



HIV/AIDS

meeting the challenge



World Health Organization
Regional Office for South-East Asia
New Delhi

20 million dead, 39.4 million infected by 2004

25 million AIDS orphans expected by 2010

13 000 new HIV infections every day globally

8000 people dying of AIDS every day,
1 every 10 seconds globally

**6.4 million people living with HIV/AIDS in
South-East Asia in 2004**

450 000 died from AIDS in South-East Asia in 2004

**95% of infected persons are NOT aware of
their HIV status**

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HIV/AIDS

meeting the challenge

WHO Project: ICP HIV 001



World Health Organization
Regional Office for South-East Asia
New Delhi
2004

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Message from the Regional Director



HIV/AIDS has assumed epidemic proportions in most parts of the South-East Asia Region, which now accounts for the second highest burden of the disease after Sub-Saharan Africa. The epidemic, though diverse in nature, has been spreading from high-risk groups to the general population.

Of the more than six million people living with HIV/AIDS in the Region, over 900 000 are in urgent need of care, support and treatment. We can combat this epidemic by scaling up evidence-based, cost-effective prevention interventions combined with rapid expansion of HIV/AIDS treatment for improving the health of millions.

Prevention remains the mainstay for controlling the HIV/AIDS epidemic. Almost two thirds of new infections projected to occur between 2002 and 2010 can be prevented by increasing the efforts to systematically scale-up condom use, and through early diagnosis and treatment of sexually-transmitted infections, targeting in particular the high-risk populations. Harm-reduction interventions which include prevention, care and treatment, and which target injecting drug users are equally important in our Region. Other interventions to curtail the spread would include counselling and voluntary HIV testing, blood safety and prevention of mother-to-child HIV transmission.

While prevention efforts are necessary to limit the spread of the epidemic, treatment has become a public health necessity in countries

with a high burden of disease. Therefore, WHO and its partners have accorded top priority to the scaling-up of treatment for people with HIV/AIDS through the "3 by 5" strategy launched in December 2003. The strategy aims to provide antiretroviral treatment to three million people with advanced HIV infection in developing countries by the end of 2005. This is an interim target of the final goal of providing universal access to treatment for all those who need it.

The "3 by 5" strategy requires us to join forces, have strong political and financial commitment, remove barriers to stigma, counter discrimination and scale-up and link the prevention, care and treatment interventions to fight the epidemic. We need to identify and mobilize necessary resources for this endeavour.

This revised edition of the advocacy booklet brings together the experiences and successes in tackling the current HIV/AIDS epidemic, as well as the new challenges ahead. It aims to contribute to improved national and regional responses, and to the formulation of evidence-based actions in the fight against HIV/AIDS in the Region. We must act now to meet the challenge by addressing this serious public health problem and providing hope to millions.

A handwritten signature in black ink that reads "Samlee Plianbangchang". The signature is written in a cursive, flowing style.

Samlee Plianbangchang, M.D., Dr. P.H.
Regional Director

The Global Situation

- ▶ The HIV/AIDS* epidemic continues to grow worldwide and accounts for the highest number of deaths by any single infectious agent.
- ▶ 95% of all HIV infections are in low- and middle-income countries.
- ▶ The highest burden is in Sub-Saharan Africa followed by South-East Asia. One fifth of the infected people live in Asia.
- ▶ Women and girls account for half of those living with HIV/AIDS.
- ▶ Young people (15–25 years) account for half of all new infections.
- ▶ More than 14 million children have lost one or both parents to AIDS.
- ▶ Unless prompt action is taken by year 2005 up to 2 million would develop AIDS and die.
- ▶ The economic costs due to the impact of AIDS could rise to US\$ 17.5 billion annually by 2010, with millions more thrown into poverty.

Globally, life expectancy is expected to drop by 10 years due to the impact of AIDS with nearly 84.5 million daily adjusted life years (DALYs) lost in 2002.

2004

WORLD STATISTICS

39.4 million

people living with the virus including
2.2 million children

4.3 million

new cases detected

3.1 million

deaths

AIDS is a global emergency.
39.4 (35.9–44.3) million adults and children are estimated to be living with HIV/AIDS as of end 2004.

Global burden of HIV/AIDS, 2004



* HIV/AIDS: human immunodeficiency virus / acquired immunodeficiency syndrome

HIV/AIDS in South-East Asia

- ▶ South-East Asia has the second-highest number of HIV-infected persons (6.4 million) among all WHO Regions.
- ▶ Four countries – India, Thailand, Myanmar and Indonesia – account for 99% of the estimated HIV burden in South-East Asia.
- ▶ Although the overall HIV prevalence in South-East Asia is low, because of the large population base the magnitude of the HIV epidemic in terms of the number of infected persons is huge.
- ▶ There are multiple simultaneous HIV epidemics which are developing in different population groups at different rates.
- ▶ HIV epidemics are largely concentrated among population sub-groups with high-risk behaviours, namely, commercial sex workers and their clients, injecting drug users, and men who have sex with men.
- ▶ In Myanmar, Thailand and six states of India, the HIV epidemic has spread among men and women whose behaviours do not put them at high risk. HIV prevalence in pregnant women attending antenatal clinics is reported to be over 1% as per national sentinel surveillance.

The first AIDS patient was diagnosed in Thailand in 1984 and HIV infections in most other countries were reported in 1986 or later. Though HIV/AIDS assumed epidemic proportions much later in South-East Asia than in the rest of the world, it is spreading very rapidly among some population sub-groups in the Region.

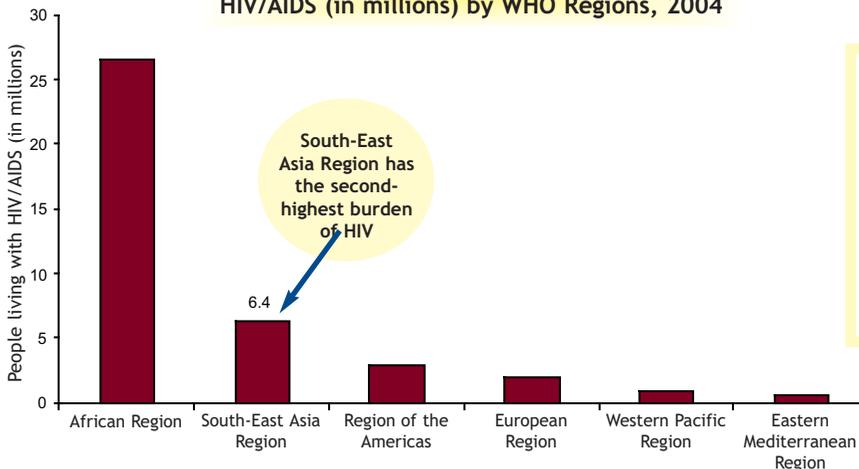
2004 SOUTH-EAST ASIA STATISTICS

6.4 million
people living with the virus including
150 000 children

780 000
new cases detected

450 000
deaths

Estimated number of people living with HIV/AIDS (in millions) by WHO Regions, 2004



12.1 million
daily adjusted
life years
(DALYs)
lost in 2002 in
the Region.

Stigma and Discrimination

- ▶ Stigma stems from fear and ignorance about the disease. This fear prevents people from seeking treatment for AIDS or from acknowledging their HIV status publicly and contributes to increasing future transmission.
- ▶ Stigma leads to discrimination.
- ▶ Women face more stigma and discrimination than men. This is because men who have sex with men keep their sexual behaviour a secret, thus increasing their own risk as well as the risk of their female and male partners, which in turn results in women often being accused of having extramarital sex whether or not this was true.
- ▶ Social taboos about sexuality may prevent open discussion and effective prevention education.
- ▶ People with, or suspected of having, HIV may be turned away from health care services, denied housing and employment, shunned by their family, friends and colleagues.
- ▶ The stigma attached to HIV/AIDS may extend into the next generation, placing an emotional burden on children who may also be trying to cope with the death of their parents from AIDS.

Stigma is the biggest hurdle to HIV prevention, care and treatment in South-East Asia. Breaking the silence is the first step in combating stigma and discrimination and is vital to improving access to HIV/AIDS care and treatment.

“There are two epidemics spreading—AIDS and the stigma against people living with HIV.”

Mr. Zahir Uddin Swapon,
Secretary General of the
Parliamentary Group on
HIV/AIDS and Member of
Parliament in Bangladesh.

Awareness about the disease is not enough unless it is accompanied by accurate knowledge or tolerance

AIDS is Changing the World We Live In and the Way We Live

Human, Social and Economic Costs

- ▶ AIDS is not just a health problem; it is a social problem, orphaning millions of children and destroying families and communities.
- ▶ AIDS, being primarily a sexually transmitted infection, mainly strikes adolescents, young adults, and those in their early middle age, killing the very people whom society relies for production and reproduction.

AIDS is affecting national economies

- ▶ Growing absenteeism and replacements due to death from AIDS among the workforce strike at the root of industrial productivity and profitability and is affecting businesses, such as tourism, agriculture, education.
- ▶ The HIV/AIDS epidemic will reduce the gross domestic product (GDP) by 1% or more.

AIDS is affecting household economies

- ▶ HIV/AIDS causes huge losses in household income, if the bread winner is affected, and puts a burden on household expenditures.
- ▶ AIDS affects the poor more severely as they are most vulnerable to infection. There is loss of income and diversion of income to health expenditures. This forces poor

families into deeper poverty leaving meagre resources for education, food or other needs for the rest of the family.

- ▶ Women make up 70% of the poor in developing countries. AIDS is increasing poverty among women, particularly in high prevalence countries, and disempowering them.

AIDS is preferentially affecting women and girls

- ▶ as care givers: When a woman's time is spent caring for a sick family member, she has less time for other productive tasks within the household. The entire family is affected increasing their vulnerability to infection.
- ▶ because of lack of basic education: HIV/AIDS is threatening recent positive gains in basic

If governments take action now, new infections can be brought down from an expected 10 million to 4 million by 2010, saving the Region US\$ 2 billion annually.

education. In high HIV prevalence countries, fewer girls have enrolled in schools in the past decade as they are the first to be pulled out of school to care for sick relatives or to look after younger siblings.

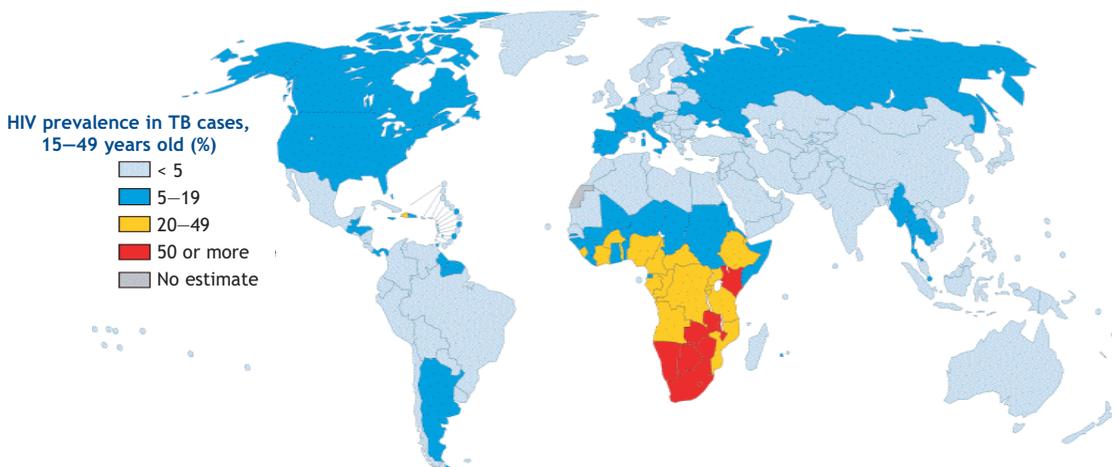
AIDS is changing the structure of populations

- ▶ There are increased dependency ratios seen in Africa with smaller numbers of working-age adults on whom both children and elderly relatives can depend.

HIV and TB: Parallel Epidemics

- ▶ HIV and tuberculosis (TB) are closely interrelated. While TB is the most common opportunistic infection and the commonest cause of death among people living with HIV/AIDS, HIV is fuelling the TB epidemic in high HIV-prevalent populations.
 - ▶ A person dually infected with HIV and TB has a 5–15% annual risk of developing TB disease compared to less than 0.1% among those who are HIV-negative.
 - ▶ More than 17 million people in Africa and 4.5 million in South-East Asia were infected with both HIV and TB in 2000.
 - ▶ More than 50% of AIDS patients in some areas of South-East Asia with higher HIV prevalence have TB coinfection.
 - ▶ TB and HIV can be managed together. Treatment of TB through Directly Observed
- Short-course (DOTS) can reduce deaths among people with HIV/AIDS while antiretroviral treatment can improve their quality of life and strengthen their immune system to fight infections like TB.
 - ▶ Rather than pursuing a dual strategy for a dual epidemic, AIDS and TB control programmes should identify mechanisms and areas for collaboration to decrease the burden of TB among people with HIV/AIDS and the burden of HIV in TB patients.
 - ▶ The regional strategy for reducing HIV/TB coinfection involves preventing HIV transmission, decreasing the progression of TB infection to TB disease, decreasing deaths and sickness due to HIV-associated TB, and strengthening health system response to HIV/TB.

Estimated HIV Prevalence in TB Cases, 2002



How Is HIV Transmitted

HIV spreads through three ways:



1 Unprotected Sex

Through exchange of body fluids, primarily during sexual intercourse between an infected person and his/her partner (man to woman, woman to man, and man to man). Physiological factors account for increased transmission of HIV from an infected man to a woman than from an infected woman to a man.

2 Unsafe Blood and Blood Products

Through exchange of infected blood during transfusion, sharing contaminated needles and syringes during injecting drug-use or rarely at health care settings.

3 Mother-to-Child Transmission

From an infected mother to her unborn child during pregnancy and delivery or, after birth, through breast-feeding.

- ▶ 25–45% of HIV-positive women during pregnancy, delivery and breastfeeding in developing countries, and in the absence of any intervention, give birth to infants infected with the virus.

The lack of knowledge about how HIV is NOT transmitted can often lead to irrational fears and the tendency to stigmatize or discriminate against people living with HIV/AIDS.

How Does It NOT Spread

- ▶ HIV is not transmitted through/by: ordinary social interactions like hugging or shaking hands; sharing of food utensils, toilets, telephones, swimming pools, as well as looking after, living or working with persons having the infection.
- ▶ HIV does not spread by mosquito bites or bedbugs, flies, lice, fleas and other household pests.
- ▶ HIV is not transmitted by the act of donating blood and carries no risk to the donor.

The Asian Epidemic

Asian countries are very large and contain many simultaneous HIV epidemics. Until now the epidemic was concentrated in high-risk populations, mainly small groups of people practicing risky behaviours, such as unsafe sex (among heterosexual, homosexual and transgenders) and needle sharing among injecting drug users.

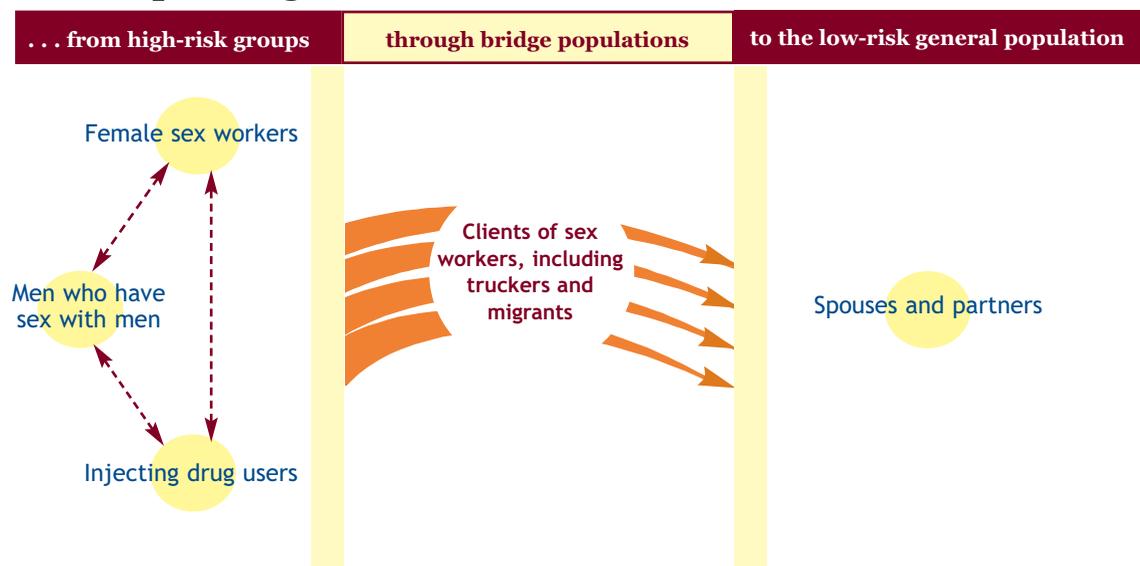
The epidemic is now slowly affecting the low-risk general population through “bridge populations” consisting of clients of sex workers, truckers and migrants, because of

- close links between sex workers and injecting drug users as well as their partners and spouses.
- migration of male populations to urban areas for work. This may increase risky sexual behaviour (such as visiting sex

workers, having multiple partners, having sex with men, injecting drug use) and thus the risk of contracting HIV infection and transmitting it to their spouses.

- high prevalence of undiagnosed and untreated sexually transmitted infections.
- organized commercial sex and trafficking of young women into prostitution.
- stigma and discrimination due to myths and misconceptions about the cause and spread, taboos about discussing sex openly and methods of prevention for HIV/AIDS.
- gender inequality, gender norms and violence against women that make women less able to negotiate protection during intercourse as well as cope with the impact of infection.

HIV is spreading . . .



Who Is Vulnerable

AIDS recognizes no borders and does not discriminate among nations. Though unsafe heterosexual sex is the main mode of HIV transmission, certain communities who consistently show high-risk behaviours (such as visiting sex workers, injecting drugs and men who have sex with men) or are in risky settings (such as clients of sex workers, truckers, migrants), are more prone to HIV infection.

There are an estimated
13 million injecting
drug users worldwide,
5.6 million across
Asia

- ▶ **Commercial female and male sex workers**
Commercial sex is widespread across Asia due to poverty and sociocultural factors. Since sex workers have more clients they can contract or transmit HIV to or from a greater number of people.
- ▶ **Injecting drug users**
Needle sharing has led to explosive local epidemics among injecting drug users, with prevalence rates of 60–90%.

- ▶ **Mobile populations**
HIV tends to move with mobile populations (such as workers migrating within and across countries, rural–urban migration of workers, fishermen, sailors, traders, construction workers, truck drivers), infecting new populations. The high-risk behaviour in these mobile groups is because of their isolated lifestyle which contributes to increased risky behaviours (such as frequenting sex workers) thereby enhancing the risk of transmission of HIV.

- ▶ **Men who have sex with men and transgenders**
This is not uncommon in Asia though rarely acknowledged and not necessarily linked to a homosexual identity. Twenty per cent of men are said to have same-sex contacts during their lifetime. As they do not understand the risk involved, they do not use condoms during such sexual activity and may infect their female partners in due course.



Other Vulnerable Groups

Women

Women are at a greater risk of becoming infected. Almost half of all newly infected adults in the world are women. Women are at greater risk due to both biological and social reasons. The epidemic has also increased the burden of HIV and AIDS-related care faced by women who are expected to provide care to family members.

- ▶ Gender norms dictate that women and girls should be ignorant and passive about sex, which greatly constrains their ability to be informed about risk reduction and to negotiate condom use.
- ▶ Gender norms cast women as being mainly responsible for reproductive and productive activities within the home in contrast to men who are cast as primary economic actors and producers outside the home.
- ▶ Gender roles account for women having unequal access to and control over key productive resources such as education, land, income and employment, and significantly reduces a woman's influence to negotiate safer sex and to cope with the impact of disease.

Women experience violence that contributes both directly and indirectly to their vulnerability to HIV.

- ▶ Violent, forced or coerced sex, increases a woman's vulnerability to HIV infection.
- ▶ Violence and fear of violence limits a woman's ability to negotiate safe sexual behavior, even in a consensual union.
- ▶ Women who are infected with HIV or who are perceived to be infected may face violence and/or abandonment.
- ▶ Fear of violence and stigma can dissuade women from seeking information on HIV/AIDS, getting tested for HIV, disclosing their HIV status, and seeking counselling and treatment.
- ▶ Women's unwillingness to be tested because of fear of violence can have a detrimental effect on larger HIV prevention and treatment programmes.



Young People

HIV/AIDS is affecting future generations now.

- ▶ One fifth of the global population is between 10 and 19 years old, most of whom live in Asia.
- ▶ Youth (15–24 years old) are amongst the largest group to get HIV and account for half of all new HIV infections worldwide.
- ▶ More than 6000 contract the virus each day.
- ▶ The risk is higher for adolescent girls because they are less in control of sexual relations and biologically more at risk.

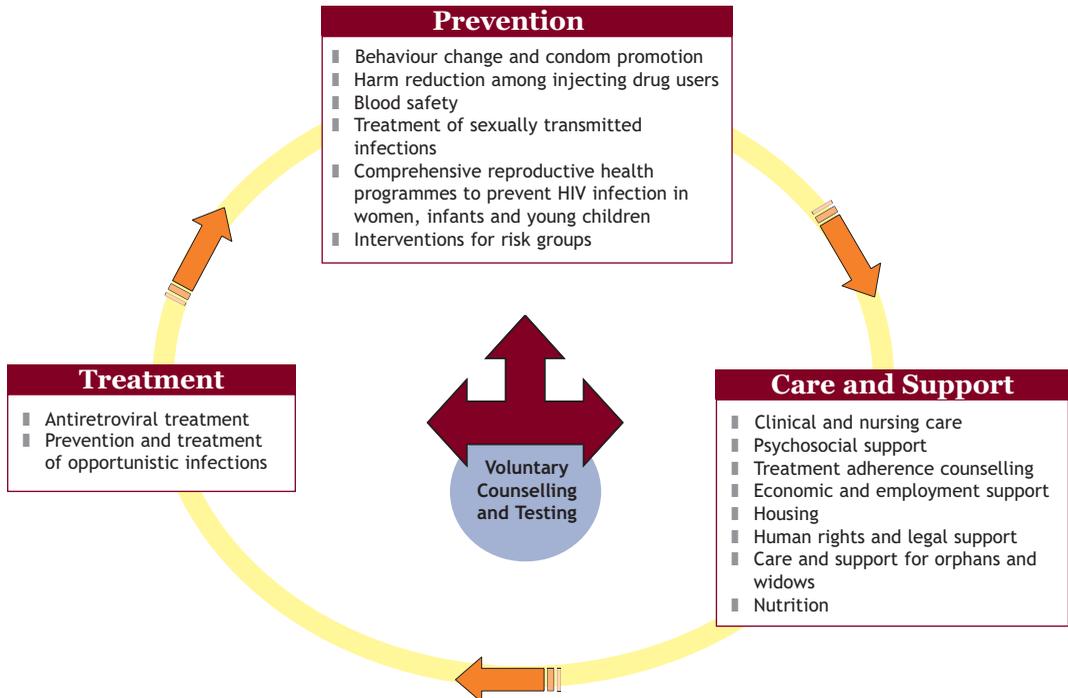
Children

AIDS affects children in two ways: (1) orphaned due to one or both parents dying because of AIDS and (2) getting HIV-infection.

- ▶ Globally, more than 2 million children under 15 years are infected with HIV.
- ▶ Half-a-million children have died due to AIDS in South-East Asia.
- ▶ In Asia, children are coerced into prostitution to support themselves or their families. Young girls are more at risk of sexual abuse.

The Prevention, Care and Treatment Continuum

Working full circle to counter the epidemic



Prevention, care and treatment work in synergy, each enhancing the other to counter the epidemic creating an impact at all levels from a person with HIV/AIDS to families, to communities and nations at large.

HIV/AIDS can be managed as a chronic disease

- ▶ HIV/AIDS can be prevented by effective behavioural changes, such as the willingness of men to use condoms, safe injecting practices, and seeking diagnosis and treatment for sexually transmitted infections.
- ▶ HIV/AIDS need not be a death sentence. Being HIV-positive does not mean having AIDS

- and not being able to live long. People with HIV infection can live healthy complete lives for nearly 10 years before the onset of AIDS.
- ▶ For people with HIV who eventually progress to AIDS too there is care and treatment available that extends and improves their quality of life.

Accelerating Prevention Activities

Comprehensive Programmes

For women and children

A comprehensive public health approach should be adopted to prevent HIV infection among women, infants and young children. These include:

- ▶ Comprehensive reproductive health programmes, as well as care and treatment for women of child-bearing age.
- ▶ Prevention of unintended pregnancies among HIV-infected women.
- ▶ Prevention of HIV transmission from mother-to-child by encouraging women to attend antenatal care facilities, accept counselling and testing, receive antiretroviral preventive therapy and adopt safer infant-feeding practices.
- ▶ Provision of care, treatment and support for women with HIV and their children and families.

Prevention programmes are reaching fewer than one in five people who need them.

For young people

Young people should be equipped with skills to protect themselves. They should

- ▶ receive sex education in schools.
- ▶ receive information about adopting safer sex practices, such as condom use.
- ▶ be encouraged to discuss about sexual health issues and advised where they can find help, either for counselling or for health clinics.

Sexual health education leads to safer sexual behaviour

In Thailand, a Life Skills Programme, incorporated as a basic science subject, teaches pupils to handle sexual needs and demands. It also works on getting boys to respect girls, and to build self-esteem among girls, so that they are more in control in their sexual relationships.

HIV/AIDS is certainly preventable. Prevention approaches should use evidence-based strategies, carefully tailored to the social and economic settings in which they are to be implemented and to the state of the national HIV/AIDS epidemics.



Targeted Interventions

For sex workers and mobile populations

- ▶ Increase advocacy for awareness of the disease, use of condoms as well as screening and treatment for sexually transmitted infections (STIs).
- ▶ Increase access to treatment for STIs.
- ▶ Educate on reducing high-risk behaviours.
- ▶ Make available free condoms at commercial sex areas and trucker rest points.

For injecting drug users

Drug users should have access to harm-reduction interventions such as:

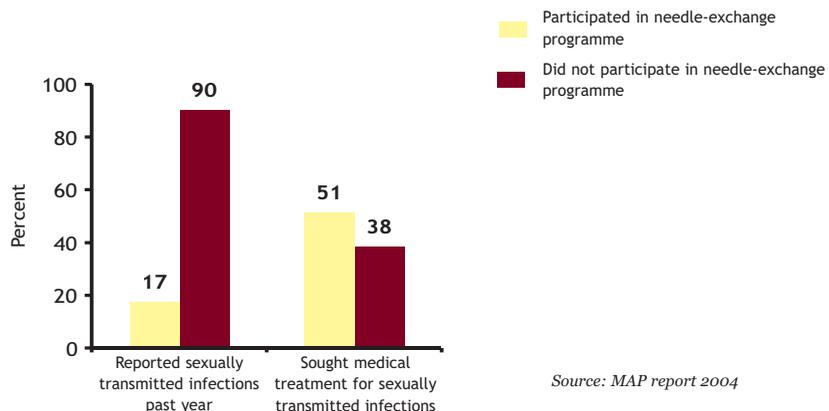
- ▶ Treatment for drug-dependence including needle-and-syringe exchange programmes and substitution therapy.

- ▶ Outreach programmes and information and education.
- ▶ Voluntary counselling and testing.
- ▶ Care and treatment for problems related to injecting drug use.

For blood safety

- ▶ Encourage voluntary donations and risk-assessment of donors for transmission of blood-borne diseases.
- ▶ Systematically screen blood before transfusion.
- ▶ Adopt universal precautions, i.e. standard procedures when handling blood from any person (such as wearing gloves, safe disposal of needles) in health-care settings.

Injectors who use comprehensive needle-exchange services report safer sex (Bangladesh)



Source: MAP report 2004

Counselling and Testing

95% of people living with HIV do not know they are infected.

The potential benefits when expanding counselling and testing are enormous. It is estimated that by 2005 there will be up to 180 million people in need of counselling and testing, annually.

Voluntary counselling and testing (VCT) is more than just providing HIV test results. It includes pre- and post-test counselling.

VCT services should be widely promoted as they have been demonstrated to be an effective public health strategy to prevent HIV transmission by reducing risk behaviours and increasing condom use.

Voluntary counselling and testing

- ▶ *Benefits individuals.* Knowing their HIV status enables those tested HIV-positive to gain early access to HIV/AIDS care, treatment and support; enables pregnant women to access interventions to prevent transmission of the virus to their infants; and those tested HIV-negative to remain negative by adopting safe behaviours.
- ▶ *Benefits communities* by reducing the denial, stigma and discrimination that surround HIV/AIDS.
- ▶ *Benefits programmes.* VCTs interface between prevention, care and treatment, and should be offered widely in health-care settings to anyone who might benefit from knowing their HIV status; VCTs serve as entry points to HIV/AIDS care and support.



- ▶ HIV testing must be voluntary
- ▶ Confidentiality must be protected
- ▶ Referral to post-test care, treatment and support services should be offered
- ▶ Counselling and testing services of quality must be scaled-up

Quality of VCT is key to success!

HIV/AIDS Care and Support

- ▶ With increasing access to complex lifelong antiretroviral treatment, which requires more than 95% treatment adherence in order to be effective, it is critical that a comprehensive care and support continuum is in place.
- ▶ **Comprehensive community- and home-based health care** is an integrated system of care and includes primary prevention of HIV, early diagnosis, clinical management, support, as well as palliative and terminal care. It involves partnership between health workers and clients/patients and members of the local community. Family, friends and peers can be trained as care providers and treatment adherence supporters.
- ▶ **Medical and psychosocial care** for people living with HIV/AIDS can be provided in day-care centres. Such centres were established as a policy of the Ministry of Public Health Thailand to promote comprehensive HIV/AIDS care and support during the early 1990s.
- ▶ **Outreach strategies** are vital for successful care, support and treatment for HIV/AIDS especially among marginalized groups, such as sex workers and injecting drug users. Effective outreach strategies bring potential patients into the care and treatment system and helps retain patients in care. The most effective programmes have formed strong links with community-based organizations representing or serving the affected groups and have used peer educators and counsellors drawn from these groups.

HIV/AIDS care and support includes care at all levels such as community- and home-based health care; day care; support services provided by civil society groups; government; non-government institutions; and health facility based clinical management.



The Treatment Initiative

In September 2003, WHO, UNAIDS, and the Global Fund to fight AIDS, Tuberculosis and Malaria declared lack of access to AIDS treatment with antiretroviral medicines a global health emergency.

Why antiretroviral treatment (ART)

- ▶ ART prolongs lives making HIV/AIDS a manageable chronic disease.
- ▶ ART will help reduce stigma and discrimination and change attitudes towards HIV/AIDS.
- ▶ ART is now affordable for developing countries and can reduce overall health costs and restore quality of life.

The “3 by 5” Initiative

The “3 by 5” initiative aims to provide ART to 3 million people with HIV/AIDS in developing countries by 2005. This is the first milestone on the way to the goal of access to ART for everyone who needs it. The intermediate “3 by 5” target for South-East Asia is to get 450 000 people on ART by the end of 2005.

Key elements of the initiative are

- ▶ political and financial commitment of governments and partners to fight the epidemic
- ▶ countering stigma and discrimination associated with HIV/AIDS by increasing public awareness
- ▶ scaling-up of effective interventions and ART.

“3 by 5” aims at a result-oriented teamwork among the many partners, strong linkages between communities, governments and international institutions, and commitment to health equity.

Why the target of 3 million?

Worldwide 6 million people with HIV/AIDS are in need of treatment. The “3 by 5” target is based on scientific analysis which has shown that it is feasible to reach 50% of those in need of ART by 2005, thus 3 million.

“3 by 5” is not only a treatment initiative

HIV/AIDS control can be achieved only if prevention, care and treatment programmes work together to minimize the risk of further infection. “3 by 5” must ensure acceleration of prevention efforts and a comprehensive response with treatment and prevention programmes enhancing each other.

What is the cost of “3 by 5”?

Projected cost of “3 by 5” for 2004–2005 is at least US\$ 5.5 billion for high-burden countries that account for 90% of the target.

- ▶ At the patient level, costs include counselling and condom distribution, antiretroviral drugs, treatment and prophylaxis of opportunistic infections, palliative care, and laboratory tests.

- ▶ At the programme level, costs include training, supervision and monitoring, recruiting community health workers, purchasing diagnostic instruments and observing universal precautions.
- ▶ Antiretroviral drugs account for the greatest proportion of the costs; treatment for opportunistic infections, palliative care and monitoring of universal precautions are other major costs.

Which are the entry points for ART?

- ▶ Clinics treating sexually transmitted infections, drug treatment centres and tuberculosis treatment (or DOTS) centres.
- ▶ Voluntary counselling and testing centres as well as antenatal care clinics.

Who gets treatment?

Equal access to treatment needs to be ensured requiring some crucial considerations with respect to gender-specific barriers and avoiding under-representation of vulnerable populations while designing treatment programmes.

“3 by 5” is achievable

“3 by 5” can be achieved if WHO and countries change the way they work. Important progress has already been made. There is

- ▶ unprecedented high-level of political commitment to treatment access
- ▶ high level of national and international financing is available

- ▶ significant decrease in antiretroviral drug prices
- ▶ simplified regimens, new treatment guidelines and a new AIDS Medicines and Diagnostic Service.

Other steps forward:

- ▶ The delivery of ART in resource-poor settings once thought impossible has now shown to be feasible.
- ▶ There is increasing funding available for HIV/AIDS in particular from the World Bank and the Global Fund to fight AIDS, Tuberculosis and Malaria; other developmental partners, as well as bilateral and UN agencies.
- ▶ An initial strategic framework for scaling up ART has already been developed by WHO.
- ▶ WHO pledges concrete support for country action.

Sustainable financing and delivery mechanisms can help extend the gains of “3 by 5” so that prevention, care and antiretroviral treatment become a part of the primary health care package at every health care centre and clinic providing lifelong treatment to all those who need it.

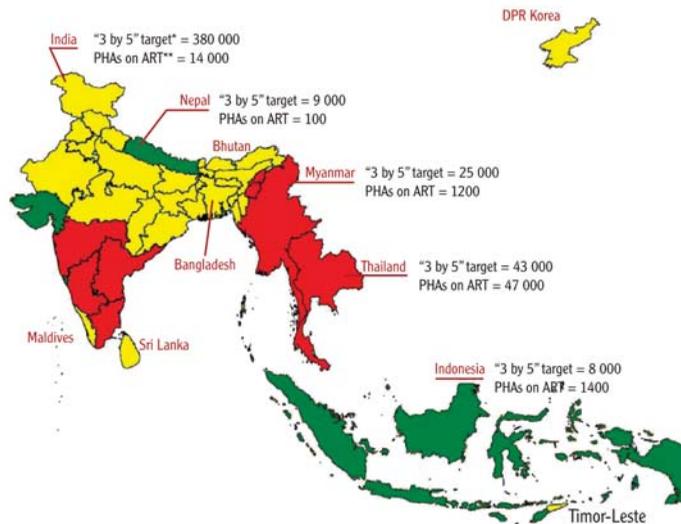
Scaling-Up Antiretroviral Treatment

- ▶ Antiretroviral treatment (ART) can keep people alive and transform HIV/AIDS from being a death sentence to a manageable chronic disease.
- ▶ Effective treatment is available but has not been accessible to millions of people in urgent need of treatment. Of the 6 million people infected in South-East Asia more than 900 000 are in urgent need of treatment but only 7% are receiving it.
- ▶ Unless this treatment gap is reduced quickly the epidemic will leave an irrecoverable human and socioeconomic devastation in the South-East Asia Region.

Why Scale-Up Treatment

Treatment scale-up would help counter the loss of human capital and productivity because the average survival time of people with AIDS can be increased from six months to five years and improve patient's quality of life so that they can continue to work, sustain families, educate their children, and interact with society.

Antiretroviral treatment status in high burden countries in South-East Asia



Classification of HIV epidemics

- Generalized (HIV prevalence >1% in pregnant women)
- Concentrated (HIV prevalence >5% in high-risk groups but <1% in pregnant women)
- Low (HIV prevalence <5% in high-risk populations)

* "3 by 5" target: 50% of people with HIV/AIDS (PHAs) with advanced HIV infection who should received antiretroviral treatment by 2005.
 ** PHAs on ART: Estimated number of people with HIV/AIDS on antiretroviral treatment in public and private health facilities.

Framework for ART scale-up

For treatment scale-up a Regional Strategic Framework has been prepared consisting of three guiding principles and five strategic elements.

Three Guiding Principles

- 1 To accelerate HIV prevention activities and to strengthen health systems, especially managerial and operational capacities, to scale-up antiretroviral treatment.
- 2 To make antiretroviral treatment an integral part of HIV prevention and care at all levels of the health system.
- 3 To implement antiretroviral treatment programmes that promote gender equality, are inclusive of children, intravenous drug users, the poor and other marginalized groups.

Five Strategic Elements

- 1 Securing political and financial commitment
- 2 Strengthening capacities of health services (infrastructure for voluntary counselling and testing, laboratory diagnosis and monitoring, as well as training of health workers)
- 3 Ensuring uninterrupted supply of antiretroviral drugs and diagnostics
- 4 Ensuring treatment adherence through partnerships, including with people living with HIV/AIDS
- 5 Monitoring and evaluating performance including operational research

Each of the above elements requires quick action. The need is urgent.

ART Scale-Up in South-East Asia

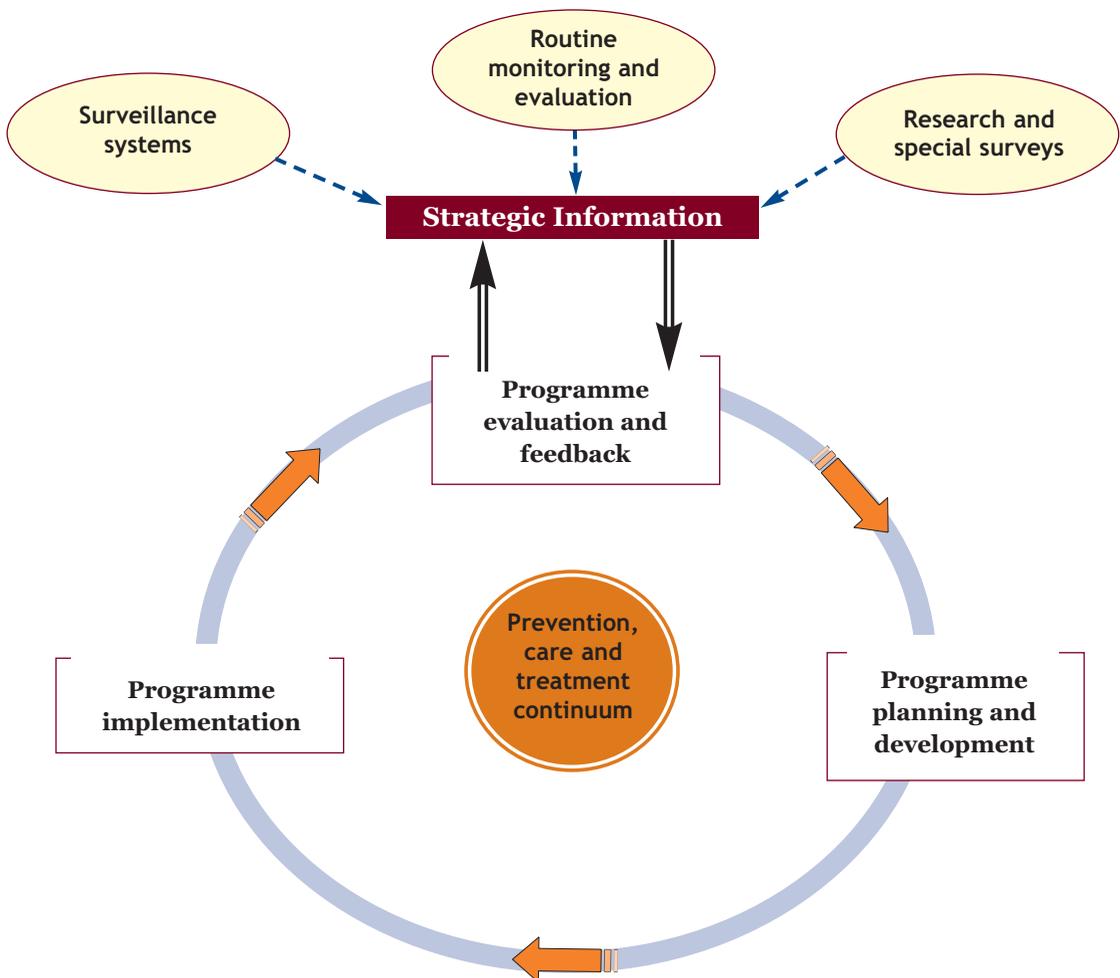
- ▶ Several countries in the Region already include ART in their national policy.
- ▶ Thailand is demonstrating that ART is not only implementable but also attainable and sustainable.
- ▶ At least one of the WHO recommended first-line antiretroviral combinations are available in Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka, and Thailand.
- ▶ Triple combination drugs now cost less than US\$ 1 a day.
- ▶ The corporate sector, non-governmental organizations and people with HIV/AIDS networks are expanding significantly to collaborate with HIV/AIDS protection and care programmes.
- ▶ There is unprecedented international commitment to assist and support countries in their endeavours to accelerate ART.

Challenges to Scale-Up

- ▶ The vast majority of HIV-infected individuals are not aware of their HIV status, especially the vulnerable and marginalized. This hinders their entry into ART programmes.
- ▶ Poverty and gender inequities are overriding constraints in implementing ART.
- ▶ Denial, stigma and discrimination are still formidable obstacles that prevent those infected or at risk to seek voluntary counselling and testing (VCT) services and treatment.
- ▶ Adequate resources are still not available in countries to substantially scale-up ART.
- ▶ Existing health systems are weak and unable to provide the needed laboratory, VCT, treatment, care and support services, especially those needed for outreach programmes and treatment adherence.

Strategic Information: Surveillance, Monitoring and Research

- ▶ One of the first steps in countering the HIV epidemic is to know the characteristic of the epidemic. In many South-East Asian countries there is not enough quality information to assess the epidemic.
- ▶ Strategic information is the knowledge generated to guide the direction of prevention and control activities.
- ▶ Strategic information can be generated from routine monitoring and evaluation systems which are built into the interventions, systematic surveillance and specially-designed research.



Control Efforts: Success Stories

HIV/AIDS treatment programmes have been successful in Brazil and Thailand. In South-East Asia many effective approaches have worked with respect to prevention of HIV/AIDS.

A Country-Level Success

Thailand's national prevention and control programme

To prevent the rapid spread of HIV/AIDS, the Royal Thai Government expanded coverage of a package of key interventions.

► Targeted intervention: promotion of condom use

In 1989, Thailand introduced a 100% condom use programme among establishment-based commercial sex workers and their clients, which was expanded nationwide in 1991. This strategy has reduced HIV infections and sexually transmitted infections among sex workers and their clients, and has had a major impact in limiting the spread of HIV in the general adult population. Since 2000, similar targeted condom use programmes have been implemented in Cambodia, China, Indonesia, India, Lao PDR, Mongolia, Philippines and Myanmar.

A national multisectoral control programme with the involvement of people with HIV/AIDS and the community can help decrease HIV infections.

► Mother-to-child HIV transmission prevention programme

In early 2000, the Thai Ministry of Public Health established a national policy on preventing mother-to-child transmission. It was the first resource-limited country to implement such a national programme. The Ministry announced and began supporting nationwide integration of a mother-to-child prevention programme into the existing maternal and child health programmes.

► Access to care for HIV/AIDS patients

Since the early 1990s, Thailand had voluntary counselling and HIV testing services and medical care including the treatment for opportunistic infections and antiretroviral treatment for HIV/AIDS patients. Since 2001, services for the treatment and prophylaxis of common opportunistic infections are covered under the government health insurance and more than half of those in need are receiving antiretroviral treatment through the public sector.

► **Community responses/networking**

The Thai government has launched a policy to promote a community-focused response among stakeholders, which includes the government, non-governmental and community-based organizations, people living with HIV/AIDS and potential community leaders. The active role of non-governmental organizations and people with HIV/AIDS is considered to be one factor that facilitated the success of Thailand's national AIDS programme. Non-governmental organizations and people living with HIV/AIDS are represented in the National AIDS Committee.

► **Day-care centres**

Hospital- and clinic-based day-care centres in northern Thailand are excellent examples of how to meet the needs of people with HIV/AIDS and establish a link between the community and the health facility.

A day-care centre is a place where people with HIV/AIDS can freely meet together and receive health education, counselling, care, socioeconomic support, and chronic ambulatory care; as well as practice income generating activities.

- The annual number of newly diagnosed HIV infections reduced from 142 819 in 1991 to 25 790 in 2001 and 19 471 in 2004. The HIV prevalence rate among men visiting sexually transmitted infection clinics dropped from 9% in 1999 to 4.6% in 2003 and among pregnant women from 1.8% in 1995 to 1.18% in 2003.

The success in Thailand is attributed to a nationwide effective political and financial commitment, multisectoral involvement, systematic epidemiological surveillance, social and behavioural research, establishment of effective interventions, and mass awareness.

A State-Level Success

APAC, Tamil Nadu, India

There are over five million cases of HIV infections in India. The AIDS Prevention and Control Project (APAC) funded by USAID introduces HIV-preventive behaviour among high-risk groups (such as sex workers, truck drivers, tourists and slum dwellers) and promotes condom use and safe behaviour among these groups.

Spreading HIV/AIDS awareness among high-risk groups increases safe behaviours.

Varalakshmi, a young sex worker in Chennai, entered the profession when she was abandoned by her husband. Earning a mere US\$ 25 to US\$ 30 a month, she has to take care of her rent and meals. Earlier, she would contract sexually transmitted infections, as many of her clients refused to wear condoms. She said: "I was helpless when they got drunk and refused to use condoms. But these days, I select my clients carefully. My hospital friends have taught me how to be careful." The APAC field workers who counsel her to always negotiate for condom use are the hospital friends she refers to. For the first time in her life, Varalakshmi feels she can make a conscious decision to protect herself.

As a result of APAC, condom usage among sex workers increased from 56% in 1996 to 88% in 2002. More than 3000 doctors were trained and over 100 000 STI patients treated. Technical help provided to condom manufacturers to meet WHO standards has improved both their quality and demand.

A Target Population-Level Success

Sonagachi, Kolkatta, India

In 1992, a unique intervention programme to reduce the incidence of sexually transmitted infections (STIs), including HIV, was launched in Sonagachi, one of the oldest and largest red-light areas in Calcutta, India, with over 4000 sex workers and their clients in 370 brothels.

- ▶ Groups of sex workers were mobilized as peer educators and trained to disseminate information. A clinic provided free treatment for STIs and promoted preventive sexual health.
- ▶ In mid-1992, only 2.7% used condoms always or often. By mid-1995, 50.1% had begun to use condoms. Those who had one or more STIs, reduced from 88% to 59% in 1993.

- ▶ Overall, condom use increased to 39% among those in the intervention programme compared to 11% in the rest of the community.
- ▶ The sex workers have formed their own cooperative – the first of its kind in Asia – in which, among other items, condoms are sold at subsidized rates.

Peer education among sex workers can bring about behaviour change and keep HIV infection at low levels.

Role of the World Health Organization

WHO is committed to provide accelerated and intensified support to Member countries in their national plans to scale up interventions.

- ▶ **Advocacy, policy and strategy:** WHO continues to advocate, in collaboration with international agencies and the private sector, prioritizing of health within the developmental agenda, using HIV/AIDS as an entry point for strengthening health systems and for health sector reform and to support development of policies, strategies and operational plans. WHO will continue efforts to build partnerships and mobilize the involvement of communities and people with HIV/AIDS for increasing access to prevention, care and treatment services.
- ▶ **Technical support:** WHO will continue to provide normative tools, guidelines and training to governments in assessing the extent and nature of the epidemic; prevention of new infections; and provision of treatment, care and support to those in need.
- ▶ **Strategic information:** WHO will provide direction and leadership on surveillance, monitoring and evaluation, as well as research priorities, including the development of vaccines, microbicides and operational research.
- ▶ **Mobilizing resources:** WHO is assisting countries to mobilize resources to implement HIV prevention, care and treatment programmes. To date, more than US\$ 400 million have been committed to HIV/AIDS programmes in the Region through resources from the Global Fund to fight AIDS, TB and Malaria.

The role of WHO in the fight against AIDS has been and remains crucial. As an international public health agency it can fulfill both technical cooperation and stewardship functions.

- ▶ **Facilitating procurement of drugs:** An AIDS Medicines and Diagnostics Service (AMDS) has been established as a network hub, helping to coordinate the many efforts still in progress so as to improve access to HIV/AIDS medicines. The AMDS intends to provide a range of support services which could be tailored to country needs.

WHO has the responsibility both to support expanded access to antiretroviral treatment and to work with countries and international partners to ensure that the new resources flowing into HIV/AIDS are invested so as to build sustainable health system capacities and national control programmes.

Role of Governments

To implement an effective control strategy governments must:

- ▶ Provide strong political leadership within and outside the health sector.
- ▶ Advocate the inclusion of health sector stakeholders (such as professionals, teachers, people with HIV/AIDS, vulnerable groups and communities, non-governmental organizations (NGOs) in national planning and decision-making.
- ▶ Ensure a comprehensive response by involving as many partners and sectors to coordinate activities of various government ministries (such as finance, labour, tourism, education, among others), NGOs, private sector and academia.
- ▶ Allocate roles and responsibilities to avoid uncertainty.
- ▶ Decentralize programme activities to the district and community levels.
- ▶ Request additional resources to carry out these responsibilities as required.

The HIV/AIDS epidemic and its possible impact on societies and nations calls for political commitment and dynamic leadership to mobilize resources for HIV/AIDS prevention, care and treatment.

Role of the Health Sector

- ▶ Health ministries are the major force for leadership and mobilization, with a responsibility to advocate for the inclusion of all stakeholders in national planning and decision-making.
- ▶ The “3 by 5” initiative is critically dependent on well-functioning health systems.
- ▶ Treatment scale-up should not undermine the capacity of health systems. International organizations, national governments, the private sector and communities can combine efforts to achieve this objective.

Health ministries need to:

- ▶ Use the United Nations Declaration of Commitment on HIV/AIDS to advocate for leadership, commitment and resources to combat the epidemic.
- ▶ Develop an HIV/AIDS leadership plan for the health sector.
- ▶ Develop a detailed funding plan for the health sector as an important element of the national strategic plan for HIV/AIDS.
- ▶ Ensure that strategy implementation is supported by mechanisms for accountability, monitoring and evaluation.
- ▶ Review regulatory and quality control measures for services, diagnostics and commodities related to HIV/AIDS.

Health system leadership, service delivery, resource provision and financing can be strengthened to implement “3 by 5” while improving and expanding many other health interventions.

What HIV/AIDS Programme Managers Can Do

- ▶ Advocate to the highest levels to secure political commitment
- ▶ Draw up national plans for implementation
- ▶ Build capacity of health services to deliver antiretroviral treatment (ART)
- ▶ Ensure uninterrupted supply of quality drugs and treatment adherence
- ▶ Involve communities in planning and delivering ART services
- ▶ Monitor progress and evaluate programme performance.

Private Health Sector

The government’s response to HIV/AIDS, at least with regard to antiretroviral treatment, depends on strong partnerships with the private health sector. The private sector needs to work in partnership with the government to implement national plans. This is because

- ▶ the majority of households in the Member countries where public health services are weak go to private hospitals/clinics or doctors. In India, 65% of households consult the private sector. Similar high proportions are expected in other countries of the Region.
- ▶ in most Member countries the private health sector remains virtually unregulated and has highly variable quality of care.

Role of Civil Society

Civil society groups, particularly people with HIV/AIDS (PHA) have been a driving force in the response to the HIV/AIDS epidemic in many countries. They have played a critical role in advocating for access to antiretroviral treatment as a human right. Civil society groups, such as community-based organizations (CBOs), have played a strong role in strengthening health sector capacity through provision of HIV/AIDS specific care and support services.

- ▶ PHA groups, NGOs and CBOs, are strong advocates for a comprehensive response to HIV/AIDS. They play an important role in persuading governments, workplaces, and other settings to abandon legislation that would have required compulsory HIV testing. They also help in addressing stigma and discrimination and advocating for access to care, treatment and support.
- ▶ In partnership with the health sector, civil society groups can offer a wide range of support services such as counselling and support, education, home-based care, training in income-generating activities and treatment adherence counselling.
- ▶ Women-led groups are strong advocates for gender equity and equality among those affected by HIV/AIDS and can offer a wide range of services to women and their families, including counselling and support, education, home-based care, and training in income-generating activities.
- ▶ PHA groups can become informed participants in medical research, policy making, and delivery of services.

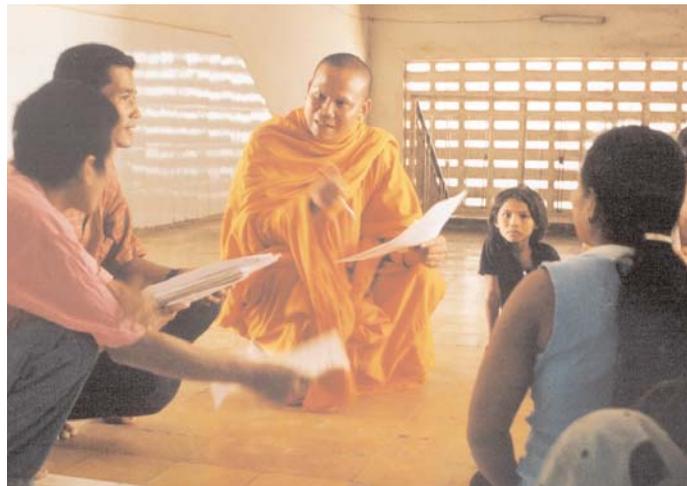
Photo Courtesy: UNICEF EAPRO

“In government we treat people living with HIV/AIDS as partners . . . they have a very important role in educating people and communities, helping to diminish stigma and discrimination, and giving mutual support. They are very important in some of our decision-making. We recognize their outstanding work.”

—Dr Sombat Tanprasertsuk, Director,
Bureau of AIDS, TB and STI, Ministry of Public Health,
Bangkok

Community participation is required for every aspect of HIV prevention and control, and includes advocacy, delivery of services and support to patients.

- ▶ Faith-based organizations are important partners in prevention, community education, care, treatment and support. They can advocate the need for treatment adherence and promoting confidence to seek treatment.



The PHA Movement in Thailand

The PHA groups in Thailand belong to rural poor communities, most members being farm or factory labourers, housewives or unemployed people. PHA groups were first established in the early 1990s as a means of providing mutual support. There are about 600 PHA groups, mostly hospital-based with a nurse supervisor and receiving funding from the Ministry of Public Health or from the local government. NGOs and PHA groups have played a key role in Thailand's response to HIV/AIDS since the first cases were notified over 15 years ago. An early advocacy effort by NGOs focused on persuading the government to abandon legislation that would have required compulsory HIV testing. In 1998 a coalition of local and international NGOs and PHA groups began to challenge the high price and monopolistic situation of antiretroviral (ARV) drugs in Thailand. Action has included the provision of legal and political support for generic drug production. A major victory was gained in 2002 when PHA won a court case against a multinational pharmaceutical company, overturning a patent on the ARV drug didanosine. NGOs and PHA groups have also lobbied for universal access to antiretroviral treatment for all PHA who need it.

Advocacy alone is not enough. In 2000, as part of a problem solving approach to the inadequacy of access to treatment, some NGOs and network of PHA groups began providing education on treatment within their own communities and cooperating with the health care system to prepare for wider availability of treatment.

What Communities Can Do

- ▶ Catalyze change in behaviour and awareness to reduce stigma and discrimination.
- ▶ Create a supportive environment and address gender inequalities.
- ▶ Empower individuals with HIV by providing legal and psychosocial support.
- ▶ Promote community capacity building by training health workers and setting up NGOs, CBOs, and self-help groups.
- ▶ Involve PHA groups for advocacy.

What CBOs and PHA Groups Can Do

- ▶ Advocate widely to policy makers on the importance of scaling up ART.
- ▶ Accelerate HIV prevention activities and help reduce stigma and discrimination.
- ▶ Build national awareness on the benefit of knowing one's HIV status and seeking treatment.
- ▶ Mobilize communities to advocate widely on the need to scale-up ART, to know their HIV status and to seek treatment.

Role of Non-Governmental Organizations

Non-governmental organizations (NGOs) can provide critical support to AIDS control programmes, because they are people-oriented and more sensitive to the needs of those affected.

Providing comprehensive client-centred HIV/AIDS care: Indian NGO YRG CARE

In 2000, Sharmila, a 28-year-old mother of two, found that she was HIV-positive and was convinced that it was the end for her. Before she could come to terms with it, her husband was also found to be infected. She was overwhelmed with depression and fear left her emotionally paralyzed. Within few weeks Sharmila turned to YRG CARE (YRG Centre for AIDS Research and Education) where she found answers to her questions on what is HIV, how long can she live, and what medications were available to treat her and perhaps extend her life. She says that counselling sessions at YRG CARE helped her cope with the disease.

“Information empowers, and I feel so relieved that I have people to talk to.”

Today, she is a client of YRG CARE and benefits from high-quality confidential care.

Source: Horizons report, 2002

What Non-Governmental Organizations Can Do

- ▶ Raise awareness among individuals, groups and communities about HIV/AIDS prevention, care and treatment; implement targeted intervention programmes for behaviour change in people engaged in high-risk behaviours.
- ▶ Provide and facilitate access to health services including treatment of sexually transmitted infections, especially for marginalized groups.
- ▶ Promote condom distribution and use and assist in mobilizing populations for voluntary donation of blood.
- ▶ Advocate for human rights, counter discrimination against people with HIV/AIDS and provide care and support at the community level and within the family.
- ▶ Become effective partners in the national response and participate fully in planning, implementation and evaluation of national as well as local-level AIDS programmes.

Role of Corporate Sector

HIV/AIDS has a profound effect on the corporate sector in all countries facing the epidemic.

- ▶ AIDS is a workplace issue because it affects labour and productivity because of loss of skills, cost of hiring and retraining, health and death benefits, and the potential of workplace conflict.
- ▶ AIDS is reducing the ratio of healthy workers to dependants.
- ▶ In a number of Member countries, collaboration between the government and the business sector has been established to ensure prevention of HIV transmission and non-discrimination.

1.3 million workers in five Asian countries (China, India, Cambodia, Thailand and Myanmar) are estimated to be unable to work by 2015 if antiretroviral treatment is not made available. *Source: ILO 2004*

The annual AIDS deaths among the working age group (15–64 years) projected to rise from 560,000 in 2005 to almost 2 million in 2015 in the five Asian countries. *Source: ILO 2004*

What the Corporate Sector Can Do

- ▶ Support HIV prevention by educating workers and their families and making condoms available.
- ▶ Encourage and provide access to counselling, HIV-testing, management of sexually transmitted infections, HIV/AIDS care and treatment.
- ▶ Support local community initiatives.
- ▶ Destigmatize the disease to prevent discrimination.
- ▶ Retain employees with HIV as long as they are medically fit to work.
- ▶ Provide care and antiretroviral treatment through the existing social security system or employee state insurance schemes.
- ▶ Large enterprises can provide antiretroviral treatment to employees and the community through public–private partnerships.
- ▶ Ensure workplace policies are in place and address issues, such as confidentiality of HIV status, legal issues, in accordance with the International Labour Organization’s Code of Practice on HIV/AIDS and the World of Work.

International Labour Organization Code of Practice on HIV/AIDS and the World of Work

The workplace has an important role to play in limiting the spread of the HIV/AIDS epidemic. The International Labour Organization (ILO) has issued a “Code of Practice on HIV/AIDS” to help reduce the spread of HIV and mitigate its impact on enterprises, workers and their families. It is based on the following key elements — prevention through education and practical support for behaviour change; non-discrimination and protection of workers’ rights, including employment security, entitlement to benefits, and gender equality; care and support, including confidential voluntary counselling and testing, as well as treatment in settings where local health systems are inadequate.

There is an urgent need to ensure that the corporate sector responds to the HIV/AIDS epidemic proactively and takes steps to manage risk, avoid workplace conflict and contribute to constructive employer–employee relations.

Role of Media

- ▶ An enlightened public is key to preventing the spread of HIV/AIDS. And, this is where media has a powerful role to play.
- ▶ The number of new HIV-infected persons in Asia is estimated to increase by 10 million each year.
- ▶ With its large population base, South-East Asia has the potential to greatly influence the course and impact of the epidemic. Asia has the advantage of 16 years of experience in Africa to make effective responses to the epidemic.

Success of any national HIV/AIDS control programme depends on ingenious media strategies involving all sections of civil society.

The media is a major advocacy channel. It can

- ▶ increase knowledge and awareness of HIV/AIDS to help fight stigma and discrimination.
- ▶ highlight efforts of countries, partners and WHO for curtailing the spread of HIV.
- ▶ write about success stories of people living with AIDS.
- ▶ study and write about vulnerable groups in their countries.
- ▶ highlight stories and examples of hidden risky behaviours.
- ▶ review if HIV prevention programmes in their countries are effectively reaching all vulnerable groups.
- ▶ write about policies regarding AIDS education.
- ▶ broadcast prevention and treatment messages on television and radio.



Additional information on HIV/AIDS can be obtained from the following WHO offices:

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The HIV/AIDS epidemic continues to grow worldwide and poses a huge human and economic burden

HIV/AIDS can be prevented

HIV/AIDS can be treated and managed as a chronic disease

Urgent scale-up of integrated prevention, treatment and care services is needed

Political commitment, civil society support, and additional and sustained resources are key to reversing the epidemic



World Health Organization
Regional Office for South-East Asia
New Delhi