

Universal Access to **HIV/AIDS** Prevention, Care and Treatment in the Health Sector

Report of the 18th National AIDS Programme Managers' Meeting
Kathmandu, Nepal, 5-7 December 2005



**World Health
Organization**

Regional Office for South-East Asia
New Delhi

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Printed in India

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral treatment
ARV	antiretroviral
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HIV/ TB	intersecting epidemics of HIV and TB
IDU	injecting drug users
MSM	men having sex with men
NACO	National AIDS Control Organization, India
NAP	National AIDS Programme
NGO	nongovernmental organization
SEA	South-East Asia
SEAR	South-East Asia Region
SEARO	South-East Asia Regional Office
STI	sexually transmitted infection
TB	tuberculosis
TCP	targeted condom programme
UNAIDS	United Nations programme on HIV/AIDS
VCT	voluntary counselling and testing (for HIV)
WHO	World Health Organization

I. INTRODUCTION

Among all WHO regions, the South-East Asia Region (SEAR) bears the world's highest burden of tuberculosis (TB). More than one third of all TB cases worldwide occur in this Region. India alone contains one fifth of the world's caseload. Five of the world's 22 high-burden TB countries¹ are in SEAR: Bangladesh, India, Indonesia, Myanmar and Thailand. Among the infectious diseases, TB remains the leading cause of adult death, with more than 600 000 deaths every year.

Member States have been implementing directly-observed treatment, short course (DOTS) for over a decade, and have achieved high levels of population coverage. Case detection, driven largely by India's dramatic DOTS expansion, has accelerated, and treatment success has remained adequate.

The regional HIV epidemic is a source of growing concern. An estimated 6.7 million people are living with HIV or AIDS in the region. Of these, 1.9 million are younger than 25, 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, the large population of the Region makes the magnitude of the HIV epidemic huge. HIV epidemics are concentrated largely among population subgroups with high-risk behaviours, including sex workers and their clients, injecting drug users (IDU) and men who have sex with men (MSM). A major concern is the further spread of the epidemic from these groups to the general population as noted in several Member States. HIV/AIDS has an increasing toll on women and young people. The Regional response to the HIV epidemic is gaining momentum with increased political commitment from Member States and improved funding from donors.

2. JOINT MEETING OF NATIONAL AIDS AND TB PROGRAMME MANAGERS

2.1 Inaugural session

On behalf of the Regional Director, the joint meeting was opened by Dr Kan Tun, WHO Representative to Nepal. He read out the Regional Director's inaugural address. The Regional Director stated that the Region had made laudable progress towards meeting the TB-related World Health Assembly (WHA) targets of 70% case detection and 85% cure by 2005. Sustained human and financial resource growth are still required to meet the targets. In

¹ The 22 countries with the highest TB burden make up 80% of the global caseload.

the past two years, Member States have made remarkable progress in increasing access to AIDS treatment resulting in a fourfold increase in the number of persons receiving antiretroviral therapy (ART). The Region remains quite far though from reaching the 2010 goals of universal access to HIV prevention, treatment, care and support services. Although major steps have been made in many countries in the Region, the Regional Director stressed that reaching the Millennium Development Goals (MDGs) will require a major commitment by all parties. He urged countries to take the steps necessary to implement the strategies as outlined in the Regional Strategic Plan on HIV/TB, and the Regional strategies for TB control and HIV control.

Dr Niranman Shestra, Chief Specialist, Ministry of Health, His Majesty's Government of Nepal, highlighted, in his opening remarks, the challenges of HIV prevention. He noted that our current understanding of the HIV epidemiology in the Region may only represent the 'tip of the iceberg' due to underreporting. Collaboration between the TB and HIV programmes was an important element of improving patient access to prevention, diagnosis, care and treatment of both diseases.

Dr Nani Nair, Regional Advisor, Tuberculosis, and Dr Ying-Ru Lo, Regional Advisor, HIV/AIDS, welcomed the participants. The joint session of the two meetings was attended by a total of 62 persons, including country representatives from all Member countries in the Region, nongovernmental organizations (NGOs), technical agencies, donors, WHO Collaborating Centres and WHO staff from HQ, Regional Office and Country Offices.

Following the introductions, Dr Keshab Bhakta Shreshtha, National TB programme manager, Nepal, and Dr Fonny Silfanus, MKes-Head, Standardisation and partnership Section, National AIDS programme, Indonesia, were nominated Chair and Co-chair for the joint session. Dr Lungten Wangchuk, National TB programme manager, Bhutan, was nominated as Rapporteur for the special joint session.

2.2 Objectives

The objectives of the joint session included discussions of activities to implement TB/HIV surveillance, HIV testing strategies and antiretroviral treatment with regard to TB/HIV co-infection at the Regional and country levels.

2.3 Regional TB/HIV update

Although the TB/HIV epidemic in Asia has the potential to be the largest in the world, some key features are unique to the Region. These include the

relationship between poverty and high-risk behaviour, the link between stigma and underutilization of diagnostic and care services, the presence of a large private sector which does not routinely report TB or HIV cases to the national programmes, the widespread availability and use of anti-TB and antiretroviral drugs, and an overwhelmed public health system with limited resources.

The Region has begun to have increasing activity in TB/HIV collaboration. Thailand is the only country in the Region, and one of the few in the world, with fully integrated HIV and TB services. Collaborative TB/HIV pilot projects are going on in India, Indonesia, and Myanmar. Other Member States are preparing pilot projects.

The past year has seen significant achievements at the Regional level. These include a Regional TB/HIV training course, held in January 2005 in Thailand. This course involved participants from four Member States with the highest burden of TB and HIV in the Region. During two weeks, the participants reviewed the latest evidence in the epidemiology and management of co-infected patients, and developed plans to improve inter-programme collaboration and patient care. An informal consultation on HIV surveillance among TB patients was held in New Delhi, from 17-18 November 2005. This consultation brought together experts from TB and HIV epidemiology with representatives from national programmes to discuss surveillance strategies and technical considerations. WHO has continued to provide support for the monitoring and evaluation of ongoing TB/HIV pilot projects.

Challenges to improve TB/HIV collaboration are significant. HIV programmes are largely vertical, with care centered in a small number of tertiary referral centers or specialized clinics. TB programmes are administratively vertical, but care is disseminated, and integrated into the primary health care systems down to the sub-district level. Operational issues remain in determining optimal cross-referral procedures, care integration, and monitoring of collaboration. Furthermore, significant administrative, social, stigma-related, and ethical barriers to successful collaboration remain to be addressed.

Regardless of these challenges, the environment for expanded TB/HIV collaboration remains extremely favourable. Although TB programmes have performed laudably in case detection, HIV programmes have yet to find success in the detection of HIV-infected patients for treatment and care services. HIV testing among TB patients is seen as an important source of

HIV case finding, and as an important gateway for patients into HIV treatment and care services. Similarly, TB programmes are increasingly challenged by poor treatment outcomes in areas with higher HIV seroprevalence among TB patients, largely related to high mortality among co-infected patients. The high mortality rates among co-infected patients is only likely to be reduced through aggressive attempts to deliver HIV treatment and care services, including antiretroviral therapy.

2.4 Report on informal consultation on HIV surveillance among TB patient

The informal consultation recognized the importance of HIV surveillance among TB patients at multiple levels. At the policy level, surveillance is needed to prioritize the implementation of comprehensive TB/HIV services and to guide decision making for the implementation of routine HIV voluntary counselling and testing. At the point of care level, the voluntary HIV testing of TB patients would be an important gateway into extended care and support for co-infected patients, including the provision of antiretroviral therapy. However, the heterogeneous nature of the HIV epidemic in the Region and the uneven and limited availability of HIV diagnosis, treatment and care services preclude the recommendation of a single surveillance strategy. Selecting the appropriate surveillance strategy depends on country-specific actors.

The first choice of many countries has been sentinel surveillance where testing is offered at selected clinical settings in selected geographic regions, often through unlinked anonymous testing. While properly conducted sentinel surveillance can produce useful surveillance information and guide policy, it does not contribute substantively to HIV case finding activities. In other settings where voluntary HIV testing is offered to all TB patients, programme monitoring of HIV testing results serves as the source of ongoing surveillance information. However, the quality of this information is affected by the availability of HIV testing and the level of acceptance.

In Ubon Ratchatani, Thailand, two years of experience with routine HIV counselling and voluntary testing among TB patients has shown an increasing level of acceptance for HIV testing. This increase may be linked to many factors, including the increasing availability of HIV care and treatment services, antiretroviral treatment, or changing patterns in HIV-associated stigma and perceptions. These findings have been instrumental in the development of the national policy to offer HIV counselling and testing to all TB patients and the use of these data for surveillance purposes. This

experience highlights how local and national surveillance strategies can be guided by operational research activities.

Unlinked anonymous testing (UAT) of HIV among TB suspects and patients is used throughout the Region and remains an important surveillance strategy. The consultation recognized that UAT is an important second surveillance option to the routine availability of data from HIV counselling and testing. At present, UAT was felt to be generally acceptable with important qualifications and safeguards.

The consultation recommended that national policies should include surveillance of both diseases by both programmes.

2.5 Country presentations and discussion

India

Collaboration between the HIV and TB programmes has become a high priority for both programmes. A training curriculum for TB and HIV programme staff has been developed and is in the process of being implemented in higher HIV-prevalence states. Pilot initiatives for surveillance are also underway, including a project focusing on intensified case finding among patients being evaluated at voluntary counselling and testing (VCT) centres. This activity has resulted in substantial TB case finding among both HIV-infected and uninfected VCT clients, and is being evaluated. In higher HIV prevalence states, UAT is ongoing in selected sentinel districts and sub-districts. Substantial work remains to be done, including operational research to improve surveillance strategies, surveillance expansion and improving collaboration and referral procedures as HIV care and treatment services begin to decentralize.

Indonesia

Currently available surveillance information from Indonesia is limited, but suggests that the HIV epidemic is concentrated in certain geographic areas and among populations with HIV risk factors, such as commercial sex workers and intravenous drug users. Indonesia has formed a central level TB/HIV working group, conducted situational analyses in four provinces, issued national guidelines for TB prevention and care in HIV-infected patients, and initiated a pilot project for cross-referrals in Jakarta. A pilot HIV seroprevalence survey among TB patients is also underway.

Myanmar

In Myanmar, sentinel surveillance was conducted in 20 districts from 1995 to 1997. Since 2000, in five districts with very high (>10%) HIV prevalence

among TB patients, collaborative prevention and control pilot programmes have been initiated. The experience from these pilot programmes has highlighted the particularly poor treatment success rates among co-infected patients, largely due to a high mortality ratio.

Thailand

Thailand has the most extensive TB/HIV collaboration in the Region and can be a world model. At the national and regional levels, TB/HIV coordinating committees have been formed. An integrated TB/HIV strategy has been developed, including the routine offer of HIV counselling and testing for TB patients, and intensified case finding of TB among persons living with HIV/AIDS. With support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), TB and AIDS clinic staff, laboratory personnel, and pharmacists in selected pilot areas have received special training in both diseases. The current plan includes expansion of the integrated TB/HIV strategy to all areas and development of a nationwide TB/HIV surveillance system,

Discussion

The discussion highlighted the importance of HIV surveillance data in defining TB/HIV strategies. Despite the relatively low overall seroprevalence of HIV among the TB patients in most Member States of the Region, HIV surveillance data are generally poor. Until high-quality surveillance data are available and suggest otherwise, TB/HIV surveillance should remain a high priority for both programmes.

The disparity between TB and HIV service availability is one of the greatest challenges facing managers as they try to devise effective collaboration strategies. At the point of care, HIV counselling and testing is not yet available to most patients. More advanced services such as secondary prevention counselling, cotrimoxazole preventive treatment, and antiretroviral treatment is yet to be started in many settings. Considerations of confidentiality make operational implementation of monitoring and evaluations systems challenging.

3. MEETING OF NATIONAL AIDS PROGRAMME MANAGERS

3.1 Inaugural session

The 18th meeting of the National AIDS Programme Managers of the WHO South-East Asia Region was held on 6 and 7 December 2005 in Kathmandu, Nepal. The meeting was attended by 35 participants, including country

representatives from Bangladesh, Bhutan, Democratic People's Republic of Korea, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand, a donor (CIDA), and WHO staff from HQ, Regional Office and Country Offices. A list of participants and their contact information is provided in Annex 1.

3.2 Objectives of the meeting

The following were the objectives of the meeting:

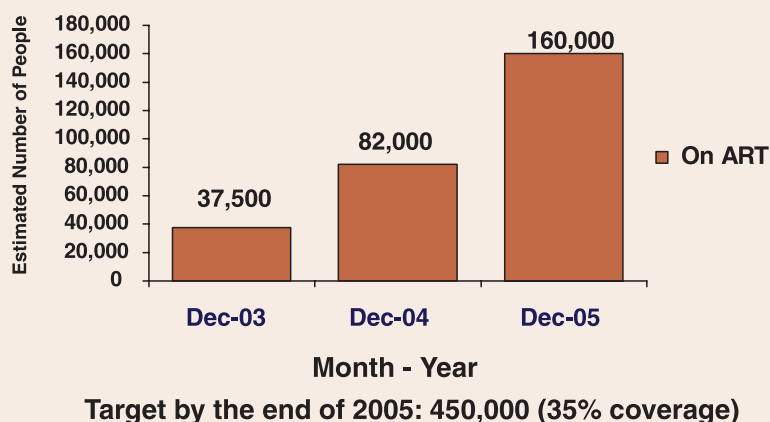
- To review progress made in strengthening strategic information systems, HIV prevention, care and antiretroviral treatment programmes in member countries towards reaching Millennium Development Goals (MDGs) and access to antiretroviral treatment
- To discuss strategies and country specific plans for strengthening health systems' capacity for strategic information systems, HIV prevention, care and antiretroviral treatment programmes towards reaching MDGs and access to antiretroviral treatment
- To discuss activities for implementing TB-HIV surveillance, HIV testing strategies and antiretroviral treatment with regard to TB/HIV co-infection at the regional and country levels

Following self-introductions, the participants elected Dr Gampo Dorji, National AIDS Programme Manager, Bhutan, as the Chairman and Dr Sujata Sumarkoon, Venerologist, National STD/AIDS Control Programme, Srilanka, as the Co-chair, and Dr. Fonny Silfanus from Indonesia as the Rapporteur.

3.3 Progress in HIV/AIDS activities in 2004

The technical sessions began with a review of the recommendations of the NAP meeting of 2004. Progress made against these recommendations and the constraints in achieving goals was discussed.

Overall, remarkable progress was made in scaling up ART. National treatment guidelines were prepared in many countries and additional funds were mobilized through GFATM, CIDA and other donors. A high level of political commitment was achieved through advocacy efforts. Procurement and supply systems, as well as monitoring and evaluation systems were developed and introduced. Training of staff of all cadres was undertaken. These efforts resulted in a fourfold increase in the coverage from 37 500 in December 2003 to 160 000 in December 2005 (Figure 1). However, 80% of those who need treatment still do not have access to treatment. As shown below (box), NAP managers face several constraints in scaling up ART.

Figure 1. Number of people on ART has in South-East Asia, 2003-2005


CONSTRAINTS IN SCALING UP ART

- Limited network of voluntary counselling and testing centres
- Inadequate support for adherence to treatment and a lack of standardized counselling guidelines
- Non-standardized regimens prescribed to patients in the private sector
- Limited availability of trained staff for monitoring and evaluation
- Lack of prequalification of locally available generic drugs
- High payment for services (eg, for CD4 in Indonesia)
- Weak communication between NGOs and the public sector
- HIV-associated stigma
- Lengthy processes for procurement of drugs
- Lack of availability, and high costs, of second line drugs

The coverage of HIV prevention interventions remains very low; less than 10% of people living with HIV/AIDS know their HIV status. It was emphasized that the momentum gained by the "3 by 5" programme should be used to move towards universal access for HIV prevention, care, treatment and support.

3.4 New strategies for control of sexually transmitted infections (STIs)

It is an established fact that effective control of STIs leads to prevention of HIV. Groups to be particularly targeted for STIs include sex workers and clients, men

having sex with men (MSM), people living with HIV/AIDS (PLHA), youth and other vulnerable groups. There are several successful examples of STI control in the region. For example, in Thailand, the 100% condom use policies, coupled with condom interventions, has led to a significant reduction in STIs. Similarly, the community empowerment interventions in Sonagachi, India, which uses peer involvement and negotiations with police and other "gate keepers" have led to a significant decline in HIV and other STIs among female sex workers.

New technologies, such as rapid diagnostics, affordable therapeutics and emerging vaccine, together with new approaches for treatment such as periodic presumptive treatment (PPT) and integrated service delivery, have presented added opportunities for the control of STIs. Some targets of the global STI strategy are the following:

- To expand use of syndromic management to 90% of relevant primary point-of-care sites and patients
- To expand point-of-care testing and treatment of syphilis in pregnancy to 90% of ANC services by 2010
- To implement prevention interventions specific for HIV positive persons in 90% of HIV clinical services by 2007
- To enhance STI surveillance in the context of HIV and behavioural surveillance by 2007
- To eliminate chancroid by 2010
- To reduce syphilis to < 2% in areas of highest prevalence by 2015

Key interventions for the control of STIs include: condom use policy, STI interventions and empowerment of sex workers; improved STI services for clients including workplace interventions for migrants/mobile populations; and improved STI services for the regular partners. Clinical interventions for sex workers include syndromic management, STI screening and periodic presumptive treatment (PPT). The purpose of PPT was clarified as to quickly bring down the STI rate, but then, with improved 100 % CUP and declined STI rates, PPT might not be necessary any more. During the discussion, the need for training of private practitioners was highlighted.

3.5 Availability of ARV medicines: an update on procurement and patents

ARV procurement is complex for several reasons. First, some countries are non-adherent with GFATM requirements regarding choice of drugs. It is a requirement by GFATM that drugs should be pre-qualified by WHO or

approved by a stringent drug regulatory authority. Prequalification is specific to product, manufacturer and production site. The latest list as well as all requirements and procedures for application and information on standards are available at: <http://mednet3.who.int/prequal>. This site also contains a link to training modules on Good Manufacturing Practices (GMP) for manufacturers. Second, procurement plans are prepared in isolation and without inputs from procurement experts. Third, forecasting quantities of ARVs is difficult due to the lack of consumption data, unpredictable scale-up plans and the fact that therapeutic regimens keep evolving.

ARV procurement is further complicated by supply management issues and intellectual property rights issues. Efficient supply management needs communication between programme management and supply managers as the lead time for some key first line ARVs is currently approaching six months. With regards to intellectual property rights, all WTO member states have to have patent laws that are in line with the requirements of the TRIPS Agreement. Most patent laws contain safeguards that can be used to produce/import cheaper generic versions. Malaysia and Indonesia have used "Government use" provisions for import/local production of generic ARVs. India will, due to the implementation of TRIPS from January 2005, have to respect a 20 year patent time from 2005 onwards. However, Indian companies will be allowed to continue production of generic pharmaceutical products that were on the market in India before 2005.

3.6 Universal access to HIV/AIDS prevention, care and treatment

In late 2003, WHO and the UNAIDS Secretariat announced a programme of work to help achieve the global target of providing three million people living with HIV/AIDS in low- and middle-income countries with antiretroviral treatment (ART) by the end of 2005. At that time, WHO and the UNAIDS Secretariat considered "3 by 5" to be a step towards achieving the goal of universal access of HIV/AIDS prevention and treatment for all who need them as a human right. HIV/AIDS featured prominently on the agenda of the 2005 G8 Summit in Gleneagles, with G8 members committing to *developing and implementing a package for HIV prevention, care and treatment with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it*. It is important to note that the G8 communiqué was framed within the context of the "Three Ones" principles.

These political commitments present an important opportunity to further intensify efforts and increase the momentum towards universal access for all countries affected by HIV/AIDS.

The guiding concepts of universal access should generate a process that is (1) led by, and fosters, national ownership, (2) based on lessons learned and builds on existing structures and capacity, (3) fosters and supports the integration of HIV prevention and treatment, and (4) furthers the "Three Ones" principles.

A framework for universal access within the health sector is being proposed which will strive to:

- Simplify complex and interrelated processes
- Highlight the importance of target-driven approaches
- Identify the ingredients for country scale-up
- Identify the core prevention, care and treatment interventions to which access should be universal
- Consider various levels of service delivery and implementation
- Offer an approach that responds to the varying epidemiology of HIV/AIDS
- Provide a reference point for guidance and direction within a public health approach, and
- Support broader health system strengthening efforts

The proposed framework acknowledges that as well as having an enabling environment in place, it is also necessary to undertake specific actions at the country level necessary for sustainable scale-up of HIV/AIDS interventions. These actions include:

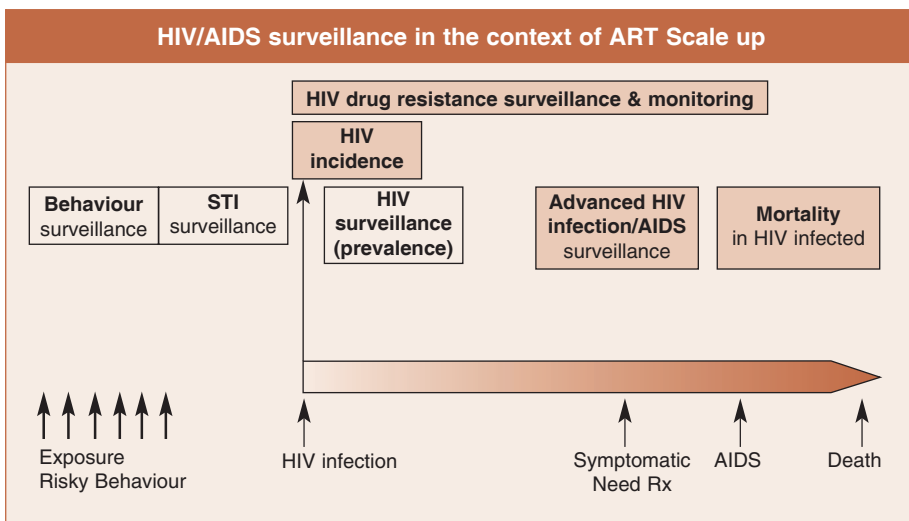
- Comprehensive and integrated HIV/AIDS scale up plans
- Ensuring strategic partnerships
- Ensuring the greater involvement of people living with HIV/AIDS
- Sound management capacity at all levels of the health system
- Comprehensive health sector planning
- Successful procurement and management of supplies of drugs and commodities
- Acquisition, management and reporting of financial resources
- Health information system for data collection and reporting, and
- Operational guidance (tools and guidelines)

3.7 Strategic information

AIDS programme managers need credible strategic information for programme planning, implementation monitoring and evaluation. Strategic

information can be generated from surveillance systems, routine programme monitoring systems and research.

Most countries in the region have well established second-generation systems specific to the status of the epidemic in the respective country. In the context of ART scale-up, however, some additions/modifications to the surveillance system are required. A schematic diagram of a comprehensive HIV surveillance in the context of ART scale up is presented below:



To strengthen the surveillance system further, there is a need to revise the AIDS case definitions in order to provide more relevant information for planning treatment needs. A previous inter-country consultation proposed to include in the definition an option of an additional criterion based on immunological factors. There is also a need to initiate HIV drug resistance surveillance and monitoring. In addition to the routine surveillance data, additional sources of data, such as national health and demographic surveys, VCT and PMTCT data, may be considered.

Specific challenges faced by national AIDS programme managers include too many reporting requirements from multiple donors, the sensitive nature of HIV/AIDS data and delays in dissemination, inadequate staff and other resources, and the lack of reporting from the multiple implementing partners.

It was suggested that countries should strengthen existing strategic unit in the country level with adequate trained staff, review/assess existing surveillance/monitoring system, harmonize information needs with various

partners, own and use their data, and proactively communicate data to all agencies and stakeholders.

3.8 Global Fund for AIDS, TB and Malaria

WHO SEARO has made significant endeavours to facilitate resource mobilization from GFATM by holding regional technical meetings, undertaking technical support missions and on-site support in preparing proposals, reviewing draft proposals through "Mock TRP" process, and participating in global fund-related meetings. While there are several success stories in terms of resource mobilization from GFATM, a major concern is the poor implementation of GFATM projects at the country level as shown below:

Implementation status of GFATM HIV/AIDS projects in SEAR countries				
Country	Round	Funds requested (5Y)	Funds approved (2Y)	Disbursed
Bangladesh	2	19,711,030	6,010,140	96%
India	2	100,081,000	26,116,000	32%
	3	14,819,773	2,667,346	6%
	4	140,878,119	25,831,024	17%
Indonesia	1	7,829,764	7,829,764	42%
	4	65,035,569	31,129,618	26%
Myanmar	3	54,300,034	6,103,009	100%
Nepal	2	11,173,542	4,365,996	21%
Thailand	1	109,353,700	109,353,700	28%
	2	81,348,535	20,073,183	39%
	3	1,371,348	911,542	53%
Total		605,902,414	240,391,322	32%

Source: www.theglobalfund.org, accessed on 29 November 2005

WHO SEARO will continue to support countries in developing feasible, properly-budgeted plans for implementation and will hold joint regular evaluation of implementation to allow for efficient results-based disbursements. It will sound "early warning" on low implementation, help resolve bottlenecks, and ensure regular communication between countries

and GF board members. As well, it will aim to strengthen communication with focal person for GFATM at Regional and country offices, advocate for coordination and timely information exchange between different stakeholders and provide technical support to member countries.

3.9 Country-specific presentations

Bangladesh: *Prevention of HIV/AIDS among youth and adolescents*

In Bangladesh, as in many other countries, the youth constitute a large and vulnerable population at risk of HIV infection. While majority of the Bangladeshi youth have heard of HIV/AIDS, effective and correct knowledge on prevention of HIV/AIDS is inadequate and major misconceptions exist about the spread of HIV/AIDS. A collaborative project between the Ministry of Health and Save the Children USA, funded through the Global Fund, was initiated to control the spread of HIV infection among this large and vulnerable target population. The programme targets in- and out-of-school youth aged 10-24 years, and also the parents, religious leaders and other stakeholders. The National AIDS Programme has designed a model project for delivering youth-friendly health services (YFHS) with technical assistance from WHO. A package of technical materials has been developed to facilitate implementation; this package includes national standards, training modules and curricula. The YFHS are delivered at 24 facilities run by the government and NGOs. At these facilities, the providers are trained in non-judgemental provision of counselling and care, providing confidential services. The impact of this programme will be measured through ongoing monitoring and evaluation.

Myanmar: *Lessons learned from 100% targeted condom promotion programme (TCP)*

Myanmar launched the 100% TCP at four pilot sites in March 2001. The TCP project has undergone several internal and external reviews since inception (with the latest conducted in July 2005). The TCP is currently implemented in 128 out of 324 township sites. The achievements of the programme include (1) increased acceptability at the community level; (2) increased use of condoms by clients; (3) early indications of reduction of STIs among FSWs; (4) strengthened partnerships at the national and township levels; (5) improved human resource capacity. Key factors in the success of the programme included support from UN and other partners, NGOs collaborations, availability of condoms, and co-operation of entertainment owners and managers.

Indonesia: *Harm reduction among injecting drug users (IDU)*

In Indonesia, HIV prevalence among IDUs ranges from 24% to 53%. High prevalence of HIV among IDUs is a common problem in most of the

countries in the region, particularly in Indonesia, parts of India, Myanmar, Thailand and Nepal.

Indonesia has implemented a comprehensive prevention, care, treatment and support programme for IDUs including needle and syringe distribution, needle cleaning, outreach services, behaviour change communication, treatment and rehabilitation. In addition, oral methadone substitution programme has started in two provinces. A key lesson learned from implementation is that multidisciplinary organizations such as the narcotic bureau, the police department, and other judiciary agencies need to work together with the health sector. Involvement of NGOs is crucial.

Major constraints in implementing IDU interventions include:

- Interference by the police, particularly at the local levels
- Lack of local acceptance of the policy on demand reduction with methadone and buprenorphine (as these are considered illicit drugs in most of the countries)
- Confrontations with the general public (as these projects promote or encourage ID use)
- Early age of injecting drug use, limited capacity of NGOs and lack of access to services due to low coverage, and poor adherence to services

The coverage of the IDU interventions is still very low and needs to be scaled up rapidly. Using the existing public health system (primary health services) may be the most feasible strategy to scale up harm reduction programme although working with NGOs should also be considered.

Thailand: *National AIDS Programme Review*

In August 2005, an extensive national programme review was undertaken in Thailand. The review included a preparatory stage which lasted for six months. Countries planning for review in the future should start well ahead of time. It is necessary to get participation from a broad base of agencies within and outside the country and engage the stakeholders in discussions. The areas included in the Thailand review included status of HIV epidemic, policy, and structure. The key findings were as follows: (1) the number of HIV infection is no longer declining as rapidly as it did in the last decade; (2) more adolescent boys and girls are engaging in risk behaviour; (3) achievement has been made in the 100% condom use programme; (4) risk of HIV infection among MSM, transgender and marginalized groups has increased; and

(5) there has been an increase in STIs. The review findings were presented to National AIDS Committee and widely disseminated through a press conference which was attended by the Minister of Public Health.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 Recommendations of joint meeting of national AIDS and TB programme managers

4.1.1 Recommendations to Member States:

- Implementation of collaborative TB/HIV activities, according to agreed national policy and plans, should be ensured.
- Joint national and sub-national TB/HIV coordinating committees, task forces and/or equivalent bodies should be established and their effective functioning should be ensured. Active participation of the national HIV/AIDS and TB programmes, under the aegis of Ministries of Health, is essential for planning, coordinating and overseeing the implementation of TB/HIV activities.
- National strategies for TB/HIV should be developed and technical and operational guidelines, based on global and regional strategies and plans, should be implemented. Current TB/HIV activities, including pilot projects, should be evaluated. Lessons learnt from experience should be used to strengthen and scale up collaborative activities, including surveillance, at the national and sub-national levels.
- Existence of an efficient two-way referral system should be ensured. Responsibilities for diagnosis, treatment, follow up, and monitoring of patients with TB and HIV should be clearly defined at all levels in the health system.
- Movement towards a routine offer of provider-initiated HIV counselling and testing of all TB patients should be initiated in a phased manner. This action should be concurrent with increasing access to HIV prevention, care, support and treatment services, and should be based on country-specific policy, plans and the burden of disease.
- Private treatment, support and care providers, NGOs, and relevant community advocates should be engaged in implementing TB/HIV collaborative activities.

4.1.2 Recommendations to WHO:

- The need for advocacy should be recognized and actively pursued. Ministries of Health and other relevant ministries should be lobbied for increased political and administrative commitment in order to facilitate the scaling-up of collaborative TB/HIV activities. In particular, health systems should be strengthened and additional human and financial resources should be secured for the expanded and effective implementation of both programmes.
- Strong inter-agency coordinating mechanisms should be established at the Regional and country levels to optimize the existing and potential contributions from various partners.
- Inter-country exchange of information and experiences on TB/HIV initiatives should be facilitated and best practices should continue to be documented.
- Member States should be assisted in developing capacity (1) to undertake planned interventions and (2) to develop an evidence base for the adoption or adaptation of international recommendations for the full range of TB/HIV interventions, taking into account both technical considerations and country-specific situations.
- Member States should be assisted in securing the necessary financial and human resources and in preparing proposals for mobilizing additional resources for implementation of expanded activities of both programmes.

4.2 Recommendations of the meeting of national AIDS programme managers

4.2.1 Recommendations to Member States:

- The process of defining and securing agreement among all stakeholders, with regard to the programme goals of universal access to prevention, care and treatment by 2010, should be initiated and continued. This process should define the core programme interventions, as well as the targets and milestones towards the universal access goals. Reflecting the context and status of the epidemic and response, countries may need to use, as a guide, the proposed WHO framework of prevention, care and treatment in the health sector.

- Efforts to decentralize health services to district and sub-district levels should continue. These efforts should aim at increasing access, coverage and utilization of HIV prevention, care and treatment services using a public health approach. The decentralization should also emphasize strengthening of capacity and human resources and full involvement of PLHA and civil society groups.
- Scale-up of interventions especially among populations with high-risk behaviour (IDU, sex workers and MSM, for instance) should be accelerated, with their full involvement, to ensure access to full range of prevention, care and treatment services and interventions. Outreach and related interventions to prevent transmission and reduce harm should extend beyond health facilities to communities and closed settings.
- Priority should be given to STI control as an HIV-prevention strategy. Initiatives should be undertaken to scale up effective interventions for high-risk populations as well as to guarantee wide access to preventive and curative STI services for all. Strategies combining elements of 100% condom policies, targeted clinical interventions and involvement of key populations should be adapted to local conditions.
- Building of robust strategic information systems and ensuring urgent expansion of comprehensive surveillance - monitoring - evaluation systems should continue. In collaboration with major stakeholders, the allocation of adequate human and financial resources should be ensured to support surveillance and M&E system. The collection and use of high quality relevant information for advocacy, programme planning and monitoring should be ensured, as should be accountability at all levels.
- Negotiations with GFATM should be launched to enable Member States to re-programme some resources, for technical assistance as well as for supporting implementation of grants.

4.2.2 Recommendations to WHO:

- Relevant national and international partners engaged in providing universal access (and in the coordination of national programme reviews and development of national strategic plans) should be brought together in dialogue.

- Technical support should be provided as needed, especially in the following activities:
 - Developing plans for expansion of HIV counselling and testing services, care and treatment services and decentralized health service delivery to district and sub-district levels,
 - Developing guidelines for second line ARVs and adherence counselling,
 - Developing guidelines for pediatric ARV therapy,
 - Developing guidelines for collaborative TB/HIV activities, and
 - Building strategic information system, including revised guidelines for case definitions, adaptation of protocols for ARV drug resistance and HIV estimations and projections.
- Countries should be offered support to scale up targeted interventions, such as, harm reduction for IDUs and 100% condom use policy.
- Countries should be assured support to strengthen STI control, and to introduce and evaluate emerging strategies and technologies.
- Countries should be offered assistance in advocacy for additional financial support to fill current funding gaps and in preparing proposals from donors where requested.
- Assistance to countries should continue in the preparation of proposals for GFATM, and technical monitoring and evaluation of the implementation of grants should also be provided.
- Staff capacity at the regional and country levels should be strengthened to support efforts to achieve the universal access goals.
- Provision of a forum for the exchange of inter-country information and experiences, and to document lessons learned should continue.

ANNEX I

PROGRAMME

Monday, 5 December 2005

Inaugural session

0900-0930

Opening ceremony

0930-1000

Group photograph

Plenary

1030-1130

TB/HIV collaboration in the SEA Region:
Strategic directions and major activities
WHO/SEARO

1130-1200

HIV surveillance among TB patients -outcome
of the SEA Regional consultation
WHO/SEARO

1230-1300

Progress with TB-HIV collaborative activities in
the SEA Region
India, Indonesia, Myanmar, Thailand

Group work

1400-1630

Country specific plans for TB-HIV interventions
in 2006-2007

Plenary

1630-1700

Conclusions and recommendations

1700-1710

Closing

Tuesday, 6 December 2005

Plenary

Objective 2: To review progress made in HIV/AIDS prevention, care and treatment

- | | |
|------------------|--------------------------------------------------------------------------------|
| 0930-1000 | Progress on scaling up HIV prevention, care and treatment
<i>WHO/SEARO</i> |
| 1000-1030 | New strategies for the control of STIs
<i>WHO/HQ</i> |
| 1100-1130 | Availability of ARVs: an update on procurement and patents
<i>WHO/SEARO</i> |
| 1130-1200 | Global framework for Universal Access
<i>WHO/HQ</i> |
| 1200-1230 | Followed by discussion |

Plenary

Objective 3: To discuss strategies and country specific plans for strengthening health systems capacity towards reaching MDGs and universal access

- | | |
|------------------|---------------------------------------------------------------------------------------------|
| 1400-1430 | HIV and young people in Bangladesh
<i>NAP Bangladesh</i> |
| 1430-1500 | Harm reduction among IDUs: Lessons learned from Indonesia
<i>NAP Indonesia</i> |
| 1530-1600 | Evaluation of the 100% condom programme: lessons learned from Myanmar
<i>NAP Myanmar</i> |
| 1600-1700 | Followed by discussion |

Wednesday, 7 December 2005

Plenary

Objective 3: continued

- | | |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 0900-0930 | HIV/AIDS strategic information: New developments and measuring MDGs
<i>WHO/SEARO</i> |
| 0930-1000 | National programme review in Thailand: Lessons learned
<i>NAP Thailand</i> |
| 1030-1100 | Preparations and process of national programme review
<i>WHO/SEARO</i> |
|
 | |
| Group work | |
| 1100-1230 | Future steps and support needs to strengthen HIV/AIDS prevention, care and treatment in countries of the region
<i>Consultations with individual country teams</i> |
| 1400-1500 | Working groups continue |
|
 | |
| Plenary | |
| 1500-1530 | The Global Fund: Issues and Challenges
<i>WHO/SEARO</i> |
| 1530-1700 | Conclusions and recommendations |
| 1700 | Closing |
| 1900 | Reception |

ANNEX 2

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