do not necessarily reflect the policies of the World Health Organization and the Joint United Nations Programme on HIV/AIDS (including its Regional Support Team for Asia and the Pacific).

This report was prepared by the World Health Organization regional offices for South-East Asia and the Western Pacific and the Joint United Nations Programme on HIV/AIDS Regional Support Team for Asia and the Pacific for governments of Member States in the regions and for those who participated in the Biregional Meeting on the Dissemination and Roll-Out of the WHO 2014 Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations from 26 to 27 November 2014 in Manila, Philippines.

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Keywords:

Acquired immune deficiency syndrome / Sexually transmitted diseases / HIV infections / AIDS-Related opportunistic Infections – penetration control

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
APCOM	Asia-Pacific Coalition on Male Sexual Health
ART	antiretroviral therapy
ARV	antiretroviral/s
CBO	community-based organization
CSO	civil society organization
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HTC	HIV testing and counselling
ITs	implementation toolkits
KP	key populations
LGBT	lesbian, gay, bisexual and transgender
MMT	methadone maintenance treatment
MSM	men who have sex with men
NGO	nongovernmental organization
NSP	needle and syringe programme
OD	overdose
OST	opioid substitution therapy
PLHIV	people living with HIV
PWUD	people who use drugs
PWID	people who inject drugs
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
RDT	rapid diagnostic testing
SESH	Social Entrepreneurship for Sexual Health
SRH	sexual and reproductive health
SOGI	sexual orientation and gender
STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
TGW	Transgender women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
YKP	young key populations

SUMMARY

In July 2014 the World Health Organization released *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*. This biregional meeting was convened to start a coordinated process for roll-out and implementation of the new guidelines.

In the Asia-Pacific region, the number of new HIV infections has declined since 2001, but has remained constant in the last five years. HIV testing and counselling (HTC) coverage is low among key populations (KP). In 2013, 1.56 million people living with HIV (PLHIV) had access to antiretroviral therapy in the region – a 25% increase from 2012. Still, only a third of PLHIV are accessing lifesaving treatment. Greater collaboration across health, justice, labour, civil society and private sectors is needed to ensure scaled-up access to services for KP.

Participants considered the high dependency on international funds to address KP needs in the context of decreasing HIV programme funding. Examples were shared of countries' activities to improve service delivery for KP. HIV/hepatitis B and C co-infections among KP are common but efforts are underway to strengthen the response. Issues surrounding critical enablers have greater profile and evidence shows that harmful laws fuel the spread of HIV and hinder the public health response. While countries are implementing WHO recommendations, bottlenecks range from lack of policy support to resource constraints. Participants identified gaps in service access for each KP, critical enablers, priority actions and partner agencies to assist KPs.

The media's role was examined to work towards more balanced and sensitive reporting of KP and HIV issues. A stakeholder mapping exercise was conducted. This exercise examined active resisters, active supporters, passive resisters and passive supporters of each KP group, and will be useful in nurturing alliances and harnessing greater support. From the Global Fund's New Funding Model an increased focus on interventions on KP and issues of sustainability, identity rights and gender issues will require greater consideration and should improve the overall response towards addressing the needs of KP in the Asia-Pacific region.

Participants agreed to recommendations on the consolidated guidelines, HIV prevention, harm reduction, HIV testing and counselling, critical enablers and good practices concerning age of consent.

1. INTRODUCTION

The World Health Organization (WHO) released *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* in July 2014. The guidelines bring together and update guidance and recommendations for five key populations (KP): men who have sex with men (MSM); people who inject drugs (PWID); sex workers (SW); people in prisons and other closed settings; and transgender people. The guidelines aim:

- to provide a comprehensive package of evidence-based HIV-related recommendations for all KP;
- to increase awareness of the needs of and issues important to KP;
- to improve access, coverage and uptake of effective and acceptable services; and
- to catalyse greater national and global commitment to adequate funding and services.

The guidelines include a new recommendation to consider PrEP as part of a package of prevention services for MSM. A recommendation is also included on community opioid overdose management, supporting provision of naloxone to people who might witness an overdose and instructing them on its administration. The guidelines reinforce recommendations for people in prisons and other closed settings.

The risk behaviours and vulnerabilities of KP result in disproportionate HIV prevalence. Yet HIV services for key populations remain inadequate. In the Asia-Pacific region, the number of new HIV infections has declined since 2001, but has remained constant in the last five years. HIV testing and counselling (HTC) coverage has remained low among KP. In 2013, 1.56 million people living with HIV (PLHIV) had access to antiretroviral therapy (ART) in the region – a 25% increase from 2012. Still, only a third of PLHIV were accessing lifesaving treatment. Greater collaboration across health, justice, labour, civil society and private sectors is needed to ensure scaled up access to services for KP.

The guidelines provide an important opportunity for Member States:

- to adjust national strategic plans to strengthen HIV surveillance among key populations;
- to refocus HIV prevention on high impact interventions at required scale and quality targeting key populations;
- to adjust HIV prevention and treatment targets;
- to strengthen partnership between stakeholders including affected key populations and PLHIV; and
- to adjust plans for HIV/AIDS funding including for the Global Fund's New Funding Model.

The biregional meeting – organized by the WHO regional offices for South-East Asia and the Western Pacific and the UNAIDS Regional Support Team for Asia and the Pacific – has helped to start a coordinated process for roll-out and implementation of the new guidelines. The meeting was held from 26 to 27 November 2014 at the WHO Regional Office for the Western Pacific in Manila, Philippines. This meeting was part of the joint WHO-UNAIDS operational plan for 2014–2015.

1.1 Objectives

The objectives of the meeting were:

- 1) to review the new 2014 *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*;
- 2) to review country targets, implementation and impact of national HIV/STI strategic plans emphasizing key populations, identifying gaps and lessons learnt;

- 3) to outline targets and actions for early adoption and rollout of the guidelines as part of national HIV/STI strategic plans and the Global Fund's New Funding Model grants in priority countries; and
- 4) to increase media awareness of the urgent need to reduce HIV and other STI among key populations.

1.2 Meeting participants

The meeting was attended by 96 participants from 14 countries, including national HIV/STI programme managers, responsible officers for key population-specific HIV programmes, representatives from nongovernment organizations (NGOs) and community-based organizations (CBOs), UN agencies, other international organizations and academic institutions. Participating countries included Bangladesh, Cambodia, China, India, Indonesia, the Lao People's Democratic Republic, Malaysia, Mongolia, Myanmar, Nepal, Papua New Guinea, the Philippines, Thailand and Viet Nam (the list of participants is available at Annex 2).

1.3 Programme

The two-day meeting included updates on the epidemiology and response to HIV and other sexually transmitted infections among KP in the Asia-Pacific region, an overview of the new guidelines, and panel discussions on the evidence for and relevance of the new recommendations for the Asia-Pacific region, in particular PrEP for MSM and overdose prevention among PWID. Country case studies focused on high impact service delivery for KP. Panel discussions included issues on TB/HIV in closed settings and HIV/Hepatitis B and C co-infections; and critical enablers and structural barriers including punitive laws, stigma and discrimination.

Participants were updated on: the survey feedback from country participants on early adaptation and adoption of the guidelines; survey results on implementing the KP guidelines by MSM and transgender communities; and the development of toolkits at the global and regional levels. During breakout sessions, participants identified concrete actions in line with the continuum cascades of HIV prevention, diagnosis, treatment and care. Challenges in HIV and KP issues were considered. Finally, a panel discussion considered the role of the media in coverage of HIV and KP issues. Short videos were also shown on accessing health-care services for KP, human rights campaigns, sexual orientation and gender identity (SOGI) issues.

1.4 Opening session

Opening remarks on behalf of Shin Young-soo, WHO Regional Director for the Western Pacific, were delivered by Corrine Capuano. Key points included that the vast majority of new HIV infections in the Asia-Pacific region occur among KP; the new guidelines emphasize a "real world" context in which HIV cannot be separated from environmental factors; and the guidelines call for governments and health providers to partner strategically with KP.

Opening remarks on behalf of Steve Kraus, Director of the UNAIDS Regional Support Team for Asia and the Pacific were delivered by Vladanka Andreeva. Key points included that more than 50% of PLHIV are not aware of their HIV status; and implementing and enforcing anti-discrimination and protective laws was crucial to the success of the national HIV response and "ending AIDS" by 2030.

Tracey Tully representing all regional community networks outlined that the motto "nothing about us without us" remains critically important in the HIV/AIDS response.

2. PROCEEDINGS

2.1 Overview of the WHO 2014 consolidated guidelines on HIV and key populations

2.1.1 Epidemiology and response to HIV and other STI among key populations in the Asia-Pacific Region

In the Asia-Pacific region, there are an estimated 4.7 million PLHIV, with 311 000 new HIV infections and 256 000 AIDS-related deaths annually. The HIV epidemic is concentrated among KP, especially in cities. Ongoing discrimination and legal barriers mean KPs are more difficult to reach. New HIV infections have remained constant in the last five years. Prevalence of hepatitis C and HIV and hepatitis C co-infections among PWID remain high in many countries in Asia. ART coverage in the Asia-Pacific region reaches less than 35% of all PLHIV. Awareness of HIV status remains central to HIV prevention, yet HTC coverage has been low among KP in the region. The Asia-Pacific region has the highest number of cases of curable STIs (estimated 67.4 million in 2008), with a high prevalence of syphilis among SW and MSM. Innovative models are needed to increase case detection in key locations and populations. Early treatment can prevent HIV transmission and deaths.

Legal barriers to the HIV response remain in at least 38 Member States in the Asia-Pacific region (such as criminalizing some aspects of sex work and same-sex activity). Since 2010 law reform progress includes legal recognition of transgender people in some countries. About half of AIDS spending was on care and treatment, mostly from domestic sources. Domestic funding was inadequate for KP prevention programmes, with spending on KP heavily dependent on international sources (slightly over 20% of funds were domestically sourced). To accelerate progress and end the epidemic, new fast-track targets for the post-2015 era are:

- Reach 90-90-90 by 2020 (90% of PLHIV knowing their HIV status, 90% of people who know their status receiving treatment and 90% of people on HIV treatment having a suppressed viral load so their immune system remains strong and they are no longer infectious)
- 95-95-95 by 2030
- Reduce new infections to 500 000 per year by 2020; 200 000 by 2030
- Zero discrimination
- Various strategic actions include implementing innovations, increasing focus, wise investments, and a human rights-based approach to address the needs of KP.

2.1.2 Highlights of the guidelines

As more than 40% of new HIV infections occur among KP it will be impossible to "End AIDS" without addressing the needs of KP, specifically:

- reducing HIV risk and vulnerability in all settings (Box 1);
- increasing access to critical services; and
- reducing stigma and discrimination, and punitive legal environment

Box 1: Increased HIV risk and vulnerability among key populations was found in all settings	
Compared to the general population, global HIV prevalence is:	49 times greater among transgender women
	20 times greater among people who inject drugs and sex workers
	13 times greater in urban areas among men who have sex with men
	5 times greater among people in prison

Most KP continues to face punitive and oppressive laws and policies, underpinned by stigma and discrimination. The guidelines include a new focus on pre-exposure prophylaxis (PrEP); and community-based distribution of naloxone. The guidelines also discuss HIV and contraception; and

drug interactions. Research shows that PrEP is safe if taken as prescribed. PrEP has been recommended for MSM as an additional HIV prevention choice within a comprehensive prevention package. The guidelines group did not recommend PrEP for PWID at this time taking into consideration the values and preferences of communities and networks and that existing HIV prevention interventions are highly acceptable, efficacious, cost-effective and have a broader impact on health beyond HIV prevention.

Opioid overdose was a leading cause of death for PLHIV who inject drugs. There was increased attention for an appropriate response and a key recommendation was that people likely to witness an overdose should have access to naloxone and be instructed in its administration for the emergency management of suspected opioid overdose.

Critical enablers were of equal importance to clinical recommendations and service delivery approaches to respond to the needs of KP. The critical enablers for KP included: laws and policies; reduced stigma and discrimination; community empowerment; and reduced violence.

Four policy technical briefs for KP were available in draft form and were undergoing final revisions at the time of writing. Revision and update to the guidelines will be ongoing as new evidence and experiences emerge. The guidelines should be a trigger for change. Partnerships are critical and community organizations need to be assisted to implement activities in partnership with health ministries and other government entities.

2.1.3 Community comments

The guidelines recognize the specific needs of transgender communities. However the broader health and psychosocial needs of transgender people require further strengthening. Guidance is required on: service packages at primary, secondary and tertiary health facilities and systematic training of health professionals to provide services that are sensitive towards transgender people's needs. PrEP needs to be for both transgender men and women and access to violence prevention is needed for all transgender people.

Transition hormone therapy and gender enhancement needs to be improved. This is important for identity issues. Psychotherapy counselling should be available for transgender people and their families. Transgender-specific policies need to be a part of national HIV programmes. Transgender communities welcome partnerships with WHO, UNAIDS and governments. It is important to highlight that "trans rights are human rights".

2.1.4 Panel discussion on PrEP

Panellists commented on the evidence and relevance of PrEP to the Asia-Pacific region from scientific and community (feasibility, availability and acceptability) perspectives. When considering the relevance of PrEP for MSM and transgender people in the region, the continuing high HIV prevalence and incidence in these populations show that PrEP can reverse the rate of new infections. Evidence of Truvada PrEP shows a crude efficacy of 44% among MSM in the IPrEx study, but among those who had detectable study drug levels, the risk for HIV infection declined by 92%. Ancillary pharmacokinetic modelling and animal studies have shown that daily intake of these agents was not needed for strong protection. Three doses a week provided nearly complete protection (two doses per week reduced HIV risk by 76% and four doses by 96%). Safety and efficacy of emtricitabine (FTC)/ tenofovir (TDF) in preventing HIV infection in MSM was firmly established but PrEP safety and efficacy among transgender women (TGW) was lacking. Generalizing results from MSM to TGW is without a scientific basis, given the different bio-physiological and risk behavioural profiles of these two groups. Although the IPrEX study was nominally conducted in both MSM and TGW, only 19 participants (1%) were TGW. These participants needed to behave like MSM to be eligible. For TGW we "need to go back to the beginning" of research with pre-clinical and Phase I

studies to earn this population a place in the international HIV PrEP and treatment guidelines. PrEP demonstration projects and studies among MSM were concentrated in North America. Countries in the Asia-Pacific region should also do demonstration projects and ensure TGW are studied separately.

Treatment as prevention will not be able to achieve complete epidemic control. The treatment cascade is a clear and helpful model but it does not include prevention. If we want to stop the HIV epidemic we need to add an HIV prevention cascade, and connect the two cascades to produce better results. Infected people need to be part of a health-care system for treatment. Uninfected people need to receive preventive health services and be monitored on a regular basis. The treatment and the prevention cascades need to be complementary and integrated.

The Asia-Pacific Coalition on Male Sexual Health (APCOM) as a key partner on HIV and MSM. APCOM were part of the guidelines roll-out at the 20th International AIDS Conference and were consulted during the guidelines' development. PrEP is a tool to reduce the spread of HIV among communities, but is not widely understood by communities. MSM communities want to be part of the process of exploring PrEP, starting with regional discussion followed by country level roll out. Targeted messages on PrEP and innovative programmes can link MSM with this prevention work.

Discussion

The participants welcome the inclusion of youth (by addressing the power imbalance in sexual relationships that limit the ability to use condoms by young people from KP) and PrEP in the guidelines. However, how will PrEP be introduced for youth while 40% of young people on ART are not adherent? and how can PrEP be effective if adherence for ART is low? PrEP can only be as good as the level of accessibility and availability. PrEP, condoms, lubes and sexual health education should be integrated.

PrEP will not prevent STIs or Hepatitis B and C. PrEP does not undermine condom programmes and increased condom use among PrEP patients was shown. PrEP can be tailored more to an individual's life: it can be taken over a period of time but not essentially for a lifetime, unlike those that are HIV infected. The focus is not just on distributing pills as we need to support the critical enablers. Restrictions to services for people under 18 should be revisited. WHO recommendations in the guidelines do not have age restrictions. While there are conditional recommendations for PrEP for transgender people, more research is needed.

2.1.5 Panel discussion: Overdose prevention for people who inject drugs

Panelists commented on evidence and relevance of the recommendation, and comment from civil society Overdose (OD) is the second most common cause of death among illicit drug users (after HIV). Up to 75% of OD (mostly accidental) takes place in the presence of someone else. OD is easily treatable with naloxone and basic life support. Naloxone is effective when delivered by intravenous, intramuscular, subcutaneous and intranasal routes of administration. People using naloxone should select a route of administration based on the formulation available, their skills in administration, the setting and local context. The guidelines recommend that people likely to witness an overdose should have access to naloxone and be instructed in its use for emergency suspected opioid overdose. Those at higher risk of opioid overdose include people who inject opioids, people who use opioids in combination with other sedating substances, and recently released prisoners. In November 2014 WHO released guidelines on *Community management of opioid overdose*.

A short film [Naloxone administration is child's play](#) was screened highlighting that with training, people can easily administer naloxone. Throughout Asia the administration of medicines via an injection often remains restricted to clinicians. This becomes a major challenge for those witnessing an OD along with issues of accessibility, availability and affordability of naloxone. Naloxone is inexpensive but can be prohibitively expensive for those most in need.

Funding for naloxone is often inadequate in national programmes when not budgeted for. When naloxone is not available at its usual price there is a tendency for excessive pricing and emergence of a black market. This issue needs to be examined by national drug control authorities in Member States. The Asian Network of People Who Use Drugs (ANPUD) recently discussed issues of price, shortage and high demand. In Manipur, India, the training response was largely driven by the NGO sector. NGOs needed to devise innovative strategies and systems with volunteers to manage ODs. Funds were often raised by the community and NGOs. The legality of administration of naloxone needs to be addressed and WHO and the wider UN family need to advocate more on this issue.

Participants raised the following issues during discussion:

- In Malaysia, OD was in the curriculum of outreach training programmes but still the roll-out of naloxone was a challenge.
- Throughout the region greater clarity was required as to who should manage OD programming as it was often not the national or local HIV programmes. A discussion at country level regarding who “owns” the programme would be useful.
- Despite naloxone being cheap and easy to store the issue of procurement remains a challenge.
- Many small-scale projects run by NGOs struggle with procurement. WHO needs to encourage countries to make naloxone more available.
- Training people in OD management was achievable and pilot studies in China produced good results, yet naloxone often requires a prescription.
- The Indonesian Government requested removal of naloxone from training videos due to non-availability of the medicine. In Indonesia data of fatal or non-fatal OD was rare and responding without evidence makes the task challenging.

2.2 High impact service delivery for key populations (achieving 90-90-90 targets)

2.2.1 Focus, Focus, Focus: Prioritizing interventions for key populations, Cambodia

Government estimations of KP and HIV prevalence show HIV prevalence is highest among PWID at 24.8%. Two major emerging challenges are decreasing HIV programme funds and the need to prioritize activities. Data was presented on HIV prevalence surveys and outreach with HTC. Outreach with HTC may be covering relatively low-risk KP and missing priority communities. There was a need to do more with less: lower the costs but still ensure high impact through more focused and streamlined activities, and to integrate the strategy for KP. The strategy for “entertainment workers”, transgender people and MSM was to look at operational districts, venues/hotspots and individuals for HIV infection. With operational districts the new approach would be:

- High priority operational districts: Intensified and streamlined services
- Intermediate priority operational districts: Streamlined services
- Low priority operational districts: surveillance, monitoring and minimum service

Interventions for PWID would require a scaled up coverage of needle and syringe programmes (NSP) with low cost. The country needs to streamline existing outreach programmes with frequency and intensity of outreach in addition to proposing alternative/innovative approaches such as secondary distributors, collaboration with pharmacies, street vendors, and fixed boxes. Creation of mini-drop in centres may need to be considered.

2.2.2 Cascade of continuum of HIV prevention, treatment, care and support, Indonesia

While encouraging signs are observed in some areas, the HIV epidemic in Indonesia is growing. HIV remains a problem for PWID, however the epidemic has shifted from injection to sexual transmission. The rapid increase in new infections among MSM is also a concern. Access to

treatment is increasing with over 45 000 PLHIV receiving ART. However this represents only 23% of those estimated to require treatment. The cascade of HIV care in Indonesia also faces the challenge of better retaining those starting treatment.

The government has substantially expanded HIV testing, focusing on priority areas and KP, to increase access to treatment. A test and treat policy is being introduced. This policy will benefit priority KP (including prison inmates) and other groups such as sero-discordant couples, pregnant women and TB/HIV and hepatitis B/HIV co-infected patients. Through these policies Indonesia hopes to rapidly expand access to ART, bridge the treatment gap and reduce morbidity and mortality particularly among KP, and optimise the prevention impact of ARV. Box 2 outlines keys for success, challenges and opportunities in HIV prevention programmes in Indonesia.

Box 2. Key for success in HIV prevention programmes in Indonesia

Partners in the HIV response in Indonesia understand that community involvement is necessary in outreach prevention programmes. Community involvement can increase HTC among KPs and improve treatment adherence among people who are HIV positive. Challenges include that in a decentralized system, central government policies require buy-in at the district level to achieve better outcomes. Misperceptions among KP about the benefits of testing and early treatment remain. Ambitious targets for HTC and treatment require substantial investment. Opportunities include ongoing high level political commitment and the adoption of universal health coverage.

2.2.3 Getting to 90-90-90 in Viet Nam

The estimated number of PLHIV in Viet Nam was 254 068 in 2013. The epidemic remains concentrated, primarily driven by PWID. However, nationally HIV prevalence among PWID is declining: in 2001 it was 30% decreasing to 10.3% in 2013. Key challenges include low coverage of HTC and ART; lack of linkages between prevention and treatment; lack of collaboration between community service organizations (CSOs) and other stakeholders; and limited resources. Viet Nam has set ambitious targets by 2020:

- 90% of all PLHIV will know their status. To achieve this HTC uptake will be increased by simplifying and decentralizing services, and adopting innovations such as promoting mobile outreach testing to remote areas.
- 90% of all people with diagnosed HIV infection will receive sustained ART. To achieve this access to services will be increased through decentralized primary health-care facilities.
- 90% of all people receiving ART will have viral suppression. One approach will be to promote adherence and retention among those on ART by linking PWID to methadone programmes which promote ART adherence.

2.2.4 Innovative approaches for HIV testing in China

In China HIV infections among MSM are increasing but lifetime HIV testing rates are low (40–50%). To increase HTC, the Social Entrepreneurship for Sexual Health (SESH) team is investigating innovative models such as crowdsourcing and social marketing. The crowdsourcing approach utilizes the Internet to mobilize stakeholders to achieve a specific task. As a tool it increases community engagement and empowers KP. SESH held an open contest for Chinese MSM CBOs to submit HIV testing promotion videos; seven videos were submitted and three were selected as finalists. A randomized controlled trial was conducted using a nationwide online cross-sectional survey among MSM and transgender people who have never been tested for HIV (N=721). Outcomes were positive and found crowdsourcing assisted with public health awareness (stakeholder engagement, more ideas and products, cost effectiveness, and more effective campaigns), engaging

stakeholders from different sectors. Crowdsourcing can be used with a wide variety of populations and health needs.

2.2.5 Discussion on country presentations

Participants raised the following issues in response to country presentations:

- We need to better understand how to mobilize communities (MSM/transgender people), apart from using the drop-in centre.
- Communities need to be more integrated into the cascade approach.
- We need to understand that simply marketing PrEP as a magic bullet for MSM and transgender people will be problematic.
- We still need to focus on human rights issues as this has a major impact on our communities. It is not about saving our lives but more about how and why our lives are worth saving.
- Our main goal is to find, test, treat and retain but we still struggle. Community-led testing is good but problems of quality assurance persist. Ongoing training and focusing on quality and confidentiality issues can improve community-led testing.
- Universal access in Thailand is good but still not reaching out to MSM. Our systems remain too passive and do not generate demand for testing. How do we change this approach? Demand generation needs to be well-funded and countries need to make it a priority.
- Perception of HIV interventions has increased among the transgender community.
- We request WHO to assist with protocols and provide direction for all KP.

2.3 Co-infections

2.3.1 TB/HIV co-infections among people in prisons and closed settings

TB and HIV affect people confined in high risk environments of prisons where there is often over-crowding, poor nutrition, injection drug use and unprotected sex. Data from prisons show high concentration of TB. TB and TB-HIV services in prisons should include policy and coordination, treatment and patient support, and drugs and supplies. Policy and coordination among different ministries is a critical prerequisite for better outcomes for TB/HIV co-infection control in prisons. Challenges exist but progress in TB control in prisons is possible and can bring about beneficial health outcomes.

2.3.2 HIV/Hepatitis B and C co-infections among key populations

It is estimated that 240 million people worldwide carry HBsAg (6–26% of all people with HIV are co-infected with HBV), 80–140 million people worldwide are HCV infected (25–30% of PLHIV are co-infected with HCV) and 72–95% of PWID with HIV are co-infected with HCV. It is estimated that 10 million PWID are exposed to HCV (in 77 countries) and an estimated 6.4 million PWID have been exposed to HBV (in 59 countries). There are many overlapping transmission and hepatitis disease progression risks among KP, including harmful alcohol use. While there are no new hepatitis-related recommendations in the guidelines, key harm reduction hepatitis prevention interventions, including low dead space NSP and peer programmes, are strongly recommended.

The viral hepatitis treatment continuum includes testing, staging and treatment. Staging liver disease in hepatitis B and C infection is important to prioritize patients with advanced liver disease or treatment, given limited resources in many countries. In April 2014 WHO released *Guidelines for the Screening, Care and Treatment of Persons with Hepatitis C Infection*. The guidelines provide specific recommendations for KP. HCV infection does not alter the indication for ART. For HBV, immediate initiation of ART is indicated in HBV HIV co-infected individuals with severe liver disease (cirrhosis) regardless of CD4 count. The World Health Assembly Resolution 67.6 in 2014 called for a comprehensive approach for advocacy, surveillance, prevention and management of viral hepatitis.

Lessons learnt from HIV will be used in the public health approach to viral hepatitis to be outlined in a regional hepatitis action plan in 2015.

2.4 Critical enablers and structural barriers

The guidelines have strong recommendations on critical enablers: law and policies; reduced stigma and discrimination; community empowerment and reduced violence against KP. Structural barriers include punitive laws, legal barriers, and stigma and discrimination that hinder access to services (including ARV treatment). Evidence from the Global Commission on HIV and the Law shows that bad laws fuel the spread of HIV and limit the public health response. New infections could be halved by 2030 with the removal of legal barriers. The Global Commission on HIV and the Law has issued a series of recommendations that focus on creating enabling legal environments. Country partners can look to these for analysis of the evidence and detailed recommendations. The WHO guidelines strengthen recommendations from other actors on the importance of addressing legal and social issues as part of effective responses to HIV/AIDS among KP.

Community empowerment through incremental changes is key to challenging stigma and discrimination. Empowered communities are healthy communities. In the Asia-Pacific region there is much variance on status and gaps of critical enablers. The health sector can take the lead but requires a multisectoral approach to achieve law reform, law enforcement and access to justice. Efforts towards good outcomes and impacts in recent years should continue.

Much has been done in the region to build political will to address punitive legal environments impacting on KP. National reviews and multisectoral consultations on legal and policy barriers to HIV service access for PLHIV and KP have been rolled out in 19 countries since 2011. National action plans for eliminating legal and policy barriers for PLHIV and KP by 2015 have been developed through participatory processes. Sharing good practices between different agencies and countries is a positive move. The regional approach to enhancing legal environments is often an effective complement to national approaches.

Stigma and discrimination is a key barrier for KP uptake of services. Legislative change is one tool among many. The involvement of national human rights commissions in documenting and responding to rights violations in health-care settings or on issues involving the police has been promising in assisting KP to seek justice. Engaging health-care providers on KP issues is also critical. Box 3 shows examples from the Philippines. KP communities need to be part of the processes at all steps and documentation of community voices remains critically important. The Global Fund strategy focuses on human rights, gender and sexual orientation and gender identity (SOGI), and is a strong signal of the availability for strategic programmes around critical enablers. The Global Fund New Funding Model national grants have announced that social and human rights interventions that focus on KP should not be ignored in favour of medical interventions. However, governments must not leave funding of critical enablers to the international community.

Box 3 Engaging partners to address key population issues in the Philippines

In Quezon City in the Philippines protective ordinances for lesbian, gay, bisexual and transgender (LGBT) communities were initiated in 2012 with an ordinance creating a Centre for violence against women and children, including LGBT. The Centre is a one-stop shop in a local government hospital where health, legal and counselling services are provided for victims of violence.

An MSM-specific health service was also established in response to a rise in HIV infections and to provide a stigma-free service. Recruitment of MSM peer educators has also helped to increase coverage of HTC among MSM. Political support and community leadership were crucial to enacting protective laws and removing policy barriers.

The Philippines Dangerous Drugs Board (DDB) is a multisectoral body of 17 members from health, justice, law enforcement and other sectors. The DDB advances understanding and progress in addressing structural barriers, such as the law that prohibits possession of drug use paraphernalia. This has been problematic with a significant HIV epidemic among PWID in some areas of the Philippines. The DDB has relaxed this law for activities carried out as part of a scientific pilot study. The study's findings can then be used to lobby for amendment of laws to allow full scale roll-out of harm reduction programmes.

Legislative change can take years. Through dialogue, initiatives and engagement with law enforcement positive responses to address the health needs of KP were achieved in an environment of legal constraints. However, sustainability needed to be considered. Political leadership changes can result in policy changes. Engaging KP in meaningful ways will always remain important. Having good laws in place is not a guarantee to resolving issues. Other barriers such as affording legal fees to seek justice still remain. A more holistic perspective to critical enablers will be required to address the needs of KP.

Discussion points raised by participants:

- International patent laws were not reflected in guidelines. WHO needs to discuss how to strengthen international patent laws.
- Much data is hidden and unused. Knowing how to access data would strengthen the response and improve our understanding of the situation.
- Trainings and more inclusive services to address KP needs are required. Working closely with nurses can be explored as nurses play a key role in health services.
- Policy changes often do not reach the community level. Without political will barriers for change will remain.
- Programmes for collaborations between law enforcement and health do not exist or are often inadequate.
- PWID cannot receive health insurance under universal health coverage in some countries.
- Budget for critical enablers receives less priority or is sometimes not allocated at all.

2.5 Early adoption and roll-out of the guidelines

2.5.1 Presentation of short survey feedback from participants

Twelve countries out of 14 responded to the survey. Box 4 provides a brief summary of the status of WHO recommendations. Three countries had initiated revision of national guidelines. In 10 countries services delivery was mostly done in partnership with KP, CBOs and NGOs. Lay providers have been utilized for condom promotion and harm reduction in nine countries. Bottlenecks include a lack of policy support and resource constraints. One country has not seen the new guidelines. General comments on recommendations included the need law and policy reviews as drug use, sex work, and same-sex activity is illegal in most countries in the region.

Box 4. WHO recommendations included in national guidelines

- Condom programme: implemented by most (10 countries)
- PrEP for MSM (new recommendation): *not* implemented by most (11 countries)*
- PrEP for sero-discordant couples: *not* implemented by most (9 countries)*
- NSP: implemented by most (10 countries)
- Opioid Substitution Therapy (OST): implemented by most (9 countries)
- Naloxone (new recommendation): implemented by 6, not yet by 5; not applicable (N/A) for 1 *
- Mental health: *not* implemented by most (7 countries)
- Cervical cancer screening: 5 Yes, 6 No, 1 not applicable

*These are new recommendations and may explain the low implementation rate.

2.5.2 Presentation of community survey results by APCOM

APCOM has produced a range of summary documents for MSM and transgender communities. A survey was undertaken to gather the response of the community to the new guidelines. There was agreement with most recommendations with wide support for community-based and community-led delivery of services. Some of the more difficult interventions to implement include PrEP, changes in punitive or discriminatory laws, and reporting incidents of stigma and discrimination. Interventions not covered in the guidelines include issues of trans-men's health and services, and possibilities of funding small CBOs to help strengthen community capacity to access services.

2.5.3 Introduction of the implementation toolkits in process

Four toolkits are in development to support implementation of the guidelines:

- 1) Sex Workers Implementation Tool (SWIT);
- 2) MSM Implementation Tool (MSMIT);
- 3) Transgender Implementation Tool (TRANSIT); and
- 4) Drug user Implementation Tool (DUIT).

These toolkits are products of collaboration between KP agencies and networks, WHO, UNAIDS, other UN organizations and international NGOs. The SWIT was completed in 2013. The other toolkits will be released in 2015. The UNAIDS-supported LINKAGES project managed by FHI 360 is drafting a cascade toolkit and will seek inputs in 2015. The toolkit will examine issues of reach, test and re-test, and treat since loss to follow up remains unacceptably high globally. Discussion included:

- Operationalizing guidelines requires more attention. Tools need piloting as variation may be seen during implementation. Direct community involvement can assist in the process.
- Need to improve documentation for stigma issues to improve the response.
- UNAIDS Indonesia has developed indicators to monitor and report on discrimination against KP in health settings.
- Creation of toolkits specific to young people from KP and those in prison would be useful.
- Need to monitor toolkit implementation.
- Need to re-think the cascade, especially keeping people in the prevention cascade.
- Stock-outs of ART occur at community level and how communities can voice their issues requires improvement.
- Tools developed by the India HIV Avahan programme (Bill & Melinda Gates Foundation) almost 10 years ago required to be tailored by each state within India due to diversity of KP and geographical and socio-cultural diversity. FHI 360 should consider lessons from this experience.

2.6 Group work: identifying gaps/opportunities in service delivery

Participants were divided into groups according to KP for a 90-minute discussion:

- to assess key issues and challenges (package of services, capacities of service providers and the critical enablers) for existing and new recommendations;
- to suggest concrete action items to address gaps identified, reflecting achievable targets and practical milestone indicators; and
- to suggest responsible agency/organization for each action point.

Each group provided a summary of their findings, available at Annex 3.

Participants raised the following issues:

- Legal barriers are an issue for all KP. There are overlapping risks for example, SW that also inject drugs or transgender people that may also be involved in sex work.
- Social protection mechanisms are not always available for KP which often results in their exclusion.
- Many young people do not feel comfortable to seek services: they may not be treated with kindness, or the prevailing laws regarding age of consent may result in their exclusion from services.
- Many prisons reflect a lack of political commitment in addressing the needs of prisoners. There was a greater need for more evidence of the situation inside prisons to generate a response from authorities and legislators.
- Curriculum for law enforcement has been developed in Cambodia and will be taken over by the police academy. This will assist the police to be sensitized to the needs of PWID.
- Representations from prisoners was lacking and it would be useful to have all KP involved in discussion over the issues surrounding prison settings.
- No compulsory treatment centres were supported by any UN agency.

2.7 Media partnerships/advocacy

2.7.1 Overview on challenges in media coverage of HIV and key population issues

Media coverage should be objective, fair and balanced. However, journalists can also reflect wider society and display unintended bias, prejudice, stigma, discrimination. This can increase when covering issues related to HIV and KP. Journalists specialized in health issues are increasingly rare. This can result in inaccurate or negative reporting. Many stories over simplify or report incorrect information, contributing to misinformation. However there are also many positive stories in the media highlighting sensitivity and understanding.

2.7.2 Panel discussion: role of media when covering sensitive issues and critical enablers

Meeting with the media is an opportunity to share informed messages with a wider audience. Media representatives should be encouraged to realize and communicate that PLHIV can have productive roles in society.

INERELA+ is a network of faith leaders on HIV. The network started with 12 religious leaders in Africa, many of whom were HIV positive. They now have centres and members around the world. Stigma and discrimination remains a key area of focus, including productive dialogue and interaction with the media to improve messages about HIV.

Asia Network for People Who Inject Drugs invites journalists to see the work they do with communities. The Network aims to benefit PWID and the general community. Positive factual messages have started to be conveyed by the media. They are now a phone call away.

ICS (LGBT community human rights organization, Viet Nam) works for wider LGBT empowerment and advocacy, which includes HIV. ICS has worked with the media, explaining issues and over time ICS has created demand from the media to visit the organization requesting community insights. ICS has become a useful source of information for the media. ICS has also joined the media in creating stories and broadcasting via social media.

In the early days, Aastha Parivaar Network of Sex Worker CBOs (India) was careful with the media when they were seeking information. Now the community works closer with journalists and over time the journalists are using more appropriate language, feature people appropriately and know what to say and not to say about PLHIV. The media are now better informed and sensitized most of the time. Communicating and talking about a success story that touches the readers is important for the media. Positive change has occurred in the last 10 years.

Discussion points by other participants included:

- The India HIV/AIDS Alliance noted that consistent reporting on sexual minorities is absent. Turnover of media personnel is high. Local media reporting is often sensationalized. Some media learn to be sensitive but often do not know how to report and unintentionally use the wrong terms. Now we have learnt to list down for ourselves ahead of interacting with the media what needs to be reported and not to be reported, as well as how to report. The media are vital and we require media champions as our allies.
- Bandhu Social Welfare Society (Bangladesh) has developed guidelines on how to work with the media. They have been offering media fellowships since 2010 and the response is huge. Selected fellows work 3–4 months with Bandhu to understand the issues. Focal points from Bandhu are assigned to help them. The media fellows need to produce news articles which are shared with Bandhu for their consent ahead of publication.
- One Nepalese participant living with HIV for 18 years and taking ART for 11 years commented that the media should take on the issues of women and HIV globally. Most HIV positive women in Nepal are spouses of migrant workers who get infected when working abroad. Media play a vital role in highlighting issues faced by women living with HIV.

2.7.3 Group work: stakeholder mapping

This activity aimed to identify: (1) active resisters (blockers); (2) champions (active supporters); (3) avoiders (passive resisters); and (4) silent boosters (passive supporters). The exercise helped participants consider strategies among potential audiences and stakeholders, to improve the structure of communications/advocacy. Many stakeholders and potential audiences fit in more than one box (mapping results are available at Annex 4).

The session concluded that media can play an active supporting or blocking role, and are able to work in tandem with other stakeholders. WHO regional offices for the Western Pacific and South-East Asia agreed to chart a communications plan to be tailored to the country level through media/communication workshops and training. Inadequate attention and investment has been made on media and communication in the HIV response especially for KP issues.

2.8 Sustainable response among key populations in the Asia-Pacific region

This session comprised overviews from India, Malaysia and the Global Fund followed by an open discussion.

India

Aastha Parivaar started in 2004 as a federation of CBOs representing SW and transgender people. The federation involves 13 CBOs and comprises 30 000 members. Their activities include HIV intervention, police advocacy, alternative livelihoods and children's education. A community driven and community managed rapid response system for SW in crisis has been established. Sustainability and alternative sources of funds are being explored.

Malaysia

Malaysia has implemented various initiatives to tackle its HIV epidemic and shown a growing political commitment to implement a range of harm reduction interventions to address HIV among PWID. Strategies include expansion of NSP and OST programme. In 2006 there were 17 methadone maintenance treatment (MMT) facilities and by June 2014 there were 449. As of June 2014 there were 79 537 registered NSP clients, and 68 515 for MMT (retention rate – 84.1%). A significant decrease of new HIV cases among PWID was shown over the years. The funding response to HIV is mostly domestically sourced.

Global Fund

Asia signed Global Fund proposals correspond to 23% of Global Fund funding (for the HIV response from 2002 until mid-2014 this amounted to US\$ 5.4 billion). The Technical Review Panel at the Global Fund identified lessons from concept notes including: prioritize interventions for greatest impact; focus interventions on KP and areas with highest burden; ensure programming is strong to address rights and gender issues that have been identified in concept notes; focus on sustainability and strengthen sustainability through more deliberate transition planning. Issues of sustainability and the development continuum were outlined; for example, under the Global Fund's New Funding Model the level of government contribution to the disease response has been considered in the allocation under the current replenishment period. The Global Fund Secretariat ensures coordination and knowledge-sharing between different work streams focusing on sustainability.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

A combination of interventions is required to respond to HIV among KP across the Asia-Pacific region. A comprehensive package of interventions recommended by WHO comprises two parts:

Part 1: Essential health sector interventions

- 1) Comprehensive condom and lubricant programming
- 2) Harm reduction interventions for substance use (in particular needle and syringe programmes and opioid substitution therapy)

- 3) Behavioural interventions
- 4) Voluntary HIV testing and counselling
- 5) HIV treatment and care
- 6) Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions
- 7) Sexual and reproductive health interventions

Part 2: Essential strategies for an enabling environment

- 1) Supportive legislation, policy and financial commitment, including decriminalization of certain behaviours of key populations
- 2) Addressing stigma and discrimination, including by making health services available, accessible and acceptable, and by partnering strategically with media to ensure and strengthen accurate coverage of HIV and key population issues
- 3) Community empowerment
- 4) Addressing violence against people from key populations.

3.2 Recommendations

3.2.1 The consolidated guidelines

- 1) Member States in the Asia-Pacific region are encouraged to adapt and adopt the guidelines, reviewing and revising national guidelines with KP participation and technical assistance from various agencies as needed.
- 2) WHO, UNAIDS and partners should support Member States to develop prevention cascade to supplement the treatment cascade in order to monitor access to services (including mental health services) for KP.
- 3) Member States are encouraged to explore ways to mobilize national funds to prevent and treat HIV, hepatitis (B and C) and other sexual reproductive health challenges for KP (e.g. more efficient use of available funds; strategic reallocation of resources; innovation in service delivery models; and partnering with local NGOs and CBOs for service delivery).
- 4) The distinct needs and issues of transgender people, distinct from MSM, require transgender-specific programme interventions, as well as monitoring and evaluation, in the HIV response.
- 5) Countries are encouraged to collect comprehensive data on transgender people, given the high HIV vulnerability that has been identified for this KP based on available data.

3.2.2 HIV Prevention

Among MSM, pre-exposure prophylaxis (PrEP) is recommended as an additional choice within a comprehensive HIV prevention package (new recommendation).

- 1) Pilot surveys and demonstration projects on PrEP should be urgently undertaken in countries with high HIV prevalence among MSM.
- 2) Formative research with careful monitoring and implementation on PrEP specific to transgender people is needed as there is little information about PrEP use for this KP.
- 3) Prevention programmes should focus on most-at-risk people within a specific KP. Innovative approaches (including web-based) can identify locations and sub-groups of KPs, intensify evidence-based interventions, and improve retention.

3.2.3 Harm Reduction

People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose (new recommendation).

- 1) Ensure that naloxone is available to people likely to experience or witness an opioid overdose with reference to WHO guidelines: *Community management of opioid overdose*.
- 2) Engage mental health, drug treatment programmes and community-led initiatives to implement overdose prevention services for people who use drugs, including training in the use of naloxone to treat opioid overdose.
- 3) Government agencies and CSOs need to work together to improve access, availability, affordability and procurement procedures, no matter who “owns” the naloxone programme.
- 4) Continue to advocate and support implementation of needle and syringe programme and opioid substitution therapy.

3.2.4 HIV testing and counselling

Voluntary HTC should be routinely offered to all KP in community and clinical settings. Community-based HTC for KP, linked to prevention, care and treatment services, is recommended, in addition to provider-initiated testing and counselling.

- 1) All partners continue to promote the scale-up of HTC and support countries to review and revise national testing strategies to enhance progress; strengthen partnerships between ministries of health and communities; support community-led efforts to promote and increase demand for HIV testing; advocate for communities as equal partners in delivery of HIV testing services at the national level and legitimize outreach testing approaches including using lay and peer workers to provide HTC using rapid diagnostic testing (RDT).
- 2) Increased efforts and use of innovations for HTC such as community-based and community-led testing; online testing, new information technologies, home-based testing and social media to increase uptake of and earlier testing and treatment for KP and their sexual partners.
- 3) Urgent need to move beyond a project approach and scale up rapidly.
- 4) Proactive efforts to explore innovative approaches for follow-up to keep KP HIV negative, and to link and retain HIV infected people in the treatment cascade.

3.2.5 Critical enablers

Community empowerment

Programmes should work toward a package of interventions to enhance community empowerment among key populations.

- 1) Encourage community-led and community-based services and strengthen community systems, structures, and capacity-building for a more sustainable response to meet KP needs.
- 2) Build KP coalitions, networks and inter- or multi-community forums.
- 3) Support the development of community-led rapid crisis response systems that facilitate access to justice for KP (e.g. as done in India).
- 4) Improve access to legal services for KP, and support the "legal literacy" for KP.

- 5) Support communities in building capacity to partner with media (local, national and regional) to strengthen coverage of HIV and KP issues, to bring about wider public awareness and advocate with social influencers.

Reduced stigma and discrimination

Health services should be available, accessible and acceptable to KP, based on medical ethics, avoidance of stigma and discrimination and the right to health.

- 1) Health-care workers, law enforcement and correctional facilities staff should be trained to provide KP-friendly services, including access to counselling, information and social support services.
- 2) Guidance should be issued for health-care workers on consent and confidentiality for people under 18 years.
- 3) Document and expand good practices of service delivery to KP in collaboration with KP community groups.
- 4) Help create more scientific data on contributions made by NGOs and CBOs at the regional and national levels based on an updated monitoring and evaluation framework for NGO/CBO participation.
- 5) Take steps to ensure that law enforcement authorities are sensitized to the health needs of KP and that their actions do not interfere with KP access to HIV and other services.
- 6) Strengthen local partnerships, through workshops and other events, with law enforcement and harm reduction services to create a climate of understanding.

Laws and policies

Laws and policies should decriminalize behaviours such as drug use/injecting, sex work, same-sex activity and non-conforming gender identity. Unjust application of civil law and regulations against KPs should be eliminated. Countries should also work towards implementing and enforcing antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against people from KP.

- 1) Engagement of KPs (including young KPs) in national legal and policy dialogues, reviews and advocacy.
- 2) Develop curricula and implement routine trainings for law enforcement authorities on HIV, human rights and non-discrimination against KP (e.g. standard operational procedures (SOP)). SOP should guide police actions towards KP and peer educators who possess condoms, injecting equipment, etc.
- 3) UN and communities to engage in intensive advocacy at the regional level on laws, policies and practices related to KP.
- 4) Engage policy-makers, parliamentarians, public health leaders and the media to work with CSOs and community to monitor stigma, and to confront discrimination against KP to change punitive legal and social norms.
- 5) Government to implement a systematic approach to collect and make use of data and local information of incidence of human rights abuses. This evidence can build a case to seek legal redress for violations by health workers, law enforcement officers and others.

Reduced violence

Violence against KP should be prevented and addressed in partnership with KP-led organizations. All violence KP should be monitored and reported, and redress mechanisms established to provide justice.

- 1) Programmes to document/monitor prevent and address violence and demonstrate best practices in eliminating violence implemented through partnerships between KP and law enforcement agencies.

3.2.6 Good practice concerning age of consent, policies and laws

Adolescents from KP: Countries are encouraged to examine consent policies and revise them to reduce age-related barriers to HIV services and to empower providers to act in the best interests of vulnerable adolescents.

- 1) Health-care providers are encouraged to provide youth-friendly/respectful services for the best benefit of all types of young KP based on medical ethics. Focus should be on sexual and reproductive health services, mental health and access to harm reduction services.
- 2) Advocacy to reform laws and policies to address the needs of young KP who use drugs is recommended.

PROGRAMME AGENDA

<i>Day 1 – Wednesday, 26 November</i>		
Time	Session	Speaker/Facilitator
08:00 – 08:30	Registration	
08:30 – 09:30	Opening Session	Zhao Pengfei
	<ul style="list-style-type: none"> • WHO Regional Office for the Western Pacific 	Corinne Capuano
	<ul style="list-style-type: none"> • UNAIDS Regional Support Team for Asia and the Pacific 	Vladanka Andreeva
	<ul style="list-style-type: none"> • Representative from civil society organizations 	Tracey Tully
	<ul style="list-style-type: none"> • Introduction of participants by group (by facilitator) 	Roy Wadia
	<ul style="list-style-type: none"> • Rationale, objectives, agenda of the meeting, administrative announcements 	Ying-Ru Lo
	<ul style="list-style-type: none"> • Group photo 	
09:30 – 10:00	<i>Coffee Break / Video show (Key Population videos)</i>	Anton Castellanos Usigli
Objective 1: To review new 2014 Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations		
Session 1: Overview of the WHO 2014 consolidated guidelines on HIV and key populations		Co-chairs
10:00 – 10:45	<ul style="list-style-type: none"> • Epidemiology and response to HIV and other STI among key populations in The Asia-Pacific region (20') 	Ying-Ru Lo and Vladanka Andreeva
	<ul style="list-style-type: none"> • Highlights of the WHO 2014 Consolidated KP Guidelines: New recommendations including PrEP, overdose prevention for PWID and critical enablers (15') 	Rachel Baggaley
	<ul style="list-style-type: none"> • Comment from community perspective (10') 	Nat Kraipet
10:45 – 12:00	Panel Discussion: PrEP	
	<ul style="list-style-type: none"> • Comment on the evidence and relevance of PrEP to Asia and the Pacific (10') 	Frits van Griensven
	<ul style="list-style-type: none"> • Comment on PrEP from community perspective (feasibility, availability and acceptability) (10') 	Midnight Poonkasetwattana
	<ul style="list-style-type: none"> • Open discussion 	
	Panel Discussion: Overdose prevention for PWID	Facilitator: Olivier Lernet
	<ul style="list-style-type: none"> • Comment on evidence and relevance of the recommendation (20') 	Gary Reid/Nick Walsh
	<ul style="list-style-type: none"> • Comment from Civil Society (10') 	Anand Chabungbam
12:00 – 13:00	Lunch break	

Day 2 – Thursday, 27 November

Objective 2: To review country targets, implementation and impact of national HIV/STI strategic plans emphasizing key populations, identifying gaps and lessons learnt		
Session 2: High impact service delivery for key populations (achieving 90-90-90 targets)		Co-chairs
13:00 – 14:20	Warm up activity	
	<ul style="list-style-type: none"> • Focus, Focus, Focus: Prioritizing interventions for key populations (10') • Cascade of continuum of HIV prevention, treatment, care and support, Indonesia (10') • Getting to 90-90-90 in Viet Nam (10') • Innovative approaches for HIV testing in China (10' including 1 minute video) • Plenary discussion (40') 	Cambodia (NCHADS and KHANA) Indonesia (Government + Community Group) Nguyen Tam John Best
14:20 – 15:00	Panel Discussion: Co-Infections	
	<ul style="list-style-type: none"> • TB/HIV co-infections among people in prisons and closed settings (10') • HIV/Hepatitis B & C co-infections among key populations (10') • Open discussion (20') 	Nobuyuki Nishikiori Nick Walsh
15:00 – 15:30	Coffee Break / Video show (KP videos)	Anton Castellanos Usigli
Session 3: Critical enablers		
15:30 – 17:00	<ul style="list-style-type: none"> • Structural barriers: Punitive laws, legal barriers, stigma, discrimination and how they hamper access to services (including ARV treatment) <ul style="list-style-type: none"> ○ Presentation - Findings and recommendations of legal reviews in The Asia-Pacific region; programmes to reduce stigma and discrimination and increase access to justice for key populations ○ Panel discussion 	Facilitators: Brianna Harrison and Edmund Settle Panellists: Edgar Galvante, Tracey Tully, Rolly Cruz
17:30 – 19:30	WHO Reception, Al Fresco (Group dynamic)	Anton Castellanos Usigli
Objective 3: To outline targets and actions for early adoption and roll-out of WHO 2014 key population guidelines as part of national HIV/STI strategic plans and the Global Fund's new funding model grants in priority countries		
Session 4: Early adoption and roll out of WHO 2014 KP guidelines		Co-chairs
08:30 – 08:40	Wrap up of Day 1	Rapporteur (Gary Reid)
08:40 – 09:40	<ul style="list-style-type: none"> • Presentation of short survey feedbacks from participants (10') • Presentation of survey results by APCOM/Youth Voice Counts (10') • Introduction of the implementation toolkits in process (e.g. SWIT, MSMIT, TRANSIT) (10') • Plenary discussion (30') 	Yu Dongbao Midnight Poonkasetwattana Stephen Mills
09:40 – 10:00	Coffee Break / (Key Population videos)	Anton Castellanos Usigli
Session 5: Group work: identifying gaps/opportunities in service delivery		Co-chairs
10:00 – 11:30	Breakout for group discussion	Facilitators

	<ul style="list-style-type: none"> • Implementation of existing recommendations for key populations <ul style="list-style-type: none"> ○ Opportunities and barriers in the health service delivery ○ Opportunities and barriers for critical enablers • Implementation of newer recommendations in the consolidated KP guidelines <ul style="list-style-type: none"> ○ Opportunities and barriers in the health service delivery ○ Opportunities and barriers for critical enablers 	
11:30 – 12:00	<ul style="list-style-type: none"> • Feedback from group work (5' each) 	
12:00 – 12:30	<ul style="list-style-type: none"> • Plenary discussion 	
12:30 – 13:30	Lunch break	
Objective 4: To increase awareness of the urgent need to reduce HIV and other STI among key populations		
Session 6: Media partnerships/advocacy		
13:30 – 13:40	Warm up activity	
13:40 – 15:15	Media presentation and panel discussion <ul style="list-style-type: none"> • Brief presentation/overview on challenges in covering HIV and key population issues • Panel discussion on the role of media when covering sensitive issues and critical enablers • Misrepresentation of key populations in media and how to prevent it 	Moderators: Vismita Gupta-Smith and Roy Wadia
15:15 – 15:30	<i>Coffee Break / (Key Population videos)</i>	Anton Castellanos Usigli
Session 7: Sustainable response among key populations in Asia and the Pacific		Co-chairs
15:30 – 16:30	<ul style="list-style-type: none"> • India • Malaysia • Global Fund • Open discussion 	Seema Sayyed Sha'ari Ngadiman Annette Reinisch
Session 8: Conclusions and recommendations		Co-chairs
16:30 – 17:00	Concrete action points at country level to be followed with timeframe	Yu Dongbao
17:00 – 17:30	Closing session <ul style="list-style-type: none"> • Representatives from participants and partners • UNAIDS/WHO 	Vladanka Andreeva Zhao Pengfei

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GROUP WORK: GAPS AND OPPORTUNITIES IN SERVICE DELIVERY

Men who have sex with men

Issues/challenges	Action items (targets/milestones)	Responsible Agency/organization
1. Reaching high-risk and hidden MSM	<ul style="list-style-type: none"> • Ensure data is generated to identify high-risk MSM <ul style="list-style-type: none"> - Mappings - RDS surveys (e.g. IBBS) - Size estimations (to persuade the government) - Risk assessment tools - Analyze HIV testing data and triangulate with other data sources • Community-led interventions <ul style="list-style-type: none"> - Move beyond project-driven peer outreach • Limit free services to high-risk MSM to ensure sustainability 	Ministry of Health and municipal / provincial health departments Regional, national and local CSOs Technical support by WHO, UNAIDS
2. Demand creation	<ul style="list-style-type: none"> • Ensure MSM or LGBT CSOs can register and received training to provide MSM-focused HIV services (e.g. community-based testing) • Recruit MSM (especially high risk) through SMS, internet and venues • Build relationships/trust with venues (saunas, clubs, etc) and convince them to provide commodities (condoms/lube) and information on services • Promote MSM-friendly services and refer clients to them • Media engagement including social media • Develop innovative approaches (e.g. online counselling and home-based testing) 	MSM community, local CSOs APCOM, YVC
3. Providing MSM friendly services	<ul style="list-style-type: none"> • Establish and promote men’s health services <ul style="list-style-type: none"> • Broader than MSM-needed services • With healthcare workers trained to provide friendly services • Provider-initiated HIV testing in healthcare settings where high-risk MSM may visit (e.g. STI clinic) • Make HIV testing as easy as possible through provision of community-based 	Ministry of Health and municipal / provincial health departments

	<p>rapid testing and oral testing</p> <ul style="list-style-type: none"> • Ensure community-based services are closely linked with MSM-friendly clinic services 	
4. PrEP	<ul style="list-style-type: none"> • Awareness-raising at country level (with government and MSM CSOs) • Promote among young, high-risk MSM (online, apps, clubs, private parties in criminalized settings) 	WHO and UNAIDS

People who use drugs

Issues/challenges	Action items	Issues/challenges
1. Legal & policy barriers	<ul style="list-style-type: none"> • Legal review • Curriculum for law enforcement (e.g. SOP) • Exposure of high level people to see best case examples 	<ul style="list-style-type: none"> • Interagency
2. Reduced Funding	<ul style="list-style-type: none"> • More with less (task shifting) • Pooling resources (integrating) • Domestic and private involvement (CSR) • Minimal package of interventions necessary 	<ul style="list-style-type: none"> • MoH with community
3. Service delivery	<ul style="list-style-type: none"> • Meaningful involvement (MIPUD) • Rapid testing • Community based testing • Active case management • Simple flexible friendly treatment models • Using technology • Scale up quality HR services • Linkages between stakeholders 	<ul style="list-style-type: none"> • MoH and CSO interaction • UN supporting process

Closed settings

Issues/challenges	Action items	Issues/challenges
1. Lack of commitment, ownership, coordination and enabling policies at the central and local ministries overseeing correctional services and health	<ol style="list-style-type: none"> 1. Policy advocacy and technical briefs to present to policy makers e.g. investment case, strategic involvement of champions 2. Changing mindsets: Promote best practices and study visits 	Ministry of Public health/MOH Ministry of Interior/Justice NGO/CBO Ministry of Finance
2. Suboptimal and inadequate services: HTC, prevention including condoms, Harm reduction, other health services in the prison, preparations for release and post-release from prison	<ol style="list-style-type: none"> 1. Resources and sharing resources across sectors including HR (peer, medical and nonmedical staff etc) 2. Capacity building: tools, guidelines, training, M&E, SOP (harmonization) 	Ministry of Health Ministry of Interior/Justice Ministry of Finance
3. Limited resources for quality healthcare including HIV, TB etc. within close settings (HR, training, health coverage, infrastructure and commodities)	<ol style="list-style-type: none"> 1. Country assessment and proper budgeting, leverage and share resources, inter- and intra-agencies 	Ministry of Health Ministry of Interior/Justice Ministry of Finance
4. Stigma and discrimination from correctional service staff – for HIV+, KP	<ol style="list-style-type: none"> 1. Training for correctional and health staff in close settings for the specific needs of the population and sub-population 	Ministry of Health Ministry of Interior/Justice Ministry of Finance
5. Difficulty to get strategic information about close settings	<ol style="list-style-type: none"> 1. Advocacy 2. Research and surveillance for needs of the populations: get prisons in the routine IBBS 	Ministry of Health Ministry of Interior/Justice Ministry of Finance

Transgender people

Issues/challenges	Action items (targets/milestones)	Responsible Agency/organization
1. Acknowledgement (legally and socially and from health perspective) that TG exist, and they have specific needs	Additions for comprehensive service package - legal support - SRS - Violence redressal - capacity building of health care sector - mental health - social and economic protection - Psychosocial support - Substance Use - social documentation - identity - Support system (old/young)	- Human rights Commission, Ministry of social protection, - Ministry of Social Welfare - Ministry of Health (STI /HIV/ National TB Programme, NCD,) - Ministry of Interiors/ Justice/House - Ministry of Education - Parliament - Decentralized Settings (city/district level) - Community itself
2. Addressing the specific barriers, stigma, timing, service modality, capacity.)		
3. Physical access and service modality and affordability.		
4. Good practices, operational research and Data (size of population, STI, SRS, hormone)	Example of good practices of health care services and how to delivery/ Comprehensive data collection and research (that include transgender men)	
5. Social Mobilization	Support community led network/ community empowerment IEC - Information Education Communication e.g. Training on healthy Life skills and nutrition for TG, Safe sex knowledge/ Substance Use	

Adolescent and Young key populations (YKP)

Issues/challenges	Action items (targets/milestones)	Responsible Agency/organization
Limited data and evidence on SRH/HIV among YKP (e.g. surveillance where possible and targeted community and other studies) to use for policy advocacy, planning and funding for programming and address evidence gaps (e.g. PrEP<18)	Age and sex-disaggregated data; inclusion of A/YKP in surveillance <18; promotion of social and community research	National partnerships between NGO, community-based, youth led networks and governments! (research, advocacy, data collection/use)*
Limited independent consent to access services <18, age restrictions to services (e.g. harm reduction), medical confidentiality and operational guidance for health workers	Engagement of YKP in national legal and policy dialogues; National policy and legal reviews and advocacy	
Limited youth- & YKP-friendly services (stigma and discrimination, challenges with transitions between pediatric and adult care, limited information for adolescent and young people living with HIV on sexuality and relationships)	Training, guidelines for health workers and facilities; partnerships with CBOs	
Limited mobilization opportunities for young communities and participation in KP networks of YKP networks and limited multisectoral partnerships	Engagement of YKP-led/-serving organizations/networks, integrating YKP in other, mentorship and skills transfers	
Violence and abuse, and mental health – limited access to counselling, support and stigma and discrimination in multiple settings outside of health	Dialogue and training of law enforcement and social workers; need for COMPREHENSIVE sexuality education & social protection services	

*With support from regional and country UN, CSO partners such as UNESCO/UNFPA/UNICEF/UNAIDS/WHO/IPPF and interagency task teams such as the Asia-Pacific Interagency Task Team on YKP, and regional networks e.g. Youth LEAD, Youth Voices Count

Sex Workers

Issues/challenges	Action items (targets/milestones)	Responsible Agency/organization
Low condom use	Not completed	Not provided
Violence against women	Work closely with law enforcement agencies	Not provided
Sex work and trafficking	Not Completed	Not provided
Stigma and discrimination	Decriminalize sex work across the region, building coalitions and networks there they are non-existent Intensive advocacy at a regional level	Not provided
Access to justice	Rapid response system (India example)	Not provided
Intersectionality	Linking with existing program More documentation and research	Not provided

GROUP WORK: MAPPING OF MEDIA COMMUNICATION STAKEHOLDERS

SEX WORKERS

Blockers: Law enforcement authorities; religious leaders; parliamentarians; city authorities; media; family; community members	Avoiders: general population; healthcare providers including healthcare workers; families; community; media
Active supporters / Champions: Community leaders, PLHIV speakers, infected and affected people; parliamentarians; celebrities; media; youth leaders	Silent Boosters: international agencies (UN agencies); other key populations with the same issues; and other allies

MEN WHO HAVE SEX WITH MEN

Blockers: Policy makers; religious sector	Avoiders: Policy makers; religious sector; MSM communities themselves
Champions: MSM; NGOs and CBOs working for them; UN System; parents/family members; teachers; celebrities	Silent Boosters: UN System; government; parliamentarians; teachers; policy makers; religious sector

*Note: stakeholders can transit at each box depending on the situation, e.g. UN system can sometimes be silent booster but also can play a strong champion to our issues

TRANSGENDER

Blockers: Law enforcement; policy makers; members of LGBT; media/journalists; judicial system	Avoiders: Education system; family and friends
Champions: Networks (transgender, positive network, LGBT network); key community leaders (more leaders); political leaders; NGOs and human rights organizations that are supportive of transgender communities	Silent Boosters: UN agencies; donor agencies; human rights agencies

*Note: all stakeholders can move from one box to the other. Public health; social welfare; human resources; financial gains are common interests which can push them to move to the champion box.

PEOPLE WHO USE DRUGS

Blockers: Policy makers; religious leaders; politicians; police; law enforcement; media	Avoiders: researchers; drug traffickers; family members
Champions: CSOs, UN agencies, MOH, NGOs	Silent Boosters: Family members; donors; religious leaders

*Notes: media investment needs to be included in the national HIV and AIDS plan, this may include investment for regular dialogue among community, media, politicians and government; training for journalists on what stories to cover and what language to use when covering issues related to HIV; training for religious leaders to promote anti-stigma and discrimination approaches; etc.

YOUNG PEOPLE

Blockers: Media editors; religious leaders; teachers, parents	Avoiders: teachers, narcotic agencies, Min of Culture, Min of Youth
Champions: Internet media, KP organizations (including those for young KP); young people;	Silent Boosters: KP organizations; government ministries for youth affairs; KPs

trained journalists; teachers	networks/organizations; law empowerment; MOH; National AIDS Committee
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*Notes: we need to work closer with media to help advocate moving all stakeholders to the Champions box

PRISONERS

Blockers: Drug sellers; government; media	Avoiders: Ministry of Justice; healthcare staff; Ministry of Finance
Champions: Families/relatives; KPs and their peers; ex-inmates; Ministry of Health; Ministry of Justice; journalists/media; NGOs	Silent Boosters: Relatives and others; Ministry of Health; Ministry of Justice

*Notes: Champions can move to become blockers and vice versa depending on the issues and situation; e.g. media can be blockers if they are not sufficiently sensitive about the issues, but they can also be champions if we work closely with them



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