



Scaling up  
**HIV/AIDS**  
Prevention, Care and Treatment

Report of the National AIDS Programme Managers' Meeting  
Bangkok, Thailand, 10-11 July 2004



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



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## List of Acronyms

|         |  |
|---------|--|
| AEM     | <b>A</b> si <b>A</b> n <b>E</b> pidemic <b>M</b> odel  |
| AIDS    | <b>A</b> cquired <b>I</b> mmuno <b>D</b> eficiency <b>S</b> yndrome                                  |
| AMDS    | <b>A</b> IDS <b>M</b> edicines and <b>D</b> iagnos <b>S</b> tics <b>S</b> ervice                     |
| ANC     | <b>A</b> n <b>T</b> e <b>N</b> atal <b>C</b> are   |
| ART     | <b>A</b> n <b>T</b> i <b>R</b> etro <b>V</b> iral <b>T</b> reatment                                  |
| ARV     | <b>A</b> n <b>T</b> i <b>R</b> etro <b>V</b> iral  |
| EQAS    | <b>E</b> x <b>T</b> ernal <b>Q</b> uality <b>A</b> ssurance <b>S</b> ystem                           |
| GFATM   | <b>G</b> lobal <b>F</b> und to fight <b>A</b> IDS, <b>T</b> uberculosis and <b>M</b> alaria          |
| GPO     | <b>G</b> overnment <b>P</b> harmaceutical <b>O</b> rganization                                       |
| HIV     | <b>H</b> uman <b>I</b> mmunodeficiency <b>V</b> irus   |
| HIV/ TB | The intersecting epidemics of <b>HIV</b> and <b>TB</b>   |
| IDA     | <b>I</b> nternational <b>D</b> ispensary <b>A</b> ssociation   |
| IDU     | <b>I</b> njecting <b>D</b> rug <b>U</b> se   |
| IMAAI   | <b>I</b> ntegrated <b>M</b> anagement of <b>A</b> dolescent and <b>A</b> dult <b>I</b> llness        |
| M&E     | <b>M</b> onitoring and <b>E</b> valuation  |
| MSF     | <b>M</b> édecins <b>S</b> ans <b>F</b> rontières   |
| NACO    | <b>N</b> ational <b>A</b> IDS <b>C</b> ontrol <b>O</b> rganization, India                            |
| NAP     | <b>N</b> ational <b>A</b> IDS <b>P</b> rogramme  |
| NGO     | <b>N</b> on <b>G</b> overnmental <b>O</b> rganization  |
| NVP     | <b>N</b> evirapine   |
| OI      | <b>O</b> pportunistic <b>I</b> nfection  |
| PEPFAR  | <b>P</b> resident's <b>E</b> mergency <b>P</b> lan for <b>A</b> IDS <b>R</b> elief                   |
| PLWHA   | <b>P</b> eople <b>L</b> iving <b>W</b> ith <b>HIV/AIDS</b>   |
| PMTCT   | <b>P</b> revention of <b>M</b> other <b>T</b> o <b>C</b> hild <b>T</b> ransmission <b>P</b> rogramme |
| RNTCP   | <b>R</b> evised <b>N</b> ational <b>T</b> uberculosis <b>C</b> ontrol <b>P</b> rogramme              |
| SEAR    | <b>S</b> outh- <b>E</b> ast <b>A</b> sia <b>R</b> egion  |
| SEARO   | <b>S</b> outh <b>E</b> ast <b>A</b> sia <b>R</b> egional <b>O</b> ffice                              |
| STI     | <b>S</b> exually <b>T</b> ransmitted <b>I</b> nfection   |
| TB      | <b>Tu</b> <b>B</b> erculosis   |
| 3TC     | Lamivudine   |
| UNGASS  | The <b>U</b> nited <b>N</b> ations <b>G</b> eneral <b>A</b> ssembly <b>S</b> pecial <b>S</b> ession  |
| VCCT    | <b>V</b> oluntary <b>C</b> onfidential <b>C</b> ounselling & <b>T</b> esting (HIV)                   |
| VCT     | <b>V</b> oluntary <b>C</b> ounselling and <b>T</b> esting (HIV)                                      |
| ZDV     | <b>Z</b> idovudine   |



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## 1. Introduction

HIV/AIDS continues to devastate families, communities and societies in many parts of the world, affecting primarily populations who are poor, vulnerable and socially marginalized. At the end of 2003, 38 million people were estimated to be living with HIV/AIDS. Out of the global total two thirds are living in Sub-saharan Africa. The South-East Asia Region of WHO (SEAR) ranks second with more than six million people. While the epidemic has not begun to reverse except in Thailand, there is a growing need for care for the number of People Living with HIV/AIDS (PLWHAs).

With the introduction of combined antiretroviral treatment (ART) in the mid-nineties, persons living with HIV/AIDS can now live longer and more productively. In countries and societies that have access to ART, a reduction of AIDS-related morbidity and mortality have led to a dramatic shift in perceptions. HIV/AIDS has transferred its image from that of an inevitable fatal condition to that of a manageable chronic illness that can be treated. However, other effects may be deleterious if ART programmes are not managed well. After a few years the average person receiving ART develops resistant strains of HIV, which can spread to others. Behavioural effects also occur slowly and cumulate. If ART changes risk behaviour, the rate of transmission will also vary, leading to changes in the epidemic path, some of which will be experienced only after several decades.

In 2002, at the 14th International AIDS Conference held in Barcelona, Spain, WHO, for the first time, announced a target for antiretroviral therapy, 3 million people by the end of 2005. A global advocacy movement pushed forward the development of a public health approach that would be necessary to achieve this target. In September 2003 the WHO Director-General Dr LEE Jong-wook along with UNAIDS and other partners declared the failure to provide ART as a public health emergency.

The "3 by 5" goal to have 3 million people in low and middle-income countries on ART by the end of 2005 is ambitious. Estimates of the necessary resources are needed to facilitate resource mobilization and rapid channelling of funds to where they are required. It is estimated that between US\$ 5.1 billion and US\$ 5.9 billion will be needed by the end of 2005 to provide ART, support programmes, and cover country-level administrative and logistic costs for "3 by 5".

Scaling up ART was again the central theme of this year's National AIDS Programme Managers' Meeting for the South-East Asia Region held from 10 to 11 July 2004 in Bangkok, Thailand. The meeting was attended by 34 participants including country representatives from Bangladesh, Bhutan, DPR

Korea, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste; non-governmental organizations (Australian Federation of AIDS Organizations); UNICEF East Asia and Pacific Regional Office (UNICEF EAPRO), World Bank, WHO headquarters, the SEA Regional Office and Country Offices. For list of participant please see **Annex I**.

The objectives of the meeting were:

- To share global, regional and country experiences on scaling-up ART and discuss issues and challenges relevant to South-East Asia and
- To identify resource needs and prioritize activities to be included in operational plans for scaling-up ART.

The agenda of the two-day meeting is attached (**Annex 2**).

The meeting elected Dr Iyanthi Abeyewickreme as the Chairperson and Dr Shyam Sunder Mishra as the rapporteur.

## 2. Inaugural Address

The meeting was opened by Dr Kumara Rai, Acting WHO Representative to Thailand, on behalf of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region. Dr Samlee stressed that control of HIV/AIDS was one of WHO's priority programmes and that the "3 by 5" initiative would guide much of WHO's work on HIV/AIDS. Along with the renewed emphasis on treatment, work on prevention, counselling and care would continue. For full text of Dr Samlee's address, please see **Annex 3**.

## 3. Global Progress Made

Globally, 56 countries have officially requested support to ART scale-up and "3 by 5" country assessment missions to 24 countries have been undertaken. Since March 2004, 35 staff from WHO headquarters and the regional offices have been sent to countries to provide support for resource mobilization, capacity building and development of implementation plans.

The HIV Department has reinforced its normative guidance and published a number of documents such as revised simplified ART guidelines, operational guides for ART scale-up in countries and "3 by 5" related technical briefs, HIV/AIDS module for Integrated Management of Adolescent and Adult Illness (IMAAI), the Human Capacity-building Plan for Scaling-up HIV/AIDS Treatment, training packages for ART delivery specifically targeted at physicians, nurses, health care workers, community treatment supporters and laboratory technicians, toolkit for injecting drug users (IDU) and sex workers, guidelines on the use of rapid HIV tests and for monitoring of antiretroviral (ARV) drug resistance.

The AIDS Medicines and Diagnostics Service (AMDS) has been established.

WHO is working with key partners to harmonize monitoring and evaluation (M&E) at patient and programme level.

A number of interim targets for scaling-up ART have been achieved (**Table 1**).

| <b>Table 1 : Targets achieved</b>              |                              |                              |
|--|------------------------------|------------------------------|
| <b>Indicator</b>                               | <b>Targets<br/>June 2004</b> | <b>Results<br/>June 2004</b> |
| Additional WHO resources allocated to "3 by 5" | US\$ 86 million              | US\$ 39 million              |
| New normative tools and guidelines             | 15                           | 33                           |
| Countries appealing to WHO for "3 by 5"        | 40                           | 56                           |
| Countries with ART targets                     | 35                           | 12                           |
| Average price for 1st line ART regimen         | US\$ 100-350                 | US\$ 484                     |
| Countries using AMDS for drug procurement      | 20                           | 29                           |
| Health workers trained                         | 10 000                       | 15 000                       |
| PLWHAs receiving ART in developing countries   | 500 000                      | 440 000                      |

WHO is aiming to increase total spending on HIV/AIDS globally from US\$ 59 million in 2002-2003 to US\$ 218 million in 2004-2005 based on the identified needs for technical assistance (**Table 2**).

| <b>Table 2 : Requests for technical assistance (56 countries)</b>         |                      |
|---|----------------------|
| <b>Area for technical assistance</b>                                      | <b>Countries (%)</b> |
| Capacity building (tools and training)                                    | 60                   |
| Medicines and diagnostics<br>(procurement, supply chain management, etc.) | 56                   |
| M&E (patient tracking system)   | 48                   |
| ART (policy and equity issues)  | 44                   |
| Human resources planning  | 32                   |
| Testing and counselling   | 28                   |
| Laboratory  | 20                   |
| Programme communication and advocacy                                      | 16                   |
| Coordination and management (understated)                                 | 15                   |
| Fund raising  | 8                    |
| Community involvement   | 5                    |
| Partnership   | 5                    |

#### 4. Scaling-up Prevention, Care and ART in South-East Asia

The South East-Asia Region is the second most affected region after Sub-Saharan Africa, with more than six million PLWHAs. There are multiple and diverse HIV epidemics in the Region. Because of the large population base and several factors that enhance the spread of HIV, including poverty, gender inequality, mobility and social stigma, SEAR is likely to increasingly suffer the brunt of the epidemic. The majority of HIV infections in the Region occur through unprotected sex between men and women. Commercial sex is the main high risk behaviour driving the sharp increases in HIV infection in the Region. In addition, injecting drug use is adding to the rapid spread of the epidemic, particularly in the north-eastern states of India, Indonesia, Nepal, Myanmar and Thailand. In areas where HIV infection has remained high among high-risk populations, it is now seeping to the non-high risk population.

As per the *Millennium Development Goals* (MDGs), governments are committed to *halt and reverse the spread of HIV/AIDS by 2015*. Progress towards achieving this goal in the Region has been mixed. Interventions to decrease HIV transmission are being implemented in a number of countries. These include condom promotion, sexually transmitted infections (STI) management, ensuring blood safety, reducing drug-related harm, targeting IDUs and prevention of mother to child transmission (PMTCT). Some of the successful examples are from Thailand where the occurrence of new HIV infections has begun to decline since 1996. The Government of Thailand had committed to nationwide coverage of a comprehensive prevention and care programme, which included from the early nineties the 100% condom programme, STI management, counselling and HIV testing PMTCT, and treatment of opportunistic infections. The Government of India has scaled up its voluntary counselling and testing (VCT) as well as PMTCT programme, covering all states by the end of 2003. Coverage of such programmes in other countries is still limited. Only three countries, Myanmar Thailand and Sri Lanka, have more than 80% voluntary blood donations although most countries have introduced to some extent screening of voluntary donors for risk factors and HIV testing of donated blood. Recently, the Governments of Indonesia and Myanmar have started HIV prevention and care programmes targeting commercial sex workers and IDUs. Indonesia has even initiated a limited-scale project to prevent HIV in closed settings such as prisons.

Systematic expansion of HIV prevention programmes such as condom promotion, STI management in particular with regard to target populations such as sex workers, truck drivers and mobile/migrant populations requires more attention by national AIDS programmes.

The scaling-up of ART in the Region is a complex process, fraught with multidimensional challenges. It demands the formulation of a carefully designed operational plan and sustained action by many partners within a well defined strategic framework for action. The WHO Regional Office for South-East Asia had therefore developed a strategic framework for action at country level. The framework was endorsed by the regional core group on scaling-up HIV/AIDS treatment as well as by the national AIDS programme managers in 2003.

The high-HIV burden countries in the Region have made important beginnings to start ART programmes. Major technical support was provided through WHO collaborative country missions, capacity building, development of tools and guidelines, provision of strategic information, as well as through advocacy efforts and partnership building.

As demonstrated in Thailand, scaling-up ART is a way to support and strengthen prevention programmes. Since antiretroviral drugs were available, the Royal Thai Government supported treatment for a limited number of persons in need and will have covered 50 000 people (more than 50% of those in need) by the end of 2004 in all regional / provincial and district hospitals.

Policy announcements to provide treatment were made on World AIDS Day 2003 in India, Indonesia, and Nepal.

India made impressive progress in a short period. Following the announcement of the initiative on 1 December 2003, the Government of India held national and sub-national consultation meetings, developed national treatment guidelines, prepared training materials and built capacity of medical and paramedical teams to deliver ART from 1 April 2004. With the assistance of WHO, antiretroviral drugs were procured and in the first six weeks of the launch of the programme, nearly 3000 patients were receiving treatment at 16 institutes in the country.

Indonesia has proposed a target to provide ART to at least 5000 people living with HIV/AIDS by the end of 2004 and to 10 000 by the end of 2005 out of an estimated 15 000 people in need. Currently, about 1300 persons are receiving ART and paying for treatment. The government allocated more than 10 billion Indonesian rupiahs for ARVs in 2004. Major efforts included the establishment of a national technical advisory group, development of a national strategic plan, tools and guidelines, and capacity building. Funds from Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) rounds 1 and 4 are available for treatment and to scale-up prevention activities.

In Myanmar, HIV services are currently provided by the public and private sectors and by non government organizations (NGOs). The national AIDS programme offers voluntary confidential counselling and testing (VCCT), diagnosis and treatment of opportunistic infections, home-based care and PMTCT. ART is currently provided in different sectors of the health system, the public sector and the private sector (for profit and non-for-profit). In Yangon, an innovative public-private pilot programme has been initiated at Waibargi Specialist Hospital in collaboration with the non-government organization MSF-Holland (AZG) with around 150 patients being treated. The national AIDS programme has proposed the following initial treatment targets: at least 2000 persons on ART by the end of 2004, at least 10 000 by the end of 2005 and at least 26 000 by the end of 2008. Major efforts in adapting tools and guidelines and capacity building are planned.

In Nepal, currently less than 100 AIDS patients receive ART in the private sector. The Government plans to support provision of ART to 250 people with HIV/AIDS during 2004. The ART programme will start in the Tekku Infectious Disease Hospital, Kathmandu. Major efforts will focus on capacity building. The funds from the 2nd round GFATM had not been disbursed although the grant agreement was signed in September 2003.

## 5. Technical Issues and Challenges in Scaling up ART

### 5.1 AIDS Medicines and Diagnostics Services

In December 2003, WHO launched the AIDS Medicines and Diagnostics Services (AMDS) as "the access and supply arm of the UNAIDS/WHO "3 by 5" strategy.

The AMDS functions as a clearing house on ARVs and HIV diagnostics. It also provides support in procurement and supply management planning, capacity building and monitoring.

So far, UN organizations and technical organizations have been working informally with AMDS. The roles, responsibilities and relations of partners are being defined. Organizations such as Médecins Sans Frontières (MSF), the US State Department President's Emergency Plan for AIDS Relief (PEPFAR), and USAID have participated as observers, while the AMDS Unit in the HIV department of WHO headquarters acts as the secretariat to this informal network.

The procurement of drugs and diagnostics will be handled by the different procurement agencies in the network (at present UNICEF Supply Division,

International Development Association, WHO Contracting and Procurement Services) with the secretariat taking a neutral position informing buyers of the options available. The AMDS secretariat has brokered technical support to several countries in South-East Asia, Africa and Eastern Europe.

## 5.2 Capacity Building for Scaling-up ART

Training and certification of health and community workers has been identified as a critical bottleneck in efforts to scale up prevention, care and ART programmes. A large number of health and community workers, from tertiary specialized hospitals down to the district level, need to be trained to enable them to contribute to HIV prevention, care and treatment. Training is needed in particular for those involved in the management and delivery of ART services, those working on testing and counselling and other entry points to ART, and the many community supporters assisting PLWHA receiving medication.

Human resource development and capacity building are complex issues that necessitate inputs from a range of stakeholders at the national level, for planning, implementation and monitoring. This is best achieved by bringing together a group of dedicated individuals and organizations in regular meetings, e.g. in the context of a *Capacity Building Working Group* as a sub-group of the appropriate *National Steering Committee*. Such a group should target a wide range of stakeholders, including the relevant government bodies (often Ministries of Health/Education/Finance), NGOs, training providers (universities and training schools), professional associations, service providers and donors.

An assessment of the national human resource situation in the health sector is seen to be a precondition for the development of a meaningful and realistic approach to human resource development at the central / regional and down to the district and community level.

Capacity building for ART should include the community, clients, clinical teams, district teams and other stakeholders. Short training courses for different health cadres are desirable followed by on-the-job training and on-site support. Targeting clinical teams in general principles of good chronic care and adherence support is desirable. The use of alternative and participatory training methods facilitate the rapid and efficient expansion of the workforce.

Thailand's capacity building plan includes five components:

- the improvement of health infrastructure including counselling and testing, health facilities, communities, procurement and supply management

- establishment of medical and laboratory networks
- training of health care providers (nurses, counsellors, medical doctors, pharmacists and laboratory technicians)
- quality assurance for clinical care, laboratory testing procedures and other interventions including accreditation of hospitals
- strengthening of referral system

The WHO Collaborating Centre for Training and Research on HIV/AIDS Clinical Management and Counselling at Bamrasnaradura Institute was established in 1997. It forms part of a collaborative network conducting activities in health care, workers training, development of training material in HIV/AIDS clinical care, dissemination of information and training in research methodology.

A *Training Workshop on Clinical Management of HIV/AIDS* has been conducted annually by this centre since 1999. International experts and WHO contributed to the regular revision of the training curriculum. As of 2004, 11 international courses have taken place: seven on clinical management and four on laboratory diagnosis of opportunistic infections. So far, 220 participants from 16 countries in Asia have attended the course.

### 5.3 Laboratory Support

Areas in which laboratories will play a critical role in implementing the “3 by 5” initiative at the country level include detection of anti-HIV antibody as well as monitoring of ART (**Table 3**). The decision on when to start and when to switch treatment is based on clinical criteria but ideally should include laboratory criteria.

The laboratory techniques for supporting ART can be effectively applied for diagnosis and monitoring if a functional network of laboratories is created. Since many of the techniques are new, a network of laboratories with suggested functions at different levels is given in **Table 4**.

In any laboratory dealing with HIV, quality is an essential element to ensure consistency, reproducibility, traceability and efficacy of products or services. In the context of HIV-related laboratory services also, quality assumes great importance since the physician utilizes the laboratory report for the benefit of the patient and the community.

Safety procedures include laboratory protection of the material to be tested, the environment and the staff. Personal and laboratory safety can be

**Table 3 : Monitoring of ART**

| <b>Monitoring</b>               | <b>Laboratory area</b>   |
|---------------------------------|--|
| Virological                     | Viral load<br>Antiretroviral drug resistance   |
| Immunological<br>Haematological | CD4 count<br>Total lymphocyte count  |
| Microbiological                 | Diagnosis of opportunistic infections<br>Antimicrobial susceptibility of bacterial pathogens<br>Reactivation of TB |
| Adverse drug reaction           | Liver and kidney function tests<br>Haematological parameters   |

**Table 4 : Suggested networking of laboratories to support the “3 by 5” initiative**

| <b>Peripheral</b>  | <b>Intermediate</b>   | <b>Central</b>   |
|--|---|--|
| Rapid HIV test<br>Haemoglobin<br>TB microscopy<br>Pregnancy test<br>Total lymphocyte count | <b>Peripheral lab +</b><br>Full blood count<br>Liver and renal function tests<br>Diagnosis of opportunistic infections<br>CD4 count | <b>Intermediate +</b><br>CD4 count<br>EQAS for CD4<br>Viral load<br>Resistance studies<br>Clinical chemistry markers<br>Diagnosis of opportunistic infections<br>Evaluation of kits and technology |

achieved only by informed, trained and responsible individuals through the application of standard precautions.

#### 5.4 Anticipating Antiretroviral Impact in Thailand Using the Asian Epidemic Model

The Asian Epidemic Model (AEM) was developed through collaboration between the East West Centre, Hawaii, Mahidol University, Bangkok and the University of the Philippines. It represents a process model that replicates HIV dynamics in Asian settings for projecting the HIV/AIDS epidemic in countries. It identifies major transmission routes as commercial sex, IDU, male-male sex, marital/extramarital sex, and mother-to-child transmission.

Key inputs are the size of the respective populations, behaviours over time and transmission parameters.

The East West Centre Hawaii, and Chulalongkorn University are currently developing a model for future ART needs based on AEM (AEM ART+). However, the projection of ART needs based on the AEM is complex. A good HIV surveillance system and recording and reporting system for ART patient tracking and programme monitoring are critical.

Issues to be addressed in the AEM ART+ are:

- What therapeutic options will exist?
- At what stage of illness is ART made available?
- What proportion of those eligible access treatment?
- What is the impact of specific therapies on survival, dropouts and shifts to second line therapy?
- What does ART do to infectivity?
- What are the behavioural changes induced, both in the community and in those on therapy?

The model proposes two groups of selection criteria (asymptomatic and symptomatic) for starting ART in combination with three treatment scenarios:

- Public
  - ◆ Public hospital system
- Augmented public
  - ◆ Hospital system supplemented by PLWHAs and NGO support
- Private
  - ◆ Treatment through drugs obtained at GPO outlets with prescription

Topics which need to be explored in the near future in Thailand where the AEM ART+ is developed are:

- Revision and updating of projections
- Number entering therapy options
  - ◆ Costs
  - ◆ Effects of expanded VCT
  - ◆ Recruitment efforts in the therapy option
  - ◆ Shifts in policy on treatment access, etc.

- Dropouts in each arm (PLWHA support, counselling)
- Deaths in each arm (adherence, improved training)
- Rate of shifts to 2nd line therapy (training, new drugs)
- Levels of resistance (adherence, prevention)
- Behaviours (behavioural disinhibition, expanded prevention with communities and PLWHA)
- Transmission rates (adherence)

## 5.5 Financing HIV Prevention and Treatment in Developing Countries

With the increasing need for HIV/AIDS care and treatment and the high cost of ART, governments should analyse costs and benefits of different options for introducing ART into HIV/AIDS control programmes.

The Government of India and the World Bank have analysed the cost and benefits of several options for use of ART. Similar efforts are being made in Thailand and in South Africa.

Three alternative plans for using and financing ART were analysed in India.<sup>1</sup> These alternative plans, or “scenarios,” are a (i) minimally interventionist plan to strengthen the private sector’s ability to manage ART (ADHERE scenario), (ii) a moderately interventionist plan to provide free ART to HIV-positive pregnant women and, if they are also infected, to their spouses and children (MTCT+ scenario), and (iii) a more generous plan to finance ART for the poorest 40 percent of all Indians with HIV infection (Below the Poverty Line) scenario.

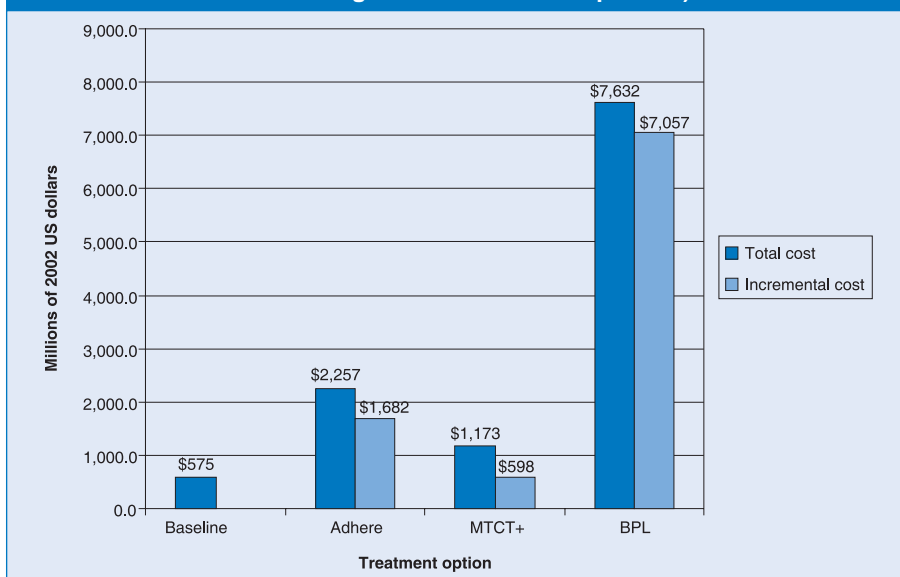
The study in India used a set of basic cost assumptions to estimate the costs and cost-effectiveness of alternative ART policies. Under these assumptions, government financing of ART would increase the present value of future health expenditures through 2033 between US\$ 598 million (for the MTCT+ programme) and US\$ 7057 million (for the Below the Poverty Line programme) (**Figure 1**).

While evidence from developing countries is limited, it is possible that condom use among those at highest risk could decline by as much as 10 percentage points or increase by as much as 40 percentage points as a result of the availability of ART. Sensitivity analysis across this range reveals that spillover effects of this magnitude would overwhelm the direct biological benefits of

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<sup>1</sup> HIV/AIDS Treatment and Prevention in India. Modeling the Cost and Consequences. World Bank 2004.

**Figure 1 : Total and incremental government cost of ART policies (in 2002 dollars using discount rate of 10 percent)<sup>2</sup>**



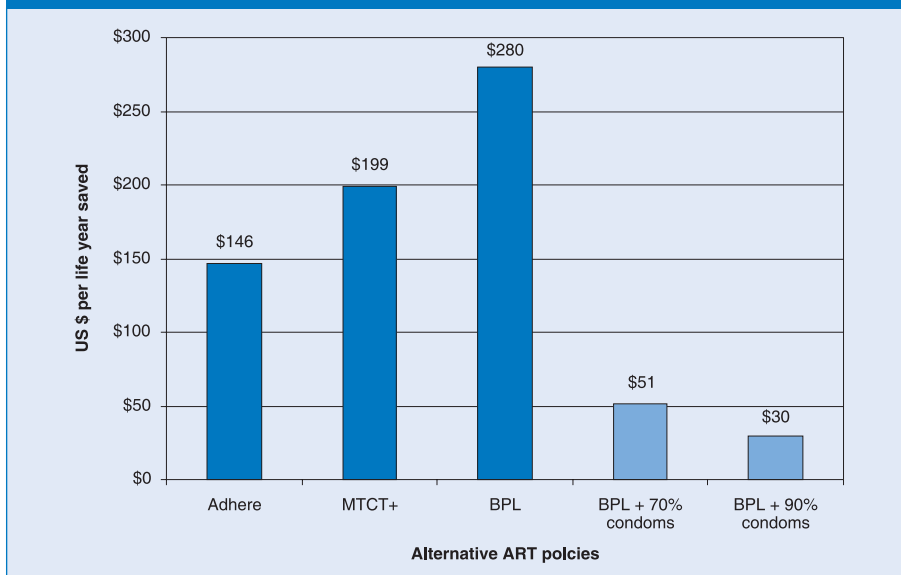
treatment. If condom use among high-risk groups in the general population drops by 10 percentage points in response to the availability of treatment, the number of new infections in 2013 would increase by 1 million, with commensurate increases in the costs of treatment. The presently increased condom use would greatly increase the benefits and reduce the costs of any treatment policy by coupling the most ambitious of the three proposed programmes, the Below the Poverty Line programme, with incentives to motivate state-level government and medical decision makers to dramatically increase condom use. Under favourable assumptions, the cost per life-year saved of the ART programme falls to just US\$ 51 if the rate of condom use was 70% (**Figure 2**). If the rate of condom use rose to 90%, the cost per life-year saved by the Below the Poverty Line policy would fall to about US\$ 30.

## 6. Country-Specific Plans for Scaling-up HIV Prevention, Care and Treatment

Participants worked in smaller groups to initiate workplans for starting and scaling-up ART which will be fine-tuned and submitted to WHO and other development partners in due course (**Annex 4**).

<sup>2</sup> HIV/AIDS Treatment and Prevention in India. Modeling the Cost and Consequences. World Bank 2004.

Figure 2 : Cost-effectiveness of alternative ART scenarios in India



## 7. Recommendations

The meeting concluded that scaling-up of ART is part of the comprehensive care and support package for PLWHAs and reaffirmed that HIV prevention efforts will be maintained.

### Action points for countries

- Accelerate scaling-up of ART to achieve national targets
- Adopt the regional strategic framework for action at country level for scaling-up ART
- Look for and use additional resources such as from GFATM to build health system capacity to implement and scale-up HIV prevention and care including ART. While scaling-up ART, countries should not lose sight of strategies and interventions accelerating prevention of HIV
- Strengthen partnerships including those with civil society and the private sector and enhance multi-sectoral collaboration
- Provide adequate laboratory infrastructure and train human resources for efficient and quality support to the HIV/AIDS programme such as HIV testing, diagnosis of opportunistic infections / STIs, and ART
- Be aware of the TRIPS Agreement and use its flexibility in protecting public health programmes

- Ensure quality, harmonize, set up and strengthen monitoring and evaluation system for ART including HIV prevention and care.

### Action points for WHO

- Provide technical support to countries in rapid scale-up of HIV/AIDS programme including ART and closely monitor implementation of these in the Region
- Continue to emphasize the importance of HIV prevention and provide technical support in strengthening prevention strategies
- Assist countries in resource mobilization
- Pro-actively provide technical support to strengthening infrastructure and training of health care workers as well as community organizations in providing quality prevention, care and ART
- Provide technical support to countries in understanding flexibilities in TRIPS Agreement and mechanisms to use these to protect public health in the context of scaling-up of the ART programme
- Finalize and disseminate the relevant regional guidelines for prevention, care and treatment and provide technical support to countries to adapt and implement these.

## Annex 1

### List of Participants

#### MEMBER COUNTRIES

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## Annex 2

### Programme

#### **10 July 2005**

##### **0830 – 1200 hours**

Welcome/Opening remarks

Dr Kumara Rai, Acting WR Thailand

Objectives of the meeting

Jai P Narain, Acting CDS, WHO/SEARO

Global and regional “3 by 5” operational plan and progress made

Teguest Guerma, WHO HQ and Ying-Ru Lo, WHO SEARO

Progress made and operational issues in ART scaling up

Country presentations: India, Indonesia, Myanmar, Thailand

##### **1330 – 1700 hours**

“3 by 5 initiative”: Issues and challenges for scaling up ART (Presentations 15 minutes)

- AIDS Medicines and Diagnostics Services  
*Jos Perriens, WHO/HQ*
- Capacity building for scaling-up ART  
*Anupong Chitwarakorn, Ministry of Public Health Thailand, Bangkok*
- Laboratory support to “3 by 5”  
*Rajesh Bhatia, WHO/SEARO*
- Anticipating Antiretroviral Impacts in Thailand Using the Asian Epidemic Model  
*Tim Brown, East-West Centre Hawaii and Chulalongkorn University, Bangkok*
- Financing HIV prevention and treatment in developing countries  
*Mead Over World Bank, Washington*

#### **11 July 2005**

##### **1000 – 1300 hours**

Break out groups and presentations: Country specific plans for scaling up HIV prevention, care and treatment

##### **14.00 – 18.00 hours**

WHO “3 by 5” satellite at the 15<sup>th</sup> International AIDS Conference

## Annex 3

### Address by Dr Samlee Plianbangchang, Regional Director WHO South-East Asia Region

(read by Dr N. Kumara Rai, Ag. WR, Thailand)

Distinguished participants, colleagues, ladies and gentlemen,

It gives me great pleasure to welcome you all to this 19<sup>th</sup> Meeting of the National AIDS Programme Managers in SEAR.

HIV/AIDS continues to devastate families, communities and societies in many parts of the world, affecting primarily populations which are poor, vulnerable and socially marginalized. At the end of 2003, 40 million people were estimated to be living with HIV/AIDS. Twenty-five million people have already died. Of the global total, two-thirds are living in Sub-Saharan Africa. The South East Asia Region ranks second with an estimated 6 million people.

Despite advances in drug development and reduction in prices of HIV medicines, only 400 000 patients in developing countries have access to antiretroviral therapy. Of these, 300 000 are in Brazil alone. Only 2% of patients in Africa and 4% in the are being treated.

In September 2003, the WHO Director-General, Dr LEE Jong-wook and Dr Peter Piot of UNAIDS declared the failure to provide treatment to HIV/AIDS patients as a global health emergency and called for providing 3 million people in the developing world with ART by 2005. By March 2004, 48 countries with the highest burden of HIV/AIDS had expressed their commitment to rapid treatment expansion and requested technical cooperation in designing and implementing scaling-up programmes. However, the overall progress in “3 by 5” has been slow and needs a major thrust at national and international levels.

Many countries of the South East Asia Region have embarked on efforts to scale up antiretroviral therapy. Besides Thailand, which is already implementing a national treatment programme, other countries, namely India, Indonesia, Nepal, and Sri Lanka recently announced initiatives on AIDS treatment.

In order to maintain the momentum, substantial strengthening of national health capacity is required. Scaling-up ART is a major managerial and logistic effort, similar to DOTS expansion for TB control. Political commitment for implementation of national strategic plans is essential. The streamlined funding mechanisms developed by the Global Fund and the World Bank are enabling many countries to access funding and expand AIDS treatment and prevention programmes faster than ever before.

Partnership is necessary to make ART scale-up a success – both in increasing access to treatment and in ensuring the appropriate and rational use of drugs. Besides WHO, UNAIDS, other donors and foundations, partnerships should include people with HIV/AIDS, NGOs, community-based organizations, private business and academic institutions. Each has a unique role to play – this partnership should be harnessed and built on a long-term basis.

One of the concerns for scaling up treatment is the availability and affordability of drugs. While thanks to the generic competition from India and other countries, the prices have come down significantly, they are still beyond the reach of most patients. It is hoped that with rapid scale-up of antiretrovirals, because of the volume and the economy of scaling, prices will be further reduced. A major concern, however, is that, in January 2005, the TRIPS agreement may come into force in some countries including India. The countries, therefore, must be prepared for this. One option would be for the generic pharmaceutical industry in the country to invoke the public health considerations of the Doha Declaration. The Declaration clearly states that the TRIPS Agreement should not prevent members from taking measures to protect public health. Thus, the Doha Declaration will form a crucial element in expanding access to treatment.

Moreover, the scale-up of ART should not be misconstrued as only focusing on treatment at the expense of prevention. Prevention still remains the bedrock of HIV/AIDS control programmes. The basic prevention interventions such as condom promotion, behaviour change, education to reduce the number of sex partners, treatment of sexually-transmitted infections, harm reduction among injecting drug users, and finally, creating an enabling environment must remain a top priority, along with the provision of treatment.

Distinguished participants, ladies and gentlemen,

This meeting of national programme managers is an excellent forum to exchange experiences on successes and lessons learnt and to give renewed direction to our collective efforts towards HIV/AIDS prevention and care at the regional and national levels. This year, the meeting is being held in conjunction with the Fifteenth International AIDS Conference which highlights the “3 by 5” initiative. This will give an opportunity to all the programme managers attending this meeting to also participate in the International Conference in the following week.

We have a lot of hard work ahead, and I am confident that you will strive hard to achieve our common goals. I assure you of continued WHO support in building national capacities and mobilizing resources to sustain and enhance every effort to improve the health of the people of our Region.

I conclude by wishing you all fruitful deliberations and a very pleasant stay in Bangkok.

## Annex 4

### Country Work Plans on Scaling-up HIV Treatment, Care and Prevention

Country : Bangladesh

| Prevention, care and treatment  | Action  | Type of support needed   | Time frame   |
|---|---|--|--|
| Political and financial commitment  | <ul style="list-style-type: none"> <li>National AIDS Committee to include working group on Care and ART</li> </ul>  | <ul style="list-style-type: none"> <li>STC</li> <li>National consultation on HIV/AIDS care and ART to be included in National AIDS Policy</li> </ul>   | November 2004  |
| Capacity building <ul style="list-style-type: none"> <li>Infrastructure</li> <li>Human resources</li> <li>Training</li> </ul> | <ul style="list-style-type: none"> <li>Build capacity for National AIDS and STI Programme (NASP) and national reference laboratory</li> <li>Adopt and implement SOP for HIV testing, CD4</li> <li>National capacity building plan in NASP and VCT centres (7), clinical management and ART, laboratories for HIV</li> <li>Training of trainers</li> <li>Adopt ART guidelines</li> </ul> | <ul style="list-style-type: none"> <li>Resource mobilization</li> <li>National consultant (3 months)</li> <li>1 STC (2 weeks)</li> <li>Send 7 medical doctors for clinical management training</li> <li>Train 10 laboratory technicians for HIV testing, diagnosis of</li> </ul> | September 2004<br><br>October – December 2004<br><br>November 2004<br><br>October 2004 |

**SOP** : Standard Operation Procedure

**STC** : Short-term Consultant

Country : Bangladesh (Continued)

| Prevention, care and treatment                        | Action  | Type of support needed  | Time frame    |
|---|---|---|---------------|
|   | <ul style="list-style-type: none"> <li>Identify one centre for HIV reference laboratory (Institute for Epidemiological Disease Control and Research, Dhaka)</li> </ul>  | <ul style="list-style-type: none"> <li>opportunistic infections and CD4</li> </ul>  |               |
| Antiretroviral drugs and diagnostics                  | <ul style="list-style-type: none"> <li>Infrastructure for laboratory</li> </ul>   | <ul style="list-style-type: none"> <li>Facilitate procurement of CD counter machine (4) ELISA machines (4)</li> <li>HIV test kits, CD4 reagent</li> </ul> | December 2004 |
| Treatment adherence                                   | <ul style="list-style-type: none"> <li>Develop model of care for improving treatment adherence</li> <li>Train medical doctors, nurses, NGOs and people living with HIV/AIDS on treatment adherence</li> </ul> | <ul style="list-style-type: none"> <li>STC (1 month)</li> <li>Field visit to Northern Thailand (6)</li> </ul>   | November 2004 |
| Monitoring and Evaluation (M&E)/ Operational research | <ul style="list-style-type: none"> <li>Develop M&amp;E system</li> <li>Train NASP staff in M&amp;E</li> </ul>   | <ul style="list-style-type: none"> <li>STC (1 month)</li> </ul>   | November 2004 |
| STI management  | <ul style="list-style-type: none"> <li>Update guidelines and training for STI</li> <li>Establish referral system to STI clinic</li> <li>Identify centre of excellence for STI management</li> </ul>           | <ul style="list-style-type: none"> <li>STC (1 month)</li> <li>National training workshop</li> </ul>   | December 2004 |

## Country : Bangladesh (Continued)

| Prevention, care and treatment  | Action  | Type of support needed   | Time frame            |
|---|---|--|-----------------------|
|   | <ul style="list-style-type: none"> <li>Train medical doctors and lab technicians and NASP (25 people)</li> </ul>  |  |                       |
| Condoms   | <ul style="list-style-type: none"> <li>Strengthen distribution system</li> </ul>  | <ul style="list-style-type: none"> <li>Discuss with PSI</li> </ul>   |                       |
| Harm reduction  | <ul style="list-style-type: none"> <li>Adopt 4 WHO harm reduction tools</li> <li>Training for NASP and other relevant persons on harm reduction (10 persons)</li> </ul>   | <ul style="list-style-type: none"> <li>STC (2 months)</li> <li>Training workshop</li> </ul>  | October-November 2004 |
| PMTCT   | <ul style="list-style-type: none"> <li>Identification of centre of excellence for PMTCT (Dhaka Medical College)</li> <li>Needs assessment</li> <li>Train PMTCT (10 medical doctors, 15 counsellors/nurses)</li> </ul>           | <ul style="list-style-type: none"> <li>STC (1 month) to work with MoH and UNICEF</li> <li>Training</li> <li>Instruments for safe delivery</li> </ul> | January 2005          |
| HIV surveillance  | <ul style="list-style-type: none"> <li>Review surveillance system (round 6 completed)</li> <li>Train field coordinators and lab technicians for STI and HIV surveillance (17 medical doctors and 20 lab technicians)</li> </ul> | <ul style="list-style-type: none"> <li>STC (2 weeks)</li> </ul>  | March 2005            |
| <ul style="list-style-type: none"> <li>AIDS case reporting and sentinel surveillance</li> <li>Behavioural surveillance</li> </ul> |   |  |                       |

PSI : Population Services International

## Country : Bhutan

| Prevention, care and treatment  | Action   | Type of support needed  | Time frame                          |
|---|--|---|-------------------------------------|
| Political and financial commitment  | <ul style="list-style-type: none"> <li>♦ Strong political commitment</li> <li>♦ Translating to action               <ul style="list-style-type: none"> <li>♦ Plan action</li> <li>♦ Budget</li> </ul> </li> </ul>  | <ul style="list-style-type: none"> <li>♦ Expertise/ consultation on plan of action</li> </ul>   | By the end 2004                     |
| Capacity building <ul style="list-style-type: none"> <li>♦ Infrastructure</li> <li>♦ Human resources</li> <li>♦ Training</li> </ul> | <ul style="list-style-type: none"> <li>♦ Laboratory network of all districts by 2007</li> <li>♦ VCT network building</li> <li>♦ Train HIV/AIDS counsellors / laboratory technicians</li> <li>♦ Provide training on programme management / ART</li> </ul> | <ul style="list-style-type: none"> <li>♦ Technical support to upgrade existing lab</li> <li>♦ Training of Trainers (TOT) on VCT</li> <li>♦ Protocol guidelines development</li> </ul> | 1 Lab by 2005<br><br>By mid of 2005 |
| Antiretroviral drugs and diagnostics  | <ul style="list-style-type: none"> <li>♦ Assessment of ARV patents</li> <li>♦ Assessment of procurement and supply system</li> <li>♦ Estimate quantity of drugs</li> </ul>   | <ul style="list-style-type: none"> <li>♦ Experts / consultation</li> </ul>  | By the end of 2004                  |
| Treatment adherence   | <ul style="list-style-type: none"> <li>♦ Integration with primary health care</li> <li>♦ Close linkages with the partners</li> </ul>   |   | By the end of 2005                  |
| M&E / Operational research  | <ul style="list-style-type: none"> <li>♦ Develop M&amp;E plan</li> </ul>   | <ul style="list-style-type: none"> <li>♦ Experts on M&amp;E needed</li> </ul>   | By mid 2005                         |
| STI management  | <ul style="list-style-type: none"> <li>♦ Maintain running programme</li> <li>♦ Update protocol/guideline</li> </ul>  | <ul style="list-style-type: none"> <li>♦ Update technical guidelines</li> <li>♦ Partnership building</li> </ul>   |                                     |

## Country : Bhutan (Continued)

| Prevention, care and treatment   | Action  | Type of support needed   | Time frame   |
|--|---|--|--|
|  | <ul style="list-style-type: none"> <li>◆ Train health workers</li> <li>◆ STI survey in districts</li> </ul>   |  |  |
| Condoms  | <ul style="list-style-type: none"> <li>◆ Reduce condom gap</li> <li>◆ Assess condom use and accessibility</li> </ul>  | <ul style="list-style-type: none"> <li>◆ Experts needed</li> </ul>                         | By mid/end 2005  |
| Harm reduction   | <ul style="list-style-type: none"> <li>◆ Assess situation</li> <li>◆ Sensitize decision makers</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Experts needed</li> </ul>                         | By mid/end 2005  |
| PMTCT  | <ul style="list-style-type: none"> <li>◆ Link with VCT/ANC</li> <li>◆ Development for ARV access</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Development of plan of action</li> </ul>          | By mid/end 2005  |
| Blood safety   | <ul style="list-style-type: none"> <li>◆ Maintain and run programme</li> </ul>  | <ul style="list-style-type: none"> <li>◆ Financial support partnership</li> </ul>          |  |
| HIV surveillance <ul style="list-style-type: none"> <li>◆ AIDS case reporting and sentinel surveillance</li> <li>◆ Behavioural surveillance</li> </ul> | <ul style="list-style-type: none"> <li>◆ Improve sentinel surveillance by yearly training</li> <li>◆ STI survey</li> <li>◆ 2nd generation survey</li> </ul> | <ul style="list-style-type: none"> <li>◆ Financial support</li> <li>◆ Expertise</li> </ul> | <ul style="list-style-type: none"> <li>◆ 2004 and every year after</li> <li>◆ STI survey every year in different districts</li> <li>◆ Behaviour survey 2006</li> </ul> |

## Country : DPR Korea

| Prevention, care and treatment  | Action   | Type of support needed  | Time frame         |
|---|--|---|--------------------|
| Political and financial commitment  | <ul style="list-style-type: none"> <li>◆ Annual national workshop of the stakeholders to discuss AIDS/STI strategies and work plan</li> <li>◆ Train 5 programme managers</li> </ul>                          | <ul style="list-style-type: none"> <li>◆ Technical support especially on epidemiology information</li> </ul>                            | December, annually |
| Capacity building <ul style="list-style-type: none"> <li>◆ Infrastructure</li> <li>◆ Human resources</li> <li>◆ Training</li> </ul> | <ul style="list-style-type: none"> <li>◆ Strengthen laboratory diagnosis</li> <li>◆ Train lab personnel</li> <li>◆ Train counsellors (200)</li> <li>◆ Expand VCT services in the peripheral areas</li> </ul> | <ul style="list-style-type: none"> <li>◆ Technical and financial support</li> </ul>   |                    |
| M&E / Operational research  | <ul style="list-style-type: none"> <li>◆ Midterm review and final evaluation of national AIDS programme</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Technical support from WHO</li> </ul>  |                    |
| Condoms   | <ul style="list-style-type: none"> <li>◆ IEC activities on-going</li> <li>◆ Condom distribution</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Condoms supported by UN agencies and NGOs</li> <li>◆ STC on condom social marketing</li> </ul> |                    |
| PMTCT   | <ul style="list-style-type: none"> <li>◆ Train ANC staff on HIV/AIDS prevention and control</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Technical and financial</li> </ul>   |                    |
| Blood safety  | <ul style="list-style-type: none"> <li>◆ Train staff of blood centres at provincial level</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Technical support</li> <li>◆ 2 STCs provided by WHO in August</li> </ul>                       |                    |

IEC : Information Education Communication

*Country : DPR Korea (Continued)*

| Prevention, care and treatment   | Action  | Type of support needed  | Time frame |
|--|---|---|------------|
| HIV surveillance <ul style="list-style-type: none"> <li>◆ AIDS case reporting and sentinel surveillance</li> <li>◆ Behavioural surveillance</li> </ul> | <ul style="list-style-type: none"> <li>◆ Train 3 epidemiologists overseas</li> <li>◆ Strengthen sero-sentinel surveillance system</li> <li>◆ Establish reporting system</li> <li>◆ Establish behavioural surveillance system</li> </ul> | <ul style="list-style-type: none"> <li>◆ 50 000 HIV tests to be supported</li> <li>◆ Technical support</li> </ul> |            |

Country : Indonesia

| Prevention, care and treatment  | Action   | Type of support needed   | Time frame                 |
|---|--|--|----------------------------|
| Political and financial commitment  | <ul style="list-style-type: none"> <li>◆ Advocacy to decision makers from the central to the provincial level as well as Parliament</li> <li>◆ Develop materials</li> <li>◆ Conduct advocacy meetings</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Technical assistance</li> </ul>   | November 2004              |
| Capacity building <ul style="list-style-type: none"> <li>◆ Infrastructure</li> <li>◆ Human resources</li> <li>◆ Training</li> </ul> | <p><i>Infrastructure:</i></p> <ul style="list-style-type: none"> <li>◆ Scale-up laboratory capacity for CD4 counts and OIs</li> <li>◆ Scale-up capacity of care and treatment services to support the increased ART targets in priority hospitals</li> <li>◆ Develop guidelines for diagnosis and treatment of OIs, laboratory support for CD4 and diagnosis of HIV</li> <li>◆ Develop guidelines for M&amp;E and resistance</li> <li>◆ Provide 25 CD4 machines</li> </ul> <p><i>Training:</i></p> <ul style="list-style-type: none"> <li>◆ Finalize guidelines for ART, laboratory and M&amp;E</li> </ul> | <ul style="list-style-type: none"> <li>◆ Additional financial support for procuring CD4 machines</li> <li>◆ Recruitment of 1 MO (24 months)</li> <li>◆ Recruitment of 4 National Professional Officers (NPOs) (24 months) for               <ul style="list-style-type: none"> <li>◆ ART</li> <li>◆ M &amp; E</li> <li>◆ Adherence and community mobilization</li> <li>◆ Training</li> </ul> </li> </ul> | November 2004-October 2005 |

## Country : Indonesia (Continued)

| Prevention, care and treatment       | Action  | Type of support needed  | Time frame   |
|--------------------------------------|---|---|--|
|                                      | <ul style="list-style-type: none"> <li>◆ TOT for ART, Laboratory, Counsellors and M&amp;E, as well as training for priority hospitals (50 hospitals x 4 topics x 4 persons= 800 persons)</li> <li>◆ Human resources</li> <li>◆ Support with technical assistance for ART, M&amp;E and adherence</li> <li>◆ Training: TOT for care and treatment, ART, case managers, laboratory, and M&amp;E</li> </ul> |   |  |
| Antiretroviral drugs and diagnostics | <ul style="list-style-type: none"> <li>◆ Support the first-line and second-line ARTs as well as diagnostics</li> <li>◆ Establish procurement and supply system</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Provide assistance to import first-line drugs as well as second-line ARTs from the UNICEF/ WHO bulk purchase mechanism (AMDS)</li> <li>◆ Develop guidelines</li> </ul> | <p>January 2005-December 2005</p> <p>November 2004</p> |
| Treatment adherence                  | <ul style="list-style-type: none"> <li>◆ Develop network between NGO and hospitals and integrate into the primary health care system</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Develop guidelines</li> <li>◆ Recruit NPO (see above)</li> <li>◆ TOT for adherence</li> </ul>  | <p>November 2004</p> <p>January 2005-June 2005</p>     |

## Country : Indonesia (Continued)

| Prevention, care and treatment | Action   | Type of support needed  | Time frame   |
|--------------------------------|--|---|--|
|                                |  | implementers (75 sites x 1 person = 75 persons)<br>♦ Support local training (75 sites x 2 person = 150 persons)   |  |
| M&E / Operational research     | ♦ Operational research on ARV drug resistance surveillance, treatment adherence and management | ♦ Develop guidelines<br>♦ Recruitment of NPO (see above)  | January 2005   |
| STI management                 | ♦ Strengthen GASP<br>♦ Strengthen RTI/STI services   | ♦ Conduct surveillance for gonococcal resistance in 4 laboratories annually<br>♦ Develop guidelines for RTI/STI activities<br>♦ TOT for RTI/STI guidelines<br>♦ Training for implementers<br>♦ Strengthen STI/RTI clinics | January 2005<br><br>January 2005<br><br>November 2004<br><br>November 2004 |
| Condoms                        | ♦ Support 100% CUP in priority settings  | ♦ Recruit 1 NPO (see above)   | November 2004  |
| Harm reduction                 | ♦ Scale up MMT in prisons and new provinces  | ♦ Develop policy and strategic framework,   | January 2005   |

**GASP** : Gonococcal Antimicrobial Susceptibility Programme

**CUP** : Condom Use Programme

**MMT** : Methadone Maintenance Therapy

**RTI** : Reproductive Tract Infections

## Country : Indonesia (Continued)

| Prevention, care and treatment  | Action  | Type of support needed  | Time frame  |
|---|---|---|---|
|   |   | guidelines and plan & action<br>♦ TOT for MMT in new sites<br>♦ Train implementers in new sites<br>♦ Provide methadone (6 sites x 200 doses)  | January 2005<br><br>November 2004                       |
| PMTCT   | ♦ Scale up PMTCT in 6 priority areas<br><br>♦ Support PMTCT plus sites with ART and care and treatment facilities         | ♦ Develop PMTCT guidelines<br>♦ TOT for PMTCT in 6 priority areas<br>♦ Training implementers in 6 priority areas (100 persons)<br>♦ Provide ART for PMTCT sites in (6 areas x 5 sites = 30 sites)   | November 2004<br><br>January 2005<br><br>January 2005   |
| Blood safety  | ♦ Scale up blood transfusion safety in capacity and quality of HIV testing  | ♦ Develop policy guidelines and operational guidelines for HIV screening  | November 2004   |
| HIV surveillance<br><br>♦ AIDS case reporting and sentinel surveillance<br>♦ Behavioural surveillance | ♦ Scale-up AIDS case reporting<br><br>♦ Scale-up sentinel surveillance<br><br>♦ Scale up behavioural surveillance surveys | ♦ Training for provincial as well as hospitals involved health care providers to increase reporting<br>♦ Develop and maintain 6 sentinel sites at 6 priority areas<br>♦ Develop and maintain 1 site | November 2004<br><br>November 2004<br><br>November 2004 |

## Country : Myanmar

| Prevention, care and treatment  | Action   | Type of support needed   | Time frame   |
|---|--|--|--|
| Political and financial commitment  | <ul style="list-style-type: none"> <li>♦ ART is already included as an essential component of prevention, care and support</li> <li>♦ Artsen Zonder Grenzen (AZG) is supporting ARV and nutrition supply</li> </ul>      | <ul style="list-style-type: none"> <li>♦ Sustainable ARV support / funds</li> <li>♦ To mobilize additional donors / resources</li> <li>♦ For WHO to allocate additional resources</li> </ul>   | As soon as possible  |
| Capacity building <ul style="list-style-type: none"> <li>♦ Infrastructure</li> <li>♦ Human resources</li> <li>♦ Training</li> </ul> | <ul style="list-style-type: none"> <li>♦ Strengthen existing lab (expansion of lab)</li> <li>♦ Capacity building of VCCT services in towns – training and expansion (Public health sector + hospital setting)</li> </ul> | <ul style="list-style-type: none"> <li>♦ Lab equipment + supplies reagents + diagnostics</li> <li>♦ Upgrades lab infrastructure</li> <li>♦ Recruitment + placement of more manpower in all necessary areas</li> <li>♦ Massive training of counsellors, nurse aids + home care providers</li> </ul> | <ul style="list-style-type: none"> <li>♦ Ongoing</li> <li>♦ Financial support is critical to scale-up for better coverage</li> </ul> |
| Antiretroviral drugs and diagnostics  | <ul style="list-style-type: none"> <li>♦ At present the country is using own budget + FHAM funds</li> </ul> <p>2003 – 1000 PLWHA for ART<br/>2004 – 2000 PLWHA for ART<br/>2005 – 10000 PLWHA for ART</p>                | <ul style="list-style-type: none"> <li>♦ International treatment experts to assist with “3 by 5”</li> <li>♦ ARVs, OIs + diagnostics to sustain + scale up treatment</li> </ul>   | Early 2005   |
| Treatment adherence   | <ul style="list-style-type: none"> <li>♦ Development of guidelines + tools</li> </ul>  | <ul style="list-style-type: none"> <li>♦ Financial resources to</li> </ul>   | Early 2005   |

**FHAM** : Fund for HIV/AIDS in Myanmar

## Country : Myanmar (Continued)

| Prevention, care and treatment | Action  | Type of support needed   | Time frame            |
|--------------------------------|---|--|-----------------------|
|                                | following WHO guidelines <ul style="list-style-type: none"> <li>◆ Support more involvement of community groups to assist in adherence</li> </ul>  | support community mobilization   |                       |
| M&E / Operational research     | <ul style="list-style-type: none"> <li>◆ Set up M&amp;E system/referral system</li> <li>◆ Develop M&amp;E indicators</li> <li>◆ Operational research on ART delivery system</li> <li>◆ Operational research on adherence + drug resistance</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Financial resources + expert assistance to implement these</li> </ul>                           | Want to start in 2005 |
| STI management                 | <ul style="list-style-type: none"> <li>◆ 100% condom programme (23 townships)</li> <li>◆ Ongoing activities<br/>2004 - 112 towns<br/>2005 - 40 new towns</li> <li>◆ STI syndromic management of all 324 townships will be strengthened in public health sector as well as hospital setting</li> </ul> | Drug + diagnostic and laboratory   | Ongoing               |
| Condoms                        | <ul style="list-style-type: none"> <li>◆ 2002 – US\$ 1.2 m available</li> <li>◆ 2003 – US\$ 1.3 M from UNFPA</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Massive social marketing needed – more advocacy is needed to allow condom use as STI</li> </ul> | Ongoing               |

## Country : Myanmar (Continued)

| Prevention, care and treatment  | Action  | Type of support needed  | Time frame     |
|---|---|---|----------------|
|   | <ul style="list-style-type: none"> <li>◆ 2004 – US\$ 1.4 M UNDP + INGO</li> <li>◆ 2005 – US\$ 1.6 M</li> </ul>  | prevention among target groups  |                |
| Harm reduction  | <ul style="list-style-type: none"> <li>◆ 2004 – 40% of IDU in 20 towns will have access</li> <li>◆ 2005 – 70% of IDU in 20 towns will have access</li> </ul>  | <ul style="list-style-type: none"> <li>◆ Training + capacity building of community, NGOs + health sector staff</li> <li>◆ Sustained financial resources needed</li> </ul>                     | Just started   |
| PMTCT   | <ul style="list-style-type: none"> <li>◆ 2004 – 128 (20% of estimated HIV positive pregnant women</li> <li>◆ Expansion of township sites planned (2004 – 36 sites, (By end 2005 – 50)</li> </ul>            | <ul style="list-style-type: none"> <li>◆ ARVs and diagnostics needed</li> <li>◆ Sustained support of UN agencies needed</li> <li>◆ Nutrition support for mothers and babies needed</li> </ul> | Ongoing        |
| Blood safety  | <ul style="list-style-type: none"> <li>◆ Advocacy meeting for donor recruitment</li> <li>◆ Supplement support to donors</li> <li>◆ Train laboratory technicians</li> </ul>                                  | <ul style="list-style-type: none"> <li>◆ Funds for training</li> </ul>  | September 2004 |
| HIV surveillance <ul style="list-style-type: none"> <li>◆ AIDS case reporting and sentinel surveillance</li> <li>◆ Behavioral surveillance</li> </ul> | <ul style="list-style-type: none"> <li>◆ Extension of sites to additional 5 sites</li> <li>◆ Re-orientation course for AIDS case reporting</li> <li>◆ Expand of 2nd generation sites (x 5 sites)</li> </ul> | <ul style="list-style-type: none"> <li>◆ Budget for training</li> <li>◆ Budget for surveillance activities (sero, behavioural and STI prevalence)</li> </ul>                                  | March 2005     |

## Country : Nepal

| Prevention, care and treatment  | Action  | Type of support needed  | Time frame               |
|---|---|---|--------------------------|
| Political and financial commitment  | <ul style="list-style-type: none"> <li>◆ Revise short term and long term operational guidelines for care and support, STI treatment, condom promotion, VCT</li> </ul> | <ul style="list-style-type: none"> <li>◆ STC for capacity building (manpower)</li> <li>◆ Financial</li> <li>◆ Technical support</li> </ul>  | End of 2004              |
| Capacity building <ul style="list-style-type: none"> <li>◆ Infrastructure</li> <li>◆ Human resources</li> <li>◆ Training</li> </ul> | <ul style="list-style-type: none"> <li>◆ VCT services to be expanded from 8 districts to 22 districts</li> </ul>  | <ul style="list-style-type: none"> <li>◆ Send STC to Nepal</li> <li>◆ Training materials workshop including monitoring of VCT services</li> <li>◆ 5 regional consultants as regional HIV/AIDS coordinators</li> </ul> | September – October 2004 |
| Antiretroviral drugs and diagnostics  | <ul style="list-style-type: none"> <li>◆ Training for ART in 5 regional centres</li> <li>◆ Training lab tech</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Clinical management training</li> </ul>  | October 2004             |
| Treatment adherence   | <ul style="list-style-type: none"> <li>◆ Orientation and training for PLWHAs, media persons, medical professionals, medical colleges for care / support</li> </ul>    | <ul style="list-style-type: none"> <li>◆ Develop training guidelines for care/support</li> </ul>  | August – September 2004  |
| M&E / Operational research  | <ul style="list-style-type: none"> <li>◆ M&amp;E in treatment centre</li> </ul>   | <ul style="list-style-type: none"> <li>◆ 5 monitoring supervisors</li> </ul>  | January 2005             |
| STI management  | <ul style="list-style-type: none"> <li>◆ Provide medicine in 9 sentinel sites and treatment centres</li> </ul>  | <ul style="list-style-type: none"> <li>◆ Budget for buying medicine</li> </ul>  | As soon as possible      |
| Condoms   | <ul style="list-style-type: none"> <li>◆ Plan and develop targeted condom programme (entertainment establish centre) + STI screening and management</li> </ul>        | <ul style="list-style-type: none"> <li>◆ STC (1 months) to work with Govt+PSI</li> </ul>  | August 2004              |

Country : Nepal (Continued)

| Prevention, care and treatment  | Action  | Type of support needed  | Time frame    |
|---|---|---|---------------|
| Harm reduction  | <ul style="list-style-type: none"> <li>◆ Expand methadone treatment from 1 to 5 clinics</li> <li>◆ Needle exchange programme</li> </ul> | <ul style="list-style-type: none"> <li>◆ Methadone STC (2 weeks)</li> </ul>   | November 2004 |
| PMTCT   | <ul style="list-style-type: none"> <li>◆ ART for mother and child</li> </ul>  | <ul style="list-style-type: none"> <li>◆ Share WHO guidelines with Ministry of Health</li> <li>◆ Support for ART</li> </ul> | Ongoing       |
| Blood safety  | <ul style="list-style-type: none"> <li>◆ Screening of blood before transfusion</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Blood test for sero prevalence in 9 sentinel sites</li> </ul>                      | Immediates    |
| HIV surveillance <ul style="list-style-type: none"> <li>◆ AIDS case reporting and sentinel surveillance</li> <li>◆ Behavioral surveillance</li> </ul> | <ul style="list-style-type: none"> <li>◆ Surveillance guidelines</li> </ul>   | <ul style="list-style-type: none"> <li>◆ STC (2 weeks)</li> <li>◆ Test kits for sentinel sites</li> </ul>                   | July 2004     |

## Country : Maldives

| Prevention, care and treatment   | Action  | Type of support needed  | Time frame     |
|--|---|---|----------------|
| Capacity building <ul style="list-style-type: none"> <li>◆ Infrastructure</li> <li>◆ Human resources</li> <li>◆ Training</li> </ul>                    | <ul style="list-style-type: none"> <li>◆ Train at least 4 medical doctors on ART</li> </ul> | <ul style="list-style-type: none"> <li>◆ Technical support from WHO to send 4 participants to clinical management training</li> </ul> | October 2004   |
| STI management   | <ul style="list-style-type: none"> <li>◆ Train community health workers</li> </ul>          | <ul style="list-style-type: none"> <li>◆ Technical support</li> </ul>   | January 2005   |
| HIV surveillance <ul style="list-style-type: none"> <li>◆ AIDS case reporting and sentinel surveillance</li> <li>◆ Behavioural surveillance</li> </ul> | <ul style="list-style-type: none"> <li>◆ Strengthen the surveillance system</li> </ul>      | <ul style="list-style-type: none"> <li>◆ WHO technical support STC</li> </ul>   | September 2004 |

## Country : Sri Lanka

| Prevention, care and treatment                                     | Action   | Type of support needed    | Time frame                 |
|--|--|---------------------------|----------------------------|
| To mobilize political commitment to create an enabling environment | ♦ Identify and support key policy makers and arrange visits to regional centers            | US\$ 15,000 for 3 persons | Second quarter 2004        |
|  | ♦ Assign roles and responsibilities within NSACP to implement care and treatment programme |                           | First quarter 2004         |
|  | ♦ Set targets for ART delivery at the central and provincial centres                       | US\$ 15,000               | Second quarter 2004        |
|  | ♦ Economic analysis of cost of ART and its link with prevention                            |                           | Last quarter 2005          |
| To improve access to quality care and treatment for PLWHA          | ♦ Develop national ARV treatment guidelines  |                           | First quarter 2004         |
|  | ♦ Develop training modules for management of OIs, ART, counselling, and adherence support  | US\$ 4,000                | First – Third quarter 2004 |
|  | ♦ Develop standardized care and ART patient recording system                               | US\$ 1,000                | First quarter 2004         |
|  | ♦ Develop a database system  |                           |                            |
|  | ♦ Develop IEC materials regarding ART  |                           | Third quarter 2004         |
| Procurement of drugs   | ♦ Develop essential list of OI drugs at national and provincial levels                     |                           | First quarter 2004         |
|  |  |                           | First quarter 2004         |

NSACP : National STI and AIDS Control Programme

## Country : Sri Lanka (Continued)

| Prevention, care and treatment                 | Action  | Type of support needed  | Time frame   |
|--|---|---|--|
|  | <ul style="list-style-type: none"> <li>◆ Procurement of OI drugs</li> <li>◆ Develop list of ARV drugs</li> <li>◆ Procurement of ARV drugs</li> <li>◆ Develop drug inventory, monitoring and distribution system</li> </ul>  | <p>US\$ 5,000</p> <p>US\$ 50,000</p> <p>US\$ 5,000</p>  | <p>Second quarter 2004 – First quarter 2005</p> <p>First quarter 2004</p> <p>Second – Fourth quarter 2004</p>  |
| Entry points to CCT identified                 | <ul style="list-style-type: none"> <li>◆ Identify entry points for care</li> <li>◆ Strengthen entry points</li> <li>◆ Establish referral system</li> <li>◆ Establish care and treatment teams</li> <li>◆ Identify and strengthen laboratory monitoring sites</li> <li>◆ Identify and strengthen experts and facilities for management of complicated OIs</li> <li>◆ Train key health care workers on ART and counseling</li> <li>◆ Clinical supervision and monitoring</li> </ul> | <ul style="list-style-type: none"> <li>◆ Technical assistance from WHO US\$ 20,000</li> <li>◆ Technical assistance from WHO US\$ 100,000</li> <li>◆ Technical assistance from WHO and local TA US\$ 40,000</li> </ul> | <p>First quarter 2004</p> <p>Second-Third quarter 2004</p> <p>Second – Fourth quarter 2004</p> <p>Second quarter 2004</p> <p>Second – Fourth quarter 2004</p> <p>Second-Fourth quarter 2004</p> <p>Second quarter 2004 – Last quarter 2005</p> |
| Community support                              | <ul style="list-style-type: none"> <li>◆ Select NGOs, CBOs</li> <li>◆ Train NGOs and CBOs</li> <li>◆ Develop contracts for care outreach</li> </ul>   |   | <p>Second quarter 2004</p> <p>Second – Fourth quarter 2004</p> <p>Fourth quarter 2004</p>  |
| <i>Access to quality VCT services improved</i> |   | <ul style="list-style-type: none"> <li>◆ Technical assistance from WHO US\$ 24,000</li> </ul>   | <p>Second quarter 2004 – Last quarter 2005</p>   |

CBOs : Community Based Organizations

## Country : Thailand

| Prevention, care and treatment   | Action  | Type of support needed   | Time frame |
|--|---|--|------------|
| Political and financial commitment   | <ul style="list-style-type: none"> <li>♦ Commitment done 30 baht scheme ART service</li> </ul>  |  | 2003       |
| Capacity building<br><br><ul style="list-style-type: none"> <li>♦ Infrastructure</li> <li>♦ Human resources</li> <li>♦ Training</li> </ul> | <ul style="list-style-type: none"> <li>♦ Support equipments (laboratory : flow cytometer, VL and resistance machine)</li> <li>♦ Create computerized data collection information and drug stock management systems</li> <li>♦ Set up a HIV care teams in health care service</li> <li>♦ Train all health personnel, PLWHA groups community in related unit every year</li> </ul> | <ul style="list-style-type: none"> <li>♦ Drug and reagents procurement and supply training (2005)</li> </ul>           | 2001       |
| Antiretroviral drugs and diagnostics   | <ul style="list-style-type: none"> <li>♦ Support ARV drug and related laboratory reagents free of charge</li> </ul>   | <ul style="list-style-type: none"> <li>♦ Viral load and drug resistance reagents (2005)</li> </ul>                     | 2001       |
| Treatment adherence  | <ul style="list-style-type: none"> <li>♦ Synthesise adherence models</li> <li>♦ Develop adherence case study guideline</li> <li>♦ Develop tools for promoting adherence</li> </ul>  | <ul style="list-style-type: none"> <li>♦ Training treatment adherence for health personnel and PLWHA (2005)</li> </ul> | 2004       |

## Country : Thailand (Continued)

| Prevention, care and treatment | Action   | Type of support needed  | Time frame                   |
|--------------------------------|--|---|------------------------------|
|                                | <ul style="list-style-type: none"> <li>◆ Develop a national adherence guideline</li> </ul>   |   |                              |
| M&E / Operational research     | <ul style="list-style-type: none"> <li>◆ Data and drug stock-monitoring system</li> <li>◆ External evaluation</li> <li>◆ Adherence M&amp;E system</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Drug resistance surveillance guideline and reagents (2005)</li> <li>◆ Adherence M&amp;E guideline (2005)</li> <li>◆ Adherence monitoring tools (2005)</li> </ul> | 2001<br><br>2004<br><br>2005 |
| STI management                 | <ul style="list-style-type: none"> <li>◆ STI treatment in universal coverage</li> <li>◆ Improve STI Surveillance</li> <li>◆ Integrate STI and TB screening into HIV clinic</li> </ul>                  |   | 2001<br><br>2005<br><br>2005 |
| Condoms                        | <ul style="list-style-type: none"> <li>◆ 100% Condom Programme</li> <li>◆ Strengthen condom promotion among those involved in casual sex, youth, migrants, IDUs</li> </ul>                             | <ul style="list-style-type: none"> <li>◆ Behavioural research among patients receiving ART (2005)</li> </ul>  | 1989<br>2004                 |
| Harm reduction                 | <ul style="list-style-type: none"> <li>◆ Set-up IDU network</li> <li>◆ Develop IDU treatment guideline (methadone/ART)</li> <li>◆ Expand methadone clinic</li> <li>◆ Provide AIDS education</li> </ul> | <ul style="list-style-type: none"> <li>◆ Operational research for needle exchange programme (2006)</li> </ul>   | 2004                         |

Country : Thailand (Continued)

| Prevention, care and treatment  | Action  | Type of support needed  | Time frame                   |
|---|---|---|------------------------------|
| PMTCT   | <ul style="list-style-type: none"> <li>◆ Set-up a national programme</li> <li>◆ Implement data and information system</li> </ul>  | <ul style="list-style-type: none"> <li>◆ Research study on triple therapy (2005)</li> </ul>                   | 2002                         |
| Blood safety  | <ul style="list-style-type: none"> <li>◆ Implement blood safety measure system</li> </ul>   | <ul style="list-style-type: none"> <li>◆ Cost-effectiveness study of national scale implementation</li> </ul> |                              |
| HIV surveillance<br><br><ul style="list-style-type: none"> <li>◆ AIDS case reporting and sentinel surveillance</li> <li>◆ Behavioural surveillance</li> </ul> | <ul style="list-style-type: none"> <li>◆ Set-up surveillance</li> <li>◆ Strengthen surveillance system: improve accuracy, coverage and methodology</li> <li>◆ Develop behavioural surveillance among general population</li> <li>◆ Develop OI surveillance</li> </ul> |   | 1984<br><br>2003<br><br>2004 |



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