The World Health Organization’s Regional Office for South-East Asia in collaboration with its Western Pacific Regional Office and UNAIDS Regional Support Team for Asia and the Pacific, Bangkok, organized an intercountry workshop on improving treatment access through the Treatment 2.0 initiative on (13–14 September 2012) in Yangon, Myanmar. The workshop brought together participants from 10 countries in the Asia–Pacific Region including Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, Papua New Guinea, Thailand and Viet Nam; development partners Clinton Health Access Initiative, United States Agency for International Development (USAID), and Centers for Disease Control and Prevention (CDC); UN agencies the United Nations Children’s Fund (UNICEF) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) and civil society partners Asia–Pacific Network of Positive People, Therapeutics Research, Education, and AIDS Training in Asia, International Treatment Preparedness Coalition and Médecins Sans Frontières. This report summarizes the challenges and opportunities for scaling up antiretroviral treatment in the Asia–Pacific Region. It also highlights the discussions and agreements on setting up a regional task team for Treatment 2.0.

Optimizing HIV Treatment through the Treatment 2.0 Initiatives

Report of the Intercountry Workshop
Yangon, Myanmar, 13–14 September 2012
Optimizing HIV treatment through the Treatment 2.0 initiatives

Report of the Intercountry Workshop
Yangon, Myanmar, 13–14 September 2012
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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
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<tr>
<td>APN+</td>
<td>Asia–Pacific Network of Positive People</td>
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<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
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<tr>
<td>ARV</td>
<td>antiretroviral</td>
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<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
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<tr>
<td>CBO</td>
<td>community-based organizations</td>
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<tr>
<td>CD4</td>
<td>cluster of differentiation 4</td>
</tr>
<tr>
<td>CDC</td>
<td>United States Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
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<tr>
<td>d4T</td>
<td>stavudine</td>
</tr>
<tr>
<td>EID</td>
<td>early infant diagnosis</td>
</tr>
<tr>
<td>eMTCT</td>
<td>elimination of mother-to-child transmission (of HIV)</td>
</tr>
<tr>
<td>FDC</td>
<td>fixed-dosed combination</td>
</tr>
<tr>
<td>FTA</td>
<td>free trade agreements</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B virus</td>
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<tr>
<td>HCV</td>
<td>Hepatitis C virus</td>
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<tr>
<td>HIC</td>
<td>high-income country</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<tr>
<td>HLM</td>
<td>UN General Assembly High-Level Meeting on HIV/AIDS</td>
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<tr>
<td>HTC</td>
<td>HIV testing and counselling</td>
</tr>
<tr>
<td>IPR</td>
<td>intellectual property rights</td>
</tr>
<tr>
<td>ITPC</td>
<td>International Treatment Preparedness Coalition</td>
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<tr>
<td>KAPs</td>
<td>key affected populations</td>
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<tr>
<td>LDC</td>
<td>least-developed country</td>
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<tr>
<td>LIC</td>
<td>low-income country</td>
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<tr>
<td>MDCs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MIC</td>
<td>middle-income country</td>
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<tr>
<td>MMT</td>
<td>Methadone maintenance therapy</td>
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<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MSM</td>
<td>men who have sex with men</td>
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<tr>
<td>NGOs</td>
<td>nongovernmental organizations</td>
</tr>
<tr>
<td>OST</td>
<td>opioid substitution therapy</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>PLHIV</td>
<td>people living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>POC</td>
<td>point of care</td>
</tr>
<tr>
<td>PrEP</td>
<td>pre-exposure prophylaxis</td>
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<tr>
<td>PSM</td>
<td>procurement and supply management</td>
</tr>
<tr>
<td>PWID</td>
<td>people who inject drugs</td>
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<tr>
<td>RTT</td>
<td>regional task team</td>
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<tr>
<td>SEAR</td>
<td>South-East Asia Region</td>
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<tr>
<td>SEARO</td>
<td>Regional Office for South-East Asia</td>
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<tr>
<td>SPC</td>
<td>South Pacific Community</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
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<tr>
<td>SW</td>
<td>sex worker</td>
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<tr>
<td>T2.0</td>
<td>Treatment 2.0</td>
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<tr>
<td>TA</td>
<td>technical assistance</td>
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<tr>
<td>TasP</td>
<td>treatment as prevention</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TDF</td>
<td>tenofovir disoproxil fumarate</td>
</tr>
<tr>
<td>TOR</td>
<td>terms of reference</td>
</tr>
<tr>
<td>TRIPs</td>
<td>Trade-Related Aspects of Intellectual Property Rights</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>VL</td>
<td>viral load</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WHO-HQ</td>
<td>WHO headquarters</td>
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</table>
1. Introduction

The Asia–Pacific Region has approximately 4.9 million people currently living with HIV/AIDS, the majority of whom live in Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Papua New Guinea (PNG), Thailand and Viet Nam. Because of the concentrated epidemic within the Region, key affected populations (KAPs) – people who inject drugs, sex workers, transgender populations and men who have sex with men – are the key drivers of disease transmission. Despite the regional success in scaling up of antiretroviral therapy (ART) among people living with HIV (PLHIV) over the years (from 280 000 in 2006 to 1 075 272 in 2011), half of the people in need are still waiting to access treatment.

The international frameworks and commitments for intensifying action against HIV – the High-Level Meeting targets of the Sixty-sixth United Nations General Assembly in 2011, UNAIDS Three Zeros Strategy 2011–2015; and the WHO Global and Regional Health Sector Strategy on HIV 2011–2015 – reiterated the need to accelerate the prevention and treatment efforts in the Region. In 2010, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) jointly launched the Treatment 2.0 (T2.0) initiative to radically accelerate and simplify HIV responses towards achieving the goals of these international frameworks. The T2.0 initiative builds on the programmatic and clinical evidence and experience gathered over the decade to expand HIV diagnosis, treatment and care. Focusing on five priority areas, it was developed as a platform to maximize the efficiency and effectiveness of HIV responses by stimulating innovation in resource-limited settings.

Since it is important that WHO regions and countries play a critical role in implementing this initiative, the WHO Regional Offices for South-East Asia (WHO-SEARO) and the Western Pacific (WHO-WPRO), in collaboration with the UNAIDS Regional Support Team for Asia and the Pacific, held an Inter-country workshop on optimizing HIV treatment through Treatment 2.0 Initiative in Yangon, Myanmar, on 13–14 September 2012. A total of 53 participants attended the meeting, including country representatives from Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, Papua New Guinea, Thailand and Viet Nam, and staff from partner agencies, namely UNAIDS, United Nations Children’s Fund (UNICEF), the United States Centers for Disease Control and Prevention (CDC), the Clinton Health Access Initiative (CHAI), the Asia–Pacific Network of Positive People (APN+), the International Treatment Preparedness Coalition (ITPC), Treat Asia and Médecins Sans Frontières (MSF). WHO was represented by staff from headquarters, and from the Regional Offices for South-East Asia and the Western Pacific and relevant country offices (See Annex 2 for list of participants).

2. Opening

2.1 Inaugural session

On behalf of the Ministry of Health, Myanmar, the meeting was opened by Dr Myo Khin, Director-General, Department of Myanmar Research (Lower Myanmar), Ministry of Health, Myanmar. After introducing the concept of the T2.0 framework and the current antiretroviral therapy (ART) provision in Myanmar, he highlighted that T2.0 will be the key approach to...
maximize scaling-up of antiretroviral therapy (ART) and HIV care services efficiently and effectively.

Dr Herbert S B Tennakoon, WHO Representative, Myanmar, delivered the message of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region. In his remarks, the Regional Director pointed out the need for more imaginative and innovative approaches to achieving the goal of universal access to HIV treatment and reaching the target of UN high-level political declaration at a time when financial resources are shrinking and there are calls for doing more with less. The T2.0 framework is designed to maximize the efficiency and effectiveness of HIV treatment through simplified and safe regimens and decentralized community-supportive care. He also stressed the role of communities and civil societies in expanding service delivery and decentralization to lower levels for early initiation of ART, better adherence and longer-term retention in care.

Additional opening remarks and welcome notes were given by Mr Steven Kraus, Director, UNAIDS Regional Support Team for Asia and the Pacific, and Dr Gottfried Otto Hirnschall, Director, Department of HIV/AIDS, WHO headquarters (WHO-HQ). Both speakers reiterated T2.0 as a key strategic framework for the battle against HIV and the importance of strong commitments, partnership and shared responsibility between governments, civil societies, developmental partners and UN agencies in implementing the T2.0 framework across countries.

### 2.2 Technical presentation on Treatment 2.0

Dr Nathan Ford, Coordinator Treatment 2.0, WHO-HQ, presented HIV/AIDS global targets, current global ART coverage, the concept of the T2.0 initiative and promising developments to implement T2.0 at country level.

The United Nations General Assembly High-Level Meeting on AIDS set new ambitious targets of reaching 15 million people on ART by the year 2015. The way to reach these targets with a current global ART coverage of 8 million (57% of those in need) will require further simplification of the model of care despite some success stories in Cambodia, Malawi and South Africa. T2.0 was developed to meet the challenges of ART scale-up by maximizing the efficiency and effectiveness of HIV treatment focusing on five priorities: (1) optimizing drug regimens; (2) advancing point-of-care (POC) and other simplified platforms for diagnosis and monitoring; (3) reducing cost; (4) adapting health service delivery systems; and (5) mobilizing communities.

**Figure 1: Priority work areas of the T2.0 strategy.**
Recent new evidence supports a move towards earlier initiation of ART for certain groups, for both prevention of HIV and tuberculosis (TB) transmission (treatment as prevention, TasP) and potential clinical benefits. The new potential approach of self-testing with a saliva-based test and potential cost benefits of optimizing antiretrovirals (ARVs) reaffirmed that T2.0 is more than just a vision, but is clearly helping to identify key advances in support of scale-up. Emerging breakthroughs in diagnostic testing and patient monitoring at POC (CD4 testing, viral load (VL) and early infant diagnosis (EID)) also bring hope to implementing T2.0 at primary care level. WHO is trying to provide a simplified guideline, safer drug options, preferably fixed-dosed combinations (FDC), with lowest drug toxicity and diagnostic techniques which can be used at community level. WHO has already issued guidance on couples’ HIV testing and counselling (HTC), including ART for treatment and prevention in serodiscordant couples in 2012, and the new consolidated HIV prevention, treatment and care guidelines will be released in 2013.

Dr Nathan Ford also indicated that while some countries, such as China and Viet Nam, have already implemented the concept of the T2.0 initiative, overall the translation of global principles of T2.0 into the national guideline in this Region was taking place slower than expected. It is estimated that the number of persons eligible for ART will increase with new evidence and new policies. Therefore, countries should also consider in advance for strategic choices to take advantage of new opportunities such as TasP in serodiscordant couples and KAPs. It was also highlighted that adopting T2.0 as a key initiative will require forward-looking policies and effective and more innovative approaches, together with further investments.

3. Setting the scene for Treatment 2.0 in the Asia–Pacific Region

At the outset, the objectives of the intercountry workshop were introduced and the expected outcomes shared with the participants. The general objective of the workshop was to develop a strategy and an action plan for implementing the T2.0 initiative in the Asia–Pacific Region.

Specific objectives were as follows:

- to orient participants to the T2.0 initiative and other technical updates for scaling up ART;
- to review current status, share experiences and lessons learnt for ARV scale-up at country level;
- to establish the Asia–Pacific T2.0 Steering Group and task teams;
- to develop an action plan for T2.0 in the Asia–Pacific Region, including a resource mobilization strategy.

The expected outcomes are:

- identification of priorities and draft action plan for T2.0 at regional and country levels;
- establishment of an Asia–Pacific Task Team for accelerating implementation of the T2.0 initiative, and endorsement of the task team’s terms of reference (TOR);
- scope and role of regional and country stakeholders.

3.1 Review of Treatment 2.0 in the Asia–Pacific Region

On behalf of WHO-SEARO and WPRO, Dr Dongbao Yu, WHO-WPRO, gave an overview on T2.0 in the Asia–Pacific Region in the context of the five pillars of T2.0. HIV/AIDS transmission in the Asia–Pacific Region has shown a decreasing trend over the past decade with an estimated
370,000 new infections in 2011 and about 4.9 million PLHIV. The epidemic seems to have been stabilized over the years and half of the people in need are receiving ART. A great diversity is noted in scaling up ART across the Asia–Pacific countries – ranging from the best coverage of 80% in Cambodia to the lowest of 24% in Indonesia and Nepal. However, almost all countries showed more or less the same percentage of treatment retention of around 70%.

**Figure 2: Trends of key HIV indicators in the Asia–Pacific Region, 1990–2011**

A review of HIV treatment and care services of the countries under the five pillars of T2.0 indicated that some countries are already making strides while others need to catch up.

- **ART regimens optimization:** all the countries within the Region have updated (or are updating) their national guidelines according to WHO 2010 recommendations. Phasing out the stavudine (d4T) regimen in Asia–Pacific countries is in progress, although some countries (notably Cambodia, Myanmar and Papua New Guinea) are still using d4T for more than 50% patients on treatment. Although all countries preferred to use FDC, tenofovir disoproxil fumarate (TDF)-based FDC is not widely available in most countries.

- **Laboratory testing and monitoring for POC diagnostics:** while countries in the Region are employing partially or primarily rapid test for HIV diagnosis, there is limited use of POC CD4 testing in most countries. VL measurements are currently not done at baseline due to limited availability and costs and this measurement is used for monitoring patients on treatment.

- **Cost reduction:** many countries in the Region use generic ARV drugs and countries such as China, India and Thailand, also have the capacity for production of these drugs. However, other countries import ARVs, both generic and patented.

- **Service delivery:** it is accepted that decentralization and integration are essential in delivering HIV care services; nevertheless, there is still substantial space for
optimization of HIV service delivery in different countries with different scenarios and health systems.

- **Mobilizing communities:** most countries involve affected communities as key stakeholders in policy formulation and programme development, but there is scope for strengthening engagement with communities and civil society stakeholders. It was stressed that the role of nongovernmental organizations (NGOs) and community-based organizations are not usually defined and most of them find it difficult to engage with the national system.

Suggested key priority actions for the Region are:

- expanding HTC;
- acceleration of d4T phase out;
- implementation of updated national guidelines – early initiation < CD4 350 or even earlier, TDF-based first-line treatment and use of FDCs;
- expanding POC diagnostics;
- decentralization of HIV services;
- linkages or integration of HTC, ART with other services;
- community support, especially for KAPs;
- testing initiatives such as treatment as prevention (TasP) and pre-exposure prophylaxis (PrEP) for key affected populations (KAPs) depending on the country epidemic context;
- strategic approaches are needed for scaling-up T2.0 in most countries with concentrated epidemics in the Region.

### 3.2 Feedback from TRIPs meeting

To implement the T2.0 initiative, which is also in line with newer WHO guidelines of TasP and PrEP of ARV at country level, it is clear that more resources will be required. In particular, improving access to affordable ARVs in Asia is one of the cornerstones in T2.0 initiative to support the efficient use of available resources.

Dr Bob Verbruggen, Regional Programme Adviser-Strategic Interventions, UNAIDS Regional Support Team for Asia and the Pacific, shared the summary findings, outcomes and follow-up actions from a regional workshop on the Use of TRIPS Flexibilities to Access Affordable ARVs in Asia held in Bangkok, Thailand, on 29–31 May 2012. The meeting helped enhance countries’ understanding of Trade-Related Aspects of Intellectual Property Rights (TRIPS), TRIPS flexibilities and the threat of TRIPS+ provisions, and allowed countries to draft country plans for the optimal utilization of TRIPs flexibilities by 2015, including protection against TRIPs+ provisions.

The rapid scale-up of ART has been possible thanks to many factors, among which increasing AIDS funding and decreasing ARV prices due to generic competition have been critical. However, funding for AIDS has flat lined (and international funding even decreased) in recent years. HIV/AIDS programmes in general, and ART programmes in particular, are largely donor-dependent in all lower income countries (LIC) and some middle-income countries (MIC) (e.g. Cambodia, Myanmar, Nepal and Viet Nam). Other countries, such as Indonesia, Malaysia and Thailand, fund most of their ART programmes from domestic resources. In either case, it is vital to keep the price of ARVs as low as possible to make rapid scale-up of ART programmes
affordable. The 2011 UN General Assembly High-Level Meeting on HIV/AIDS (HLM) and the Association of Southeast Asian Nations (ASEAN) Declaration of Commitment contain strong language in favour of “full use of TRIPS flexibilities and promotion of generic competition”.

The framework that determines the commercialization of medicines, including ARVs, is defined by the 1995 World Trade Organization (WTO) Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and the 2001 Doha Declaration on Public Health-related TRIPS flexibilities. Since 2001, various countries have adapted their legal framework to comply with the TRIPS agreement and make use of the public health-related flexibilities. India has been a leading generic producer since before 1995, providing over 85% of global ARV needs in low- to middle-income countries. Indonesia, Malaysia and Thailand have issued “compulsory licences for government use” to ensure access to generic ARVs (through import and/or local production).

The pre-workshop country mapping exercise showed important price differences between generic and originator ARVs, as well as for the same originator drug, depending on whether there was a “threat” to use a compulsory licence or not. Three countries in the Region – Cambodia, Myanmar and the Philippines – do not produce any ARVs domestically.

Most first generation ARVs are available as generic drugs. However, with the exception of the least-developed countries (LDCs), in most countries in the Region, patents have been filed or granted for newer generation first-line or second-line ARVs including tenofovir.

All countries except Myanmar have either created or amended their International Patent Law in line with the TRIPs agreement and its flexibilities. However, in most countries, the legal framework does not yet provide space to make full use of TRIPS flexibilities. Myanmar and Cambodia are not yet required to comply with TRIPs due to their LDC status; however, it is important for them to have legislation in place for optimal use of TRIPs flexibilities by the time their exemption expires.

A key concern is the proposal by high-income countries to include tighter “TRIPS+” provisions in Free Trade Agreements (FTA) (e.g. EU–India and Trans-Pacific Partnership Agreement). At the workshop, countries shared experiences and positions (India, Malaysia, Philippines, Thailand and Viet Nam).

Some of the recommendations of the workshop included certain steps listed as follows:

- Intellectual property rights (IPR) and access to vital medicines are everybody’s business. Countries need to increase awareness, preparedness and capacity.
- A multisectoral coordination mechanism involving all stakeholders including civil society is critical.
- All low- and middle-income countries should ensure that their national intellectual property legislation allows for optimal use of TRIPS flexibilities and protection against “TRIPS+” provisions.
- LDCs should ensure extension of their exemption period for IPR on medicines (even if they access WTO and develop adequate legislation).
- South–south collaboration, including experience sharing on trade negotiations and legal revision, technology transfers and joint research (e.g. within ASEAN), should be strengthened.

Since the workshop, the organizing TRIPS working group has continued their collaboration in support of the implementation of country action plans in Cambodia, China, Indonesia, Malaysia, Myanmar and Viet Nam. This working group is to be formalized under the T2.0
regional task team (RTT), while inviting other partners such as WHO and UNICEF. A key challenge is the dependence on a handful of legal experts to advise countries.

Further information may be obtained from the workshop web site: http://asia-pacific.undp.org/practices/hiv aids/trips-flexibilities-workshop-may2012.html

3.3 PLHIV networks activities – mapping summary

An overview of ongoing activities of PLHIV networks in selected areas within the Asia–Pacific Region was reported by Mr Shiba Phurailatpam, Regional Coordinator, Asia–Pacific Network of Positive People. These activities indicated the existing level of community engagement and the evidence of good practices through community-based service delivery programme. They also highlighted the gaps and needs for strengthening community engagements at local level.

Most high-burden countries in the Region (except Cambodia and Malaysia) are included in the network profiles. The main themes of the existing activities are advocacy, community-based service delivery and support groups. Several important activities are taking place under different categories. For example, HIV testing is one of the existing activities in China and India; monitoring and reporting activities such as treatment quality/hospital monitoring, drug quality and supply/stock-outs are being carried out in all networks except Myanmar.

As regards funding, most community-based delivery programmes (except Thailand) are insufficiently funded. Few countries include these services in their national strategies. Legal services such as property disputes and children’s access to education are largely provided through in-kind support while India and Nepal get support and linkages with networks of lawyers.

The coverage of network profiles mentioned is wide: 13 affiliated provincial groups in Papua New Guinea; 100–130 groups in China, Nepal and Viet Nam; approximately 10,000 individual members in Myanmar; 200,000+ members in India; 70,000 members in Thailand; 200+ individual members in the Philippines and 400+ individual members in Indonesia. Despite the fact that the network groups are providing an extensive range of services with model integrated programmes to affected and infected populations, limited or lack of government support and recognition is a key concern for ongoing activities.

Discussions following the presentation highlighted the need for possible integration of HIV testing and counselling (HTC) services through the community-based service delivery programmes to reach the services to KAP, especially people who inject drugs (PWID). However, the cost of HTC, legal issues of test kits being used by lay people and lack of taskshifting were cited as key barriers.

The key recommendations of the discussion include:

- consideration of community-based service delivery through PLHIV networks under country national strategy;
- expanding HTC service beyond the hospital and clinics into communities;
- supporting the community-based organization not only for advocacy but also for simple service provision such as HTC;
- providing capacity building training for the T2.0 initiative, HIV treatment regimens and drug toxicity to the care providers across all sectors.
4. Experience from countries

The representatives from 10 high-burden countries in the Asia–Pacific Region presented reports on the current situation of HIV control in individual countries, and country-specific experiences on opportunities and challenges for implementation of T2.0.

4.1 Country presentations

The following observations were made:

- despite the challenges in implementing T2.0 at country level, some have begun to adapt and implement the T2.0 approaches in their national responses to HIV;
- almost all countries reported late treatment initiation of ART (CD4 count <200 cells/mm³) that leads to poor treatment outcome, early mortality and HIV transmission;
- phasing out d4T is in progress but current usage is reported in most countries;
- there is limited use of POC diagnostics in most countries;
- more needs to be done for decentralization and integration in most countries for cost-effective service delivery through the T2.0 initiative;
- limited financial and human resources are “continuing challenges” in many countries.

Cambodia shared the evolution of health-sector responses, the model of HIV service delivery, experiences and challenges to get universal access to ART and what it took to get the prestigious UN Millennium Development Goals (MDGs) award. Cambodia has set its aim to eliminate new HIV infections by 2020 through a linked response that includes combination of ART as prevention, prevention of mother-to-child transmission (PMTCT) and targeted interventions for KAPs.

Cambodia also shared valuable lessons learnt as follows:

- knowing the country’s HIV epidemic is key to effective responses;
- community-initiated or peer-initiated HTC as key entry to the HIV treatment and care services for the community and KAPs;
- effective mobilization, coordination and linkage between the community, PLHIV and district health services facilitated the rapid expansion of HIV services.

The recent major challenges for Cambodia have been partner involvement, work overload with low salary, limited leadership and management capacity at subnational levels, fragmented health and community systems (PHC, TB, malaria, HIV, etc.) and financial sustainability.

China reported its new AIDS policy of “Test as intervention” and “Treatment as Prevention”. Since the main mode of transmission of HIV in China is sexual contact, “Treatment as Prevention (TasP)” was announced as a national strategy in 2011 and the specific focus is on serodiscordant couples. TasP with test and treat strategy has been initiated among target populations – serodiscordant couples, sex workers, MSM and PWID.
The current treatment guidelines in China are as follows:

<table>
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<th>Clinical criteria</th>
<th>CD4 level</th>
<th>Recommendation to treat</th>
</tr>
</thead>
<tbody>
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<td>Acute syndromes</td>
<td>Any level</td>
<td>Treat</td>
</tr>
<tr>
<td>WHO stage III/IV</td>
<td>Any level</td>
<td>Treat</td>
</tr>
<tr>
<td>Any WHO stage</td>
<td>≤ 350/mm³</td>
<td>Treat</td>
</tr>
<tr>
<td>Any WHO stage</td>
<td>350–500/mm³</td>
<td>Treat if:</td>
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<tr>
<td></td>
<td></td>
<td>1 higher VL (e.g. &gt;100 000 copies/ml);</td>
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<tr>
<td></td>
<td></td>
<td>2 rapidly declining CD4 (e.g. decrease &gt;100/mm³ per year), age &gt;65.</td>
</tr>
<tr>
<td>Any WHO stage</td>
<td>Any level</td>
<td>Treat if:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 coinfected with active HBV</td>
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<tr>
<td></td>
<td></td>
<td>2 HIV-associated nephropathy</td>
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<td></td>
<td></td>
<td>3 active TB</td>
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<td></td>
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<td></td>
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<td>5 HIV-positive in serodiscordant couples.</td>
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</table>

The main challenges in adapting T2.0 in China are:

- availability of FDC and generic formulation of ART drugs;
- active involvement of community-based organizations (CBOs) for HIV testing, effective follow-up and referral mechanism;
- multisectoral collaboration and integration between HIV programmes and the health system for management of co-morbidities, PMTCT and methadone maintenance therapy (MMT).

India has already been implementing most of the activities outlined in the T2.0 framework. The main issues facing the county include:

- maintaining quality of care and POC diagnostics– availability of CD4 machines and diagnostic facilities for EID;
- the need for further decentralization and expansion of ART services and legislative issues related to task shifting, for example, nurses in India cannot prescribe legally;
- increasing costs of newer ARV drugs;
- standardization of care in other facilities – intersectoral, defence and paramilitary forces;
- budget distribution for incremental rise in treatment costs with increased testing and coverage since India is spending three quarters of resources in HIV prevention activities.

Indonesia reported limited availability of CD4 machines and VL testing, inadequate decentralization for ARV provision at peripheral level and patchy community involvement in HIV prevention and care services as key barriers for adapting and implementing the T2.0 framework.

Malaysia reported its current issues of HIV response in implementing T2.0: d4T is still being used as a short-term measure and will be replaced with TDF-based regimen in the near future;
compliance is a big issue in homeless mobile PLHIV; service delivery system has not been fully integrated between the programmes (needle exchange programmes, MMT, TB and PMTCT). TasP in discordant couples has been introduced as premarital testing and is mandatory in Malaysia. As regards POC diagnostics, CD4 machines will be available at district level by 2013. Mobilizing services at community level through NGOs and CBOs and decentralized service delivery will help reduce the gap for access to services between the rural and city populations. Offering counselling services by trained nurses beyond office hours helps in increasing access and availability of HTC.

Myanmar expressed its view that T2.0 is an opportunity to expand the HIV services, although several challenges remain. These challenges include: inadequate ART coverage (only 30% of patients in need are on treatment); limited financial and human resources; limited availability of POC diagnostics and monitoring tools; weak coordination and integration with other sectors; and an inadequate individual patient tracking system from diagnosis to treatment, including follow-up and referral. Stigma and discrimination remain big challenges to assess those in need, particularly KAPs, for providing services.

Nepal also briefed on the situation of HIV responses emphasizing limited human and financial resources.

Papua New Guinea shared their barriers in scaling-up of HIV services under the T2.0 framework. Regarding POC diagnostics, CD4 machines are not available at the peripheral level for monitoring of disease, despite the fact that rapid HIV testing has already been introduced in 400 countrywide testing sites since 2010. Inadequate monetary and human resources for restructuring health system are identified as “continuing challenges” to speed up HIV responses in Papua New Guinea.

Thailand noted the recently held National Consultation on Strategic Uses of ARV and identified steps to be followed that also embrace the T2.0 framework, TasP and PrEP. Thailand plans to improve the service delivery through policy changes on testing and treatment, that is equity of treatment in migrants, non-Thai, youth under 18, decentralization and task-shifting. Ongoing consultations are being carried out to treat all HIV-infected pregnant women with option B+, seropositive partners regardless of CD4 count, infected KAP regardless of CD4 count and seronegative KAPs for PrEP. Operation research will be done as pilot studies for HTC among KAPs; test and treat for all KAPs and PrEP. Thailand also discussed some important issues in scaling up of HIV services: low uptake of voluntary counselling and testing (VCT) (parental permission is needed for HTC that leads to delayed HIV treatment in youth below 18 years of age); limited access to ARVs among migrants and disconnect between public health services; and community prevention programmes, stigma and discrimination.

Viet Nam is proactively adapting the T2.0 pillars to maximize therapeutic and preventive benefits of ART through expanded ART coverage, earlier ART initiation and long-term retention. The pilot study has already been conducted in two provinces with priority activities under five pillars. Additional components of the elimination of mother-to-child transmission (of HIV; PMTCT), early ART initiation for prevention of serodiscordant couples and costing study were also included in T2.0 pilots. Capacity-building and preparation for POC diagnostics, decentralization and integration of HIV services and community mobilization activities are in process as an early phase for implementation of T2.0 within the country. Meanwhile, Viet Nam enhanced the synergy between HIV prevention and treatment. Financial sustainability is a major concern for Viet Nam, as it is now accorded middle income country (MIC) status with fewer opportunities for accessing donor funding while the national ART programme is heavily funded through external resources. Viet Nam is promoting the most efficient and cost-effective service delivery models in implementing HIV services through pilot initiatives using the T2.0 service delivery approaches.
5. Expanding HTC in concentrated epidemics

Dr Nicole Seguy, HIV/AIDS Team Leader, WHO-China, shared the importance of HTC in scaling up of HIV services and new WHO guidance on HTC and the ways to improve HTC coverage with WHO recommended HTC strategies in concentrated and low-level epidemics.

Achieving countries’ commitments towards zero new HIV infections by 2015 cannot be realized unless the countries scale up HTC and earlier initiation of ART. HTC is a key entry point to HIV services. Thus, timely knowledge of HIV status is essential for expanding access to HIV treatment and prevention and improving HIV/AIDS treatment outcomes. It is expected that more than 80% of PLHIV should be informed of their results to achieve the international goals of HIV.

In the Asia–Pacific Region, testing uptake is still very low, particularly among KAPs, and less than 50% of PLHIV know their status despite the fact that major progress has been made over the years. Limited demands for testing and testing opportunities are key challenges for increasing HTC coverage.

Successful Asian pilot studies – community-based HTC in China, mobile HTC in Viet Nam, peer-led HTC in Bangkok – for scaling up HTC among KAPs were also shared with participants.

The presenter indicated “finding most people who are HIV+” as a goal with three main strategies: reaching those high-risk groups and partners of known PLHIV; demand creation; and service improvement in terms of policy and quality. WHO recommended the following HTC strategies to improve HTC coverage in concentrated and low-level epidemics:

- expand and diversify testing options and settings; facility-based HTC and community-based HTC, including outreach to KAP; and home-based testing;
- simplify testing – not only by health staff but also by CBO staff (peers) using rapid tests at point of services;
- conduct regular testing for people with high-risk behaviour and combine with other tests such as syphilis;
- support couple HTC/disclosure to sexual partners detected positive;
- increase demand: for example, using the Internet to encourage MSM to seek services;
- improve appropriate follow-up and support to obtain final test result and CD4 and ensure link to care and treatment through CBO-health services collaboration;
- respect privacy, confidentiality and non-discrimination.

In conclusion, the presenter urged the countries to revise their national HTC strategies and tools for training and quality assurance mechanism in expanding HTC services. The importance of integration with NGOs/CBOs/peer educators was stressed for scaling-up of HTC and earlier initiation of ART. Countries are encouraged to address HTC as an entry point and strengthen monitoring and evaluation system to assess the efficiency of the prevention-test-treat cascade.

5.1 Innovative approaches for expanding HTC and identifying positive

After the presentation of HTC expansion in concentrated epidemic, five working groups were formed to identify opportunities, challenges and resource needs for increasing the proportion of PLHIV who know their HIV status in order to reach the HIV care and treatment–related targets by 2015 and to maximize preventive benefits of ART.

Most countries identified mobilizing CBOs, peer counsellor/educators, religious leaders, faith-based organizations, NGOs and KAP networks for creating and enabling environment and
trusted entry points to scale up HTC services. Apart from the traditional HTC testing strategies, an outreach camp approach, mobile testing and Internet or mobile SMS services using technology were reported as innovative approaches for HTC. Malaysia, Nepal and Thailand mentioned that for PWID HTC services should integrate with Methadone maintenance therapy (MMT), opioid substitution therapy (OST) and other harm reduction services and also include other related agencies such as police and anti-drug department.

The main challenges highlighted included: access to KAPs and their willingness for HTC; building institutional capacity such as skilled workers, simplified diagnostic tools, a procurement system and quality assurance for HTC; integration of programmes and linkages to follow-up services and funding; legal barriers; stigma and discrimination. There was need for technical assistance (TA), training and updates on HTC guidelines, financial and human resources.

There was a consensus that scaling up of HTC among KAPs and young active population through community-based testing would be cost-effective to find those infected earlier and at higher CD4 levels that can further reduce transmission of HIV and yield better clinical outcomes. Countries are encouraged to establish better linkages between HIV services and community. It is expected that research or sentinel survey at country level will provide better evidence for these innovative strategies.

6. **Establishment of an Asia–Pacific Task Team on Treatment 2.0**

The background, main purposes and future activities of the proposed RTT for accelerating the implementation of the T2.0 framework were introduced. During the session, the objectives, outcomes, membership, secretariat support and key activity areas of the RTT were shared, discussed and revised. The initial proposal of having a two-tiered structure was rejected by most of the participants and it was suggested to have a one-tiered RTT. For the purpose of efficiency and effectiveness, it was agreed to have more virtual discussions and interactions through an online portal like Sharepoint. The face-to-face meeting would be limited to not more than once in 18–24 months. The RTT would be set up until the end of 2015 when the need, structure and function would be reviewed. The terms of reference (TOR) were reviewed in a latter session after the identification of country and regional priorities.

6.1 **Country priorities**

The country participants identified innovative country priority areas to face the challenges for scaling up of HIV responses within the five pillars of the T2.0 framework. Under each pillar, most countries depicted the gaps/challenges, priority action, timeline, country resource and TA needs at regional and/or global level. They were also asked to select the top three priorities for the regional level from the country priorities identified. Annex 3 shows the detailed information on country and regional priorities identified by the Member countries.

6.2 **Regional priorities**

Regional priorities were identified from the country priorities presented.

*Proposed priorities for the Regional Task Team include:*

(1) Promote access to affordable drugs and diagnostics by following ways:

- legal framework related to IPR/TRIPS;
- domestic production;
OPTIMIZING HIV TREATMENT THROUGH THE TREATMENT 2.0 INITIATIVES

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PSM, including international bidding and pooled procurement;
- dialogue with pharmaceutical industry;
- mobilizing high-level political leadership.

(2) Improve access to key diagnostics and lab monitoring technologies:
- quality assurance (QA), including standard operation procedure and algorithm – HIV diagnosis, CD4 and VL – especially Point of care (POC) technology (rapid test);
- diagnosis of co-morbidities – hepatitis B virus (HBV), hepatitis C virus (HCV), syphilis and TB;
- mobilize political leadership to adopt POC technologies, including professional exchange.

(3) Promote innovations to support service delivery, including diversification of HTC, decentralization and integration:
- mobile/outreach/community-based HTC, especially for KAP, and partner HTC. Migrants constitute vulnerable groups in many countries and innovations for their inclusion in HIV prevention, care and treatment are important;
- taskshifting (involvement of non-health-care workers);
- decentralization and integration;
- community mobilization/community outreach for KAPs.

(4) Ensure strategic information, operational research and knowledge sharing by the following measures:
- monitoring and evaluation of quality, progress and impact;
- operational researches on innovative approaches;
- pharmacovigilance and HIV drug resistance monitoring;
- knowledge-sharing through unified database – pricing, best practices and treatment matters;
- development and maintenance of a regional database on treatment access.

6.3 Terms of reference of Regional Task Team for Treatment 2.0

After setting the priorities areas for Asia-Pacific RTT, countries and partner representatives brainstormed and revised the proposed TOR during the session. The draft TOR is shown in Annex 4.

7. Panel discussion with civil society and development partners

A panel discussion focused on the implementation of T2.0 in the Asia-Pacific Region with the representatives from civil society and developmental partners: UNAIDS, UNICEF, CDC, CHAI, Treat Asia, ITPC, MSF and APN+.
The key discussion points are summarized as follows.

- The Asia–Pacific Region can give a realistic hope for catalysing the next phase of HIV treatment response towards eradicating AIDS.
- All partners expressed a positive view and commitment on the T2.0 initiative which can embrace all the HIV responses (eMTCT, TasP and HIV-related co-morbidities) despite clear challenges.
- The strong political leadership, involvement of civil societies and collaboration between national AIDS programmes and developmental partners can become the key drivers of this initiative.
- Political leadership and civil society organization involvement for facilitative legal frameworks that promote HTC for young KAPs (<18 years); access to affordable drugs through TRIPs flexibility or price negotiation with drug companies; mitigation of impact of HIV on PLHIV and their family in an environment free from stigma and discrimination.
- Community and civil society participation is critical in implementing all the five pillars of the T2.0 framework (advocacy, HTC, POC diagnosis, prevention and treatment literacy, follow-up and referral, adherence and nutritional support).
- Intensification of HIV testing and counselling is identified as the top priority for the Region in detecting positives – an innovative approach/strategy is indispensable to reach KAPs and young active population.
- Availability of diagnostic and monitoring tools is accepted as “a continuing challenge” and it is expected to be overcome in the near future.
- RTT will provide support as a sharing platform network for good practices and lessons learnt from the countries within the Region.
- Enhancing RTT with other working groups is critical to avoid duplication.
- Countries are encouraged to do analysis of cost-effectiveness of the programmes; share the ongoing experiences in responding to the epidemic; share challenges and request help from the funding agencies, particularly The Global Fund to Fight AIDS, Tuberculosis and Malaria, according to the needs.

8. Closing session

The closing remarks were delivered by Dr Iyanthi Abeyewickreme, WHO, and Dr Bob Verbruggen, UNAIDS, who acknowledged the valuable comments for developing the RTT’s TOR and the tremendous progresses made at country level in implementing the T2.0 framework. WHO also stated that the RTT’s TOR will be finalized and distributed to participants of the meeting for review and feedback. WHO-SEARO will also explore the possibility of setting up a Sharepoint site for the T2.0 RTT with the ICT Unit.
Annex 1

Agenda

(1) Objectives of the meeting
(2) Treatment 2.0 in the context of Asia Pacific
(3) Feedback from TRIPs Meeting
(4) Role of communities
(5) Country presentations – opportunities and challenges for scaling up T2.0
   - Cambodia
   - China
   - India
   - Indonesia
   - Malaysia
   - Myanmar
   - Thailand
   - Viet Nam
(6) Expanding HTC in concentrated epidemics
(7) Innovative approaches for expanding HTC and identifying positives
(8) TORs of the Proposed Regional Steering Group and task team
(9) Country priority setting
(10) Synthesis of country priorities
(11) Regional priority areas based on identified country priorities
(12) Role of civil society organizations
(13) Role of development partners
(14) Conclusions and recommendations
### Annex 2

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## Annex 3

### Country and Regional priorities

<table>
<thead>
<tr>
<th>Country</th>
<th>Optimize drug regimens</th>
<th>Simplified diagnostics</th>
<th>Reduce costs</th>
<th>Adapt delivery systems</th>
<th>Mobilize communities</th>
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<tbody>
<tr>
<td>Cambodia</td>
<td>D4t phase out</td>
<td>Expanding POC CD4 and Viral load</td>
<td>Price reduction of first line</td>
<td>Identify costed minimum service package of interventions</td>
<td>Access to and retention in care of mobile population</td>
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<td>Improved forecasting and projection of drugs and diagnostics</td>
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<td>Improving quality of services</td>
<td>Strengthens informal and formal community networks</td>
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<td>Documenting experiences</td>
<td>Engage public security agencies for supporting key populations</td>
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<td>Strengthening strategic information</td>
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<td>Active case-finding and follow up of positive pregnant women</td>
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<td>China</td>
<td>TDF based first line</td>
<td>Expand new strategies for HIV testing</td>
<td>Price negotiation for reducing TDF price</td>
<td>Analysis of existing challenges in service delivery – potential roles of CBOs, strengthen coordination across programmes led by MoH</td>
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<td>Option B+ (TDF based triple regimen) for positive pregnant women</td>
<td>Peer led rapid tests for MSM</td>
<td>National capacity for producing generic TDF bases triple combination</td>
<td>Establish Govt – CBO cooperation mechanisms</td>
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<td>Decentralized testing approaches – engaging township and village level</td>
<td>Ask Indian companies to register paediatric ARVs in CHN</td>
<td>Establish country task force on T2.0</td>
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<td>India</td>
<td>D4t phase out; reducing cost of FDCs, monitoring drug toxicities at sub-national level</td>
<td>PITC in ANC settings; expanding POCs and reducing costs, expansion of facilities for VL measurement, field testing of home based testing kits</td>
<td>Continued use of TRIPS flexibilities to reduce cost of ARV</td>
<td>Piloting of cost-effective service delivery model for standardize care in health care settings. Mobilizing MARPs through outreach services to access ART services</td>
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<td>Exemption of statutory taxes and import duties etc</td>
<td>Capacity building of health care providers in general health care system presently not in HIV care</td>
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<td>Generate competition for Propriety item</td>
<td>Continue the present work on community engagement</td>
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<td>Unified model of care and support</td>
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<td>Functional integration with general health care delivery system</td>
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<td>Centralise bulk procurement and efficient supply chain management</td>
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<td>Put the MDG 6 (+4 +5) target as the responsibility of the Ministry of Home Affairs down to district to decentralize HIV prevention, care and treatment at district level</td>
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<td>Indoneisa</td>
<td>D4t phase-out</td>
<td>Provision additional POC CD4 machines</td>
<td>Put the MDG 6 (+4 +5) target as the responsibility of the Ministry of Home Affairs down to district to decentralize HIV prevention, care and treatment at district level</td>
<td>Involving KAP organization into service delivery system (in Papua FBO will be more suitable) to increase demand to health care</td>
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<td>More involvement of professional organization to disseminate the new ART CL</td>
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<td>Include HIV care in the HF accreditation requirement</td>
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<td>Maldives</td>
<td>Tenofovir based regimen &amp; once a day regime to become a preferred choice&lt;br&gt;Revision of existing ART guidelines&lt;br&gt;Training of primary care providers – doctors/ pharmacist/ nurse counsellor</td>
<td>Expansion of HCT to both community based and health provider by using simpler rapid test e.g oral-quick HIV test for KAP&lt;br&gt;Mobile VCT to higher education institution / national training services with education campaign/ survey - to capture youth at risk&lt;br&gt;Providing cheaper CD4 at peripheral clinics</td>
<td>Government to negotiate the price reduction of CD4 and VL&lt;br&gt;Alternative suppliers&lt;br&gt;Use of generic drugs through CL</td>
<td>Use mail services ART dispensing from PHC&lt;br&gt;Participation of CBO&lt;br&gt;Part of KPI of health providers&lt;br&gt;Strengthen existing public health services (PMTCT/MMT/ needle exchange/STI/ SRH/ TB/ART treatment)&lt;br&gt;Upgrade existing web-based surveillance and treatment outcome at local and central levels</td>
<td>Web-based communication&lt;br&gt;Training peer educators/ other stake holders&lt;br&gt;Provide incentives - output based.&lt;br&gt;Regular annual meeting for planning, review progress and achievement/ innovation</td>
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<td>Myanmar</td>
<td>Need to do country situational assessment on ART service provision&lt;br&gt;Strengthening of PSM (Forecasting, quantification)&lt;br&gt;Promotion of better procurement &amp; delivery by suggesting for pool procurement system setup</td>
<td>Decentralize lab services up to sub-bp level HCW&lt;br&gt;Strengthen the referral linkage with peer &amp; outreach activities&lt;br&gt;Development of SOP &amp; guidelines&lt;br&gt;Utilization of simplified diagnostic &amp; monitoring tools</td>
<td>TRIPS core working group formed&lt;br&gt;Review of draft IP-laws</td>
<td>Strengthen the Integration&lt;br&gt;Expansion of COC&lt;br&gt;Community based testing &amp; treatment programme&lt;br&gt;Capacity building for decentralization (IMAI)</td>
<td>Capacity building for community action&lt;br&gt;Strengthen the linkages among the implementing partners</td>
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<td>Nepal</td>
<td>D4t phase out&lt;br&gt;Switching to FDC&lt;br&gt;Training of health care providers&lt;br&gt;Treatment literacy for patients and their caregivers</td>
<td>Expanding use of POCs for CD4&lt;br&gt;Review of regulatory framework for decentralizing POC diagnostics</td>
<td>Due to high cost of procurement through global mechanisms, explore possibility of horizontal procurement from countries that produce generics&lt;br&gt;Exploring possibilities for domestic production</td>
<td>Geographic challenges, mobile populations, increased work load, lack of use of data for local decision making are some of the main challenges. To address these, explore possibilities of virtual training, on-site mentoring, use of technology for data collection, analysis and use and also for patient tracking and monitoring</td>
<td>To reduce stigma and discrimination and increase access for vulnerable population, link community based services to health care delivery systems</td>
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<tr>
<td>Country</td>
<td>Optimize drug regimens</td>
<td>Simplified diagnostics</td>
<td>Reduce costs</td>
<td>Adapt delivery systems</td>
<td>Mobilize communities</td>
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<td>Papua New Guinea</td>
<td>Order FDC in next ARV consignment Optimizing Global Fund R10 resources (Training/supervision) part of HR support High level advocacy for resource (government/development partners) mobilization to cover HR and operations Review/dialogue on capitalizing on $80m rural health improvement programme to strengthen decentralization</td>
<td>Engage the provincial hospitals in HIV service planning Support NGOs/FBOs HIV services planning Synchronizing type of CD4 machines purchased Move to PIMA Buy VL machines</td>
<td>Help review the TRIPS legal framework</td>
<td>High level advocacy for resource (government/development partners) mobilization to cover HR and operations Review/dialogue on capitalizing on US $ 80m rural health improvement programme fund to strengthen decentralization Engage the provincial hospitals in HIV service planning -Support NGOs/FBOs HIV services planning</td>
<td>High level dialogue to strengthen coordination of communication engagement Mobilize funding More use of PLWHIV for advocacy/service delivery and training Mapping of KAP and encourage HTC services using networks</td>
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<td>Thailand</td>
<td>D4T phase out Dose reduction of ARVs to reduce toxicity and cost eg. Efavarenz, LPV/r fixed-dosed combination with Tenofovir based</td>
<td>Promote better understanding of using a rapid test among stakeholders Develop a guideline of a same day result and rapid test use and policy support Provide CD4 count with test result at the same day</td>
<td>Dose reduction of ARVs to reduce toxicity and cost Ensure that Thailand is not excluded from the medicines patent pool Operational research for costing different models of service delivery</td>
<td>Decentralization of HTC: community-based, task shifting, engage communities in outreaching approach eg. village health volunteer to promoting early testing Positive prevention by peer group Using website or SMS to promote access to service delivery Integration of MMT with HTC</td>
<td>Community self-help group Decentralization of HTC: community-based, task shifting, engage communities in outreaching approach eg. Village health volunteer to promoting early testing PCM mechanism which is composed of government representatives and KAPs in that area Promoting ownership by local governments to take more active roles in HIV prevention in their responsibility district</td>
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<tr>
<td>Country</td>
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<td>Viet Nam</td>
<td>d4T phase-out – by end 2012 in 2 provinces, by end June 2013 in whole country. Include TDF/3TC/EFV “3 in 1” FDC in EML and list for health insurance.</td>
<td>True POC-HIV diagnosis (rapid test algorithm) Expanded use of POC CD4 in remote districts/communes Introduction of POC VL (as price decreases) Further expansion of gene expert EID capacity building at lower level of health facilities</td>
<td>Promote efficient and cost-effective service delivery models travel cost ↓ due to decentralization, OI treatment/hospitalization cost ↓ due to earlier treatment initiation Staffing cost ↓ due to integration of services Capitalize on TRIPS flexibilities Cost analysis, provincial AIDS spending analysis (PASA)</td>
<td>Decentralize to commune health station, based on burden (e.g. reported cases) and based on key informants. Integrate/linkage services to establish “one-stop” services Starting with HTC-MMT-ART Further improve linkage with TB, MCH and ST</td>
<td>Engaging HIV prevention outreach, peer educators, village health care workers, PLHIV, KAP: To reach out to key populations, To create demands for earlier/regular HTC and timely ART initiation by talking the benefits of doing so To link to health facilities for HTC, treatment, care Developing treatment literacy materials Further supporting peer educators/home-based care teams: To support adherence and retention across continuum of prevention and care</td>
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**Proposed priorities for Regional Task team**

1. **Access to affordable drugs and diagnostics:**
   - legal framework related to IPR/TRIPS;
   - domestic production;
   - PSM, including international bidding, pooled procurement;
   - dialogue with pharmaceutical industry.

2. **Diagnostics and laboratory monitoring technologies:**
   - QA, including SOP and algorithm - HIV diagnosis, CD4, VL – especially POC technology (rapid test);
   - diagnosis of co-morbidities - HBV, HCV, syphilis, TB;
   - mobilize political leadership to adopt POC technologies, including professional exchange.
(3) Bring innovation to service delivery, including diversification of HTC, decentralization, integration:

- mobile/outreach/community-based HTC, especially for KAP, and partner HTC;
- task-shifting (involvement of non-HCW);
- decentralization and integration;
- community mobilization/community outreach for KAPs.

(4) Strategic information, operational research and knowledge sharing:

- monitor and evaluation of quality, progress and impact;
- operational researches on innovative approaches;
- pharmacovigilance, HIV DR monitoring;
- knowledge sharing through unified database – pricing, best practices, treatment matters;
- cost analysis – efficiency, sustainability.

**Comments from audience**

- Modelling study to support decision makers – cost of action/inaction.
- Mobilize high-level political leadership/commitment (need to reach grass-roots level):
  - reduce stigma, mobilize resources, catalyse changes;
  - Protect/promote/fulfil human rights.
- Public–private partnership.
- Addressing stigma, discrimination and other barriers for KAP to access HIV services.
- Regional database on treatment access.
Annex 4

Draft Terms of Reference for Regional Task Team on Treatment 2.0 for Asia and the Pacific

Background

In the Asia–Pacific Region, at the end of 2011, the number of people living with HIV receiving ART in Asia and Pacific has increased steadily from 280,000 in 2006 to 1,075,272 in 2011 out of 2,367,515 in need. However, the Region continues to lag behind the global average of 47%, and an estimated 1.5 additional million people need to access ART by end 2015 for the Region to achieve its share of the 2011 Political Declaration target of 15 million by 2015.

Most people living with HIV are still starting treatment too late for it to fully exert its benefits for themselves and for their intimate partners. Early and equitable access to diagnosis and treatment is hampered by stigma, discrimination and punitive laws and by lack of accessible service delivery points. Limited access to rapid diagnostic technology and poor linkages between HIV prevention, counselling and testing and treatment and care services compound delayed initiation of ART.

Vertical service delivery also hampers effective linkages between ART and prevention of parent-to-child transmission services and the treatment of co-morbidities (e.g. tuberculosis, viral hepatitis), reflected in regional coverage lagging behind global averages.

Furthermore, with the decrease of international AIDS funding since 2010, countries are facing financial constraints to continue scaling up towards and sustaining universal access to ART. Finally, countries are facing new challenges to produce and/or procure affordable generic ARV drugs using the flexibilities embedded in the 2001 Doha Declaration on the TRIPS Agreement and Public Health.

At the same time, there are unprecedented opportunities to accelerate treatment scale-up.

The 2010 WHO Guidelines recommend starting treatment at a CD4 cell count of 350/mm³ and proposes more effective and better-tolerated first-line ARV regimens.

In July 2010, UNAIDS and WHO jointly launched the Treatment 2.0 initiative as a platform to radically simplify and catalyse scale up of ART through combined action on five priorities: optimizing drug regimens, advancing point-of-care testing and other simplified platforms for diagnosis and monitoring, simplifying and decentralizing delivery systems, and mobilizing communities and protecting human rights, and saving costs. Specific roles of the regions and countries remain to be defined.

The Political Declaration endorsed by all Member States at the June 2011 High Level Meeting includes the ambitious targets of putting 15 million people on ART by 2015 (or 80% of the expected number of eligible people by then) and to reduce mortality due to TB among PLHIV by 50%. The Declaration also encourages optimal use of TRIPS flexibilities to facilitate access to ARVs and commits countries to bridge the AIDS funding gap by 2015.

The results of the HPTN052 trial give compelling evidence that early treatment effectively contributes to prevention of sexual transmission of HIV and hence puts ART firmly into the package of HIV prevention options.

Treatment as prevention is the term used to describe HIV prevention methods that use ART in HIV positive persons to decrease the chance of HIV transmission independent of CD4 count.
Treatment 2.0 looks at ways to provide better services to a larger number of persons at lesser cost and in a way that helps to retain them on lifelong ART. This would greatly benefit prevention efforts.

**Goal**

To reduce the regional burden of HIV and narrow the treatment gap through accelerated implementation of the Treatment 2.0 framework of action in the Asian–Pacific region and generation of evidence based policy and programme guidance to help countries reach the HIV Care and Treatment related targets committed in the June 2011 Political Declaration:

- to reach 80% of PLHIV eligible for ART;
- to reduce deaths due to tuberculosis among PLHIV by 50%.

**Guiding principles**

- Informed by and responsive to country plans, needs and context;
- Promoting human rights based and equitable responses;
- Community involvement and ownership;
- Action- and results-oriented with clear roles and accountabilities;
- Simple and low-cost operating procedures.

**Objectives**

- Advocate and support mobilization of national leadership, communities, donors and other partners;
- Promote policy and programmatic coherence and collaboration among key stakeholders;
- Provide technical guidance for the operationalization and adaptation of global policies and guidelines and monitoring implementation;
- Promote and support stronger operational linkages among HIV prevention, testing, care and treatment services and between HIV and TB, PHC, MNCH/SRH, NCD services;
- Document and promote exchange of best practices and experience among members and other stakeholders.

**Structure and composition**

*Regional Task Team (RTT)*

The aim of the RTT is to decide on and update the overall regional strategic direction and priorities, and to guide and oversee the activities and deliverables of the thematic working groups.

Membership will include senior officials from HIV country programmes and one representative each from UNAIDS RST, WHO SEARO and WHO WPRO, UNDP, APN+, USAID, CDC, ASEAN, SAARC and SPC (South Pacific Community) secretariat are also proposed (pending further discussion).
The RTT will meet virtually every six months and face to face every 12–18 months to review progress, review and revise priorities, and provide updated guidance for the Thematic Working Groups.

**Thematic Working Groups (TWG)**

The aim of the Thematic Working Groups are to plan and provide technical support activities and products as identified by the Regional Task Team.

Membership to the task teams will be based on individual expertise in areas relevant to T2.0 work streams. Members will include experts from countries, WHO, UNAIDS, UNDP, CHAI, CDC, USAID, FHI, AusAID, National Centre for Global Health and Medicine, Japan, APN+, ITPC, Treat Asia, MSF, any other agencies as relevant.

The TWG will meet face to face once in 12–18 months together with the RTT. Virtual meetings will be held at least once every three months and as needed to implement each TWG’s action plan.

Updates from all TWGs will be posted on the dedicated Sharepoint for the Regional Task Team. The Secretariat will be responsible for maintaining the Sharepoint online workspace.

**Secretariat**

The UNAIDS Regional Support Team and the WHO Regional Offices for South-East Asia and Western Pacific will share Secretariat functions for the Core Group and the Task Teams. WHO and UNAIDS Country Office staff will support the work of the Secretariat.

**Duration of the Steering Group and Task Teams**

The Regional Task Team will initially be formed until the end of 2015.

**Possible priority areas of work**

1. Support to T2.0 and effectiveness of service delivery and phased implementation through:
   a. Expanding HTC service including partner and couples HTC;
   b. Introduction of point of care testing;
   c. Adaptation and implementation of treatment guidelines including:
      i. introduction of treatment as prevention (TasP) through multicountry demonstration projects/implementation research and phased implementation;
      ii. simplified service delivery, improved service linkages/continuum of care, decentralization;
      iii. community involvement for generating demand and improving adherence; community-based testing and treatment services; linkages with KPR prevention services.
   d. Improved management of coinfections (HIV–TB, hepatitis B and C)
(2) Optimization of use of TRIPS flexibilities and other mechanisms to expand and sustain access to affordable ARVs:
   a. advocacy for and development of country capacity and action plans on optimizing the use of TRIPS flexibilities;
   b. sharing of experiences, South–South cooperation, pooled procurement;
   c. feeding back of regional agenda and experiences towards the global level.

(3) Increased (efficiency of) funding for ART (as part of evidence-informed, prioritized and adequate funding for country responses):
   a. country needs estimates, resource planning and mobilization;
   b. increased service delivery efficiency.

(4) Operations research and monitoring and evaluation:
   a. support to national operations research;
   b. monitoring and evaluation of impact;¹
   c. development of a multicomponent regional treatment database;
   d. joint reviews and reports.

(5) Knowledge sharing, good practice publications.

Possible activities and deliverables of the Regional Task Team

- Regular review, progress monitoring and update of the work plans and activities of the RTT and the TWGs.
- High-level advocacy and communication with national and international stakeholders.

Possible activities and deliverables of the Technical Working Groups
(as per respective workplans)

- Regular virtual meetings to implement agreed workplan.
- Manage communication to and from countries and other relevant stakeholders.
- Follow-up and monitor progress including progress reviews, good practice publications.
- Targeted advocacy products for use with governments, communities, donors, global partners.

¹ Non-exhaustive list of areas which should gradually be included (besides the U/AGAPR indicators on coverage and retention):
ARV regimens 1st/2nd/3rd line, ARV availability/stock-outs, procurement mechanisms and prices,
ARV resistance
Equity (access for KPR and other vulnerable groups, rural areas etc.), affordability/cost, quality, S&D/human rights violations
Reduction of HIV incidence and prevalence
Reduction of HIV and non-HIV associated comorbidities and deaths
Survival and quality of life
- Technical briefings and workshops.
- Technical support missions in countries.
- Exchange visits and other south-to-south cooperation activities.
- Develop and maintain a regional treatment database.
The World Health Organization's Regional Office for South-East Asia in collaboration with its Western Pacific Regional Office and UNAIDS Regional Support Team for Asia and the Pacific, Bangkok, organized an intercountry workshop on improving treatment access through the Treatment 2.0 initiative on (13–14 September 2012) in Yangon, Myanmar. The workshop brought together participants from 10 countries in the Asia–Pacific Region including Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, Papua New Guinea, Thailand and Viet Nam; development partners Clinton Health Access Initiative, United States Agency for International Development (USAID), and Centers for Disease Control and Prevention (CDC); UN agencies the United Nations Children’s Fund (UNICEF) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) and civil society partners Asia–Pacific Network of Positive People, Therapeutics Research, Education, and AIDS Training in Asia, International Treatment Preparedness Coalition and Médecins Sans Frontières. This report summarizes the challenges and opportunities for scaling up antiretroviral treatment in the Asia–Pacific Region. It also highlights the discussions and agreements on setting up a regional task team for Treatment 2.0.

Optimizing HIV Treatment through the Treatment 2.0 Initiatives

Report of the Intercountry Workshop
Yangon, Myanmar, 13–14 September 2012