

HIV/AIDS Prevention, Care and Treatment in the South-East Asia Region

Report of the 19th Meeting of the
National AIDS Programme Managers
Bali, Indonesia, 29-31 October 2007



**World Health
Organization**

Regional Office for South-East Asia

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CONTENTS

Acronyms	v
1. Introduction	1
2. Objectives of the meeting	2
3. Inaugural session	2
4. Overview of HIV and STI situation and response in the WHO South-East Asia (SEA) Region	3
4.1 Progress on scaling up HIV prevention, care and treatment	3
4.2 Country situation and responses	5
5. Key challenges and opportunities for scaling up HIV/STI prevention, care and treatment in the health sector	6
5.1 HIV/STI prevention and treatment: reaching the unreached	6
5.2 Strengthening of health services	11
6. Monitoring and reporting on the health sector's response to HIV and STI towards universal access, 2007–2010	15
Issues and challenges for M&E	16
7. Human resource development for the HIV/STI prevention and control programme	17
8. Support to Member countries for capacity building and implementation by WHO Regional Office for South-East Asia	18
9. Country-specific priorities and plans for 2008–2009	19
10. Conclusions and Recommendations	20
Annexes	
1. List of participants	25
2. Programme	28
3. Recommendations from monitoring and evaluation consultation	30
4. Proposed country-specific activities on HIV/STI prevention, care and treatment, 2008–2009	32

ACRONYMS

AAAH	Asia–Pacific Action Alliance on Human Resources for Health
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
CCC	comprehensive continuum of care
CD4	cluster of differentiation 4
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HIV-DR	HIV drug resistance
HRH	human resources for health
IDU	injecting drug user
IMAI	Integrated Management of Adult and Adolescent Illness
IMCI	Integrated Management of Childhood Illness
M&E	monitoring and evaluation
MDG	Millennium Development Goal
MSM	men who have sex with men
NACO	National AIDS Control Organization (of India)
NGO	nongovernmental organization
OI	opportunistic infection
PITC	provider-initiated testing and counselling (for HIV)
PLHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
SAARC	South Asian Association for Regional Cooperation
SEA	South-East Asia (Region)
SEARO	Regional Office for South-East Asia
STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
TI	targeted intervention
UNAIDS	Joint United Nations Programme on AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1. INTRODUCTION

The South-East Asia Region has an estimated 3.6 million people currently living with HIV/AIDS, which is the second-largest affected population among all regions after sub-Saharan Africa. The Region is at high risk for a massive spread of the HIV epidemic not only due to the large size of the population and high burden of sexually transmitted infections (STIs) but also due to prevailing risk behaviours and vulnerabilities. Explosive epidemics among injecting drug users (IDUs), sex workers and men who have sex with men (MSM) have occurred in Thailand, Myanmar, India and, more recently, Indonesia and Nepal.

In order to combat the HIV epidemic and reach the goal of universal access to HIV prevention, treatment, care and support by 2010, and the Millennium Development Goal (MDG) of halting and reversing the HIV epidemic trends, there is an urgent need to accelerate the scaling up of HIV prevention, care and treatment services. Specific attention is needed on sustained advocacy for an enabling environment, in particular, for targeting interventions at high-risk populations, providing technical support to strengthen human resource capacity, ensuring sustained financing for HIV programmes and strengthening strategic information systems to monitor and guide the national response to the HIV epidemic.

The World Health Organization (WHO) is committed to support Member countries in developing comprehensive and sustainable national AIDS programmes. WHO plays a key role in HIV/AIDS prevention and control in the health sector through providing strategic direction, normative guidance and technical support for national AIDS programmes – through long-term staff in high-burden countries and in-country technical missions. In addition, WHO promotes information exchange, facilitates intercountry meetings, helps in capacity building, and supports new initiatives to further improve the implementation of HIV/AIDS prevention, care and treatment programmes.

The National AIDS Programme Managers' Meeting is an effective forum for sharing experiences between countries, which subsequently leads to strengthening of national AIDS programmes. This annual meeting provides an opportunity for AIDS managers and WHO to review the progress made in AIDS control over the past year, identify and discuss key constraints, formulate possible strategies for replicating successes, and draft plans for the implementation of those strategies at the national and regional level.

The 19th National AIDS Programme Managers' meeting of the South-East Asia Region was held in Bali, Indonesia, from 29 to 31 October 2007. The meeting was

attended by 38 participants from Bangladesh, Bhutan, India, Indonesia, the Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support Team for Asia and the Pacific, WHO Secretariat, and a WHO adviser. For the full list of participants, see **Annex 1**.

2. OBJECTIVES OF THE MEETING

The following objectives were agreed upon:

- To review the overall HIV situation and discuss the health sector's response, particularly in the context of the MDGs
- To discuss current challenges and opportunities for scaling up HIV prevention, care and treatment interventions
- To develop a consensus on key indicators for HIV prevention, care and treatment
- To identify follow-up actions by Member countries and WHO in scaling up HIV prevention, care and treatment interventions.

The three-day meeting included country presentations on the HIV/STI situation, discussions on the response in the Region and recommendations; challenges and opportunities for scaling up HIV/STI prevention, care and treatment in the health sector with the theme of "reaching the unreached"; monitoring and evaluation (M&E); human resource development; and country workplans on strengthening HIV/STI prevention, care and treatment with support from WHO and other partners. The programme of the meeting is given in **Annex 2**.

3. INAUGURAL SESSION

The message of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, to the participants was delivered by Dr S.R. Salunke, WHO Representative to Indonesia. In his remarks, Dr Samlee pointed out the importance of addressing the overlapping epidemics of HIV, STI and tuberculosis (TB) in the Region, and the need to increase the coverage of critical interventions for these to have a palpable impact. Reaching female, male and transgender sex workers, and IDUs as well as other vulnerable populations such as young people and migrants with HIV prevention and care interventions remains a pre-eminent priority. Dr Samlee noted that scaling up of services requires the strengthening of primary health-care facilities and bolstering of human resources. He called upon programme

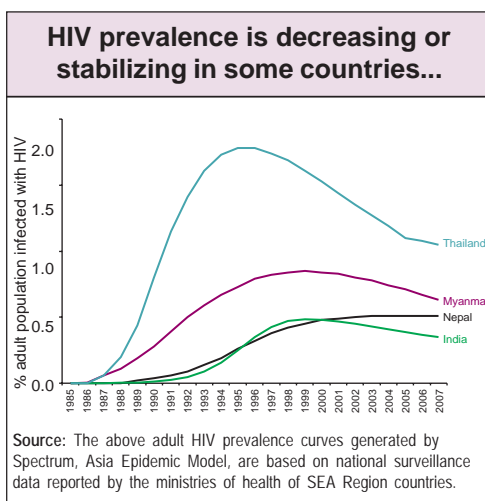
managers to evaluate the progress made through periodic reviews of the health sector response to HIV, and to continue efforts towards sustainable development of HIV services.

On behalf of the Ministry of Public Health, Indonesia, the inaugural address was delivered by Dr Naydai Roesdai, Senior Adviser to the Minister of Health, Indonesia, who declared open the 19th Meeting of National AIDS Programme Managers.

4. OVERVIEW OF HIV AND STI SITUATION AND RESPONSE IN THE WHO SOUTH-EAST ASIA (SEA) REGION

4.1 Progress on scaling up HIV prevention, care and treatment

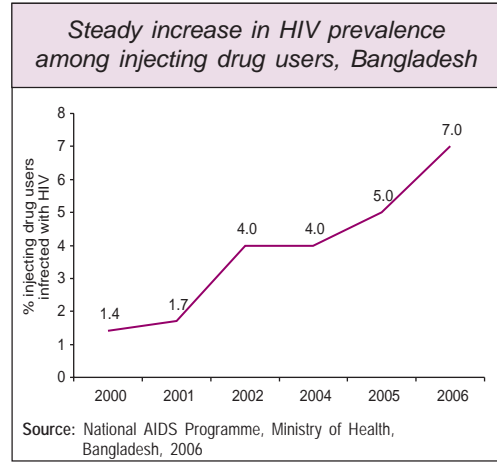
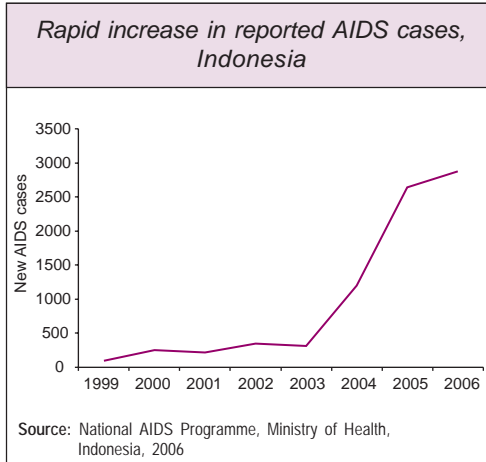
A regional update was presented, highlighting the successes of and current challenges facing HIV/AIDS and STI intervention programmes, and the role of the WHO SEA Region in supporting Member countries. The current estimated number of people living with HIV globally was revised by WHO and UNAIDS and released on 1 December 2007 (World AIDS Day). The number of people living with HIV/AIDS in the SEA Region was estimated at less than four million. This estimate is much lower than previous figures, largely due to revised epidemiological methods based on population surveys, which give lower estimates than those based on antenatal surveillance.



HIV/AIDS trends in countries of the SEA Region vary. Some countries where the epidemic is at an advanced stage and where prevention efforts have been scaled up have shown a perceptible stabilization or decline.

In several countries with more concentrated epidemics, however, HIV incidence is high and its prevalence is increasing rapidly, particularly among populations at highest risk such as sex workers and MSM.

...but HIV/AIDS is still increasing in other countries



The prevalence among IDUs also remains high, and transmission of HIV in prisons is being recognized as an important factor for the spread of HIV in the community.

In terms of response, countries have made considerable progress in scaling up prevention and care efforts in the Region. Some countries such as India and Myanmar are showing encouraging progress in the coverage of prevention services using innovative approaches for key populations such as sex workers. India and Thailand are among the countries with the highest number of people receiving antiretroviral therapy (ART) globally. Thailand is among the nine countries globally with more than 75% coverage of ART for those in need. India, Thailand and Indonesia are also taking steps to monitor HIV drug resistance (HIV-DR).

WHO has a clear mandate to provide support to these efforts, particularly those delivered through the health sector. The main areas of work by WHO include continuing technical support to national AIDS programmes, facilitating the review of national programmes (as with Thailand, Myanmar, Sri Lanka and Indonesia) and strengthening second-generation surveillance.

The Regional Office has developed new management tools and technical strategies, including training modules on *National AIDS programme management* and a *Regional strategy for the prevention and control of STIs*. WHO is also working with other agencies to develop guidelines and tools for the prevention of HIV transmission among IDUs.

WHO continues to promote the expansion of HIV testing and counselling across the Region. Provider-initiated testing and counselling (PITC) has been introduced and efforts made to improve the understanding of PITC, which is already the norm in some services. For example, there is a very high coverage of antenatal PITC among pregnant women in Thailand where antiretroviral (ARV) prophylaxis is available.

WHO has also updated guidelines for HIV treatment and some of these have been adapted at the country level. Simplified guidelines for primary and secondary facilities, and standardized recording and reporting forms have also been developed and adapted for Indonesia, India and Myanmar.

WHO has been a key partner of countries in their efforts to mobilize resources, particularly from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).

Lessons learnt:

- Targeted prevention programmes do work and can reverse the growing trend of HIV epidemics.
- Integration of prevention and care at points of service delivery is feasible and leads to better outcomes.
- Surveillance systems are fundamental for evidence-based programmes and policies.
- The health sector response continues to play a lead role in the multisectoral national response, and strong national AIDS programmes within health ministries are needed to coordinate the efforts of multiple partners.

The way forward:

- Focus on accelerating prevention among populations at highest risk.
- Achieve sufficient coverage of services for HIV prevention, care and treatment.
- Create an enabling environment for programme implementation with strong national AIDS programmes leading the health sector response.

4.2 Country situation and responses

During the three-day meeting, each country representative presented a poster depicting the HIV situation in the country. The presentations focused on the magnitude of the HIV burden, progress made in scaling up HIV prevention, care and treatment services, challenges and constraints, and future priorities for

controlling HIV. These poster presentations were followed by a brief question-and-answer session. The poster presentations of all countries can be accessed through the South-East Asia Regional Office website at the link <http://www.searo.who.int/aids>.

5. KEY CHALLENGES AND OPPORTUNITIES FOR SCALING UP HIV/STI PREVENTION, CARE AND TREATMENT IN THE HEALTH SECTOR

5.1 HIV/STI prevention and treatment: reaching the unreached

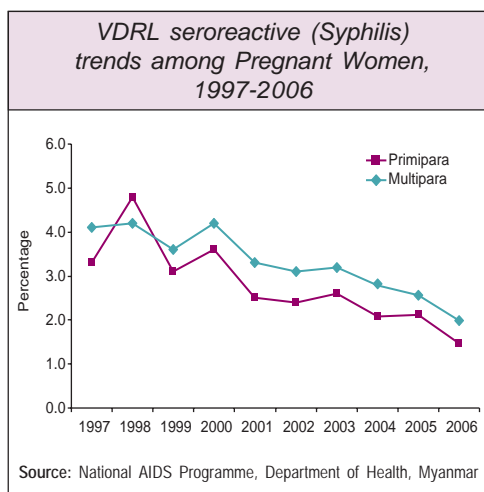
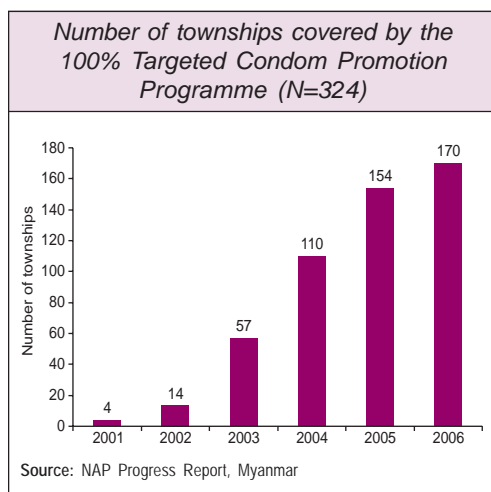
The presentations of the representatives from India, the Maldives, Myanmar and Thailand highlighted the importance of reaching marginalized and vulnerable populations with HIV interventions and services.

Controlling sexual transmission of HIV and other STIs in Myanmar

Dr Kan Oo, Assistant Director (HIV/AIDS), Ministry of Health, reported that Myanmar has the third-highest burden of HIV in the Region with an estimated 242 000 people living with HIV. Over 60% of all infections are through sexual transmission and nearly 30% through injecting drug use. Myanmar has recently developed a multisectoral “National Strategic Plan on HIV and AIDS 2006–2010” that is focused on reducing HIV risk vulnerability and impact, and on provision of essential services. Priority is given to high-risk groups such as sex workers, MSM, IDUs and migrant populations. Myanmar has also substantially expanded the “100% Targeted Condon Promotion Programme” from only four townships implementing the programme in 2001 to over 170 in 2006.

Available reports indicate that in 2006 approximately 40% of sex workers had access to at least some elements of the prevention and care package of services. Over 28 000 MSM were reached by such services in 2006. In 2006, nearly 50 million condoms were distributed free in the country through social marketing.

Surveillance trends suggest that prevention efforts are having an impact. HIV prevalence has been declining for several years in high-risk populations and among pregnant women. Behavioural surveys show that over 50% of clients of sex workers report consistent condom use. Myanmar has also documented a decreasing prevalence of syphilis among pregnant women and declining trends of curable STIs.



New paradigm in HIV prevention in Thailand

Dr Werisit Sittitrai, Director, Strategy and Planning Bureau, Thai Red Cross Society, Thailand said that the AIDS intervention programmes are better equipped and informed at present than they were earlier. After fighting the epidemic for more than 20 years, HIV/AIDS now needs an exceptional response, he added.

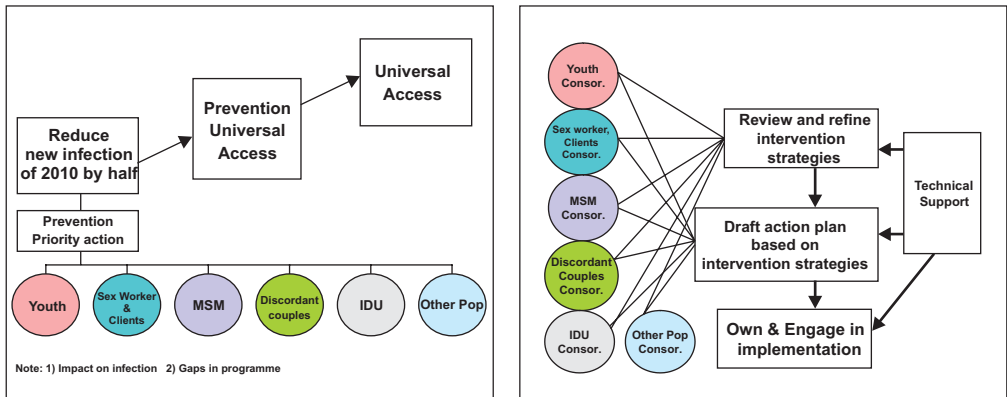
Despite the successes in both prevention and care over the years, Thailand is now facing new challenges as many people are engaging in risk behaviours, young people are becoming sexually active at an earlier age and the number of concurrent partnerships is increasing. There remains a large gap between societal perceptions and the realities of adolescent sexuality: many young people view sexual intercourse before marriage as normal, while many parents are still of the opinion that sex education in schools is not appropriate.

Other challenges include the lack of awareness and understanding about HIV/AIDS. There are many prevalent misconceptions about HIV and the AIDS epidemic. The situation in Thailand has also changed and the government cannot manage the response to the epidemic on its own. There is an increased need to recognize the complementarity between the government and other sectors in the interventions against AIDS. It is also necessary to ensure continued coverage, effectiveness and sustainability of the response to and interventions for HIV/AIDS in Thailand. Achieving intensive and universal coverage of prevention and care requires new forms of response adapted to the social situation.

The current prevention strategies approved by the National AIDS Committee include public information and education to raise awareness about HIV/AIDS and STIs. Other important strategies include strengthening partnerships in key areas, promoting ownership and real engagement by local governments. Mechanisms, including a sustainable fund from the national health scheme and strong information systems, are being put in place in Thailand to implement these strategies.

Thailand is also promoting partnerships with clear rules of participation based on common goals. In each area, consortia of partners review and refine interventions and strategies, and draft action plans.

In addressing the issue of “Reaching the unreached” it is important to make health services available and accessible to target populations. The key to success is the unflinching effort to reach those most in need.



Strengthening HIV prevention among drug users in the Maldives

Dr Ali Nazeem, Senior Registrar in Medicine, Indira Gandhi Memorial Hospital presented the situation in and national response of the Maldives in addressing vulnerability to HIV due to identified high levels of drug use.

Although levels of injecting drug use are reportedly still low, the Maldives is potentially vulnerable to drug abuse since it comprises a group of islands with easy access to illegal traffickers. The island nation conducted a rapid assessment of drug use and risk behaviours in 2003. The findings included clear evidence that drug use is increasing, particularly among the youth. Lack of awareness and

marginalization of drug users were identified as reasons for the use of drugs and relapse among those who complete treatment. The primary drugs of abuse were opioids (over 70%) with 8% of users reporting use by injection. Drug abuse was also associated with having multiple sexual partners and inconsistent condom use.

The findings of Rapid Situation Assessment -2003

- Injecting drug use
 - ▶ 33% indicated of having seen drug being injected
 - ▶ 8% reported having injected drugs
 - ▶ Brown sugar was drug reportedly injected
 - ▶ Cleaned needle with hot water (unsafe)
 - ▶ 1 out of 9 indicates having shared syringes

The findings of Rapid Situation Assessment -2003

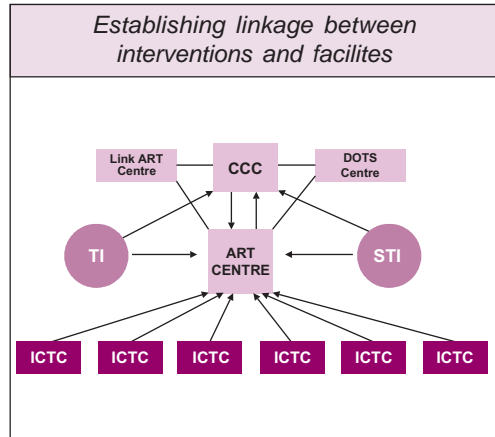
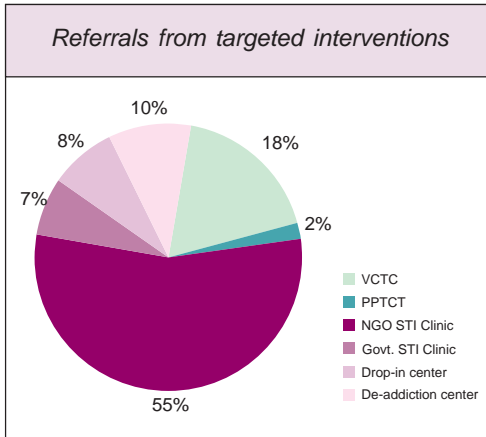
- Sexual behaviour – among drug users
 - ▶ 75% reported the experience of sex.
 - ▶ With regard to the number of sex partners, only 24% said 1, 17% said 2, 14% said 3, 13% said 4, 12% said 5 and 20% said 6 or more partner.
 - ▶ With regard to the condom use pattern, 36% said 'rarely', 30% 'all the time', 22% 'most of the time', 12% 'sometimes'.

Drug users remain a hidden population which makes them more vulnerable to HIV. Among these groups, sex work in addition to drug use is responsible for further increasing the risk of acquiring HIV.

ART targets in India: who is being reached and who is not

Rapid progress has been made in scaling up provision of ART in India. Dr Bachani, Joint Director, National AIDS Control Organization (NACO) presented an update of the progress and addressed an important equity issue: who is being reached and who is not by ART services?

Beginning with eight centres in April 2004, ART had been scaled up to 137 centres by December 2007. By end of 2007, 123 000 patients were receiving free treatment at government centres. WHO guidelines are followed and CD4 testing is provided free of cost. About 60% of patients are male. Children were first enrolled in 2006 and currently about 8000 of them are on treatment. About 71% of patients who started ART in 2004 were reportedly still on treatment two years later. A substantial increase in CD4 levels and weight gain was reported for different cohorts of patients enrolled. The target for 2012 is to have 250 operational ART centres.



VCTC: voluntary counselling and testing centre; PPTCT: prevention of parent-to-child transmission; NGO: nongovernmental organization; STI: sexually transmitted infection; ART: antiretroviral therapy; CCC: community care centre; TI: targeted intervention; ICTC: integrated counselling and testing centre.

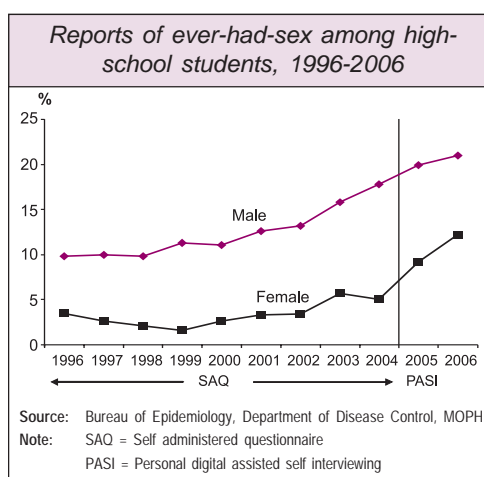
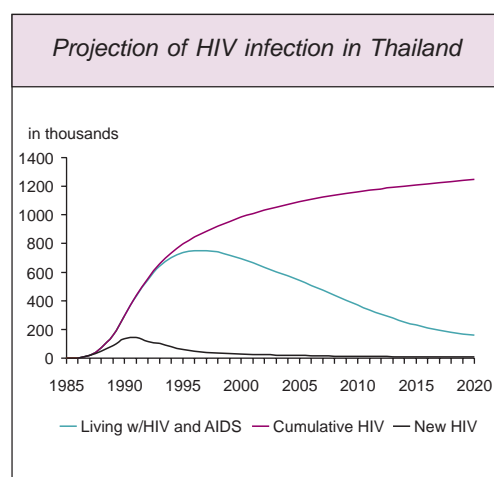
There are, however, still big gaps in coverage. Of the estimated proportion of people living with HIV/AIDS (PLHA) in need of treatment, only 20% are accessing it. Only an estimated 18% of PLHA from high-risk groups are referred for care and treatment. Services are provided not only by the public sector but also through NGO programmes and by the private sector, which treats an estimated 35 000 persons. The private sector in India is considering several ways to increase access to ART for those who need it. The ART centres need strong linkages with other clinical services with good referrals including from TB centres. There is also a need for better counselling services so that HIV-positive people register for ART before they reach the late stages of the infection. More effort is needed to mobilize PLHA networks in the country.

The session concluded with the recommendations that packages of prevention, care and treatment services should be tailored and adapted to the specific populations they are meant to reach. Linkages between targeted prevention interventions and HIV counselling and testing, care and treatment services should be strengthened to ensure equity of access by high-risk populations. This should be done in consultation with a consortium of partners providing services. There is also a need to adapt programmes to address changes over time in risk behaviours and other epidemiological factors.

5.2 Strengthening of health services

Scaling up of HIV services in Thailand

Dr Sombat Thanprasertsuk of the WHO Country Office in Thailand, shared the lessons learnt on HIV intervention efforts in Thailand. Despite successes in reducing HIV transmission in the past and a very high coverage of the ART programme, a number of challenges still remain. Continuous commitment at all levels is necessary in order to achieve the targets set in the National Strategic Plan for 2007–2011. The high incidence of HIV during the early 1990s was reduced by nearly 90% and this early control of the epidemic enabled Thailand to scale up HIV care, support and treatment to higher levels in recent years. However, sexual behaviour patterns are changing, particularly among young people, requiring prevention efforts to be refocused.

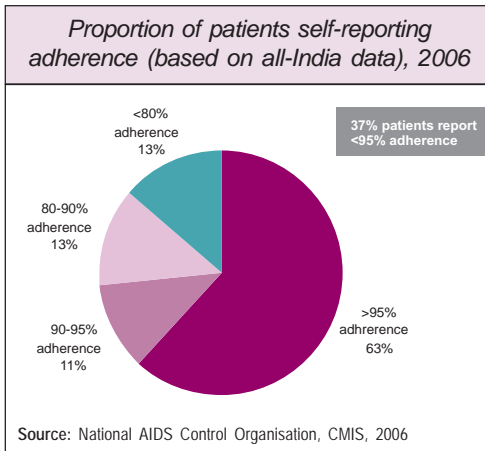


While trying to sustain interventions that have proven successful, the AIDS programme has initiated new projects in several areas including surveillance, prevention, treatment, care and support. For example, in the prevention programme, health promotion and prevention efforts for PLHA have been scaled up to include all hospitals. In the area of treatment, the development of in-house reagents for estimating viral load and genotyping to detect drug resistance in HIV has begun with the expectation that they will be widely used in the future. Importantly, human resource capacity has to be continuously built up and financial resources made available for the long term.

ART monitoring and second-line ART within the public health approach

Dr Po-Lin Chan, Medical Officer (HIV/AIDS), Office of the WHO Representative to India, was of the view that strong strategic information systems – including M&E systems, surveillance and operational research – form the backbone of national programmes. In ART programmes, data analysis of programme performance is essential and, in universal access to ART, plans must also incorporate the assessment and control of HIV-DR. It has been seen that performance data on

adherence is an important indicator of drug resistance. Globally, WHO has developed an essential package to monitor the emergence HIV-DR with recommendations for countries to monitor, using HIV-DR early warning indicators, and prevent HIV drug resistance.



It is emphasized that good first-line treatment is the best strategy to delay the need for expensive second-line treatment. Regarding second-line ART regimens, the issue of optimum regimens that are feasible within a public health approach and the need for defined criteria for

switching from a first-line to a second-line regimen at an appropriate time are very important.

HIV/AIDS prevention, care and treatment at the primary care level in Bhutan

Dr T.B. Rai, Medical Specialist, Jigme Dorji Wangchuk National Referral Hospital, pointed out that Bhutan is still classified as a low HIV-prevalence country. Up to October 2007, there have been a total of 125 cases of HIV infection, and 24 of these have already died. Of the 101 people living with HIV, 17 are currently being treated with ART. A broad-based, multisectoral approach is followed, with integration and decentralization through the network of public community health services.

Bhutan has made considerable progress in several areas, including achieving high levels of public awareness on HIV and AIDS, establishment of a surveillance

programme, blood screening services, training of health-care workers, and the decentralization and integration of HIV/AIDS activities. However, Dr Rai also emphasized the relevant social aspects of AIDS such as the persistent problems of stigma and discrimination, unabated risk factors for transmission of HIV in the community; and challenges to preventing cross-border spread of the virus.

Indonesia's experience with decentralized health services for HIV/STI prevention, care and treatment

Dr Dyah Erti Mustikawati, Head of the Section for Evaluation and Reporting, Ministry of Health, mentioned that Indonesia is a country with a large population and diversified culture. She stated that in terms of its HIV epidemic, a perceptible increase in the number of AIDS cases has been reported in recent years. Increasing prevalence in high-risk populations has made the epidemic a concentrated one, with certain areas having a generalized epidemic. In several areas, STI prevalence rates are high in high-risk groups such as with female sex workers.

Prevention services at peripheral level – targeted interventions:

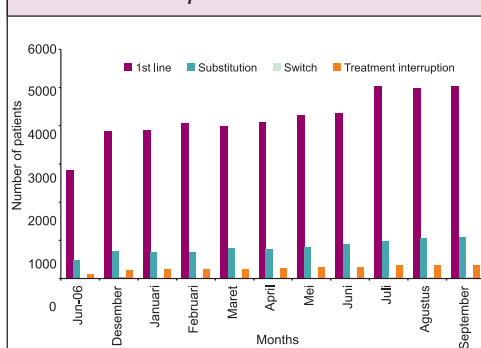
IDU:

- Outreach, peer education, methadone maintenance, needles syringe programmes, rehabilitation

Sex workers:

- Intensified STI services (good quality STI treatment, outreach, regular screening) plus
- in 4 model sites: periodic presumptive treatment

Treatment outcomes of patients on ART, September 2007



Source: MOH, Indonesia, 2007


The National AIDS Programme is attempting to roll out implementation in several areas, including surveillance and ART as well as prevention. Dr Dyah said that prevention activities have been conducted for different high-risk and vulnerable populations, including IDUs and sex workers, with the involvement of the community and civil society partners. Given the challenge of decentralization, she stressed the need to strengthen information systems, which are required at the peripheral levels to supply data to the provincial and central levels of the health administration.

Health-care financing and resource mobilization for the HIV/AIDS programme in India

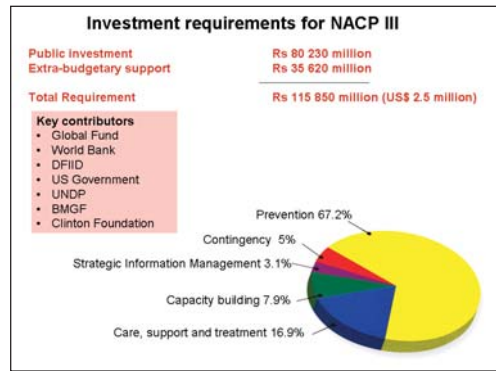
Dr D. Bachani, Joint Director of the National AIDS Control Organisation (NACO), India, suggested that resource mobilization can be facilitated by an in-depth understanding of HIV epidemics and evidence-based planning, and assessment of programme managerial capacity to effectively use resources. He cited the example of India; a revised estimate prepared recently showed that the estimated number of HIV-infected persons in the country had reduced. Further analysis of vulnerability factors was conducted to develop phase III of the National AIDS Control Programme, and priorities were established. The Programme will require around US\$ 2.2 billion in the next five years, and the government and other donor agencies will contribute up to 90% of this amount, he informed.

Saturation of high-risk groups...

- From 764 interventions in 2007 to 2100 in 2012
- Saturation of 80% High Risk Groups
- Increase coverage of underserved groups like MSM and IDU & Bridge Populations
- Shift to community led structures – target of 50% TIs to be Community Based Organisations



respect and dignity
EVERYONE'S RIGHT



The session concluded with discussions and a consensus on several key points. All participants agreed that adherence support is a core element of ART programmes. The better the adherence, the longer and less expensive the use of first-line regimens. The issue of adherence must be addressed on an individual basis (at the micro level); several methods are available to improve and maintain high adherence including regular and continuing counseling, and information sessions for patients receiving ART. Peer groups of PLHA under treatment can be trained to provide assistance and remind defaulters through home visits. Methods to monitor adherence such as the pill count technique are also available. Data from early warning indicators will guide the programme about the likelihood of emergence of HIV-DR in the community and help further strengthen adherence programmes to prevent the development of resistance.

It was also pointed out that many of the issues identified from the presentations and discussions should be enriched and formulated into concrete recommendations for action. With this in mind, it was suggested that other partners, including representatives from civil society, should be included in future meetings.

6. MONITORING AND REPORTING ON THE HEALTH SECTOR'S RESPONSE TO HIV AND STI TOWARDS UNIVERSAL ACCESS, 2007–2010

Dr Petchsri Sirinirund, Senior Expert in Preventive Medicine, Ministry of Public Health, Thailand, who had chaired the WHO Informal Consultation on Monitoring and Evaluation (M&E) held during 26–27 October 2007 in Bali, presented the summary and conclusions of the proceedings of the consultation. The diversity in M&E systems in line with the variation in magnitude and scale of the epidemic between different countries of the Region was highlighted. M&E systems are not static. Since an epidemic evolves over time, there may be a need to modify M&E systems and generate new information to understand its implications better. In general, the need for strong M&E systems was well understood by national AIDS programmes. However, there remain several constraints that need to be overcome to fully apply M&E systems as an integral part of programme planning and implementation. In many countries, M&E systems were designed for donor projects, and such project-specific fragmented systems have led to duplication of efforts in collecting and reporting information. Furthermore, the information that is collected from M&E systems is seldom analysed sufficiently or disseminated to appropriate stakeholders. M&E is thus looked upon as a requirement for donor reporting rather than as a tool for guiding the national response to the epidemic. The quality of data is also an issue in many countries.

Each country should use a minimum set of key indicators to measure the progress of health sector interventions towards achieving the goal of universal access. A generic framework of indicators was presented for measuring the availability, coverage and impact of health sector interventions. These health sector interventions include prevention of sexual transmission and transmission through injecting drug use, testing and counselling, prevention of mother-to-child transmission (PMTCT), care and treatment including ART, prevention of HIV/TB, and prevention in the health-care setting. Apart from monitoring the priority interventions, it is also important to measure progress in strengthening key

components of the health system to support the scale-up of priority interventions such as procurement and supply management, human resources, financing and information systems.

A list of recommendations was presented – nine for national AIDS programmes, and four to WHO, UNAIDS and partners for strengthening M&E systems in the country (see **Annex 3**).

It was reiterated during the discussion that reporting requirements from donors, with many indicators specific to individual projects, are too burdensome, especially for NGOs and those conducting small projects. However, there have been continuing efforts to harmonize the indicators for reporting at the global and regional level to avoid additional workload at the national and subnational levels.

It was also pointed out that the availability of adequate human resources is crucial for scaling up HIV services, hence the need for important indicators to monitor human resource development. To ensure that M&E systems are being implemented well it is necessary to have indicators for monitoring their implementation.

Issues and challenges for M&E

- Donor-driven M&E leads to parallel systems and duplication of efforts in collecting and reporting information.
- Coordination is limited.
- Linkages are lacking across interventions and among departments for sharing of information.
- Health systems are weak and the capacity of the M&E system is limited (no staff, no infrastructure).
- There is a lack of completeness of reporting.
- Validity (accuracy) of the information is questionable.
- Size estimates of high-risk groups are uncertain.
- Not enough analyses/triangulation are being carried out, resulting in failure to link M&E outputs with programme interventions.
- M&E reporting and dissemination is not systematic.

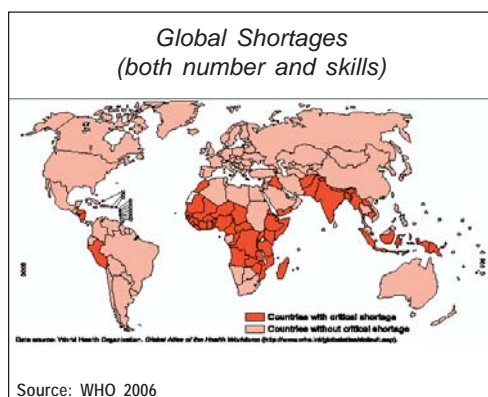
The countries were divided into three groups according to the scale of the epidemic. In each group, discussions were held on whether the recommendations of the M&E consultation were relevant and agreeable, and what next steps and technical assistance would be required to operationalize these recommendations.

The session concluded with the consensus that M&E is a crucial component of the national response to the HIV epidemic and needs to be accorded high importance. All countries agreed to implement the recommendations at the country level. Areas where technical assistance was required from WHO, UNAIDS and partners were listed country-wise. The need to harmonize technical assistance provided by WHO, UNAIDS and other partners was strongly emphasized by the countries. Countries also articulated the need for conducting advocacy workshops at the country level to share the discussions and recommendations of this workshop for a consolidated plan of action for M&E.

7. HUMAN RESOURCE DEVELOPMENT FOR THE HIV/STI PREVENTION AND CONTROL PROGRAMME

A briefing on HIV/AIDS and the health workforce involved in the prevention of HIV was provided by Dr Piya Hanvoravongchai of the Asia–Pacific Action Alliance on Human Resources for Health (AAAH).

Human resources are a crucial component of the health system. Shortages, skill imbalance, maldistribution, migration, poor management and support systems, and a weak knowledge base are considered key factors that affect the global human resources to combat health crises. In addition, there are local challenges



HR management systems

- **Personnel systems:** workforce planning (including staffing norms), recruitment, hiring and deployment.
- **Work environment and conditions:** employee relations, workplace safety, job satisfaction and career development.
- **HR information system:** integration of data sources **to** ensure timely availability of accurate data required for planning, training, appraising and supporting the workforce.
- **Performance management:** performance appraisal, supervision and productivity.

that affect human resources for health at the regional level. These include emerging pandemics and health threats, rapid private sector growth, inadequate public sector investment, globalization and increase in international trade in the health services. Scaling up of HIV/STI prevention, care and treatment requires investment in primary health care (PHC) and human resources for health (HRH).

The Human Resource for Health Action Framework was developed by AAAH to assist governments and health managers to develop and implement strategies for achieving an effective and sustainable health workforce. The action areas for HRH include: management system, finance, education, leadership, policy and partnership. Examples of short- and long-term activities of these action areas were presented.

In recent times, there have been many opportunities to support health workforce development. The *World health report 2006: working together for health* calls for national leaderships to urgently formulate and implement country strategies for the health workforce with suitable international assistance. The Global Health Workforce Alliance, a new global partnership, will draw together and mobilize key stakeholders engaged in global health to help countries improve the way they plan for, educate and employ health workers. The Global Fund allows health systems strengthening activities to be included in its applications. Using the Global Fund to improve the health workforce situation is encouraged.

Tools are available to assist countries in developing human resources for the HIV/AIDS programme. These include *Tools for planning and developing human resources for HIV/AIDS (2006)*, *Human resource management assessment tool for HIV/AIDS environments (2003)*, among others.

Member countries expressed their interest in developing a human resource plan for HIV/AIDS and requested WHO and its partners to provide technical support in this area.

8. SUPPORT TO MEMBER COUNTRIES FOR CAPACITY BUILDING AND IMPLEMENTATION BY WHO REGIONAL OFFICE FOR SOUTH-EAST ASIA

The WHO Regional Office for South-East Asia introduced a discussion on support for capacity building and implementation to Member countries, which included the main areas of technical support that are currently provided by WHO.

In the areas of strategic information and improving the understanding of epidemics and response, the Regional Office continues to emphasize strengthening of systems for surveillance and M&E. In addition, it plans to continue supporting national programme reviews and HIV estimations and projections. New staff are being recruited to support surveillance and prevention of HIV-DR.

The HIV/AIDS unit of the Regional Office has designated staff to support countries in controlling or keeping a check on their HIV and STI epidemics. In terms of preventing sexual transmission, the Regional Office has introduced new tools and is building a pool of consultants to support the implementation of its *Regional strategy for STI prevention and control*. Similarly, the new regional focal point on harm reduction will support interventions among IDUs with new tools and partnerships, such as with the South Asian Association for Regional Cooperation (SAARC), UNAIDS and United Nations Office on Drugs and Crime (UNODC).

The Regional Office plans to sustain the momentum in scaling up HIV services. New guidelines include those on provider-initiated testing and counselling (PITC), paediatric ART and clinical services for IDUs. Regional training capacity in the Integrated Management of Adolescent and Adult Illness (IMAI) is being expanded and an assessment of early experiences with the IMAI is in process. WHO is also working closely with UNICEF and other partners to increase access to PMTCT, and HIV and STI services for young people.

The Regional Office also prioritizes support to build capacity in programme management and health systems strengthening. Regional experts are available to support country-level training using the new *National AIDS programme management* modules. Regional partnerships are being developed to strengthen health system capacity, particularly in human resource development.

Countries indicated the need for technical support by WHO in the above areas. It was suggested that the country teams should discuss their needs and make proposals in subsequent sessions using the matrix provided.

9. COUNTRY-SPECIFIC PRIORITIES AND PLANS FOR 2008–2009

The country teams, comprising the national programme manager, representatives from each country and WHO Country Office staff, discussed among themselves and with staff from the HIV/AIDS unit of the Regional Office and Headquarters the

priority activities for 2008–2009. Activities that need to be conducted to scale up prevention, care and treatment of HIV/AIDS and STI in Member countries were discussed. **Annex 4** shows the proposed activities and need for technical and financial support from WHO and other partners. These proposed actions will be implemented by national AIDS programmes (NAPs) and the progress monitored during 2008–2009.

10. CONCLUSIONS AND RECOMMENDATIONS

In concluding the 19th Meeting of AIDS Programme Managers, participants highlighted the key issues and proposed recommendations for countries, WHO, UNAIDS and other partners with emphasis on the immediate actions needed for the coming year.

One key issue is the diversity of epidemics and the national responses to them across the Region. This has clear implications for country action and regional support to improve access. Yet this diversity across the Region also shows that universal access targets are feasible if tailored to the country's context and epidemic patterns.

For example, countries with the most advanced epidemics have already made impressive gains in scaling up prevention, care and treatment, and have clear evidence of declining HIV infection levels. Importantly, this progress in slowing their epidemics is also making it easier for high-burden countries to scale up HIV services for those infected.

Countries with fast-growing, concentrated epidemics, however, face the basic challenges of containing their epidemics while preparing to provide care and treatment, often for widely dispersed populations in need. These countries are at a critical juncture as transmission among populations at highest risk is increasing rapidly and threatens to disseminate more widely. Effective prevention now will make universal access targets more achievable in the future.

Countries with low-level epidemics remain vulnerable to the spread of HIV. However, there are examples of strong prevention responses that appear to have greatly reduced the chances of spread of HIV. These countries face a different set of challenges in organizing HIV services for the few people living with HIV.

Recommendations for countries

Countries should focus on five main areas – strengthening implementation capacity, unblocking critical barriers to prevention, increasing access to other services, promoting enabling environments and strengthening M&E – in order to progress towards universal access. Key recommendations for countries made at the meeting are as follows:

- (1) Strengthen implementation capacity at all levels
 - Integrate HIV more widely into the health services using primary health care approach.
 - Develop near- and medium-term human resource development plans for HIV as an integral part of the overall health system and the process of strengthening human resources.
 - Engage partners and increase their ownership in order to extend the reach of the national response. Ensure a clear role for the national programme in coordinating with the health sector.
 - Take a systematic approach to estimating financial needs and mobilizing funds, and relate these to the national plan, and build capacity to spend these resources well.
- (2) Unblock critical barriers to effective prevention programmes in order to slow HIV transmission. Emphasis should initially be on:
 - Prevention of sexual transmission: condom use, STI control and HIV prevention among most-at-risk populations including sex workers, MSM, transgender people and IDUs.
 - Prevention of IDU-related transmission: promoting harm reduction targeting drug users.
 - Extension of interventions to marginalized communities and inmates of prisons.
 - Linking targeted prevention interventions to needed HIV services including counselling and testing, HIV care and treatment.
- (3) Continue to increase access to other services including HIV counselling and testing, PMTCT, care and treatment. Attention should be paid to equity of access for marginalized populations.

- Strengthen rational use of first-line treatment and provide adherence support to delay the development of HIV-DR.
 - Strengthen monitoring, procurement and supply management systems as well as implement early warning indicators.
- (4) Continue to create an enabling environment to maximize the reach of interventions and services. Advocate for reducing stigma and discrimination, and engage key stakeholders and gatekeepers in the response.
- (5) Strengthen M&E: Disseminate, implement and monitor operationalization of the recommendations of the technical consultations on M&E (see Annex 4).

Recommendations for WHO

WHO was urged to continue advocating at higher and appropriate levels for the creation of an enabling environment, unblocking barriers to critical prevention interventions and increasing access to needed HIV care, support and treatment, particularly for vulnerable populations.

In these areas, WHO should continue to provide normative guidance and technical assistance to control sexual and IDU-related transmission. WHO's implementation support in these areas to countries should emphasize scaling up targeted interventions and strengthening STI control.

Similar support is needed to increase access to HIV counselling and testing, PMTCT, and care and treatment services. Countries particularly require WHO assistance in promoting the rational use of and adherence to first-line treatment, thus delaying the development of HIV-DR. Priority technical support should be focused on monitoring ART, strengthening procurement and supply management, and implementing early warning systems for HIV-DR.

In these areas, WHO should provide support for capacity building and implementation through several channels. These include facilitating intercountry consultations and exchanges of best practices, technical support to strengthen the capacity of community health workers and volunteers (such as training support for the IMAI/Integrated Management of Childhood Illness [IMCI]), and assisting countries in formulating national human resource development plans.

WHO should also advocate for and support engagement of multisectoral partners and at the same time ensure the responsibility of national AIDS programme managers in coordinating the health sector response.

Recommendations for WHO, UNAIDS and partners

It was recommended that WHO, UNAIDS and partners support countries in implementing the recommendations of the M&E technical consultation, including adherence to the following action points:

- Advocate for increasing the importance of the M&E system as an integral and vital component of the process of HIV policy formulation and programme development.
 - Document regional best practices on M&E processes and the value added to policies and programmes.
- Organize annual intercountry meetings of national programme and M&E staff to encourage the use and linkage of strategic information generated by M&E systems with programme planning and implementation.
- Constitute a regional technical expert group that will meet periodically to discuss and resolve technical issues on M&E, as well as monitor progress in strengthening the M&E system at the country level.
 - Ensure linkage of the discussions and recommendations of the regional technical expert group with those of the national technical working group on M&E.
- Harmonize the technical support provided to countries on M&E among WHO, UNAIDS and other partners.

THE BALI 2007 COMMITMENT TO ACTION

National AIDS programme managers and representatives committed to take action and report on the following four areas at the 20th meeting of the national AIDS programme managers:

- (1) Unblock barriers to critical prevention programmes.
- (2) Rationalize ART provision to minimize cost and delay the emergence of drug resistance.
- (3) Increase implementation capacity with an initial focus on strengthening human resources.
- (4) Strengthen M&E.

Actions (2008-09)	Focus and rationale
<p>Unblock barriers to critical prevention programmes. Initial focus:</p> <ul style="list-style-type: none"> • 100% condom and STI control • Harm reduction 	<p>Interrupting transmission is the first priority, particularly in countries with poor control of HIV and STI epidemics.</p> <p>Initial focus is on addressing barriers to scaling up (1) targeted condom and STI interventions to slow sexual transmission, and (2) proven harm reduction interventions to prevent injection-related transmission.</p>
<p>Rationalize ART provision</p>	<p>Rational ART provision reduces morbidity and mortality, slows the development of HIV-DR and reduces cost. It involves effective first-line treatment, adherence support and close monitoring with early warning indicators.</p>
<p>Increase implementation capacity Initial focus: human resources.</p>	<p>Scaling up of HIV/STI prevention, care and treatment requires investment in PHC and human resources for health.</p>
<p>Strengthen M&E</p>	<p>M&E is a crucial component of the national response. All countries agreed to implement the recommendations of working group with technical assistance by WHO, UNAIDS and other partners.</p>

Annex 1

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Annex 2

PROGRAMME

29 October 2007

09:30-10:30 Opening ceremony

Overview of HIV and STI situation and response in the South-East Asia Region

10:30-10:45 Progress on scaling up HIV prevention, care and treatment in the SEA Region
(*Dr Ying-Ru Lo, WHO/HQ*)

Key challenges and opportunities for scaling up of HIV/STI prevention, care and treatment in the health sector: Select issues

- 10:45-12:15 Round-table discussion on “Reaching the Unreached: Current challenges”
- Controlling sexual transmission of HIV and other STIs: Myanmar's experience (*Dr Kan Oo*).
 - New paradigm in HIV prevention in Thailand (*Dr Werasit Sittitrai*).
 - Strengthening HIV prevention among drug users in Maldives (*Dr Ali Nazeem*).
 - ART targets in India: Who is being reached and who is not (*Dr D Bachani*).
- 12:15-12:45 *Poster presentation on HIV and STI situation and responses (Bhutan, Indonesia).*
- 14:15-14:45 Scale-up of HIV services in Thailand – Key elements
(*Dr Sombat Thanprasertsuk*).
- 14:45-15:00 ART monitoring, second-line drug regimens (*Dr Polin Chan*).
- 15:30-15:45 HIV/AIDS prevention, care and treatment at primary care level
(*Dr T.B. Rai*).
- 15:45-16:00 Decentralised health services for HIV/STI prevention, care and treatment at the peripheral level: Indonesia experience (*Dr Dyah Erti Mustikawati*).
- 16:00-16:30 Health-care financing and resource mobilization for HIV/AIDS programme (*Dr D Bachani*).
- 16:30-17:00 Discussions.

30 October 2007***Monitoring and reporting on the health sector's response to HIV and STI towards universal access 2007–2010***

- 08:30-09:30 Core indicators to monitor progress on HIV prevention, care and treatment
(*Dr Petchsri Sirinirund, Chair of the consultation on monitoring and evaluation*).
- 09:30-11:00 Group work on next steps for strengthening country-level HIV/STI monitoring and reporting systems.
- 11:00-12:00 Presentation of group work and discussions.
- 12:00-12:30 Poster presentation on HIV and STI situation and responses (Bangladesh, India).

Health services in HIV and STI prevention and control at the peripheral level

- 14:00-17:30 Observation tour on delivery of health services for HIV- and STI-infected at the community level in Bali.

31 October 2007

- 08:30-09:15 Human resource development for HIV/STI prevention and control programme (*Dr Piya Hanvoravongchai, Coordinator, AAAH*).
- 09:15-09:45 Capacity building and implementation support to member countries by WHO/SEARO.
- 10:00-11:30 Country group work on workplan for 2008–2009.
- 11:30-12:30 Poster presentations on HIV and STI situation and responses (*Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste*).
- 13:30-14:30 Conclusions and recommendations.
- 14:30–16:30 Consultations with individual country teams.

Future steps and support needs to strengthen HIV/AIDS prevention, care and treatment in countries of the Region.

Annex 3

RECOMMENDATIONS FROM MONITORING AND EVALUATION CONSULTATION

Next steps for strengthening national M&E systems

By Member States (with support from WHO, UNAIDS and other partners):

- To review current M&E systems in the country and urgently implement a minimum M&E package that is suitable for the level of the epidemic. The essential ingredients of the M&E package may include: national M&E plan, an M&E unit, key performance indicators, technical working group, adequate budget, dedicated staff, adequate infrastructure, standard data collection forms, channels for data flow, data analyses, use and dissemination, and quality assurance.
- To monitor the operationalization of the M&E system against these minimal required standards.
- To create a core team of national M&E experts in the country. The members of the core M&E team may be drawn from the Ministry of Health, other ministries, academia, civil societies and the private sector.
- To recruit and train adequate M&E staff at the national and subnational levels and build their capacity, particularly for data analyses and use.
- To improve estimation of the size of populations at high risk. Train staff on mapping and estimating the size of populations with high-risk behaviours.
- To monitor the quality of data by regular supervision and provide feedback for improving completeness and accuracy of data.
- To monitor compliance of the health services with the principles of counselling, confidentiality and consent in implementing HIV counselling and testing services.
- To organize regular joint meetings of country-level M&E and programme staff, and ensure that key performance indicators are identified, achieved and linked to programmatic interventions.
- To prepare and disseminate an annual M&E country report which includes analyses of the epidemic situation, programme performance and outcomes.

WHO in conjunction with UNAIDS and other partners:

- To advocate for increasing the importance of the M&E system as an integral and vital component of the HIV policy formulation and programme development process.
- To document regional best practices on M&E processes and add value to policies and programmes.
- To organize annual intercountry meetings of national programme and M&E staff to encourage the use and linkage of strategic information generated by M&E systems with programme planning and implementation.
- To constitute a regional technical expert group that will meet periodically to discuss and resolve technical issues on M&E as well as monitor progress in strengthening the M&E system at the country level.
- To ensure linkage of the discussions and recommendations of the regional technical expert group with those of the national technical working group on M&E.
- To harmonize technical support on M&E to countries among WHO, UNAIDS and other partners.

Annex 4

PROPOSED COUNTRY-SPECIFIC ACTIVITIES ON HIV/STI PREVENTION, CARE AND TREATMENT, 2008–2009

Strategy	Activities	BAN	BHU	IND	INO	MAL	MMR	NEP	SRL	THA	TLS
1. Policy and strategies	Health sector response review.	Review of STI/HIV-AIDS Programme.	Review of STI/HIV-AIDS Programme.		Follow-up recommendations of external review 2007.		Follow-up recommendations of external review 2006.	Review of STI/HIV programme.	Follow-up recommendations of external review 2006.	Follow-up recommendations of external review 2005.	
	Revision of STI/HIV strategies.			Develop new national HIV strategies in the health sector. Finalize STI strategy and follow-up by Plan Of Action of provinces.				Form task force and organize consultations with stakeholders to integrate HIV into the health sector plan.			Finalize HIV/STI strategy.
	AIDS Programme Management Course.	Training for programme managers in select provinces using WHO training modules on programme management.	Training for programme managers using WHO training modules on programme management.	HIV management training for district programme managers – prioritize high prevalence districts/ states.	Adapt the WHO National AIDS Management modules to Indonesia and conduct training.		Adapt AIDS programme management training modules to township-level AIDS/STI teams (2008-2009).		TOT – attend regional training. In-country training of district level programme managers.		Adapt manual for HIV/STI programme management. Training national HIV/STI staff on programme management and technical issues.

Strategy	Activities	BAN	BHU	IND	INO	MAL	MMR	NEP	SRL	THA	TLS
				Training on AIDS Programme Management at national and state level (150 persons/6 batches minimum) prioritize high-prevalence states							
2. HIV/STI prevention	Strengthening STI control.		ToT for field workers in the district.	Capacity building development of training material and pilot training for STI private practitioners. Linking all targeted interventions (TIs) including truckers projects to ICTC, care, support treatment services, improving access – pilot project in linking and referrals.			STI management training modules. Roll out training on STI management at peripheral level. Strengthen public-sector staff on targeted interventions.	Update STI management guidelines.	Assessment of STI services in the era of health-care reform. Guideline development on sexual health and STI management for health staff. Forum on new technology in HIV/STI prevention and feasibility study.	Revise STI syndromic management guidelines.	

Strategy	Activities	BAN	BHU	IND	INO	MAL	MMR	NEP	SRL	THA	TLS
3. HIV/AIDS care and treatment	Care and treatment.		Technical assistance for adaptation of WHO training modules for care, treatment and counselling for health workers.	Training on comprehensive continuum of care (CCC) (100 CCCs). Develop job aids/refreshers training for ART centre staff, including for second-line staff. Capacity building of RC/JDs (ART) network.	Develop strategy for incremental scale-up of services, definition of needs at each level. Develop national OI treatment guidelines and charts.	Train health-care providers in select facilities to implement HIV/AIDS care and treatment.				Scaling up success services in ART programme. Guideline on nutrition management for HIV/AIDS. Training to expand the practice of nutrition management guideline.	Develop standard protocol for ART and OI treatment. Strengthen existing ART centres, train ART staff and procure ART and drugs for prophylaxis of OIs.
	IMAI development.			Upscaling of IMAI after review of pilot for district/sub-district.	Review of impact of delivered trainings (ART, IMAI and others). Expansion of IMAI materials (e.g. IDU, adherence support, TB/HIV).				Implement-ation of IMAI as pilot. Adaptation of IMAI tools to country situation.		
	ART monitoring, recording and reporting.	Strengthening ART monitoring system.		Capacity building in M&E ART in NACO and major states for the staff of ART centres (DEO/IMO) and M&E of CCCs.	Development of a scale-up strategy to ensure good quality of ART M&E reporting.				Implement-ation of ART M&E.		Develop ART management including recording and monitoring including database.

Strategy	Activities	BAN	BHU	IND	INO	MAL	MMR	NEP	SRL	THA	TLS
4. VCT	VCT services.	Support VCT scale-up in targeted districts.		Refresher training for counsellors, especially in ART adherence, continuum of care.		Develop standards for HIV testing and counselling. Train service-providers in counselling and testing. Campaign to encourage uptake of VCT services.	Organize National consultation on TC and PITC. Strengthening VCT monitoring tools. HR training on VCT/PITC.			Workshop on counselling services and system development.	Develop national strategy and guidelines for VCT and PMTCT. Support and improve existing VCT centres. Establish four VCT centres in Dili and 5 centres in high-priority districts.
	VCT monitoring recording and reporting.			PPTCT programme review and assessment.				Further strengthening VCT monitoring recording and reporting.	Implement M&E tools.		Develop VCT monitoring, recording and reporting.
5. Strategic Information	Strengthening second generation surveillance. (SGS)		Continue training programme managers in epidemiology.		Develop ANC surveillance for select sites. Strengthening of HIV sentinel surveillance.	Develop national capacity in conducting second-generation surveillance.	Surveillance: HSS strengthening Surveillance: HSS strengthening BSS expansion. STI prevalence survey among high-risk groups SWs + bridge populations.	National TOT training in SGS. Orientation/training of DPHO in SGS.			Develop guidelines for second-generation surveillance. Train national and district staff on second-generation surveillance. Implement second-generation surveillance in six high-priority districts.

Strategy	Activities	BAN	BHU	IND	INO	MAL	MMR	NEP	SRL	THA	TLS
	HIV estimates and projections.		Continue training programme managers in epidemiology.	Surveillance, estimation and projections.			HIV estimation.	Orientation/training of PH staff in understanding on estimation and projections.			
	HIV drug resistance surveillance and monitoring.			Capacity building of four institutions in HIV-DR monitoring.	Conduct gonococcus resistance survey. Develop HIV-DR monitoring as part of surveillance. Analysis of ART data (early warning system).		HIV-DR monitoring + surveillance national strategy development.	Initiate orientation to drug resistance for NPHL & hospitals. Train assigned laboratories to initiate preparation for monitoring of DR.			Develop surveillance system to monitor drug resistance. Develop strategy and guidelines for the management of HIV-DR.
	Programme monitoring and evaluation.	Train national and district staff on M&E.	On-going activities.	Capacity building of epidemiologists and M&E officers.	Develop an M&E (health programme) masterplan with harmonized reporting and yearly reporting.	Develop routine monitoring system for drug-user interventions.	Development of M&E core group and plan.	Train PH staff in programme monitoring.		Workshop to maximize utilization on M&E data.	Develop framework for M&E. Train national and district staff on M&E.
	Operational research.							Training of additional PH staff in operational research.			

Strategy	Activities	BAN	BHU	IND	INO	MAL	MMR	NEP	SRL	THA	TLS
6. Health systems strengthening in Sustainable financing.	Human resource development for HIV.	Develop HRD Master Plan.	External assessment of need to strengthen HRM & HRD in NACO.	Develop human resource development plan for HIV and finalize of strategy.				Orient policy-makers from sectoral departments and ministries. Review, update training modules for different levels of the health workforce.		Strengthen information system on health workforce in HIV/AIDS programme. Develop human resource plan for HIV/AIDS programme.	
	Procurement and supply management.	Strengthen ARV procurement and prequalification.	Assess current supply chain management in drugs, diagnostics and reagents to initiate this work area.				Strengthening procurement and supply management of ART/OI.				Procure laboratory equipment.
	Laboratory strengthening.	Strengthen laboratory systems to support ART programme.	Assess national reference laboratories on HIV and capacity building needs, including NACO.	Laboratory strengthening			Laboratory support for monitoring ART (CD4) training OI diagnosis training for harm reduction. Improve laboratory capacity in support to STI diagnosis.	Training in NEOAS for HIV, CD4, STIs and viral load testing.			Develop national standards for QA of laboratories. Establish EQA scheme for laboratories.



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