

Scaling-up **HIV** Prevention, Care and Treatment

Report of a Regional Meeting

Bangkok, Thailand, 31 October - 2 November 2006



**World Health
Organization**

Regional Office for South-East Asia

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Acronyms

AIDS	acquired immunodeficiency syndrome
AusAID	Australian Agency for International Development
ADB	Asian Development Bank
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
ATS	amphetamine-type stimulant
ASEAN	Association of South-East Asian Nations
CBO	community-based organization
CCC	comprehensive and continuous care
DFID	Department for International Development
FHI	Family Health International
GFATM	Global Fund for Fighting AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HIV DR	HIV drug resistance
IDU	injecting drug user
IMAI	integrated management of adult and adolescent illnesses
MARPS	most-at-risk populations
MDG	Millennium Development Goals
MSM	men who have sex with men
NACO	National AIDS Control Organization of India
NGO	nongovernmental organization
PITC	provider-initiated testing and counselling (of HIV)

RDMA	Regional Development Mission of Asia of USAID
RTG	Royal Thai Government
SEA	South-East Asia
SEAR	South-East Asia Region
STI	sexually transmitted infection
SW	sex worker
T&C	testing and counselling
UNAIDS	United Nations Programme on AIDS
UNGASS	United Nations General Assembly Special Session (on AIDS)
UNICEF	United Nations Children's Fund
UNODC	United Nations Office of Drug and Crime
USAID	United States Agency for International Development
VCT	voluntary counselling and testing (of HIV)
WHO	World Health Organization

1. INTRODUCTION

The HIV/AIDS pandemic has reversed the course of human development and eroded improvements in life expectancy in countries with a high prevalence of infection. Since the first cases of acquired immunodeficiency syndrome (AIDS) were reported in 1981 in the United States, infection with the human immunodeficiency virus (HIV) has grown to pandemic proportions, resulting in more than 65 million infections and 25 million deaths. At the end of 2006, an estimated 39.5 million people were living with HIV/AIDS (PLHA).

The HIV epidemic in the South-East Asia Region is a source of growing concern. An estimated 7.2 million people were living with HIV/AIDS at the end of 2006. Of these, 1.9 million were younger than 25 years of age, including 120 000 children. South-East Asia bears the second highest number of HIV-infected persons among all WHO Regions, behind sub-Saharan Africa.

Although the overall HIV prevalence is low (0.7%), the large population of the Region of more than 1.6 billion people makes the magnitude of the HIV epidemic huge. The HIV epidemic in this Region is diverse and is largely confined to populations most at risk such as injecting drug users (IDUs), sex workers (SWs) and their clients, and men who have sex with men (MSM) and their partners. Rapid HIV transmission through these overlapping networks drives the Asian HIV epidemic, yet these highly affected populations often have the least access (less than 20%) to even basic prevention and care services.

Access to care and antiretroviral therapy (ART) has been accelerated through the *i3 by 5i* initiative (to treat 3 million by 2005). The annual number of PLHA and receiving ART in the Region has doubled every year over the past 3 years and, as of December 2006, is estimated to be 170 000 persons. Although this fell short of the regional target of 50% of people in need receiving ART and with only a fraction of children receiving treatment, the Initiative has served to increase political commitment and created partnerships in facing the epidemic. It has also contributed to capacity building of health services, strengthening of infrastructure and logistics for the supply of drugs and diagnostics, and reducing the stigma attached to the disease. However, key challenges include the poor capacity of health systems; health information systems that are not geared towards reporting to the United Nations General Assembly Special Session (UNGASS) and Millennium Development targets and indicators; and insufficient allocation of national resources for scaling-up and sustaining prevention, care and treatment programmes.

The meeting brought together senior representatives from the Ministry of Health, programme managers from national AIDS programmes as well as from reproductive health and adolescent health programmes, representatives from nongovernmental organizations (NGOs) and development partners to exchange information and provide a platform for technical and strategic discussions on scaling-up HIV prevention, care and treatment interventions. A total of 85

participants attended the *Regional Meeting on Scaling-up HIV Prevention, Care and Treatment Interventions*. These included representatives from 10 Member States of the South-East Asia (SEA) Region (Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste), the United Nations Children's Fund's (UNICEF) Regional Offices for East Asia and the Pacific and South Asia, the United Nations Office on Drugs and Crime's (UNODC) Regional Office for East Asia and the Pacific, United Nations Programme on AIDS (UNAIDS) Country Support Team for Asia and the Pacific, Asian Development Bank (ADB), the Association of South-East Asian Nations (ASEAN) Secretariat, Australian Agency for International Development (AusAID), the Canadian International Development Agency (CIDA), Department for International Development (DFID), the European Commission, Family Health International (FHI), the United States Agency for International Development (USAID), and the World Health Organization's (WHO) Country Offices for China, India, Indonesia, Myanmar, Nepal and Thailand, as well as WHO Regional Offices for South-East Asia and the Western Pacific and Headquarters.

The meeting was held in Bangkok, Thailand, on 31 October to 2 November 2006. It was presided over by the Permanent Secretary, Ministry of Public Health, Thailand. The daily sessions were chaired by Dr Anupong Chitwarakorn, Senior Expert, Department of Disease Control, Thailand and co-chaired by Dr Abdus Salim, National AIDS Programme Manager, Thailand on the first day, by Dr D. Bachani, Joint Director National AIDS Control Organization (NACO) of India and Dr (Ms) Khin Ohnmar San, Assistant Director (AIDS/STD), National AIDS Programme Myanmar on the second day and by Mr Mohammed Rameez, National AIDS Programme Manager, the Maldives and Dr Gampo Dorji, National AIDS Programme Manager, Bhutan on the third day. The Rapporteurs were Dr Sunil Gupta, Joint Director, National Institute of Communicable Diseases India, Dr (Mrs) Saroj Praseed Rajendra, Chief of Monitoring and Evaluation Division, Nepal and Dr Suginarti, Directorate-General of Medical Services, Indonesia.

2. OBJECTIVES

The meeting had the following specific objectives:

- (1) to review the HIV/AIDS situation, the lessons learned so far and the gaps and constraints in successful implementation of national HIV/AIDS control programmes in the SEA Region;
- (2) to identify strategies for accelerated scaling-up of HIV prevention, care and treatment interventions towards achieving the HIV-related Millennium Development Goals (MDGs) at country level;
- (3) to agree on specific targets and indicators for regularly tracking progress; and
- (4) to identify areas for building partnerships among Member States and partners.

The deliberations at this meeting would provide inputs to Member Countries in preparing/amending their HIV/AIDS strategic plan for the prevention and control of HIV and sexually transmitted infections (STIs) with a view to achieving the MDGs by 2015 and for new global initiatives such as Universal Access to HIV prevention, care and treatment. Technical support plans for WHO and development partners would also be discussed.

3. INAUGURAL SESSION

On behalf of the Regional Director, the meeting was inaugurated by Dr Thierry Mertens, Special Representative of the Regional Director on the Public Health Initiative, who read out the Regional Director's inaugural address. The Regional Director warned that this Region was at high risk for a massive spread of the HIV epidemic not only due to the large size of the population and the high burden of STIs but also due to the prevailing risk behaviours and vulnerabilities. Explosive epidemics among IDUs, SWs and MSM have occurred in Thailand, Myanmar, India and, in more recent years, in Indonesia and Nepal. The SEA Region is not an exception to the documented low global coverage of prevention, care and treatment services. Despite the fact that effective and cheap interventions exist such as condom use programmes targeting SWs and MSM, and harm-reduction programmes targeting IDUs, coverage of these prevention interventions across the Region remains poor. The Regional Director called on Member States and development partners to strengthen efforts for scaling-up HIV prevention, care and treatment interventions while focusing on priority populations and essential intervention components in order to rapidly have the maximum impact.

The Permanent Secretary, Dr Prat Boonyavonvirot highlighted in his opening remarks that Thailand and other countries must decisively commit to ensuring universal access to HIV prevention interventions targeting MARP and vulnerable populations in response to the global Universal Access initiative. He announced that Thailand has committed to reducing new HIV infections by half of projected figures by 2010. He also called upon Member Countries to guarantee universal access to HIV treatment, care and support. All Thais are now guaranteed access to ART. Financing of ART has been integrated into the national social and health insurance programmes in Thailand. The Royal Thai Government has also committed to expanding social services for at least 80% of individuals and families in need, including vulnerable children, orphans and the elderly. He reminded the audience that to achieve the targets of scaling-up HIV interventions, effective mobilization of all sectors of the society, involving local, national and international partners, will be an essential pillar leading to success. Civil societies, in particular PLHA, who have contributed significantly to previous successes in responding to AIDS, will continue to play a critical role working with central and local government partners.

4. KEY STRATEGIES AND INTERVENTIONS FOR SCALING-UP HIV PREVENTION, CARE AND TREATMENT

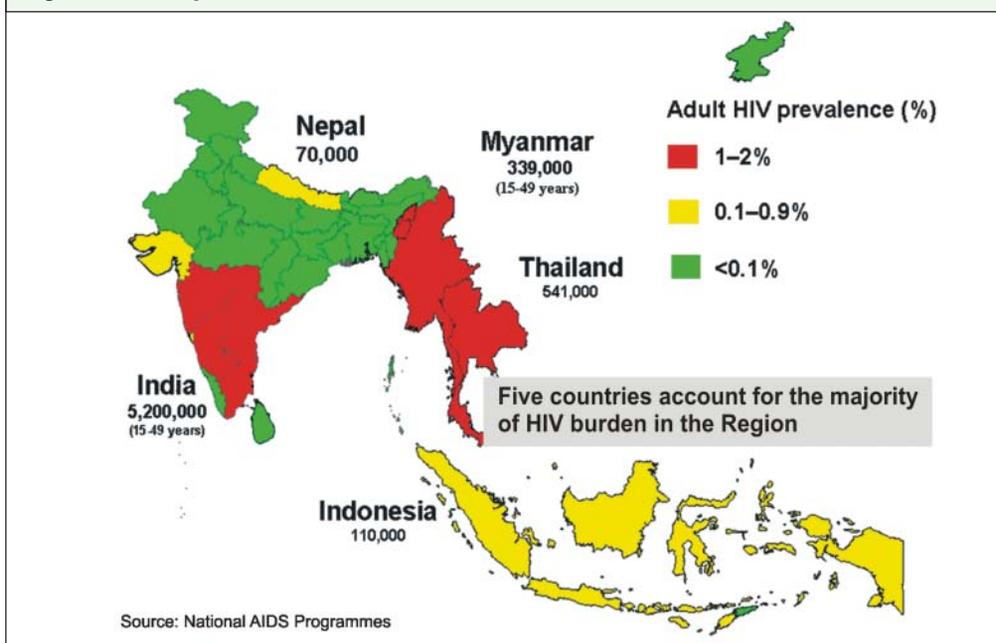
4.1 The HIV epidemic

Member States of the WHO SEA Region include Bangladesh, Bhutan, DPR Korea, India, Indonesia, the Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

The overall adult HIV prevalence in SEA is 0.7%, relatively much lower than the 5.7% in sub-Saharan Africa. However, due to the large population of more than 1.6 billion people, even a low HIV prevalence means a large number of PLHA. At the end of 2006, there were an estimated 7.2 million PLHA in SEAR. Of these, 0.77 million were newly infected and 550 000 persons died of AIDS.

Five countries – India, Indonesia, Myanmar, Nepal and Thailand – account for nearly all HIV transmission in the Region. Six states in India as well as Thailand and Myanmar have generalized epidemics with HIV prevalence rates greater than 1% among women attending antenatal care (ANC) (**Figure 1**). Recently, there has been an alarming growth of epidemics in Indonesia and Nepal; these countries have now surpassed the 5% HIV prevalence rate in high-risk groups (i.e. concentrated epidemics). There is a threat that in other low-level epidemic

Figure 1: HIV prevalence in South-East Asia, 2005



countries such as Bangladesh the epidemic will become concentrated as the prevalence rises steadily among drug-using and sexual networks.

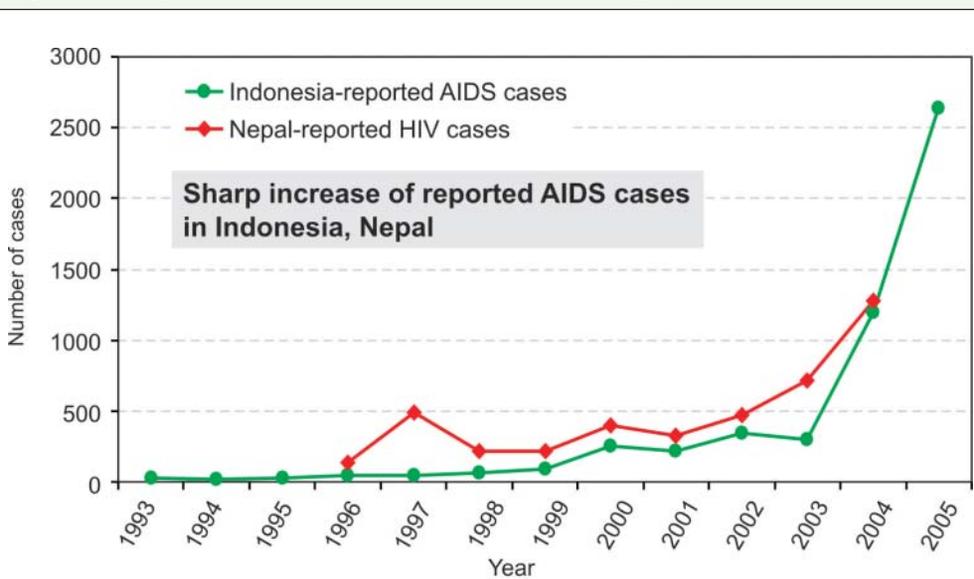
Unsafe sex and injecting drug use are the main drivers of HIV epidemics in SEAR with the greatest burden of infections concentrated in MARPs such as SWs and their clients, IDUs and MSM. Among reported AIDS cases, sexual transmission accounts for 86% of infections in India, 82% in Thailand, 76% in Nepal and 67% in Myanmar. In Indonesia, HIV infection has been largely confined to IDUs (52%) but is increasingly spreading among SWs and their clients/partners.

The epidemic has been successfully reversed in Thailand, and there are indications that the epidemics in Myanmar and the state of Tamil Nadu in India are declining. However, recent rapidly growing epidemics have been reported in Indonesia and Nepal (**Figure 2**).

Despite the high transmission rates in these multiple and overlapping networks, intervention coverage for populations most at risk remains alarmingly low, estimated to be under 5% for IDU and MSM populations and a mere 20% of SWs in the Region. As a result, only 30% of SWs in Indonesia report consistent condom use. In Bangladesh, 93% of IDUs report sharing injecting equipment.

An estimated 2 million young people 15-24 years of age, are living with HIV in SEAR; most SWs are under 25 years of age, and young drug users are known to be at increased risk for infection. Migrants and mobile populations are also

Figure 2: Reported AIDS cases - Indonesia and Nepal, 1993-2005



vulnerable, often engaging in commercial sex or drug use, and facilitating transmission between urban and rural areas, and across large distances.

4.2 From HIV prevention to universal access: a health and human rights perspective

Since the beginning of the HIV epidemic, HIV and AIDS have disproportionately affected people and communities which were stigmatized, marginalized, disenfranchised and subjected to unequal treatment. Countries where the initial response to HIV has made an impact on decreasing the estimated number of annual new HIV infections are those where human rights principles such as participation, nondiscrimination and access to information, essential services and life-saving technologies have inspired policies and programmes. Countries that failed in their early response to the epidemic are those where inequality, persisting discrimination, and denial of access and participation aggravated the state of disempowerment and risk of infection among vulnerable communities and individuals. Twenty-five years into the epidemic, these facts are known, the evidence is available, and yet the global response to the epidemic remains tragically inadequate.

It was realized during the early years of the HIV epidemic that persisting stigma and discrimination generated and fuelled the spread of the virus. For example, in Thailand, as well as in other countries where the affected communities were mobilized and fully engaged as a solution rather than the source of the problem, the scaling-up of HIV prevention, care and support has been successful as demonstrated in 2006.

Box 1: Key elements for universal access and ensuring human rights

- Enhancing political commitment;
- Striving towards financial sustainability;
- Addressing issues of human resources and supply management;
- Integrating treatment and prevention, and
- Ensuring equitable access.

A sound public health approach inspired by human rights-based principles helps identify where people are in the greatest need, what interventions would best respond to these needs and how resources should be allocated. The combined moral, instrumental and legal value of human rights has strengthened HIV-related policies and programmes, and given rise to a new public health approach with a focus on people's dignity, equality and participation, stimulating greater governmental commitment and accountability to fulfil national and international obligations.

4.3 Scaling-up interventions targeting populations most at risk

There are notable examples of success in slowing and even reversing HIV epidemics in the Region. High coverage of interventions for populations at highest risk have been achieved in several countries, using public health sector services such as the 100% Condom Programme in Thailand, NGO-operated services such as the Avahan Initiative in India (Figure 3) and mixed approaches such as the 100% Targeted Condom Promotion Programme in Myanmar.

These successes have several elements in common, including harnessing of political commitment at the highest level, involvement of communities, mapping of populations and emphasis on an essential package of intervention components that can be scaled up efficiently. Coordination across sectors with stakeholders such as the police has helped to establish an enabling environment for interventions.

Box 2: What constitutes an essential intervention package for high-risk populations?

- Involving affected communities in outreach;
- Providing condoms and STI services for SWs and MSM; and
- Providing sterile injecting equipment and opioid substitution therapy for IDUs.

4.3.1 Preventing HIV transmission by targeting sex workers

Interventions for HIV and STI in sex work should be for SWs, with the participation of SWs and among SWs. To be comprehensive, these interventions should include prevention as well as care and treatment, and social and economic support.

The 100% Condom Programme: Prevention interventions targeting SWs and their clients such as the 100% Condom Programme are cost-effective and have been identified as major contributors to the reduction of new infections and overall prevalence in countries that have such programmes.

Box 3: The core principles of the 100% Condom Programme

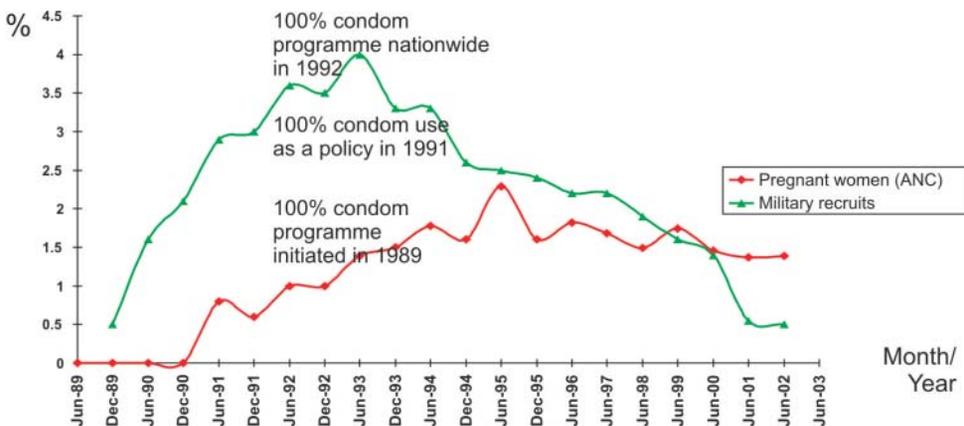
- Creating an enabling environment to empower SWs in all sex establishments to refuse sex services if customers do not want to use condoms so that customers will not be in control of the sex services with regard to condom use;
- Reaching out to SWs;
- Providing free condoms;
- Local authorities and owners of sex businesses taking responsibility for promoting and maintaining such an enabling environment.

It is estimated that the 100% Condom Programme in Thailand has averted 5 million new HIV infections. HIV prevalence among military recruits had peaked in the early 1990s and has since declined (**Figure 3**). Since then, similar programmes have been replicated and adapted in other Asian countries such as Cambodia, Mongolia, China and Myanmar.

Sonagachi empowerment model: In the Sonagachi district of Kolkata, India, HIV prevention efforts began with peer interventions and STI clinic services. With increasing involvement of the SW community, services were strengthened to address a range of health and social harms faced by SWs. STI/HIV services are now part of a broader effort to improve conditions for the community (community-led structural interventions). HIV prevalence remains low in Kolkata compared with other Indian cities. Over 60 000 SWs participate actively in all aspects of community interventions and clinic-based services throughout the state of West Bengal. Savings and credit schemes have reduced their dependency on sex work, and self-regulatory boards effectively address a range of abuses from trafficking to child prostitution.

Avahan India AIDS Initiative. In order to scale-up effective interventions for SWs and other high-risk populations in India's six highest HIV-prevalence states, Avahan (funded by the Bill and Melinda Gates Foundation) supports NGOs to organize outreach, community mobilization and dedicated clinics for SWs (**Figure 4**). These clinics provide STI services including syndromic case management, regular check-ups and treatment for asymptomatic infections. Condoms are promoted and distributed by outreach and clinic teams. Local

Figure 3: HIV prevalence among military recruits, Thailand (1989-2003)

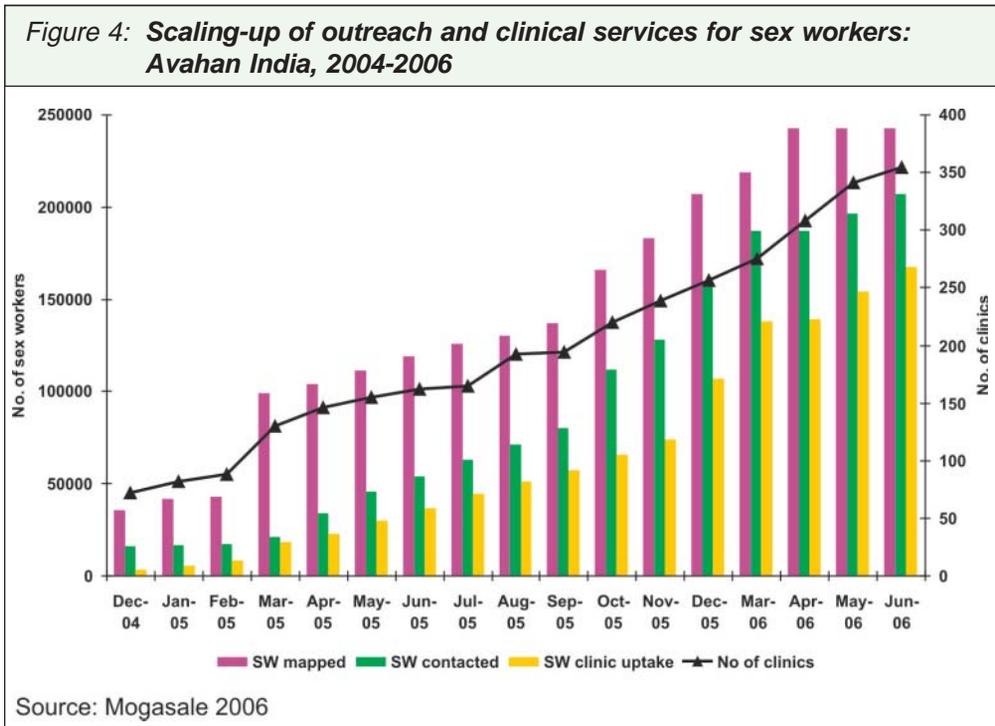


Source: Sentinel sero-surveillance data, Division of Epidemiology, Ministry of Public Health.
Remarks: Switching from bi-annually (June and December) to annually (June) since 1995.
Conscript data in November of each year since 1995 were not shown here.

advocacy work is carried out with the police and others to promote enabling conditions for prevention work. Involvement of SWs is promoted in intervention activities, from community outreach to provision of clinical services.

4.3.2 Preventing HIV transmission among injecting drug users

Injecting drug use is a major driver of the HIV epidemic in the Region. In some Asian countries, 50-70% of HIV infections are attributable to injecting drug use. Of the 13 million estimated IDUs in the world, 3.3 million live in South and South-East Asia.



Heroin smoking is popular in the Region. However, since the late 1960s there has been a transition to injecting heroin and other pharmaceutical drugs. This is now well established in many countries such as Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand. The factors responsible for the transition from non-injecting to injecting use include the escalating cost of heroin enhanced by reduced supply, decrease in the quality of available heroin and easy availability of pharmaceutical drugs. Pharmaceutical preparations that are often injected in combination (cocktails) include synthetic opioids, benzodiazepines and antihistamines. In recent years, the use of amphetamine-type stimulants

(ATS) has increased in the Region, particularly in Cambodia, Myanmar and Thailand. Although ATS is less commonly injected than opioids, there is an association between ATS use and increased sexual risk behaviour, especially among youth.

Sex work and injecting drug use are closely linked in most settings. This sets up a particularly high-risk environment for HIV transmission and also has the potential to create an important "bridge" to the general population. A study from an area of eastern India, which borders Nepal, Bangladesh and Bhutan, found that over 50% of male IDUs visited an SW in the previous year. This has significant implications for cross-border transmission of HIV. In Chennai, India, not only were HIV rates among female sex partners of IDUs very high, but there was also an alarmingly low perception of HIV risk among them.

Preventing HIV transmission among IDUs requires a holistic approach which includes not only demand and supply reduction, but also effective harm-reduction interventions and alternative approaches, along with care and treatment services.

However, coverage by harm-reduction interventions is lowest in countries with the highest IDU prevalence and most limited resources. Only an estimated 0.4% of IDUs are covered by opioid substitution treatment (OST) and coverage by ART is also very low. Community- and prison-based programmes hardly go further than demonstration projects although successful initiatives have shown that harm-reduction interventions could be implemented in Asia. Examples of such interventions include the outreach and needle-syringe exchange programmes in Bangladesh, substitution therapy with buprenorphine in India, and substitution therapy with methadone and prison-based initiatives in Indonesia.

A case study from Bali illustrates a comprehensive response to HIV among IDUs. Outreach to the more than 4000 IDUs in Bali is done by community health centres and two NGOs focusing on behaviour change, treatment and rehabilitation, OST, needle and syringe exchange programmes, voluntary counselling and testing (VCT) and referral for ART. The Kerobokan Prison programme provides a methadone maintenance programme for approximately 35 inmates, ART for approximately 15 inmates (most on methadone), condoms and promotion of the use of bleach for cleaning injecting equipment by the medical services, VCT, group counselling and pre-release peer education.

There is an urgent need to prioritize scaling-up of prevention interventions for IDUs in the Region through promotion of partnerships, capacity building of health workers and engagement of the IDUs themselves.

As highlighted at the 2006 Toronto AIDS Conference "There is no need for any more evidence or pilots, harm reduction works!"

Box 4: The key components of an effective harm-reduction package targeting drug users

- A supportive policy and legislative environment;
- Community outreach, with a focus on peer approaches;
- Behaviour change communication, including risk-reduction information;
- Access to clean needles and syringes as well as their safe disposal;
- Drug dependence treatment, particularly OST;
- HIV testing and counselling (voluntary and confidential)
- Prevention of sexual transmission through distribution of condoms and prevention and treatment of STIs;
- HIV/AIDS treatment and care, including ART; and
- Primary health care, including hepatitis B vaccination, vein and abscess/ulcer care, overdose management.

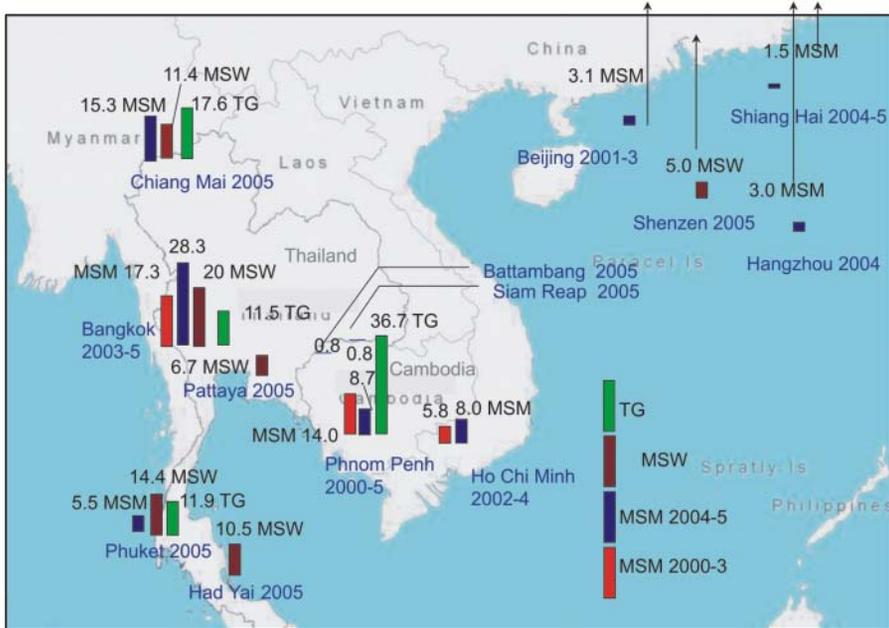
4.3.3 Preventing HIV transmission targeting men who have sex with men

Male same-sex identities and behaviours are diverse, complex and fluid in Asia. There is increasing visibility, organization and even commercialization, with varied places of socialization and meeting such as bars, clubs, saunas, massage parlours, streets and parks.

With this diversity and visibility comes increased recognition of sexual risks among MSM. Data from China, Viet Nam, Laos, Cambodia and Thailand show that 50% or more of MSM reported recent unprotected anal intercourse. As a consequence, surveillance data for STIs show increasing rates of infection. The prevalence of antibodies to syphilis among selected populations of MSM in China, Viet Nam, Cambodia and Thailand varies from 6% to 14%. And with increasing levels of STI prevalence, HIV is also on the rise. The prevalence of male same-sex behaviour varies from 2-3% to 9-10 % in some young populations in Asia. If the HIV prevalence among these men reaches 10-20% it may contribute to 5-25% of HIV infection in the country. Between 2003 and 2005, HIV prevalence among MSM in Bangkok increased from 17% to 28% (**Figure 5**). A recent survey in Nepal showed a 5% prevalence of HIV among MSM in Kathmandu.

Data from China, Viet Nam, Laos, Cambodia and Thailand show considerable levels of risk, with approximately 50% or more of men reporting recent unprotected anal intercourse.

Figure 5: HIV prevalence among men having sex with men in South-East Asia, 2000-2005



MSM—men who have sex with men, MSW—female sex worker, TG—transgender

Box 5: Key components of effective interventions to decrease HIV/STI transmission among MSM

- Provision of condoms and water-based lubricants must be urgently scaled-up, as consistent condom use remains low while partner numbers remain high.
- MSM-friendly STI and HIV services are needed. STIs serve as co-factors that enhance HIV transmission
- Increasing access to HIV counselling and testing services. People who do not know their HIV status are less likely to take protective measures with their partners and access ART programmes. Only a small proportion of MSM seek HIV testing and counseling, which contributes to the invisibility of the epidemic among MSM in Asia.
- Destigmatization of HIV and same-sex behaviours is crucial to facilitating access to this population and ensuring coverage of services.
- High-risk settings and environments call for structural interventions that reach out to saunas, bars, massage parlours, as well as internet-based interventions.
- MSM need to be added as a sentinel population for national surveillance.

4.4 STI prevention and control

Prevention and control of STI is slowing down the sexual transmission of HIV. An estimated 340 million new cases of curable STIs occur every year throughout the world, with the largest proportion (44%) in South-East Asia. STIs increase the susceptibility to HIV as well as the risk of its transmission. Surveillance of STI trends can provide an early warning of the potential emergence of HIV and can serve as an evaluation tool for HIV prevention programmes.

WHO SEARO is in the process of adapting the global STI control strategy endorsed by the World Health Assembly in May 2006. The regional strategy has three main objectives with defined priorities and interventions:

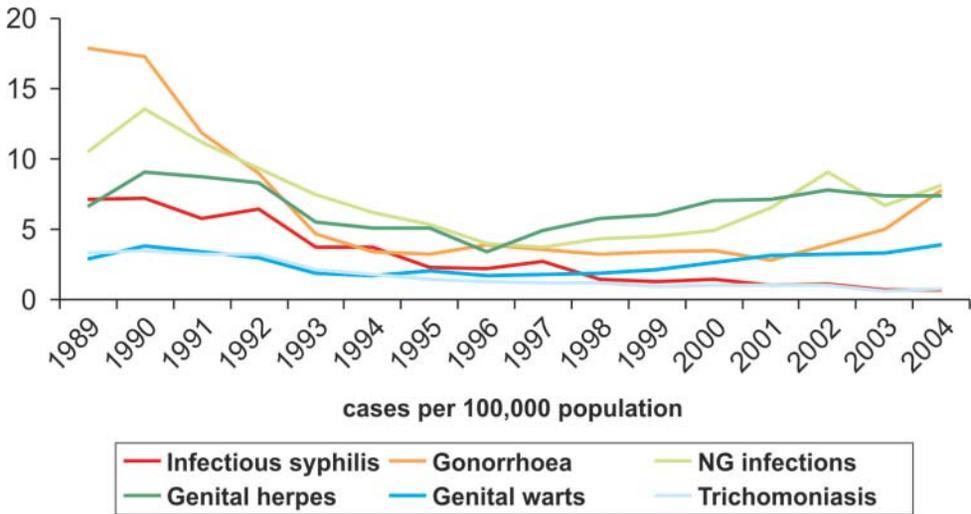
- (1) **Cutting the incidence of HIV and STIs in high transmission networks.** This is achieved through effective interventions that focus on sex work such as peer outreach, condom programmes, STI services and strengthening enabling environments.
- (2) **Improving STI case management for all.** Management of STIs can be improved by raising STI awareness and health care-seeking behaviour, including STI services as part of reproductive health and primary health care, and promoting youth-friendly services and collaboration with the private sector.
- (3) **Ensuring reliable data to guide the response.** This includes strengthening of STI surveillance, case reporting, prevalence surveys and monitoring the coverage of services.

STI data can be a sensitive indicator of sexual transmission. Surveillance data for syphilis has shown that there has been a progressive decline in reported infections among pregnant women in countries such as Thailand, India and Myanmar. On the other hand, an increase in the reported infections in syphilis among MSM in some countries points to continued risk-taking behaviour and inadequate efforts at prevention. In Sri Lanka, reliable surveillance data from sentinel STI clinic sites show a steady decline in infectious syphilis but a recent increase in gonorrhoea and other STIs (**Figure 6**).

4.5 Prevention of mother-to child transmission of HIV and treatment of seropositive infants and children

In the year 2000, heads of states signed the UNGASS declaration. This included targets such as a reduction by 20% in the proportion of infants infected with HIV by 2005, and by 50% by 2010; ensuring that 80% of pregnant women accessing ANC have information, counselling and other HIV prevention services available to them; and that women and their babies have access to ARV preventive therapy to reduce MTCT of HIV.

Figure 6: *Incidence of sexually transmitted infections per 100 000 population, Sri Lanka, 1989-2004*

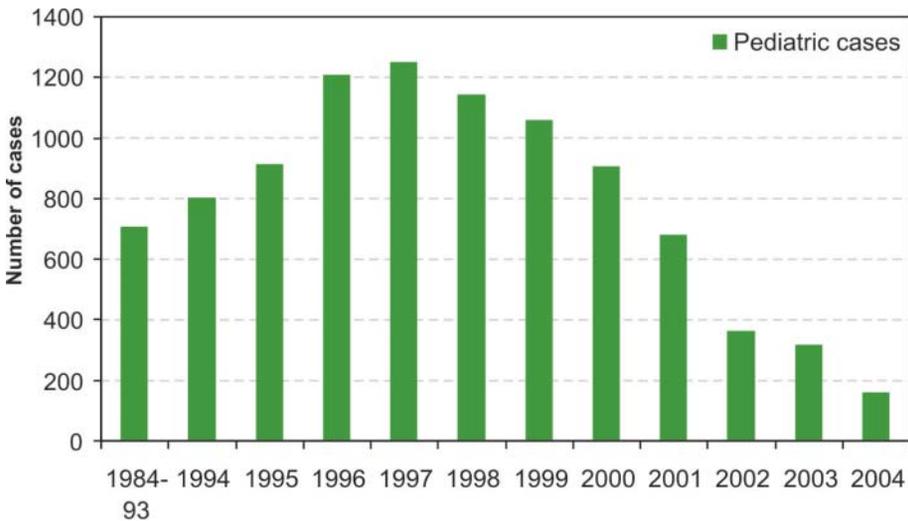


Source: National STD/AIDS Control Programme, Ministry of Health, Sri Lanka

Of the 11 million child deaths due to HIV/AIDS, the majority are in sub-Saharan Africa, South-East Asia and Latin America. Diarrhoea and pneumonia are still the primary causes of under-five mortality (U-5M) in South-East Asia. For example, in India districts with a high HIV prevalence are not the same as those with a high U-5M. Similar situations have been reported from other Member Countries. Although HIV is not yet the major cause of U-5M in South-East Asia, Member Countries with an HIV prevalence >1% among pregnant women attending ANC have committed to preventing paediatric HIV infections through the implementation of prevention of mother-to-child transmission (PMTCT) programmes.

Successful MTCT prevention programmes are complex interventions in which the ARV regimen is but one component. To date, MTCT prevention efforts in resource-constrained settings have mostly focused on reducing MTCT around the time of labour and delivery, which accounts for one-third to two-thirds of overall transmission, depending on whether or not breastfeeding occurs. Interventions focusing on the prevention of vertical HIV transmission need to be complemented by interventions that address the primary prevention of HIV infection (particularly in women of childbearing age and their partners), prevention of unintended pregnancies among HIV-infected women, and the provision of care, treatment and support for HIV-infected women, their children and families.

Figure 7: **AIDS cases among children aged 0-4 years, Thailand, 1984-2004**



Source: Ministry of Health, Thailand

As of 2006, global coverage is low of interventions to reduce the number of infants infected with HIV. Of the total number of women giving birth annually, only 10% are HIV-tested and only 9% of women who test HIV-positive receive preventive ART. In South and South-East Asia, out of an estimated 67 million births annually, only 5% of pregnant women are offered preventive ART. In Thailand out of the 639 363 women who gave birth, 98% attended ANC, 99.7% were HIV-tested and 93.8% received ARV preventive therapy in public sector health facilities. As a result, the number of reported AIDS cases among children less than 5 years of age declined significantly (**Figure 7**).

According to UNAIDS/UNICEF estimates of 2005, globally 14 000 children below 14 years of age are in need of ART, but the actual proportion of children receiving it remains low.

In generalized HIV epidemics with an ANC prevalence >1%, all pregnant women should be offered HIV testing and counselling, preventive ART, infant-feeding counselling, and care and ART for the family. In concentrated and low-level HIV epidemics, interventions should focus on primary prevention and prevention of unwanted pregnancies.

4.6 Expanding access to HIV testing and counselling

Expanding access to HIV testing and counselling is one of the five key strategic components of WHO's work in the area of HIV/AIDS. The wide availability of HIV testing and counselling services is critical for a comprehensive national

response to HIV/AIDS. Both HIV-negative and HIV-positive persons can benefit from HIV prevention education and behaviour change communication, as these are effective in reducing transmission. Those who are HIV positive can access care, treatment and support services.

Despite the importance of HIV testing and counselling services, access to such services remains unacceptably low across South-East Asia. This lack of access is a barrier to increasing coverage of HIV care and ART, and implementing collaborative tuberculosis (TB)/HIV programme activities. TB centres have outnumbered HIV testing and counselling facilities and HIV care and treatment services by more than 10-fold, thus inhibiting efforts to integrate the detection and treatment of these two interconnected diseases.

Scaling-up and ensuring good-quality HIV testing and counselling services coupled with the use of affordable and accessible testing technologies are urgently needed. Apart from having clear policy guidance on testing and counselling approaches, and the range of settings in which HIV testing and counselling services should be offered and made available, there is a need to build capacity and intensify implementation to keep pace with the growing HIV/AIDS epidemics.

Since the HIV test became available in 1985, the "**3 Cs**" continue to be the principles underpinning the conduct of HIV testing of individuals.

HIV testing of individuals must :

- be **confidential**;
- be accompanied by **counselling**; and
- only be conducted with informed **consent** (meaning that testing should be both informed and voluntary).

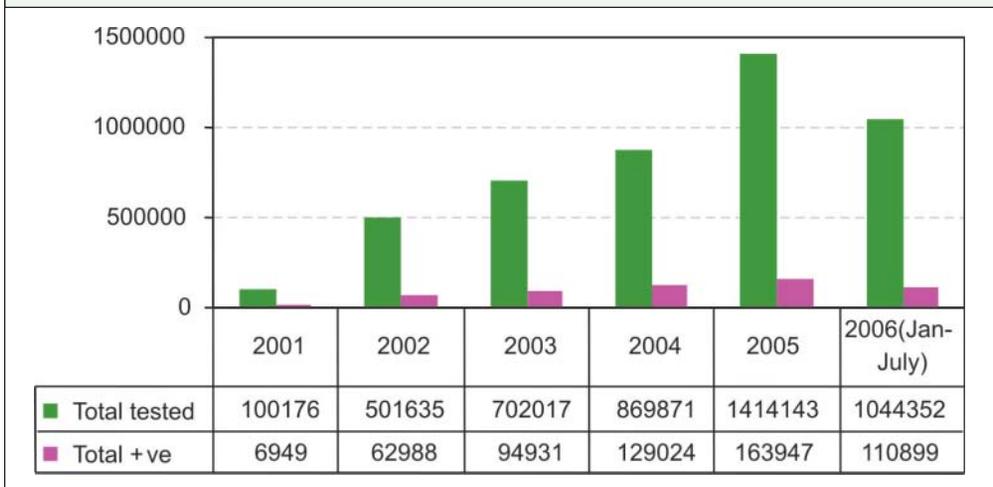
In many low- and middle-income countries, the primary model for HIV testing is the provision of **client-initiated** VCT services.

So far, stand-alone VCT services do not reach a sufficient number of clients to enable large-scale access to care, support and treatment. As a result, complementary approaches are currently under discussion, such as "**Provider-initiated Testing and Counselling**" (PITC) in health-care settings. PITC is defined as a routine **recommendation** of HIV testing and forms a part of the diagnostic procedures; it is also recommended to all those at high risk, e.g. patients with STI and TB. However, PITC cannot be implemented in a vacuum and the guidelines, which are in process, should emphasize the integration of PITC into the national plan and national guidelines. The underlying principles for VCT apply for PITC: confidentiality, voluntarism and informed consent. This clearly distinguishes PITC from mandatory testing. However, routine

recommendation is meant to increase awareness of and access to knowing one's HIV status in health facilities, at a moment in time when patients can be easily reached. PITC consistent with human rights principles is an accepted strategy to expand access to care. When introducing PITC, a basic package of services including ART should be locally available. In addition, appropriate legal policies and frameworks need to be in place to protect the rights of the individual. A regional consultation is planned in 2007 to clarify the UN position on HIV testing and counselling for Asia and the Pacific.

The National AIDS Control Organization (NACO), India has established VCT centres in Microbiology Departments of Medical Colleges and District Hospitals. From 63 centres in 1997, it grew to more than 900 by March 2006, covering all 600 districts in India. Key programme elements include the development of simplified operational VCT guidelines, standard operating procedures for HIV testing, strengthening of the external quality assurance scheme (EQUAS) for HIV testing, and a standardized training programme for trainers, counsellors and laboratory technicians. A monitoring and supervision system integrated into the national computerized management information system (CMIS) was established. Counsellors complete pre- and post- test counselling forms. As of July 2006, more than 3 million people have been HIV-tested in these centres (**Figure 8**). PITC has been established in ANCs and group counselling is offered to all pregnant women. Of those counselled pre-test, 95% were HIV-tested with informed consent.

Figure 8: HIV testing and counselling in India



4.7 Scaling-up of care and antiretroviral treatment

WHO has elaborated public health guidelines to support and facilitate the implementation of ART in resource-limited settings. Key components of the guidelines include

- (1) standardization and simplification of ARV regimens; and
- (2) use of a scientific evidence base to support treatment protocols and avoid the use of substandard treatment leading to poor outcomes and the emergence of HIV drug-resistant strains.

Rapid scaling-up of ART is based on comprehensive systems for care, support and treatment, and by involving people living with HIV (PLHIV) as well as the broader community in the planning and implementation of services. Exceptional progress has been made in the Region on scaling-up ART since November 2003 when the WHO "3 by 5" Initiative was launched. Today, there are nearly 170 000 people on ART (**Table 1**).

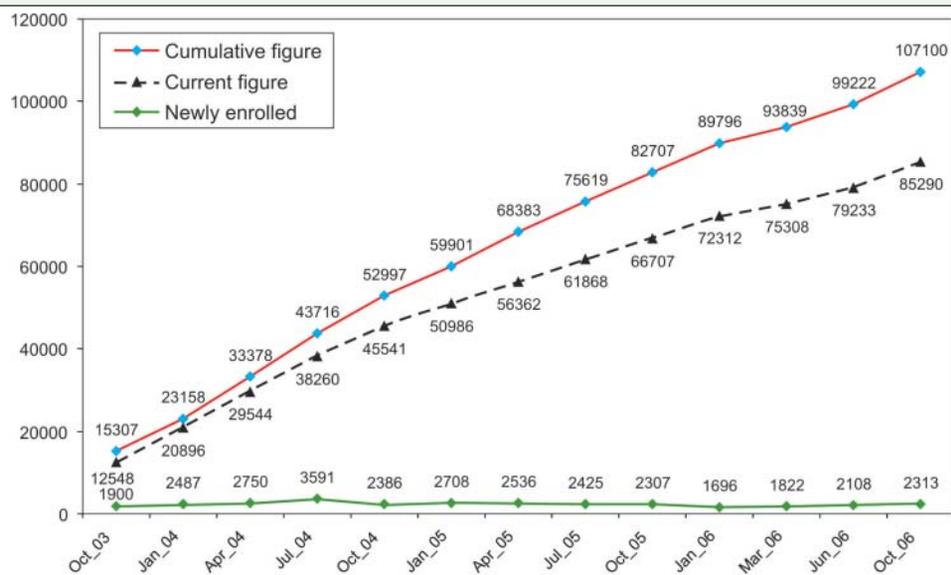
Table 1: Antiretroviral therapy (ART) coverage in SEAR countries, 2003–2006

Country	Estimated number of AIDS cases, 2006	Estimated number of people ever started on ART in the public and private sectors by			
		Dec 2003	Dec 2004	Dec 2005	Oct 2006
Bangladesh	1 300	†	5	n/a	n/a
Bhutan ^β	†<100	†	5	6	13 ^β
DPR Korea	n/a	n/a	n/a	n/a	n/a
India ^{β*}	970 000	0	3 500	23 700	52 663
Indonesia	18 500	1 350	2 500	3 300	6 042
Maldives	n/a	†	0	†1	†1
Myanmar [*]	67 000	1 200	1 500	3 700	5 000
Nepal ^{β*}	11 000	75	75	210	473
Sri Lanka	<500	25	25	44	66
Thailand ^β	100 000	15 307	52 997	88 261	107 100
Timor Leste	n/a	n/a	n/a	n/a	n/a

* Government, FHAM and NGO-supported programme
^β Government-supported programme
^{*} Intersectoral partners and GFATM

The Royal Thai Government (RTG) reached the national treatment target of delivering ART to all those in need by the end of 2006 due to its substantial prevention efforts since the early 1990s. Many other countries in the Region have followed Thailand's example. The rapid expansion of ART coverage was possible through strong political commitment and by harnessing the full potential of the strong public health system in Thailand. The ART delivery system was initiated at the same time at tertiary-level hospitals and the district level of health facilities (**Figure 9**).

Figure 9: Number of people with advanced HIV infection enrolled into Anti-Retroviral Treatment Programme, Thailand, 2003-2006



Source: Ministry of Public Health, Thailand

With full commitment from the highest level of the Government, India has managed to rapidly scale up ART, which has reached tertiary-level facilities. An estimated 700 000 PLHIV have advanced HIV infection and need ART. The Government of India launched the free ART programme in April 2004 in eight ART centres; by June 2006, 96 public sector health facilities were delivering ART. Currently, only first-line ARVs are used in the national programme. A total of 42 000 people have ever started ART, and about 62% of these are on first-line therapy. Children and women are still underrepresented; however, a new initiative to increase the number of children on treatment will soon be started with support of the Clinton Foundation and UNITAID.¹ As in Thailand, a continuum-of-care referral network will be the preferred model for implementing HIV care in India: VCT serves as a central entry point, supplemented by PITC, entry from TB clinics, general health services and NGOs. Private practitioners clearly linked with HIV care services will follow up all those identified as being HIV positive.

Consultations have been held in India, Indonesia and Myanmar on strengthening the quality of health care and expanding services from ART referral hospitals to first- and second-level facilities. Building partnerships and developing a team approach to chronic care management can be done with the involvement of

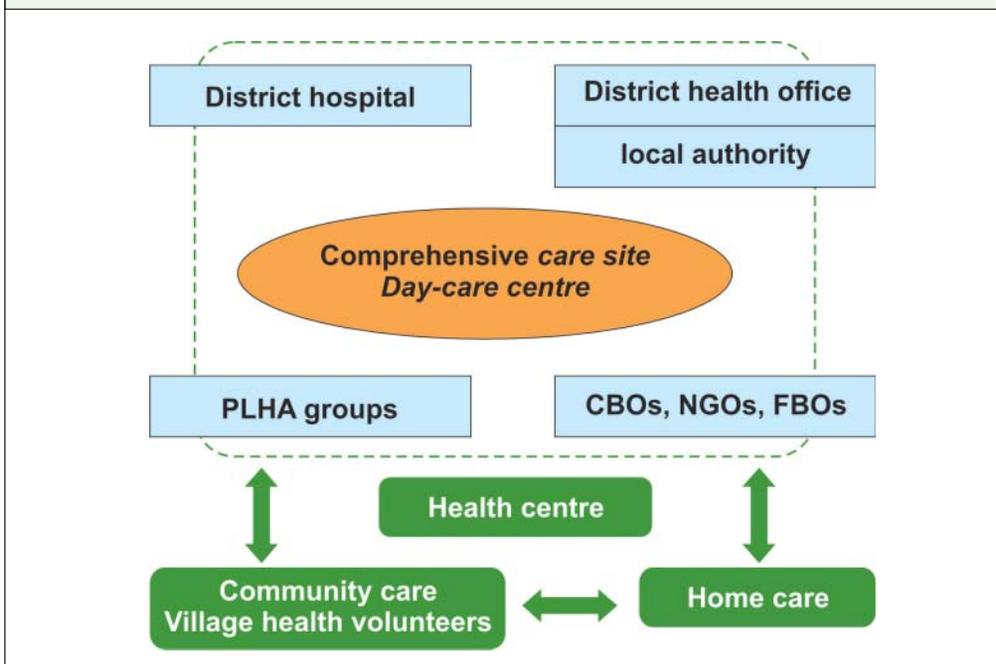
¹ France, Brazil, Chile, Norway and the United Kingdom decided to create an international drug purchase facility called UNITAID to be financed with sustainable, predictable resources. This financing mechanism aims to respond to the specific needs of developing countries, increasing the supply and lowering the prices of drugs without compromising their quality.

PLHIV, health-care workers, NGOs and community-based organizations (CBOs). The meetings discussed essential service packages for each level of the health system, and the roles and responsibilities of implementing partners. A service delivery model is the WHO-promoted concept of continuum of care with day-care centres/centres of comprehensive continuum of care (CCC) serving as "hubs" (Figure 10).

Box 6: Key elements for rapid scale-up of ART as part of comprehensive care

- Defined organizational structures from central to subdistrict level including clear roles and responsibilities of each partner;
- Working in partnership and having a team approach to chronic care management using the continuum-of-care model;
- Involving PLHIV groups;
- Guidelines that have a simplified and comprehensive approach;
- Defined essential service packages for each level of the health system;
- Standardized and harmonized training programme;
- Uninterrupted supplies of drugs and diagnostics; and
- Standardized patient monitoring and reporting system.

Figure 10: *Team building at districts/subdistrict or township level*



For expansion of the continuum of care and ART as part of chronic care management, **a standardized and harmonized training programme** is being implemented in India, Indonesia and Myanmar using simple WHO guidelines and training materials for the integrated management of adolescent and adult illnesses (IMAI). IMAI builds on existing WHO materials and uses a syndromic approach to the diagnosis and management of illnesses including HIV. IMAI plays a role in training at the primary and secondary levels, and needs to be adapted to country guidelines and situations. The following guides and manuals are under development/being developed:

- 4 IMAI guides and modules (Acute care, Chronic care, Palliative care and Principles of good chronic care);
- 2 additional guides (Tuberculosis care with TB/HIV co-management and Caregiver booklet) and modules;
- Training and job aids, and
- Course director/facilitator and participant manuals for the different modules targeting first- and second-level health facilities as well as nurses and medical doctors.

Complementary to the clinical guidelines and tools, a standardized monitoring and reporting system has been proposed by WHO. WHO SEARO tools for ART monitoring using paper-based recording and reporting have been adapted in India, Indonesia, Myanmar and Nepal. Recently, an Epi-Info based software has been developed in collaboration with the Centers for Disease Control and Prevention (CDC), Atlanta.

HIV and STI should be a component of pre- and postgraduate training curricula for medical doctors, scientists, laboratory technicians and nurses.

WHO will continue to work with Member Countries in scaling-up HIV care and treatment services, which now requires making available services and resources at the primary and secondary levels of the health system, with specifically tailored, simplified tools and training materials. Decentralization of services to the peripheral level should include good guidance, mentoring and supervision from the national level. Peripheral health services should be prepared to offer and provide HIV testing and counselling; ensure uninterrupted supply of drugs, diagnostics and condoms; and involve community representatives, village health volunteers and health-care workers. Scaling-up must ensure that a high quality of services is maintained.

4.7 Antiretroviral drug resistance surveillance: strategies for prevention, surveillance and monitoring

HIV drug resistance (HIV DR) occurs when the virus mutates and is able to reproduce in the presence of ARV drugs. The consequences of drug resistance

include treatment failure, the need to start on more expensive second-line treatment resulting in increased direct and indirect health costs, the spread of resistant strains of HIV, and the need to develop new anti-HIV drugs. Because HIV has a very high mutation rate, and as ART should be continued for life once it has begun, some degree of HIV DR will emerge among persons on treatment even if appropriate ART is provided and adherence is supported. HIV DR is drug- and regimen-specific, and the emergence of HIV DR must be balanced against the benefits of providing ART. Such benefits include improved health outcomes and decreased HIV/AIDS-associated morbidity and mortality. WHO and CDC have developed two protocols: (i) drug resistance threshold surveillance, which indicates the resistance in recently transmitted HIV, and (ii) the ART monitoring protocol, which examines the level of primary resistance in patients on ART over a period of at least 12 months (up to 24-36 months). Both these protocols require a minimum of financial and human resources.

Over the past year, WHO SEARO in conjunction with WHO HQ has been assisting Member States in planning for HIV DR surveillance by conducting or facilitating the following activities:

- Inter-country capacity-building workshop on prevention, surveillance and monitoring of HIV DR in Hanoi;
- Technical briefing of national AIDS programme staff in India, Indonesia, Myanmar and Thailand;
- National consultation on HIV DR protocols in India;
- Establishment of national HIV DR committees in India and Indonesia, and next in Thailand;
- Assessments of laboratory capacity for measuring drug resistance in India and Indonesia;
- Technical assistance to countries (India and Indonesia) for the preparation of national protocols on HIV DR surveillance and monitoring;
- Training in laboratory methods including genotyping, and
- Training in using an HIV DR database

HIV DR national working groups have been established in India and Indonesia. In India, NACO has approved a protocol to implement threshold and monitoring surveys in two sites each. In Indonesia, a threshold survey among IDUs has begun in Jakarta. A national consultation to plan for HIV DR surveys has begun in Thailand. In Myanmar, national commitment to begin HIV DR surveys has been garnered.

In collaboration with partners, WHO will continue its efforts to support HIV DR surveillance in the Region.

5. MONITORING AND EVALUATION OF AIDS PROGRAMMES

Monitoring and evaluation (M&E) of increasingly large and complex national AIDS programmes is one of the most difficult challenges for programme managers. Having reliable data to measure progress is of great importance as governments are called upon to report on global indicators of progress towards UNGASS and MDG targets. Specific challenges faced by national AIDS programme managers include too many reporting requirements from multiple donors, the sensitive nature of HIV/AIDS data, delays in dissemination of data, inadequate staff and other resources, and the lack of reporting from multiple implementing partners.

There are too many indicators, each often requiring multiple inputs. The National AIDS Programme in Thailand, for example, has a total of 60 key indicators. There is a lack of harmonization of indicators and tools for data collection. Each programme such as the PMTCT and ART have their own set of indicators and recording and reporting tools. The multisectoral nature and decentralization of many interventions complicates monitoring across ministries and sectors, and different levels of the health-care system. In addition, governments require financial data. In some cases, it is difficult to determine the denominators for coverage as the estimated size of the population is not known, as in the case of orphans and vulnerable children, IDUs and MSM.

It was suggested that countries should strengthen the existing strategic unit at the country level by allocating adequate resources, assigning trained staff, reviewing/assessing the existing surveillance/monitoring system, harmonizing information needs with various partners, using standardized recording and reporting tools, owning and using their data, and proactively communicating data to all agencies and stakeholders.

National AIDS programmes should use available resources to collect essential data for programme planning and implementation. Data can be collected from HIV surveillance [biological, behavioural and HIV/AIDS case surveillance), surveys, estimations and projections, and ongoing programme monitoring. Data for measuring coverage indicators in different population groups can be collected through special periodic surveys outsourced every 2-3 years. The monitoring system should include a quality assurance scheme and make more use of information technology. As a follow up, a regional meeting has been proposed to agree on key indicators that all countries use for reporting, including the recording and reporting formats, training tools and use of information technology. It was proposed to establish a regional M&E network in Asian countries.

6. PRIORITIES OF DEVELOPMENT PARTNERS

AusAID: Australia plays a major role in combating the spread of HIV/AIDS in the Asia-Pacific region, through its Global HIV/AIDS Initiative. The Government has committed a total of from Australian \$600 million 2000 to 2010 to combat the HIV pandemic globally. AusAID has major projects that focus on reducing the transmission of HIV among IDUs. For example, the Asia Regional HIV/AIDS Project (ARHP), which has been implemented in four sites (Myanmar, Viet Nam and Yunnan and Guangxi provinces in southern China) aims to strengthen the capacity of both the health and public security sectors of governments to reduce the transmission of HIV among in IDUs. The AusAID Regional Harm Reduction Project (ARHP) are ongoing in Indonesia and six countries in South Asia. AusAID highlighted the importance of and need for donor harmonization.

Asian Development Bank (ADB) is a multilateral development financial institution with 66 members, 47 from the Region and 19 from other parts of the world. It is a regional body with 19 resident missions in Asia and 3 subregional offices in the Pacific region. ADB's first counterparts are finance, budget and planning ministries. Its mission is to support developing member countries to reduce poverty and improve the quality of life of their citizens. Its main instruments are policy dialogue, loans, technical assistance, grants, guarantees and equity investments. In the area of HIV/AIDS the ADB supports capacity building, and specific projects. Asian Development Fund (ADF) IX operations and assistance to reduce poverty in the Region will use 2% of its resources as grants for HIV/AIDS and other infectious diseases. To channel funds for technical support to countries, memoranda of understanding have been arrived at/signed with UNAIDS for HIV and WHO for avian influenza. The Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific is funded by the Government of Sweden and will finance the Regional Technical Assistance (RETA) for the prevention and control of HIV/AIDS in Asia and the Pacific.

Association of South-East Asian Nations (ASEAN). ASEAN commitment is from the highest level through mobilizing political leaders. The ASEAN Summit Declaration on HIV/AIDS adopted by the 7th ASEAN Summit in 2001 acknowledges that prevention is the only effective way to combat the spread of HIV and AIDS. ASEAN Member Governments pledged to "lead and guide the national responses to the HIV and AIDS epidemic as a national priority to prevent the spread of HIV infection and reduce the impact of the epidemic by integrating HIV and AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of national development planning, including poverty eradication strategies and sectoral development plans". The ASEAN Task Force on AIDS (ATFOA) was established in 1993. ATFOA is the key ASEAN body coordinating regional cooperation on HIV and AIDS, and follows directives set by ASEAN Leaders. ATFOA is now preparing key outcome documents for the 12th ASEAN Summit Special Session on HIV and AIDS. This is the second time leaders will

convene a Special Session. ATFOA is committed to working with partners to implement its 2006-2010 ASEAN work programme on HIV/AIDS phase III.

Department for International Development (DFID). Since 1997, DFID has invested £1.5 billion to strengthen health systems in the developing world. Over the next three years, DFID will commit a further £1.5 billion to tackle HIV and AIDS. The UK Government pushed for the creation of a framework, called the Three Ones, to encourage greater coordination and cooperation among donors. The Three Ones calls for one AIDS action framework, one national AIDS coordinating authority and one system to monitor and evaluate the effectiveness of what the international community is doing. All major donors signed this framework in April 2004. UNAIDS received major contributions from DFID to support implementation of this framework. DFID's focus is on human rights and increasing access to sexual and reproductive health services, especially for women and girls. Other support is targeted at harm-reduction interventions and access to care and treatment, as well as increasing access to essential medicines and making maximum use of flexibilities in TRIPS. DFID has allocated considerable resources to support major initiatives to control the spread of HIV and AIDS in Bangladesh, Cambodia, China, India, Myanmar, Nepal, Pakistan and Viet Nam.

Family Health International (FHI). FHI provides support to 65 countries globally and has 12 country offices and 17 provincial offices in Asia; the Regional Office is in Bangkok. The Asia Regional Programme (ARP) provides technical, financial, administrative and management support to FHI's country offices and their partners. The ARP works throughout the region to strengthen HIV/AIDS prevention, care and support activities; provide leadership and capacity development; and fill critical gaps in countries where the US Agency for International Development (USAID) has a presence. FHI also extends USAID's reach to new countries. USAID is the largest supporter of FHI's HIV/AIDS prevention and population activities in Asia.

USAID. The Regional Development Mission of Asia (RDMA) is located in Bangkok, Thailand but manages programmes that benefit, for example, China, Laos, Myanmar, Thailand and Viet Nam. USAID's regional programmes in Asia focus on HIV/AIDS and other infectious diseases, the environment, governance and economic reforms, and special foreign policy interests such as trafficking and humanitarian assistance. The RDMA approach targets MARPs. USAID focuses on coverage of a minimum package of services and key hot-spots among populations where HIV prevalence is highest. This includes components such as strategic information, capacity building, community mobilization, policy advocacy, and decreasing stigma and discrimination.

United Nations Programme on AIDS (UNAIDS). UNAIDS is fully committed to driving the process towards achieving universal access to HIV prevention, treatment, care and support by 2010. A number of country and regional consultations were facilitated to move towards universal access including for

low HIV-prevalence countries. UN co-sponsors and development partners have proposed three non-negotiable targets:

- 80% of MARPs reached by comprehensive programmes
- 60% behavioural change among MARPs
 - Percentage of MARPs who both correctly identify ways of preventing the transmission of HIV and reject major misconceptions about HIV transmission
 - Percentage of female or male SWs reporting the use of a condom with their most recent client
 - Percentage of MSM reporting the use of a condom the last time they had anal sex with a male partner
 - Percentage of IDUs who have adopted behaviours that reduce the transmission of HIV, i.e. avoid using nonsterile injecting equipment or are on methadone substitution treatment and use condoms in the past 12 months (for countries where injecting drug use is an established mode of HIV transmission)
- 80% of those who are eligible for receiving combination ART receive it.

UNAIDS calls upon partners to support the revision of national strategic plans and provide unified support to the development of national M&E systems.

WHO. WHO is committed to the goal of universal access. To this end, the Organization will continue to lead the health sector response in the prevention and control of HIV/AIDS. The following five strategic approaches will guide WHO's work over the next five years:

- **Strengthening HIV and STI prevention:** The number of new HIV infections continues to increase each year in SEAR-therefore, clearly, prevention programmes still remain the top priority. Priority prevention interventions will focus on the commonest modes of HIV transmission in the Region, namely: (i) prevention of sexual transmission by providing an essential package of services that includes prevention and management of STIs and 100% condom use to vulnerable populations; (ii) prevention of HIV transmission through contaminated needles by harm-reduction programmes and infection control in health-care settings; (iii) prevention of MTCT of HIV; and (d) ensuring blood safety.
- **Enabling people to safely know their HIV status through HIV counselling and testing:** Less than one in ten HIV-infected persons know their status. Knowing the HIV status is a starting point for accessing care, treatment and support services. Therefore, it is imperative to scale-up high quality counselling and testing services based on the principles of confidentiality and informed consent.

- **Accelerating the scaling-up of HIV/AIDS treatment and care:** The priority interventions under care and treatment include: (i) Provision of ART for children and adults; (ii) prevention and management of opportunistic infections (OIs); (iii) care, including nutrition, palliative and end-of life care, and; (iv) linking HIV and TB services.
- **Investing in strategic information to guide a more effective response:** A robust information system is central to tracking the epidemic and monitoring the impact of interventions. Integrated surveillance for HIV/AIDS, STIs and risk behaviours will be promoted and systems for monitoring HIV DR will be set up. The health sector's efforts towards universal access will be monitored and appropriate operational research will be facilitated.
- **Strengthening and expanding health systems:** Prevention, care and treatment interventions cannot be scaled up unless existing health systems are reinforced. WHO will guide Member States in developing national strategic plans; strengthening systems for procurement, supply and management; developing and managing human resources; strengthening laboratories and networking with key partners.

7. CONCLUSIONS AND RECOMMENDATIONS

The meeting concluded that significant progress has been made by Member States in expanding access to the prevention of transmission of HIV and STIs, and to HIV testing and counselling, care and treatment. Strategic information systems have also been strengthened. National AIDS programmes continue to play a key role in the multisectoral response to HIV/AIDS towards reaching universal access targets and the MDGs.

The key programmatic issues identified at the meeting were:

- Laws and regulations inhibiting sound public health programme planning and implementation;
- Prevailing stigma and discrimination;
- Lack of comprehensive capacity-building plans;
- Gaps between national policies and actual implementation of interventions, particularly those at the peripheral levels of the public health system;
- Need for expanding access to quality services at primary- and secondary-level health facilities, including monitoring and supervision;
- Need for sustained financing for the rapid scale-up of HIV and STI interventions;
- Lack of integration of HIV/AIDS programmes with other health programmes.

Recommendations to Member States

The following were identified as key focal points for action by Member States:

- (1) Member States should advocate with ministries of health, other concerned ministries, planning commissions, leaders of law enforcement agencies, religious bodies and regional bodies such as ASEAN and the South Asian Association for Regional Cooperation (SAARC) for reviewing laws, policies and regulations that inhibit the implementation of interventions to prevent HIV transmission among MARPs such as SWs, IDUs and MSM/transgender persons.
- (2) In order to support expansion of access and coverage of interventions at the peripheral levels, ministries of health should strengthen human resources and capacities at the primary and secondary levels of the health system for coordination, health programme management and quality service delivery for the prevention, care and treatment of HIV and STIs as part of their overall health-care services.
- (3) National AIDS programmes of Member Countries should define the framework of essential packages for HIV prevention, care and treatment interventions, and models for scaling up such as the continuum of care at the primary and secondary levels of the public health system. Continuum of care encompasses HIV and STI prevention services as well as ART.
- (4) National AIDS programmes should be the pivotal and driving force behind the rapid expansion of quality HIV counselling and testing services, which should ensure commitment to the core principles of confidentiality, counselling and informed consent. Existing client-initiated approaches should be complemented with provider-initiated counselling and testing in certain health-care settings. HIV counselling and testing should be part of an essential package of HIV prevention, care and treatment services.
- (5) National AIDS programmes should strengthen HIV strategic information systems including routine monitoring, biological and behavioural surveillance, estimations of burden of HIV infections/disease, and research to guide decision-making and planning. A review of the national AIDS programme should be undertaken at regular intervals.
- (6) National AIDS programmes should strengthen partnerships with the nongovernmental and private sectors, for the purpose of facilitating the development of networks of self-help groups for PLHA and peer groups to expand coverage of interventions.
- (7) Member Countries should realize the economic implications of the HIV epidemic and review resource needs and gaps, and arrange finances for rapid scaling-up.

Recommendations to WHO and development partners

It was resolved at the meeting that WHO and development partners:

- (1) Should pursue high-level advocacy with the ministries of health and other related ministries, leaders of law enforcement agencies, and regional bodies such as ASEAN and SAARC for increased political commitment to scale up HIV prevention, care and treatment interventions. This includes promoting essential interventions to prevent transmission of HIV among MARPs such as SWs, IDUs and MSM/transgender persons.
- (2) Should provide technical support for human resource development at the primary and secondary levels of the health system. Such support would include strengthening capacity in coordination, programme management and quality service delivery to scale up HIV and STI interventions for prevention, care and treatment to the peripheral level within the ambit of the overall health services.
- (3) Should provide technical support to Member States to define the framework of essential packages for prevention, care and treatment interventions, and support the development and expansion of service delivery models for scaling-up interventions such as the continuum of care at the primary and secondary levels of the public health system.
- (4) Should provide policy and normative guidance for rapid expansion of access to quality HIV counselling and testing services while ensuring the core principles of confidentiality, counselling and informed consent. Existing client-initiated approaches should be complemented with provider-initiated counselling and testing in certain health-care settings. HIV counselling and testing should be part of an essential package of HIV prevention, care and treatment services.
- (5) Should continue to support the strengthening of HIV strategic information including routine monitoring, biological and behavioural surveillance, estimations of burden of HIV infection/disease, programme monitoring and evaluation and research as well as prevention, monitoring and surveillance of HIV DR. The review of national AIDS programmes and reporting against a core set of indicators continue to be key components of WHO's support to Member States.
- (6) Should advocate for partnerships with the nongovernmental and private sectors, networks of self-help groups for PLHA and peer groups to actively engage them in expanding the coverage of interventions.
- (7) Should continue technical support to Member Countries for resource mobilization, financing and establishment of national AIDS accounts for implementing national strategic plans for HIV and STI prevention and control.

Annex 1

PROGRAMME

Tuesday, 31 October 2006

0945–1015	The HIV epidemic in South-East Asia and lessons learnt	Dr Ying-Ru Lo, WHO/SEARO
1015–1045	Human rights approach to HIV prevention, care and treatment	Professor Daniel Tarantola, University of New South Wales, Australia
1045–1115	Scaling-up interventions targeting populations most at risk: strategies and interventions	Mr Richard Steen, WHO/SEARO
1115–1230	HIV and injecting drug use in South-East Asia: opportunities and barriers for scale up Comprehensive IDU programmes: a case study from Indonesia Discussant: Professor Nick Crofts	Dr Suresh Kumar Dr Nunung B. Priyatni, Indonesia
1330–1430	HIV/STI interventions for sex workers Targeted condom programmes: a case study from Myanmar Discussant: Dr Anupong Chitwarakorn	Dr Wiwat Rojanapithayakorn, WHO/China Dr Khin Ohnmar San, National AIDS Programme, Myanmar
1430–1530	Interventions to prevent HIV transmission among men having sex with men in South-East Asia A case study from Nepal Discussant: Dr Gampo Dorji	Dr Philippe Girault Mr Sunil Pant, President, Blue Diamond Society, Nepal
1545–1645	HIV/STI vulnerability and most at risk adolescents: linking HIV and AIDS with SRH A case study from Bangladesh Discussant: Mr Jacques Jeugman, ADB	Dr Chaiyos Kunanusont, UNFPA Dr Md Abdus Salim, Bangladesh
1645–1700	Discussion Discussion with individual country teams: Bangladesh, Bhutan	WHO

Wednesday, 1 November 2006

0900–0915	Scaling-up HIV/AIDS care and treatment	Dr Ying-Ru Lo, WHO/SEARO
0915–000	- New strategies for HIV testing and counselling - Scaling-up HIV counselling and testing: a case study from India	Dr Clement Chankam WHO HQ Dr D. Bachani, Joint Director, National AIDS Control Organization, India
1000–1030	- PMTCT and treatment of infants and children: status of implementation, challenges and opportunities	Dr Myo Zin Nyunt, UNICEF ROSA

1045–1100	Discussant: Dr Penny Miller, FHI	
1100–1130	Open discussion	
1130–1230	Break-out groups to discuss priority activities for scale-up of interventions	
	<ul style="list-style-type: none"> • Group 1: Expanding interventions targeting IDUs • Group 2: Expanding interventions targeting sex workers • Group 3: Expanding interventions targeting high-risk men having sex with men • Group 4: Expanding access to care and treatment including VCT • Group 5: Strengthening HIV surveillance 	
1400–1500	Group discussion continued	
1515–1600	Feedback from break-out groups	Chairperson/Rapporteurs
1600–1630	Open discussion	
1630–1730	Discussion with individual country teams: India, Indonesia	WHO

Thursday, 2 November 2006

0900–1000	Measuring progress in scaling-up interventions: setting targets and selecting key indicators Plenary discussion	Dr Sombat Tanprasertsuk, Bureau AIDS/TB and STI, Thailand
1000–1030	Statements by Partners Australian harm reduction initiatives and programmes in South-East Asia ADB priorities for expansion of HIV programmes in Asia UK Government commitment to support HIV/AIDS in Asia	Dr Philippe Allen, AusAID Mr Jacques Jeugman, ADB Dr Michael O'Dwyer, DFID
1045–1200	ASEAN response to HIV and AIDS FHI programme on HIV/STI prevention, care and treatment USAID programme on HIV/AIDS in Asia Global and regional process toward universal access WHO Regional strategies towards scaling up HIV prevention, and treatment	Dr Bounpheng Philavong Dr Penny Miller, FHI Mathew Friedman Dr Sun Gang, UNAIDS RST Dr Ying-Ru Lo, WHO SEARO
1200–1230	Conclusions and recommendations	
1330–1500	Discussion with individual country teams: Maldives, Myanmar, Nepal	WHO
1515–1600	Discussion with individual country teams: Sri Lanka, Thailand, Timor-Leste	WHO

Annex 2

LIST OF PARTICIPANTS

Member Countries

Bangladesh**Dr Md Abdus Salim**

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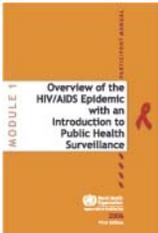
Annex 3

RECENT WHO SEARO PUBLICATIONS



Management of HIV infection and antiretroviral therapy in infants and children

Successful scaling-up of antiretroviral therapy (ART) requires the rational use of antiretroviral drugs. These guidelines cover the diagnosis of HIV infection in infants and children, followed by patient evaluation, prevention and management of opportunistic infections, when and how to start antiretroviral therapy, when to switch and how to ensure treatment adherence



Module 1: Overview of HIV/AIDS epidemic with an introduction to public health surveillance

This module provides an introduction to the HIV/AIDS epidemic and public health, with a focus on South-East Asia.



Module 3: HIV Serosurveillance

The module is intended to train district-level surveillance officers in the planning and implementation of serosurveillance.



Module 4: Surveillance for sexually transmitted infections

This module is intended to train public health officers to develop and operate systems for sexually transmitted infection (STI) surveillance.

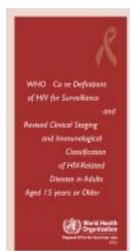


Module 5: Surveillance of HIV risk behaviours

This module is intended to train public health officers in the planning and implementation of behavioural surveillance.



WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in children younger than 15 years of age



WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults aged 15 years or older



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