SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV/AIDS

Since the last session, there have been three important international developments: the International Treatment Access Coalition was launched in December 2002; the Global Fund to Fight AIDS, Tuberculosis and Malaria announced a second round of approved proposals in January 2003; and the global health sector strategy for HIV/AIDS was adopted by the Fifty-sixth World Health Assembly in May 2003 (Annex 1).

While most countries in the Region still have low HIV prevalence, several have concentrated epidemics in high-risk populations such as sex workers and injecting drug users. The danger of a wider epidemic cannot be discounted.

Additional resources from the Global Fund and other sources will enable countries to: (1) strengthen primary prevention of HIV, (2) maintain and improve second generation surveillance systems; and (3) plan or implement HIV/AIDS care, including antiretroviral treatment. WHO will continue to support countries to coordinate plans, mobilize and implement additional resources; strengthen analysis of epidemiological surveillance data; support the expansion of successful prevention interventions through, for example, a strategic framework for a harm-reduction-based approach to HIV prevention among injecting drug users in Asia (Annex 2); and develop HIV/AIDS care activities through, for example, activities to scale-up the delivery of antiretroviral therapy in the Region (Annex 3).

This annual report is presented for the information of the Regional Committee and for discussion at its fifty-fourth session.
1. CURRENT SITUATION

A detailed analysis of the STI and HIV/AIDS situation in the Region is contained in *The Work of WHO in the Western Pacific Region: 1 July 2002–30 June 2003* (pp. 51-64).

Since the 26th special session of the United Nations General Assembly on HIV/AIDS, held in New York in June 2001, United Nations agencies, and particularly WHO, have been working closely with their Member States to ensure that the Declaration of Commitment on HIV/AIDS adopted by the special session is reflected in concrete actions and achievements.

In December 2002, in Dakar, Senegal, the International Treatment Access Coalition (ITAC) was launched. The mission of ITAC is, first, to expand access to HIV treatment for all people living with HIV/AIDS who need it and, second, to be a catalyst for partnership at international, regional and national levels, particularly in resource-limited settings. ITAC will form a platform for WHO’s efforts to ensure that 3 million people in the developing world living with HIV/AIDS are provided with ARV treatment by 2005 and for the achievement of the HIV/AIDS treatment provisions of the Millennium Development Goals. ITAC will also bolster the World Bank’s Treatment Access Programme (TAP), and other public and private HIV treatment access initiatives.

The ITAC partners (associations of people living with HIV/AIDS, community-based organizations, nongovernmental organizations, private companies, foundations, academic institutions, governments and multilateral organizations, including WHO) recognize that increasing the affordability, availability and uptake of HIV treatments will require significant changes to the way each organization works.

ITAC will have four key functions: (1) information exchange among the many partners involved, (2) collaborative HIV treatment programmes; (3) development of policy and technical tools; and (4) advocacy, to support the individual and combined efforts of ITAC partners.

In the second round of approved grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria in January 2003, three proposals addressing HIV/AIDS, from Cambodia, Mongolia and 11 Pacific island countries, were successful. Taken together with the grants to Cambodia, the Lao People’s Democratic Republic and Viet Nam in the first round, total support for HIV/AIDS projects from the Global Fund has reached US$ 53.5 million. The success rate of the proposals from countries in the Region is largely due to excellent and close collaboration between countries and UNAIDS and WHO.
The Fifty-sixth World Health Assembly in May 2003 adopted a global health sector strategy for HIV/AIDS for 2003-2007. The objective of the strategy is to give fresh impetus to countries’ responses to the epidemic and to confirm WHO’s key role in providing technical leadership to health systems to combat HIV/AIDS (Annex 1).

There have been several important recent developments in the Region:

(1) The continued implementation of second generation HIV surveillance has led to better quality data and more sophisticated analysis and use of epidemiological data. As well as monitoring the epidemic, data have been used to design interventions and measure their impact. They show that:

- There were an estimated minimum of 1.2 million HIV infected people in the Region at the end of 2002, although the regional prevalence rate is still low.

- In Cambodia, which still has the highest HIV prevalence rate in Asia and a generalized epidemic, it is encouraging that there has been a decrease in HIV prevalence in some vulnerable groups, which may be related to well-targeted prevention efforts.

- There are focal areas of high HIV transmission leading to increasing HIV prevalence among vulnerable groups (e.g. sex workers and their clients and injecting drug users) in some countries, particularly China, Malaysia, Papua New Guinea and Viet Nam. In Papua New Guinea there is a danger that a generalized epidemic may develop.

- Other countries have recorded stable HIV prevalence (e.g. the Philippines), low prevalence (e.g. the Lao People’s Democratic Republic, Mongolia, Pacific island countries) or have not recorded any cases of HIV/AIDS (e.g. Cook Islands, Niue, Tokelau).

- High and increasing levels of sexually transmitted infections, particularly among young adults, continue to be recorded, suggesting that high-risk sexual behaviour is still increasing in many settings, particularly in Mongolia, the Philippines and various Pacific island countries.

---

1 “Second generation surveillance” systems aim to integrate data from biological and behavioural surveillance in order to improve the explanatory power of surveillance data. Such surveillance systems facilitate the targeting of surveillance and intervention activities and the monitoring and evaluation of the impact of interventions.
• The number of individuals developing AIDS continues to increase rapidly in Cambodia, China, Malaysia, Papua New Guinea and Viet Nam. Annual numbers of AIDS deaths in the Region are projected to increase to about 130,000 by 2005.

(2) The need for and effectiveness of harm reduction strategies are becoming more widely accepted. In collaboration with WHO Headquarters and the South-East Asia Region, the Regional Office has developed a strategic framework for a harm-reduction-based approach to HIV prevention among injecting drug users in Asia (Annex 2). These strategies are being increasingly used in countries where transmission through needle and syringe sharing by drug users is the primary mode of transmission (e.g. China, Malaysia and Viet Nam), although so far this is usually only on a limited scale or in pilot projects.

(3) The promotion of condom use in targeted vulnerable groups began in countries that are particularly affected by the epidemic, but it is now being practised in some countries with a low prevalence of HIV (e.g. the Lao People’s Democratic Republic and Mongolia). In many countries, rates of condom use are increasing significantly among individuals at high risk of infection.

(4) There are now more effective partnerships among governments, United Nations agencies, bilateral and multilateral partners and nongovernmental organizations (NGOs). These partnerships are strengthening support for STI, HIV and AIDS prevention and care activities.

2. ISSUES

(1) There is a risk that the ‘low HIV prevalence’ status of the Western Pacific Region may lead to complacency. Several countries in the Region have large populations, so the low regional prevalence rate can mask large numbers of infections and significant human costs.

(2) There is also a danger that increasing levels of HIV infection among highly vulnerable groups in some countries may lead to the epidemic spreading to the wider community. This would greatly increase the risk of more serious epidemics in future. Efforts to reach those most at risk of infection with large-scale interventions of proven effectiveness must continue and indeed be increased.
(3) Although there is already extremely high HIV prevalence among some IDU populations, in others it may still be possible to prevent large-scale HIV epidemics. Surveys in China, Malaysia and Viet Nam show that the percentage of sex workers injecting drugs is increasing in all three countries. There is also evidence that this is facilitating the spread of HIV into the wider community. Effective large-scale interventions to reduce the sharing of needles and syringes are urgently needed.

(4) The increase in the number of individuals developing AIDS requires more active interventions to reduce the burden on individuals, families, communities and local health services. Providing broader access to ARV, and ensuring their rational use, should now be considered in selected settings where HIV testing and counselling is available, as part of comprehensive HIV/AIDS care. Countries are encouraged to participate in WHO’s support for the expansion of ARV treatment in the Region, such as the consultation on “ARV scale-up as part of comprehensive HIV/AIDS care in the Western Pacific Region” in January 2003 (Annex 3).

3. ACTIONS PROPOSED

The following actions are proposed for consideration by Member States.

(1) Strengthen political commitment to reduce STI and HIV transmission. Effective interventions such as “100% condom use” and harm reduction among IDUs are dependent on strong support at national, local and community levels.

(2) Intensify prevention, targeting the most vulnerable individuals, paying particular attention to promoting condom use, strengthening services for sex workers and implementing harm reduction programmes for injecting drug users.

(3) Strengthen surveillance in order to focus interventions on those most at risk of infection, to ensure that changes in HIV transmission patterns are detected at an early stage, and to enable the impact of prevention and care programmes to be more closely monitored.

(4) Improve HIV/AIDS care by: (a) preparing national strategic plans for HIV/AIDS care, (b) formulating policies on the provision of drugs for HIV and AIDS treatment (including ARV), (c) developing guidelines on comprehensive HIV/AIDS care and clinical management, and (d) implementing care and support for people living with HIV/AIDS in the community and in health care settings.
FIFTY-SIXTH WORLD HEALTH ASSEMBLY

Agenda item 14.4

Global health-sector strategy for HIV/AIDS

The Fifty-sixth World Health Assembly,

Having considered the draft global health-sector strategy for HIV/AIDS;¹

Mindful of WHO’s role, as a cosponsor of UNAIDS, in ensuring that the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly special session on HIV/AIDS (June 2001) is followed up;

Deeply concerned about the unprecedented burden the HIV/AIDS epidemic is placing on the health sector, and acknowledging the central role of that sector in providing an expanded, multisectoral response;

Conscious of the opportunities and challenges presented by the availability of new resources to Member States through mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and from the World Bank, bilateral agencies, foundations and other donors;

Acutely aware of the need to strengthen health-sector capacity in order: (a) to absorb and manage resources; (b) to improve planning, prioritization, development of human resources, programme management, integration and implementation of key interventions, mobilization of nongovernmental organizations, and assurance of service quality and sustainability; and (c) to support research as part of national responses;

Equally conscious of the need simultaneously to expand activities in prevention, treatment, care, support, surveillance, monitoring and evaluation, as essential and mutually supportive elements of a strengthened overall response to the HIV/AIDS epidemic;

Aware of the corresponding increase in demand by Member States for technical support, normative guidance and strategic information in order to make optimal use of resources and to maximize the impact of interventions;

Recalling that resolution WHA53.14 requested the Director-General, inter alia, to develop a global health-sector strategy for HIV/AIDS and sexually transmitted infections,

1. TAKES NOTE of the global health-sector strategy for HIV/AIDS;

¹ Document A56/12, Annex.
2. **EXHORTS** Member States, as a matter of urgency:

   (1) to adopt and implement the strategy as appropriate to national circumstances as part of national, multisectoral responses to the HIV/AIDS epidemic;

   (2) to strengthen existing, or to establish new, structures, and to mobilize and engage all concerned parties, within and beyond the health sector, in order to implement the strategy through the health and other concerned sectors and to monitor and evaluate its effectiveness;

   (3) to take all necessary steps, including the mobilization of resources, to fulfil their obligations under the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly special session on HIV/AIDS, including those related to access to care and treatment; and efforts to prevent HIV infection;

   (4) to strengthen measures of cooperation and support, both bilaterally and multilaterally, to fight the HIV/AIDS epidemic whether directly among themselves, or through WHO or other competent international and regional institutions;

   (5) to reaffirm that public health interests are paramount in both pharmaceutical and health policies, to recognize the difficulties faced by developing countries in effective use of compulsory licensing in accordance with the Declaration on the TRIPS Agreement and Public Health (Doha Declaration), and, when necessary, to use the flexibilities in the TRIPS Agreement in order to meet the needs of developing countries for drugs against HIV/AIDS;

3. **REQUESTS** the Director-General:

   (1) to provide support to Member States, on request, in implementing the strategy and evaluating its impact and effectiveness;

   (2) to cooperate with those Member States that request technical support in the preparation of their submissions to the Global Fund to Fight AIDS, Tuberculosis and Malaria;

   (3) to take the necessary steps to assure that offers of bilateral and multilateral collaboration and support submitted by one or more Member States with regard to fighting the HIV/AIDS epidemic are widely disseminated and promoted among the rest of the Member States, and periodically to assess the impact of this proceeding at the Health Assembly;

   (4) to support, mobilize, and facilitate efforts of Member States and all other concerned parties to achieve the goal of providing in a poverty-focused manner, equitably and to those most vulnerable, effective antiretroviral treatment within the context of strengthening national health systems, while maintaining a proper balance of investment between prevention, care, and treatment, and bearing in mind WHO’s target of reaching at least three million people with HIV in developing countries by 2005;¹

   (5) further to mobilize Member States and all parties in support of actions taken by countries with an AIDS epidemic, especially developing countries, to obtain affordable and accessible drugs to combat HIV/AIDS;

¹ Document A56/12.
(6) report to the Fifty-seventh World Health Assembly through the Executive Board at its 113th session on progress made in the implementation of this resolution.

Tenth plenary meeting, 28 May 2003
A56/VR/10

= = =
A STRATEGIC FRAMEWORK FOR A HARM-REDUCTION-BASED APPROACH TO HIV PREVENTION AMONG INJECTING DRUG USERS IN ASIA

Table of contents

1. INTRODUCTION ...................................................................................................... 12
   1.1 Goal and objectives of the strategic framework .............................................. 13
   1.2 What is harm reduction? ................................................................................. 13
2. BACKGROUND ...................................................................................................... 14
   2.1 Epidemiology of HIV and drug use ............................................................... 14
   2.2 Decreasing the burden of HIV among drug users ....................................... 15
3. GUIDING PRINCIPLES ...................................................................................... 17
4. THE REGIONAL STRATEGIC FRAMEWORK ................................................. 17
   4.1 HIV surveillance .......................................................................................... 18
   4.2 Prevention of HIV infection .......................................................................... 18
A STRATEGIC FRAMEWORK FOR A HARM-REDUCTION-BASED APPROACH TO HIV PREVENTION AMONG INJECTING DRUG USERS IN THE WHO WESTERN PACIFIC REGION

1. INTRODUCTION

Drug use, particularly injecting drug use, is being increasingly reported across the world. Social and cultural circumstances that create or facilitate unsafe behaviour among drug users can have an explosive effect on the spread of HIV. This has been the case in many parts of the world, including the Western Pacific, where blood-to-blood transmission through the sharing of injecting equipment has had a dramatic impact on HIV infection rates. In the WHO South-East Asia and Western Pacific Regions, extensive blood-to-blood transmission has been reported from China, Indonesia, Malaysia, Myanmar, Nepal and Viet Nam.

Countries participating in the Bi-Regional Partners Meeting on Harm Reduction among Injecting Drug Users in China, Indonesia, Myanmar and Viet Nam\(^2\) reported continuing high rates of HIV prevalence among drug users and increasing evidence of injecting drug use. For these countries, the continued spread of HIV through needle and syringe sharing and the potential for secondary spread are serious issues. Other countries are concerned about the potential for this mode of transmission to create an HIV problem, exacerbate an existing problem or undermine gains made against other modes of transmission. Recognizing that comprehensive national strategies should address all modes of transmission, the WHO Regional Offices for the South-East Asia and Western Pacific Regions are collaborating to develop a biregional approach to HIV prevention among injecting drug users (IDUs).

While there have been substantial efforts to introduce harm reduction responses in countries in these regions, most have been small-scale projects. In order to encourage the expansion of such projects, WHO will develop a biregional strategic plan to facilitate country-based work plans for a harm reduction response to the spread of HIV through the sharing of needles and syringes.

\(^2\) Bi-Regional Partners Meeting on Harm Reduction among Injecting Drug Users in China, Indonesia, Myanmar and Viet Nam, Ha Noi, Viet Nam, 7-9 October 2002. Copies of the report of the meeting are available from manuelm@wpro.who.int.
1.1 Goal and objectives of the strategic framework.

<table>
<thead>
<tr>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>To decrease the burden of HIV/AIDS among injecting drug users in the South-East Asia and Western Pacific Regions of WHO.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To achieve high level political support in both regions for a strategic response, based on the harm reduction approach.</td>
</tr>
<tr>
<td>• To reduce HIV incidence through the sharing of needles and syringes in drug use in both regions.</td>
</tr>
</tbody>
</table>

It is recognized that this framework and its intended strategic plan encompass only one element of the response to HIV as it affects drug users. A comprehensive response would include prevention and education targeted at all modes of transmission and would also include treatment and care. HIV treatment and care are in themselves effective prevention activities, providing opportunities for prevention and education. Treatments that reduce the viral load also reduce the risk of transmission. Surveillance is another essential element of a comprehensive response.

1.2 What is harm reduction?

Harm reduction is the employment of evidence-based public health interventions to prevent or reduce the negative health consequences associated with the sharing of needles and syringes and to improve the health and social status of those at greatest risk.

A harm-reduction-based strategy means a comprehensive package of interventions that reduce the negative consequences of injecting drug use for both the individual and the community.

Harm reduction has been demonstrated to be effective in reducing the spread of HIV through needle and syringe sharing. It has the support of the United Nations system, but it has become a difficult term to use because it has come to mean different things to different people. It is important to note that harm reduction is not an exclusive approach, as it operates in tandem with other approaches to drug use, sharing some strategies with the traditionally accepted responses; demand and supply reduction.
2. BACKGROUND

2.1 Epidemiology of HIV and drug use

Of the global total of 40 million people living with HIV/AIDS at the end of 2001, 28.1 million (70%) were in sub-Saharan Africa, followed by 7.1 million (18%) in Asia. The overwhelming share of the global HIV burden is borne by low and middle-income countries, where 95% of the people living with HIV/AIDS live. The HIV pandemic remains driven predominantly by sexual, and primarily heterosexual, transmission.

In 2001 alone, an estimated 1.07 million adults and children were newly infected with HIV in Asia. If ranked by adult prevalence, blood-to-blood transmission through injecting drug use is the primary mode of transmission in four of the most affected countries in Asia and the secondary mode in three more. Epidemics among injecting drug users have been reported from China, India, Indonesia, Malaysia, Myanmar, Nepal, Thailand and Viet Nam.

Figure 1. HIV epidemics in IDU populations in Asia
2.2 Decreasing the burden of HIV among drug users

The response to HIV spread through injecting drug use has been expressed in four key documents: UNGASS Declaration of Commitment on HIV and AIDS; the UN position paper Preventing the transmission of HIV among drug abusers; the WHO paper A global health sector strategy for HIV/AIDS 2003 – 2007; and the ASEAN workplan program on HIV/AIDS 2002-2005.

Collectively these papers identify the need for a comprehensive prevention programme, based on the harm reduction approach. In response to the spread of HIV through needle and syringe sharing, the approach includes advocacy, information and education, access to the means of prevention (e.g. condoms and lubricants, needles and syringes, cleaning materials), voluntary and confidential HIV counselling and testing, and the availability of and referral to a range of care and treatment options.

WHO response

The South-East Asia and Western Pacific Regional Offices recognize the need to promote effective national responses to prevent the spread of HIV. The HIV/AIDS programmes in the two regions will guide countries based on the Bi-Regional strategic framework for a harm-reduction-based response to HIV and injecting drug use and encourage the implementation of a collaborative intersectoral response at country level.

Although there is evidence that the spread of HIV through needle and syringe sharing in drug use can be managed, responses in this area have in some instances not been as effectively developed and implemented as those for other modes of transmission. There may be complex reasons for this and in such cases WHO can advocate and support a more effective response.

Partners in a regional response

Organizations and agencies that can contribute to the response include:

- United Nations agencies and programmes, in particular the United Nations Office on Drugs and Crime (UNODC), United Nations Children’s Fund (UNICEF) and the United Nations Joint Programme on AIDS (UNAIDS);

- regional bodies and programmes, including the United Nations Regional Taskforce on Drugs and HIV Vulnerability, ASEAN, the AusAID Regional HIV/AIDS Project (ARHP) and the Asian Harm Reduction Network;
Annex 2

- international agencies, including nongovernmental organizations, Family Health International (FHI), the Centers for Disease Control - Global AIDS Programme (CDC - GAP); and

- funding agencies, including the Australian Agency for International Development (AusAID), the UK Department for International Development (DFID) and the United States Agency for International Development (USAID).

**Bi-regional Partners Meeting on Harm Reduction among Injecting Drug Users.**

Recognizing the need for an improved response and the importance of collaboration, WHO convened a Bi-Regional Partners Meeting on Harm Reduction among Injecting Drug Users in China, Myanmar, Indonesia and Viet Nam in October 2002.

The main recommendations of this meeting were:

- A call for urgent action should be issued to prevent and reduce HIV epidemics among injecting drug users through harm reduction.

- The following WHO guidelines should be applied:
  
  - *Advocacy guide for effective HIV prevention among injecting drug users;*
  
  - *Training guide for HIV prevention outreach to injecting drug users;*
  
  - *Policy and programme development guide for HIV prevention and care among injecting drug users;*
  
  - *Technical guide to rapid assessment and response;* and
  

- A regional contact group should be formed. It should work with and through existing mechanisms wherever possible to assist in the adaptation and implementation of the guidelines, formalizing and organizing national networks and relationships to provide more advocacy at regional and international conferences, forums and meetings, including with UN theme groups in each country.

- Cross-border issues should be considered.
• Capacity-building through intercountry training should be prioritized. ‘Regional resource centres’ with the capacity to provide training to local and regional consultants should be established.

3. GUIDING PRINCIPLES

• WHO has an important role to play in the response to HIV/AIDS.

• The most effective approach to prevent the transmission of HIV through the sharing of needles and syringes is one based on harm reduction.

• A multisectoral response will be most effective, particularly one involving other ministries responding to illicit drug use.

• Responses to illicit drug use, particularly to injecting drug use and drug dependence, must take account of the health and social consequences of HIV spread among injecting drug users and how such spread may be reduced.

• Representatives of the IDU community should be involved in planning, implementing and monitoring harm reduction initiatives. Furthermore, peer education needs to be recognized and strongly supported as a cornerstone of effective approaches to HIV/AIDS among IDUs.

• The framework should accommodate the varying epidemiological, sociological and cultural environments that exist in the South-East Asia and Western Pacific Regions.

4. THE REGIONAL STRATEGIC FRAMEWORK

In response to the need to reduce the prevalence and incidence of HIV transmission through the sharing of needles and syringes in drug use, the bi-regional strategic framework presents a programme with a time frame and management plan including:

• surveillance of HIV among drug users within the context of global second generation surveillance;

• prevention and education for drug users and those at risk;
Annex 2

- treatment and care for people who are HIV positive;
- treatment and care for people who are drug dependent; and
- monitoring and evaluation.

4.1 HIV surveillance

An important component of any programme will be the availability of reliable data. The purpose of HIV and illicit drug use surveillance may be summarized as:

- to monitor and report on the impact of HIV on injecting drug users;
- to demonstrate the magnitude of the contribution to HIV epidemics of cases related to injecting drug use;
- to provide information for advocacy, policy decisions, programme planning and the development of performance indicators; and
- to monitor and report the impact of national programmes and their collaborative efforts.

4.2 Prevention of HIV infection

Prevention of HIV transmission can be achieved with an appropriate combination of:

- HIV prevention information and education;
- access to the means of prevention (condoms and lubricants, needles and syringes, cleaning materials);
- voluntary and confidential HIV counselling and testing; and
- the availability of and referral to a range of treatment options.

Prevention of HIV transmission can most effectively be achieved through:

- Partnerships, at all levels, including intersectoral collaboration among ministries and departments that target drug users in some way. Building these partnerships should be a strategic objective.
- Appropriate public health policy and health services, including the need for the health sector to contribute to the government’s response to issues of drug dependence and treatment.
• Supportive political and social environments. Reorienting existing services and developing new ones can be a complicated and difficult process requiring political will and support. Advocacy and public education campaigns are needed to develop these.

• Community support and capacity. The communities affected by HIV and drug use should be empowered, through knowledge and participation in decision-making, to develop their own responses to the challenge of HIV and drug use.

• Ensuring individuals are capable of acting to protect themselves and others. This can best be achieved through information, education, and access to the means for prevention. Another important factor is the existence of a supportive social and cultural context that encourages and supports decision-making.

Prevention of HIV transmission can best be achieved by activity across all relevant sectors of government at national, provincial and local levels, including:

• the health sector;

• public security;

• social security;

• justice;

• drug control; and

• collaboration with international and regional agencies and the nongovernmental sector.
ARV SCALE-UP AS PART OF COMPREHENSIVE HIV/AIDS CARE IN THE WESTERN PACIFIC REGION

Table of contents

EXECUTIVE SUMMARY ........................................................................................................ 22
1. GLOBAL AND REGIONAL CONTEXT ........................................................................... 23
2. PLANNING AND IMPLEMENTATION OF HIV/AIDS CARE IN THE WESTERN PACIFIC REGION ........................................................... 23
   2.1 Regional framework for planning and implementing HIV/AIDS care ............... 23
   2.2 Complementary strategies for developing HIV/AIDS care at the local level ... 26
   2.3 Enabling environment and supportive functions ................................................. 27
3. COUNTRY RESPONSES ................................................................................................. 27
   3.1 Cambodia ............................................................................................................ 27
   3.2 China .................................................................................................................. 29
   3.3 Papua New Guinea ............................................................................................. 29
   3.4 Viet Nam ............................................................................................................. 31
4. INCREASING AVAILABILITY OF ARV TREATMENT .............................................. 32
   4.1 Cambodia ............................................................................................................ 32
   4.2 China .................................................................................................................. 33
   4.3 Papua New Guinea ............................................................................................. 34
   4.4 Viet Nam ............................................................................................................. 34
ARV SCALE-UP AS PART OF COMPREHENSIVE HIV/AIDS CARE
IN THE WESTERN PACIFIC REGION

EXECUTIVE SUMMARY

In order to address the rapidly growing need for HIV/AIDS care in the Western Pacific Region (particularly in Cambodia, China, Papua New Guinea and Viet Nam), national operational frameworks and a series of guidelines for comprehensive HIV/AIDS care are being developed. In addition, small-scale pilot projects have been implemented. However, these initiatives need to be accelerated, with particular emphasis on capacity building for the delivery of antiretroviral (ARV) treatment, which is becoming increasingly available in developing countries. Countries with significant numbers of AIDS cases will receive and/or allocate significant funding for HIV/AIDS care, including ARV treatment, in the coming years.

At the global level, the Declaration of Commitment on HIV/AIDS that was adopted at the 26th special session of the United Nations General Assembly in 2001\(^3\) and the International HIV Treatment Access Coalition have established a number of targets, including the provision of ARV treatment for 3 million people by 2005. In keeping with these global efforts to accelerate access to ARV treatment in developing countries, the WHO Western Pacific Regional Office convened an informal consultation in January 2003 with the following objectives:

1. to share the experiences of Cambodia, China, Papua New Guinea and Viet Nam with regard to HIV/AIDS care, including ARV treatment; and

2. to identify key issues for developing and implementing national action plans on comprehensive HIV/AIDS care with particular emphasis on ARV treatment.

The meeting was held over a three-day period. On the first day, background information on comprehensive HIV/AIDS care, including scaling-up ARV treatment, was provided. This was followed by country reports. The second day focused on planning, implementing and expansion of HIV/AIDS care, including ARV treatment. The third and final day focused on increasing the availability of ARV.

---

1. GLOBAL AND REGIONAL CONTEXT

The following subjects were presented and discussed:

- technical updates on ARV treatment for developing countries;
- global developments on issues related to HIV/AIDS care, including ARV treatment;
- greater involvement of people living with HIV/AIDS (PHA) and HIV/AIDS care;
- outcomes of the International Roundtable on Increasing Access to HIV Treatment in Resource Poor Settings, Canberra, Australia, September 2002; and
- experiences from northern Thailand.

2. PLANNING AND IMPLEMENTATION OF HIV/AIDS CARE IN THE WESTERN PACIFIC REGION

2.1 Regional framework for planning and implementing HIV/AIDS care

A draft regional framework was presented. It was agreed that the following strategies could be implemented at the local level in most countries with a significant HIV/AIDS care burden.

1. Creating partnerships between public health services, medical services, peer support and NGOs/ community-based organizations at the intermediate levels (the “day care centre” approach)

The aims of such partnerships include care provision, management, capacity building and coordination at the intermediate levels of health system. They require an HIV care team and/or coordinator.

Partnerships can be achieved through a day care centre or similar mechanism, which allows PHA to meet freely and regularly and conduct a wide range of activities facilitated and supported by health workers. Such a centre can serve as a hub linking health facilities at different levels for
effective and sustainable HIV/AIDS care. Day care centres represent an intermediate level between
the home and the wider community and decisions about establishing such centres should be based on
the number of PHA in the area, the capacity of health facilities and physical access by PHA.

With regard to ARV treatment, the day care centre approach would contribute to equitable case
selection for enrolment, professional and peer education and counselling for PHA and their families,
adherence to treatment (including directly observed treatment, short-course, DOTS, for tuberculosis,
tracing of dropout cases, etc).

(2) Expanding voluntary counselling and testing (VCT) linked to care

The expansion of voluntary counselling and testing (VCT) should be based on the profile and
projected profile of the epidemic.

Simple, inexpensive and user-friendly testing methods should be used where appropriate. More
emphasis should be placed on integration and/or linkage of VCT to health care services.

With regard to ARV treatment, it is important that clients are provided with accurate
information on both the advantages and the constraints of the treatment, including its availability,
affordability, effectiveness and the complicated nature of its administration.

(3) Integrating HIV/AIDS care into health facility services

It is crucial that health facilities become PHA-friendly through staff training and workshops,
universal precautions, post-exposure prophylaxis (PEP), etc.

Medical care should include prophylaxis, diagnosis and treatment of opportunistic infections,
(including TB), ARV treatment, and prevention of mother-to-child transmission (PMCT).

Educational support and health promotion for self care, home care, treatment, nutrition, family
planning, prevention of further HIV transmission, and other aspects of AIDS care should be
conducted in close collaboration with the day care centre.

TB/HIV-related services require systematic identification of areas for collaboration between
HIV/AIDS and TB programmes.²

With regard to ARV treatment, health facilities at all levels should complement each other. This will lead to better case management and more appropriate laboratory services.

The functions that need to be shared by health services at different levels should include:

- specialty referral services for ARV treatment;
- prescription of first- and second-line regimens and management of side effects;
- care and support for ensuring adherence to and monitoring of ARV treatment (for example, at the day care centre, which could possibly prescribe first-line regimens); and
- basic care and support, including directly observed treatment, short-course (DOTS) for tuberculosis, or “buddy services” at the community level.

(4) Establishing home and community competence for HIV/AIDS care

Home and community are sometimes the source of stigma and discrimination. However, they have the potential to play very important positive roles in providing psychosocial and economic support, as well as basic health care for PHA and their families, including orphans.

Home- and community-based care can lead to increased awareness of HIV/AIDS and prevention of HIV transmission in the community through care and support. In this regard, home- and community-based care should go far beyond home-visits.

Ensuring multisectoral commitment for comprehensive care is also vital.

Local information, education and communication (IEC) materials should be produced. These should employ a range of participatory approaches and promote constructive dialogue through community groups and other channels.

With regard to ARV treatment, families and community members can support adherence to treatment with continuous support and backup from the day care centre and health facilities. Buddy systems and DOTS for tuberculosis patients could be considered to maximize adherence.
(5) **Responsiveness to a range of diverse and changing situations**

PHA and their needs vary according to area and change over time. Significant attention should be paid to ensuring systems are responsive, particularly at the local level. Day care centres can both reflect the local context and promote mutual learning and collective action.

A monitoring and evaluation system that leads to appropriate and timely national and local actions is needed. Simple indicators to identify progress and constraints of the local responses will be helpful.

Funding mechanisms should also facilitate responsive local systems. For instance, some proposal-based funding encourages participation and collaboration of key players such as public health and medical professionals, PHA groups, community-based organizations, NGOs and local authorities.

It is important that monitoring and evaluation indicators related to ARV treatment be developed. These should be an integral part of the overall monitoring and evaluation system for HIV/AIDS care. The ARV resistance surveillance network, which is now being developed at regional and national levels, will be able to provide information on the status of ARV treatment in each country.

### 2.2 Complementary strategies for developing HIV/AIDS care at the local level

According to the country/local context, including the stage of the HIV epidemic, the dominant mode of HIV transmission, the availability of existing services, and the progress of responses, the following complementary strategies should be considered:

1. prevention of mother-to-child transmission as a major entry point of care;
2. extensive home visit services where feasible;
3. extensive involvement of community-based organizations where available;
4. expanding peer support at community level where the level of stigma and discrimination is reduced;
(5) links to rehabilitation camps for injecting drug users (IDUs) and sex workers; and

(6) expanding outreach activities to increase access/utilization of marginalized PHA.

2.3 Enabling environment and supportive functions

In order to support these strategies for HIV/AIDS care at the local level, the following enabling actions should be carried out:

(1) Policies, strategies, guidelines, regulations and a legal framework to promote an essential package of HIV/AIDS services should be put in place. PHA should be key players in this process, and there should be a multisectoral approach to care, with particular attention to issues related to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS agreement).

(2) Human resources capacity should be strengthened through training and supervision.

(3) The drug supply system for procurement, distribution and rational use of HIV drugs and laboratory services, including the CD4 count, should be improved.

(4) Sound financial management should be put in place. This should include government subsidies, insurance schemes, and development of criteria for exemptions.

(5) Monitoring and evaluation and collection and distribution of information and experiences should be carried out. The development of an ARV resistance surveillance system is crucial.

3. COUNTRY RESPONSES

3.1 Cambodia

In 2002, 157 000 people between the ages of 15-49 years were living with HIV/AIDS and there were 22 000 AIDS patients. In that year there were approximately 9000 new infections (about 25 per day) among people in 15-49 age group, as well as 2600 newly infected children.
Annex 3

The development of a continuum of care suitable for the Cambodian context is an urgent priority if provinces are to be prepared for the introduction and eventual expansion of ARV treatment. The draft national framework for a continuum of HIV/AIDS identified the following major strategies:

1. partnerships between public health and medical services and PHA groups at the operational district level;
2. a strong referral mechanism between home, community and institutional care;
3. effective involvement of PHA in all aspects of care;
4. reinforcement of health facilities to provide high-quality care services; and
5. “care packages” at each level of the health system.

Pilot projects on a continuum of care, supported by the Asian Development Bank (ADB) and the French Government through WHO, are starting in several provinces in collaboration with other international agencies and NGOs. “MMMs” (friendly support centres) will be attached to the outpatient departments of referral hospitals or health centres at the operational district level. Such centres are expected to play major roles in care provision, management, coordination and capacity building. They promote peer support of PHA and provide a wide range of services, including information and education, referral, and counselling (pre- and post-test and supportive). The Cambodian Network of PHA (CPN+) already has 24 support groups with approximately 4000 members.

TB/HIV pilot projects are planned for four provinces. These will develop mechanisms for coordination and consistency of care and standardize tools for treatment, under the national TB/HIV framework. These projects will be an integral part of the continuum of care initiative.

There are approximately 680 PHA receiving ARV treatment at present. These patients are mainly treated in the major referral hospitals in Phnom Penh. More funding to enable HIV/AIDS care to be scaled up, including the provision of ARV treatment in Phnom Penh and the provinces, will be provided by the national budget, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and several major international donor agencies, including the Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau (ESTHER). It is anticipated that there will 3000 patients receiving ARV treatment in 2003 and 15000 in 2005. However there are considerable concerns about sustainability when funding from these external funding sources ceases.
Implementing ARV treatment in the provinces urgently requires continuum of care and capacity building with an emphasis on the operational district level and “MMMs” are expected to play a major role in this.

3.2 China

In 2002, there were an estimated 1 million people living with HIV/AIDS in China. By the end of 2001, an estimated 80 000-100 000 people were living with AIDS. The majority of HIV-infected persons live in rural areas, with injecting drug users accounting for 68% of HIV/AIDS cases.

The framework on comprehensive HIV/AIDS care at the local level, which was recently developed with support of WHO, emphasizes the importance of partnership between medical services and public health services (Center for Disease Control and Prevention, China, CCDC) as well as promotion of peer support of PHA. The “warm house” (which is similar to a day care centre) will serve as a key mechanism for care provision, coordination, management and capacity building of key players. Such houses will be established at different levels within the health system, according to HIV prevalence.

HIV/AIDS care will be established in 100 city and county-based sites. These sites will include Hubei Province, where a comprehensive care model will be developed with the support of WHO. The capacity of county hospitals will be strengthened to enable them to provide ARV treatment and treatment for opportunistic infections.

In addition, VCT models for different populations (plasma donors, IDUs, sex workers, etc) will be developed.

In 2002, the number of cases receiving ARV treatment was still limited (around 100 cases). However, the Government has been taking measures to scale-up ARV treatment. These include: (1) distributing domestically manufactured ARV drugs for 3000 cases to Henan province free of charge, with domestically manufactured ARV drugs to be distributed free to a further 20 000 cases in 2003, (2) ordering several hundred imported ARV drugs (based on a bidding process), and (3) drafting regulations on management of ARV treatment.

3.3 Papua New Guinea

There are now 5000 confirmed cases of HIV/AIDS in a total population of 5 million. The highest HIV prevalence is between the ages of 25 and 29 years. However, a great deal is unknown as
documentation is inadequate and the predominant modes of transmission are poorly understood. The majority of HIV/AIDS cases are found in the National Central District and Western Highland Province.

In 2002, a review of the Papua New Guinea National HIV/AIDS Medium Term Plan was conducted. This involved development of counselling and community care and support which includes; (1) ensuring that prevention is linked to counselling and support services, (2) that voluntary testing has pre-test counselling as a prerequisite, and (3) that a national HIV/AIDS counselling network be developed.

The national budget for health care is very inadequate, which accounts for the insufficient HIV/AIDS care. ARV treatment is non-existent, although treatment of some opportunistic infections is available (notably through the national tuberculosis programme and treatment for pneumocystis carinii pneumonia, PCP). Treatments for other common opportunistic infections are either unavailable or inadequate. There is little collaboration between the tuberculosis and HIV programmes and there are no HIV/AIDS care centres. However, one or two NGOs and community-based organizations provide ad hoc assistance. In addition some PHA are stigmatized and there is insufficient participation by PHA in decision-making and advocacy. There is no financial assistance for PHA to engage in public education and there are no advocates with appropriate HIV/AIDS education skills.

Major activities of the first phase should include:

- development of a plan of action to build the capacity of health systems in order to increase access to HIV treatment in the context of comprehensive care;

- development of national treatment guidelines following the approach in WHO Guidelines for a Public Health Approach, and Scaling up ARV in Resource-Poor Settings;

- establishment of pilot centres in the public health system (Port Moresby General Hospital) and in the church health system (these pilot projects will be integrated into the existing health care system).

In the second phase, ARV treatment will begin through a day care centre in a high prevalence area. Selection criteria will be developed for the day care centre, and it will be housed within a system that is already functioning well.
3.4 Viet Nam

By the end of 2002, cumulative totals of 59,200 HIV infected cases, 8,793 AIDS cases and 4,889 AIDS-related deaths had been reported. Around 60% of HIV infections occurred through injecting drug use. Furthermore, injecting drug use is increasing among sex workers. HIV infections are now increasing among pregnant women and military recruits. Approximately 61% of new infections are among people under 30 years. It is estimated 130,000 people are currently infected with HIV.

The strengths in Viet Nam include a good public health care network, with 60% of commune health centres having doctors. Women’s Unions and other organizations who have millions of members who can be mobilized to address HIV/AIDS issues.

An HIV/AIDS management, counselling and care network has been established in 40 provinces. Health centres at the commune level play major roles in providing basic care, while district health centres focus on administrative work. In some areas, peer support groups of PHA (Friend to Friend Club) have been promoted.

Viet Nam will receive US$12 million from the Global Fund to Fight AIDS, TB and Malaria over the next four years to implement comprehensive HIV/AIDS care including ARV treatment, prevention of mother-to-child transmission and VCT in 20 provinces. Activities to be implemented in relation to the Global Fund project include:

- finalization of a draft national operational plan on comprehensive HIV/AIDS care;
- revision of national guidelines on HIV/AIDS diagnosis and treatment;
- formulation of other guidelines/documents related to HIV/AIDS care and support at all levels, with particular attention to VCT and home-community based care;
- continued improvements to HIV/AIDS management, care and counselling;
- strengthening of community responses, mobilizing multi-sectoral and mass organizations; and
- promotion of PHA participation.

A pilot HIV/AIDS care project in Ho Chi Minh City will serve as a model for the provision of comprehensive HIV/AIDS care, including ARV treatment. It will be supported and expanded by the
Global Fund project. A package of care will be provided through district health centres, commune health centres, PHA groups, families and communities, including mass organizations. Day care centres will be established at the district health centres as a focus of care provision, coordination, management and capacity building.

Activities that can accelerate access to ARV treatment include: (1) better advocacy to policy-makers and key stakeholders, (2) strengthening infrastructure and manpower, (3) revising and updating national guidelines to conform with WHO guidelines for ARV treatment, (4) coordination with local ARV manufacturers, (5) coordination with NGOs, bilateral agencies, UN agencies and mass organizations, and (6) coordination among concerned government ministries.

4. INCREASING AVAILABILITY OF ARV TREATMENT

4.1 Cambodia

(1) TRIPS and patents

As a least-developed country, Cambodia will have until 2016 to enact intellectual property legislation that is compliant with the TRIPS agreement. Cambodia is not yet a World Trade Organization (WTO) member, although it is seeking membership. It may therefore be asked to implement TRIPS before the 2016 deadline, as part of its accession negotiations. Cambodia is currently revising its patent laws.

(2) Status and need for ARV drugs

ARV drugs are not included in the current version of the national essential medicines list, but it is anticipated that Cambodia may follow the example of the WHO model list and include them in future. Six different ARV drugs, and two different combination products, have been registered.
(3) **Procurement**

There is no procurement mechanism for ARV drugs in the public sector. Some NGOs, however, import ARV drugs for use in their projects. Local production of ARV drugs is underway.

(4) **Supply and distribution**

ARV drugs are available in the private sector; their use and distribution in the private sector is currently not regulated.

### 4.2 China

(1) **TRIPS and patents**

China has already enacted intellectual property legislation that complies with the TRIPS agreement. The Ministry of Health has been actively involved in the development of the patent law; the Chinese patent law contains provisions (such as compulsory licensing, parallel importation and a ‘Bolar provision’) that can be used to safeguard access to medicines. However, the Ministry of Health has no experience as yet regarding their actual use.

(2) **Status and need for ARV drugs**

Most ARV drugs are patent protected in China. In order to facilitate access to ARV drugs, China has set up a fast-track mechanism for the licensing of generic ARV drugs and has granted tax-free status to imported drugs. More than 10 ARV drugs have been licensed to be purchased by hospitals. China’s recommended treatment guidelines correspond with WHO’s second-line treatment recommendations; this is largely due to the fact that the drugs that WHO recommends as first-line treatment are not widely available. ARV drugs are not included in the essential drug list.

(3) **Procurement**

China has initiated local production of ARV drugs. AZT, ddI, d4T, and NVP are manufactured domestically with an average price of US$350-US$460 per year. China does not, therefore, depend on WHO’s pre-qualified suppliers. In addition, China has recently indicated its interest in joining the Accelerating Access Initiative. Funding for ARV drugs has thus far been exclusively from government sources.
Annex 3

(4) Supply and distribution

The Government of China has recently begun to distribute ARV drugs.

4.3 Papua New Guinea

(1) TRIPS and patents

Papua New Guinea has a patent law that was recently reviewed by an expert to determine whether it contained workable provisions for compulsory licensing and parallel importation.

(2) Status and need for ARV drugs

ARV drugs are not yet registered; standard treatment guidelines have not yet been developed.

(3) Procurement

Local production of ARV drugs is not a feasible option; importing them is the only choice. Currently, there is no procurement mechanism for ARV drugs.

(4) Supply and distribution

At present, ARV drugs are not available in Papua New Guinea.

4.4 Viet Nam

(1) TRIPS and patents

Viet Nam has applied to be a WTO member by 2005; thus, while it is not yet bound by the TRIPS agreement, it is likely that preparations are being made to design patent laws that are in line with TRIPS.

(2) Status and need for ARV drugs

ARV drugs are not included in the current version of the national essential drugs list, but the list is revised regularly; they may therefore be included in future, in line with the WHO model list. Detailed projections for ARV requirements are available, but these could probably be increased, if additional donor funding becomes available.
(3) **Procurement**

One company has recently started local production of some ARV drugs; however, the market is small. This is partly related to the fact that funding for ARV drugs thus far has been provided exclusively by the Government, and has been relatively limited.

(4) **Supply and distribution**

ARV drugs are available in the private sector; their use and distribution in the private sector is currently not regulated.