Gaboron, Botswana
16-18 November 2005

Comprehensive Response to HIV/AIDS Prevention and Care

Thailand-Africa Partnership

Workshop Report

Ministry of Foreign Affairs of Thailand

UNDP Thailand

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Design and layout by Keen Publishing (Thailand) Co., Ltd.

ISBN: 974-94231-2-7

FOREWORD

The social and economic costs of HIV/AIDS are enormous. It is a problem that is not merely limited to health; it is also a clear threat to global human security.

The challenge of HIV/AIDS to humankind was reconfirmed when the High-Level Panel on Threats, Challenges and Change identified in its 2004 report that HIV/AIDS is among the threats to global peace and security. People are threatened through loss of livelihood, incomes, social ostracism and discrimination, family disruption, loss of well-being, and ultimately, loss of life. On a larger scale, entire nations are affected, as the epidemic places a severe strain on health care infrastructure, social security schemes, and national budgets, competes with other national priorities such as social development and defense, impedes growth, and devastates entire national economies.

The response to this large-scale international epidemic requires comprehensive and collective efforts from all sectors of society. Indeed, everyone, from the local level to the highest echelons of government is a stakeholder in this fight.

Thailand's response to HIV/AIDS is a story of impressive achievements. Thailand was one of the first countries in the world to see a decline in HIV/AIDS prevalence in the 1990s, signifying its achievement of the sixth Millennium Development Goal. Thailand and other members of the Human Security Network have agreed that HIV/AIDS is a human security agenda. As the chair of the Human Security Network from May 2005 to May 2006, Thailand wishes to further promote international cooperation on HIV/AIDS within the Network and beyond, through partnerships with governments, NGOs, civil society organizations and the private sector and promoting the sharing of experiences and best practices across regions, with a particular emphasis on Asia and Africa.

HIV/AIDS is one of the leading causes of death on the African continent. Roughly two-thirds of the global population of people living with HIV/AIDS reside on the continent. It is a continent that is in critical, urgent need of support to help combat the spread of the epidemic and provide care to those already infected.

Given the above situation, and in line with the Royal Thai Government's foreign policy, the Thai Government, through the Ministry of Foreign Affairs, and UNDP Thailand, organized two workshops in Africa in 2005 in the countries of Kenya and Botswana, focusing on comprehensive responses to HIV/AIDS prevention and care. This focus area was selected based on the fact that both Thailand and African countries have experience implementing programmes and activities to fight the HIV/AIDS epidemic and providing care to those affected through the active involvement and support of all stakeholders at all levels.

The first workshop was organized in Nairobi, Kenya from 22-24 June 2005, with senior participants from government agencies and NGOs from Burkina Faso, Djibouti, Gabon, Ghana, Kenya, Mali, Nigeria, Somalia, Sudan and Uganda. Fifteen participants, from the Ministry of Public Health, Chiang Mai University, youth community groups and organizations of people living with HIV/AIDS, participated in the workshop as experts and resource persons.

The second workshop was organized in Gaborone, Botswana, from 16-18 November 2005, with senior participants from government agencies and NGOs from Botswana, Lesotho, Madagascar, Mozambique, South Africa, Swaziland, Zambia and Zimbabwe. Over 15 Thai experts and resource persons from the Ministry of Public Health, the Government Pharmaceutical Organization, organizations of people living with HIV/AIDS, faith-based organizations, and the Thailand Business Council on AIDS participated in the workshop.

The reports of these two workshops provide key discussion points, experiences, practices, lessons learned in both Thailand and African countries, and recommendations on comprehensive responses to HIV/AIDS, both at the national and community levels.

It is hoped that the workshop reports will be useful as references and tools for policy makers and key development partners in addressing the increasing challenges of HIV/AIDS in Thailand and African countries. These workshops are only one of the efforts currently being implemented through Thailand's partnership with the African continent, based on pursuit of the Millennium Development Goals and the UN Declaration of Commitment on HIV/AIDS.

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Ministry of Foreign Affairs

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Thailand International Development
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Ministry of Foreign Affairs

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Thailand

ACKNOWLEDGEMENTS

The United Nations Development Programme (UNDP) Thailand would like to express our appreciation to the many individuals, organizations and communities who participated in the workshop. We are grateful for the hospitality shown to us by our African hosts. Special thanks go especially to the Government of the Republic of Botswana, the UNDP Country Office in Botswana for acting as co-hosts for the workshop, and UNDP Country Offices in the invited African countries. Their active involvement and support have greatly contributed to its success.

We would like to extend special thanks to our local resource persons from Botswana and South Africa, as well as the local host organizations for inviting us to visit their projects in the field and in their respective communities.

This workshop benefited greatly from the full commitment, substantive guidance and participation of H.E. Dr. Virachai Virameteekul, Vice Minister of Foreign Affairs of Thailand. We would also like to thank the Thailand International Development Cooperation Agency (TICA), the Department of International Organizations and the Royal Thai Embassy based in Pretoria, for their active involvement in organizing the workshop, from planning to the final stages.

We are also thankful to our Thai partner organizations for their active participation in planning the workshop programme and contributing to the workshop sessions, including UNAIDS Thailand, the Ministry of Public Health, Thailand-US CDC Collaboration Programme (TUC), the Thai Network of People Living with HIV/AIDS (TNP+), Payap University and the Thailand Business Coalition on AIDS (TBCA).

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ACRONYMS

ABC	"abstain, be faithful, use condoms" – an advocacy approach to HIV/AIDS prevention
AIDS	Acquired Immunodeficiency Syndrome
ANC	absolute neutrophil count – a method for monitoring immune system response in AIDS patients
ART	antiretroviral therapy
ARV	antiretroviral – drugs used in the treatment of HIV/AIDS, i.e. AZT, ZDC
ASO	AIDS-Response Standard Organization (Thailand)
BBCA	Botswana Business Coalition on HIV/AIDS
BOCAIP	Botswana Christian AIDS Intervention Programme
BONASO	Botswana Network of AIDS Organizations
BONEPWA	Botswana Network of People with HIV/AIDS
CBO	community-based organization
CD4	immune system "helper" cells; also known as "T-cells" – CD4 counts are monitored in AIDS patients to track immune system response
CMS	Central Medical Stores (Botswana)
DMSAC	District Multi-Sectoral AIDS Committees (Botswana)
GPO	Government Pharmaceutical Organization (Thailand)
HIV	Human Immunodeficiency Virus
ILO/USDOL	International Labour Organization/United States Department of Labor
IVD	intravenous drug
MCH	maternal and child health
MDG	Millennium Development Goal
MSM	men who have sex with men
NACA	National AIDS Coordinating Agency (Botswana)
NGO	non-governmental organization
NSF	National Strategic Framework (Botswana)
OTOP	One Tambon (sub-district) One Product (Thailand)
PCR	polymerase chain reaction – an HIV testing technique
PLWHA	people living with HIV/AIDS
PMTCT	preventing mother-to-child transmission
SADC	South African Development Community
STI	sexually transmitted infection
TNP+	Thailand Network of People Living with HIV/AIDS
TRIPs	trade-related intellectual property rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VCT	voluntary counselling and testing
WHO	World Health Organization
WTO	World Trade Organization

MOROCCO
TUNISIA
ALGERIA
LIBYA
EGYPT
WESTERN SAHARA
MAURITANIA
MALI
NIGER
SENEGAL
GAMBIA
GUINEA BISSAU
CHAD
SUDAN
ERITREA
DJIBOUTI
BURKINA FASO
BENIN
GUINEA
NIGERIA
ETHIOPIA
SOMALIA
SIERRA LEONE
COTE D'IVOIRE
TOGO
CENTRAL AFRICAN REPUBLIC
LIBERIA
GHANA
CAMEROON
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DEMOCRATIC REPUBLIC OF CONGO
RWANDA
BURUNDI
TANZANIA
ANGOLA
MALAWI
ZAMBIA
ZIMBABWE
MOZAMBIQUE
MADAGASCAR
NAMIBIA
BOTSWANA
Gaborone
SWAZILAND
LESOTHO
SOUTH AFRICA

Countries participating in the workshop held in Gaborone, Botswana 16-18 November 2005

INTRODUCTION

Background

When HIV and AIDS emerged two decades ago, the world could not predict how the epidemic would evolve. Even today, experts, governments and community leaders are still unable to describe with certainty the best ways of combating it.

Despite tireless efforts and dedicated leadership from both the community and government levels and a visible stakeholder involvement, the HIV/AIDS epidemic continues to wreak havoc on communities worldwide. It has devastated local healthcare systems, destroyed livelihoods, broken apart families and furthered social disparities. It has widened the gap between the rich and the poor, pushing already marginalized groups such as women and children even further to the periphery of society. It has, in fact, devastated whole nations and even entire regions – socially, by creating stigma, and economically, by whittling away at national reserves and foreign investments.

It is therefore evident that the world has passed the stage of conjecture. The full force of the epidemic is being felt, and governments and communities have realized that proactive measures must be formulated, enacted and shared with other nations if the world is to halt the spread of HIV/AIDS.

Thailand is proud to have emerged as one of the international success stories in the fight against the HIV/AIDS epidemic. Through dedicated community and government efforts, Thailand has managed to make great progress towards achieving Millennium Development Goal 6 – to halt and reverse the spread of HIV/AIDS by 2015 – culminating in a dramatic reversal of HIV/AIDS prevalence in the country in the 1990s.

Community groups and AIDS activists gained unprecedented influence in policy-making and programming processes, often spearheading efforts which were then adopted by the government and implemented on a national level.

Thailand would not have been successful in responding to the epidemic without such firm and focused government commitment, driven by strong community leadership. Such commitment provided a powerful impetus for a broad-based response and led to a huge increase in domestic funding for HIV/AIDS action programmes.

In addition, active community leadership and strong government commitment helped to create an institutional and political environment conducive for broad-based cooperation between key government agencies, NGOs, community groups, the media and the private sector.

As individual nations formulate their own responses to the epidemic, information exchange becomes a critical step towards developing a global approach to the fight against HIV/AIDS. Thailand, as a nation that has experienced notable success in halting the spread of HIV/AIDS, can be a valuable partner to other nations currently battling the epidemic.

Transferring these good practices and lessons learned involves efficient and effective partnering. The Thai government, with the support of the UNDP, has initiated a South-South approach to kick-start Thailand's international cooperation in HIV/AIDS prevention and response.

To initiate the implementation of this South-South approach, the Royal Thai Government and the UNDP Thailand Country Office organized the first Thailand-Africa workshop on "Comprehensive Response to HIV/AIDS Prevention and Care" in Kenya in June of 2005. The workshop was conceived an integral part of Thailand's policy to broaden and deepen partnerships with African countries in all areas of mutual interests in accordance with the Government's "Look West" policy. It serves as concrete example of Thailand's determination to promote "partnership for development" with Africa in a spirit of "South-South Cooperation". The success of the Kenya Workshop led to the organnization of the second workshop in Gaborone, Botswana, during 16-18 November 2005.

Because African nations are currently facing the devastating effects of a raging HIV/AIDS pandemic, spreading across national borders, ravaging economies and eliminating entire populations, Thailand identified this issue as the top priority for engaging in information-sharing and partnership. Thailand's success in combating and reversing its own epidemic place it in a prime position to be a valuable partner to African nations in information and resource exchange.

This report details the outcomes of the second workshop, "Comprehensive Response to HIV/AIDS Prevention and Care", held in Gaborone, Botswana 16-18 November 2005, bringing together eight of the hardest-hit nations of southern Africa.

Objectives

The workshop objectives embraced the aspects stated below:

- Supporting government foreign policy, especially in promoting the exchange of experiences, lessons learned and best practices on HIV/AIDS among Thailand and African countries;

- Sustaining the momentum generated by the XV International AIDS Conference hosted by Thailand in July 2004;

- Raising the profile of HIV/AIDS in the context of human security and implementing the human security network medium-term work plan for 2003-2005.

The **medium-term work plan** includes:

- Resolving to implement the Declaration of Commitment on HIV/AIDS;

- Forging partnerships with NGOs, civil society and the private sector in addressing HIV/AIDS;

- Promoting the sharing of experiences and best practices in addressing HIV/AIDS across regions, with particular emphasis on Asia and Africa;

- Incorporating HIV/AIDS prevention, care and treatment into programmes or actions that respond to emergency situations and, where appropriate, factoring HIV/AIDS into international assistance programmes;

- Promoting international technical cooperation on HIV/AIDS; and
- Promoting global partnerships on HIV/AIDS in pursuit of the MDGs and the UN Declaration of Commitment on HIV/AIDS.

Profile of participants

The workshop brought together a core group of experts and specialists from a broad spectrum of backgrounds, representing Thailand and eight southern African countries: Botswana, Lesotho, Madagascar, Mozambique, South Africa, Swaziland, Zambia and Zimbabwe.

The African representatives included experts, specialists, officials and other actors as well as stakeholders and NGO representatives in the following areas/disciplines: national AIDS councils and coordinating agencies; directors in the public service, the medical field and health departments; national AIDS programme managers; programme and advocacy coordinators, including those dealing with PLWHAs, at-risk groups, ART and prevention; networks of HIV/AIDS service organizations, including faith-based institutions; UNV specialists; focal points for HIV/AIDS programmes; cluster managers; private sector specialists, including workplace HIV/AIDS specialists; business coalitions; and experts in the fields of finance and marketing.

Participants from Thailand were drawn from the following key positions and disciplines: directors of the health sectors; faith-based missions; business coalitions; and research and development institutions, including a pharmaceutical organization. The Thailand team also included directors of networks for PLWHAs, programme specialists in training and communication, and technical officers, representatives and programme advisors working for various UN agencies.

The Thailand organizing team was comprised of high-level officers from government ministries, public health organizations, development corporations and programme officers.

The full list of participants can be found in Annex III.

Methodology

The methodological approach adopted in facilitating the workshop was highly participant-driven, and discussion-centred, centring on animated group discussions, interaction with experts, and collective actions. The aim of this approach was to create a space for openness in sharing knowledge, expertise, lessons learned and emerging challenges, and resulted in a united approach to consensus building.

SUMMARY OF OPENING REMARKS

Dr. T.L. Moeti
Deputy Permanent Secretary
Ministry of Health, Botswana

The Deputy Permanent Secretary's welcome remarks centred on the following issues:

- The magnitude of the HIV/AIDS epidemic is working against socio-economic development and threatens the flow of hard-earned investments into Africa. There is therefore a need to formulate a unified approach by African nations to fight the epidemic.

- Knowledge and discussion must be generated about the adverse effects of the epidemic on the future of youth and their survival in Southern Africa as well as that of unborn children and infants.

- Botswana's national response must take into account the lessons and experiences of other countries. Information exchange is a critical step in the right direction.

The Deputy Permanent Secretary upheld Thailand as a role model in combating the HIV/AIDS epidemic:

> [Thailand's] pragmatic approach to prevention programmes, provision of services, open discussions, intimate aspects of human relations and determination to achieve coverage of the hard-to-reach groups is commendable. For this endeavour, Thailand needs to be congratulated.

He added that:

> Countries in Africa have much to learn from Thailand, in terms of public policy, HIV/AIDS prevention and behavioural programmes, that afforded Thailand to achieve a marked difference in reducing the incidence of sexually transmitted infections.

However, Dr. Moeti recognized that in Southern Africa, the scale of the problem is much greater. He stated that the prevalence rates in Botswana, for instance, are very high. In response, government expenditures directed towards programmes to reverse the epidemic have been substantial, and efforts are being made in Botswana to halt the spread of the epidemic.

HIV/AIDS goes beyond health concerns, Dr. Moeti continued. It adversely impacts productivity and vulnerable groups, worsens poverty and leads to other forms of human deprivation. It is important, in this regard, to maintain a clear focus on all the MDGs.

The Deputy Permanent Secretary concluded by emphasising that lesson sharing between Thailand and African countries will be valuable.

Ms. Viola Morgan
UNDP Resident Representative, a.i. for Botswana

The UNDP Resident Representative, a.i. for Botswana opened by welcoming the delegates on behalf of the Government of Botswana and the UNDP Country Office. She emphasized the importance of South-South cooperation and the need for developing partnership. Ms. Morgan's address centred on the following key issues:

- HIV/AIDS is a global crisis, and Southern Africa has been the hardest-hit.

- The epidemic has devastated entire regions and, in particular, has widened the gulf between the rich and the poor.

- With firm political commitment and strategic approaches, there is hope that the epidemic can be reversed.
- Lessons shared between Thailand and the eight Southern African countries will be valuable, particularly in terms of Thailand's success in meeting MDG 6.

Ms. Morgan added that Botswana has its own success story to be shared. She explained that the nation's President is on the forefront in leading the reversal of the epidemic and the Government of Botswana should be hailed for providing ARV medication at no cost.

She again stated that Thailand should be commended forsharing its experiences with other developing countries.This is a clear demonstration of setting a benchmark for HIV/AIDS excellence and outlining win-win strategies for halting the epidemic,she explained.

Concluding the presentation, Ms. Morgan expressed gratitude to the Thai Government for its unwavering contribution to the fight against the epidemic. She closed by saying that these lessons are lessons of hope and can be shared globally, because a lesson learnt is a lesson not to be forgotten.

H.E. Dr. Virachai Virameteekul
Vice Minister for Foreign Affairs, Thailand

His Excellency the Vice Minister of Foreign Affairs began by thanking the parties in attendance for their participation and organization. He acknowledged that such high-level representation will ensure future implementation of policies and sustained partnership.

The Vice Minister's address centred on the following key points:

- Thailand considers partnership with Africa a high priority and is committed to working towards its expansion, in keeping with the eighth MDG's call for global partnership and development.
- The fight to reverse the spread of HIV/AIDS is a global battle, and one that should be fought through solidarity on the part of all nations.
- The cornerstone of Thailand's successful approach has been to acknowledge and recognize community responses, allow participation of people living with HIV/AIDS, and involve workplace strategies and initiatives.
- Thailand's experiences with a national ARV programme, its affordability, extent of coverage, procurement and monitoring system are some of its most valuable lessons to be shared.

The Vice Minister explained that Thailand and Africa have a history of sharing information and ideas. Thailand and UNDP previously organized a forum entitled "The Consultation on Africa – Thailand Partnership for Development" aimed at defining the scope and priority of Thailand's development cooperation with Africa. In addition, the Vice Minister cited the success of the workshop held previously in Nairobi, Kenya. These meetings, along with the present one in Botswana, are a testimony to South-to-South cooperation, he stated.

Underscoring the need for an urgent response to the growing HIV/AIDS epidemic, the Vice Minister stated that the continuous loss of millions of lives in the face of new medicine and science should be viewed as unacceptable. Much more must be done in solidarity to fight the epidemic, he added, to further supplement international endeavours pursued by the world's governments and UN agencies.

"We no longer have the luxury to be patient", the Vice Minister of Foreign Affairs noted.

The Vice Minister explained that Thailand has an approach to human security that is enhanced by an established human security network based on stakeholder involvement. The network draws members and observers from all continents. He noted that the network aims at "creating a world where people are free from fear, want, and are able to live in dignity".

The Vice Minister concluded by reiterating the need for a united approach:

> The world is at risk. HIV/AIDS has claimed more lives than any weapons of mass destruction. The challenge facing everyone is to make suggestions and recommendations, however ambitious, aimed at less suffering outside this hall. This is a race against time and the fight must consider a team approach.

Mr. Jonathan Lewis
UN Acting Resident Coordinator for Botswana

The UN Acting Resident Coordinator focused his presentation on the following key points:

- Despite the efforts made by governments, civil society, communities and international organizations, the epidemic continues to flourish. The fight against HIV/AIDS in Southern Africa is not just a public health issue – it is a fight for survival.
- Weak community involvement and participation has been a major impediment to the fight against HIV/AIDS and must be strengthened if nations are to see a reversal of the epidemic.
- Innovative interventions and strategic partnerships are necessary to fight the epidemic, and the UN recognizes partnerships like the one initiated by the Royal Thai Government as a positive example.

Mr. Lewis praised the combined efforts of UNDP and the Thai Government. He explained that learning from each other, exchanging experiences and forming partnerships across sectors of societies from tiny communities, through to giant companies and multi-national corporations is critical.

Building new dynamic networks, such at this workshop, will identify success factors, Mr. Lewis added. It will encourage learning from both failures and successes and will enable the reaching of the Millennium and UNGASS declarations.

The war can be won if inspiration is drawn from success stories, resource application, ingenuity, compassion, and helping sectors of society and communities, he stated.

Lessons to be learnt from Botswana, Thailand, Brazil and Uganda will motivate what already works, the UN Acting Resident Coordinator concluded.

Lt. Gen. Mompati S. Merafhe
Minister of Foreign Affairs and Internal Cooperation, Botswana

As part of the official business, the Minister of Foreign Affairs and Internal Cooperation warmly welcomed the Thai Vice Minister of Foreign Affairs at a lunch meeting. He emphasized the key points below:

- It is of vital importance to share issues of mutual interest, including HIV/AIDS.
- The magnitude and the nature of the epidemic in Botswana make this type of partnership and information sharing of critical importance at this time.
- There is a need for a collective approach to turn the epidemic around in order to meet the UN declaration of commitment on HIV/AIDS.
- The long-term commitment between Thailand and Botswana in a number of critical issues of interest, such as trade and investment, tourism and human resource development, should be further explored.

The Minister of Foreign Affairs congratulated Thailand for overcoming the effects of the tsunami and welcomed the delegates at a cocktail reception hosted by the Thai government.

EXPERT PANEL DISCUSSIONS: HIV/AIDS POLICY RESPONSES AND CHALLENGES

THE OVERALL SITUATION AND CHALLENGES FOR HIV/AIDS PREVENTION AND CARE IN AFRICA

Dr. Kwame Ampomah
UNAIDS Country Coordinator, Botswana

Dr. Ampomah began by drawing attention to the broader picture, which encompasses the Millennium Development Goals. He cited speeches made by Odiambo Djijo of UNDP Kenya and the Prime Minister of Lesotho at the Lesotho Summit attended by the heads of states and governments from the SADC Region. His references emphasized the magnitude of the epidemic, the rise in infection rates and the urgency to confront the pandemic and deal with its impact on the people and long-term economic development of the region.

He further quoted a trade union leader, who said that **major factors contributing to the increasing spread of the HIV/AIDS epidemic** were:

- Public health policy failures and societal structures; and
- Limited information on HIV/AIDS for the critical mass, the existence of a host of myths and legends, including sensationalist media stories, and vicious rumours.

"Ignorance can literally kill us by exposing ourselves to infection and leading to vicious stigmatization of people with HIV", the speaker quoted.

Dr. Ampomah also posed questions: "Where did we go wrong? Where have we failed? Is everything right with our HIV/AIDS policies?"

Key points that emerged in the presentation included the following:

- In many ways, prevention programmes have failed to reach the most at- risk in every part of the world.

- The instant response to the SARS outbreak in comparison to that of the HIV/AIDS epidemic is an interesting point of discussion for scientists and epidemiologists to note.

- The AIDS epidemics ravaging the southern African region are highly varied both between and within sub-regions.

"It is therefore inaccurate to speak of a single 'African' epidemic and misleading to apply insights about the epidemic gleaned from specific parts of sub-regions to the entire Sub-Saharan African region," Dr. Ampomah noted.

Dr. Ampomah cited examples of countries where prevention efforts have been effective. These included South Africa, in terms of prevalence decline in pregnant women, decline of prevalence rates among 15-24-year-old rural dwellers in Zambia and decline in prevalence of the age 15-29 cohort of urban women in Zambia.

Other countries cited as examples of declining prevalence were Uganda in East Africa and Cameroon and Cote d' Ivoire in West and Central Africa.

The presenter went on to present further key HIV/AIDS challenges in Africa and effective principles of HIV/AIDS prevention, as well as essential policy actions, programmatic actions, national level responses and critical issues of treatment.

He further reiterated that harmonizing policies and programmes with the MDGs is critical. Despite budgetary constraints, certain government departments, CBOs and companies in southern Africa have taken up the fight against HIV/AIDS against tremendous odds. These stakeholders are mitigating the impact of HIV/AIDS through prevention efforts, disease management programmes, treatment, care and support both for the infected and the affected, he explained.

In conclusion, Dr. Ampomah stated: "We cannot have chosen a more typical country to deliberate in than Botswana, which typifies a country resolved against all odds to beat HIV/AIDS."

BOTSWANA'S HIV/AIDS SITUATION: CHALLENGES FOR PREVENTION AND CARE

Mr. Peter Stegman
Advisor
National AIDS Coordinating Agency

The presentation by Mr. Peter Stegman provided an in-depth look at the general HIV/AIDS situation in Botswana, with statistics and graphs presenting HIV/AIDS prevalence through various demographic breakdowns.

This was followed by a discussion on the National Strategic Framework (NSF), a document spearheaded by the National AIDS Coordinating Agency (NACA). The NSF calls for a multi-sectoral approach, which articulates Botswana's determination to reverse the epidemic through stakeholder contribution at all levels.

Mr. Stegman's presentation covered the following key points:

- National goals and achievements of the NSF to date;

- Various programmes outlined for implementation in the NSF, including orphan care, ARV therapy, PMTCT programmes, VCT, and community responses;

- Challenges posed in the implementation of these programmes.

THAILAND'S POLICIES AND CHALLENGES ON HIV/AIDS

Dr. Siriporn Kanshana
Inspector-General
Ministry of Public Health of Thailand

Dr. Siriporn Kanshana outlined the magnitude and nature of the epidemic in Thailand, sharing prevalence rates of the epidemic for different populations, including drug users, sex workers, males with multiple partners, pregnant women, youth and mobile populations. The Director General also shared statistics on cumulative infection rates, numbers of PLWHAs, new AIDS cases, new HIV infections and cumulative deaths.

Dr. Siriporn then shared Thailand's national AIDS plan for 2002-2006, which includes five strategies aimed at fighting the epidemic. The different stakeholders involved in implementing HIV/AIDS programmes were named as government, academic institutions, NGOs and PLWHAs.

Issues of the government's budgetary process and contribution were also discussed and shared. Interesting success stories of reversing the epidemic emerged and included discussion of the following **aspects of Thailand's response**:

- The existence of a strong political commitment to the fight against the HIV/AIDS epidemic;
- Solidarity at the national level;
- Civil society involvement and engagement; and
- Research and development programmes.

The presenter also brought forth the following **challenges** that exist in implementing the programmes:

- Sustainability of prevention and the need to uphold momentum;
- ART non-compliance and the need for monitoring programmes;
- The need to empower community groups;
- The need to up-scale prevention programmes for IVD users, mobile populations and youth.

CIVIL SOCIETY RESPONSE TO HIV/AIDS IN BOTSWANA

Mr. D. Motsatsing
Botswana Network of AIDS Organizations (BONASO)

In the first part of this presentation, Mr. Motsatsing provided information which served to contextualize civil society responses to the epidemic in Botswana, giving a historical time line of the response. He also shared BONASO's mission statement, membership drive and growth as well as BONASO's key partners as an umbrella service organization.

The second part of the presentation outlined the main **functions and activities of BONASO**. These include:

- Policy influence and advocacy roles, through representation at different forums and networking approaches;
- Capacity building, including mobilization of resources;
- Information dissemination and communication modes; and
- Other programming activities.

Mr. Motsatsing also shared with the delegates the available grants to communities, the approaches to partnering, the main funding areas and the types of groups targeted for funding.

An overview BONASO's programming activities targeted to end users, its impact on communities and its organizational operation and structure were also shared, including an evaluation which revealed a number of positive approaches to containing the epidemic.

Finally Mr. Motsatsing considered the following **challenges**:

- Financial and technical resource constraints;
- Increased demands hiking the expectations;
- Limited infrastructure and office equipment;
- Challenges of sustaining projects on the ground;
- Lack of own funding and sustainability strategies.

PLENARY SESSION

Following the Expert Panel Presentations, the participants were given an opportunity to interact with the presenters, ask questions, share their own experiences and provide comments. The questions, comments and responses that emerged are documented below.

Botswana seems to have done extremely well in the access and provision of ART. Why is it that some individuals are still on the waiting list?

There is an overload of core sites, which is overwhelming for the health personnel. This is an issue of the inadequate capacity of the health sector. The health system requires strengthening in this regard and the suggestion is to develop private partnerships to reduce the burden on the health care system.

Does Botswana have the capacity to maintain and sustain the roll-out process of VCT services?

The low uptake of VCT programmes is mainly attributed to the issue of stigma. Although the bias report did not elaborate on this issue, stigma and denial is an issue that Botswana is still grappling with in terms of VCT uptake. This has an effect on the successful roll-out of the programme. The number of people who have enrolled in the VCT programme is quite substantial. The process has begun and up-scaling of VCT programmes is anticipated in the near future. 3000 patients have already been identified and the process is ongoing.

Should Botswana be outsourcing these services to NGOs such as BOCAIP, which is working in the area of VCT?

Outsourcing the VCT services is a complex decision. Capacity issues and relevant expertise come into play, in terms of the technicalities of the personnel involved. Sustaining service delivery is important, including expert requirements relating to management and issues of adherence.

Information presented on Cameroon and Côte d'Ivoire indicated a reduction in the prevalence rates of HIV/AIDS. Can these results be attributed to the levels of the strain?

The statistics on HIV/AIDS prevalence differ from region to region, between countries and between districts. We therefore cannot assume that levels of strain factor into these differences.

There was no specific mention of attrition rates in the presentations. This is cause for concern, as this factor is closely related to the HIV/AIDS epidemic in terms of maintaining and sustaining human resources and their development.

Attrition is an important issue as it relates to many aspects of the epidemic and development. The fact that it was not mentioned is an oversight.

Mention is constantly made about women and HIV/AIDS and their importance as a target group. Why is there no mention of men's groups?

Women are targeted because they are the often the most infected and affected. However, men's groups have been mobilized in some countries and are involved and enrolled in the HIV/AIDS programmes.

How do you confidently measure the result of 100 per cent condom use in Thailand?

The 100 per cent results recorded on condom distribution and their use are based on partnerships established with different institutions, including hotels, bars and brothels. Collaboration and networking strategies have been developed with these partners, who in turn cascade condom distribution and use to a critical mass.

There was mention about the media spreading sensationalized or even fictional stories, which tend to fuel the epidemic by presenting misleading information. South Africa is struggling with a similar problem. Can we share experiences on how some countries deal with the situation?

While the Media is often viewed as spreading sensational stories about the epidemic, it is nonetheless important to link with the media as a strategic partner if the epidemic is to be contained

BONASO has an interesting approach in terms of its structure and networks. Is the organization viewed as a mouthpiece of the government?

BONASO does not see itself as the government's mouthpiece. Its contribution is of a complementary nature, sustaining dialogue with the government on issues of resource allocation in a cordial manner. However, because the government has stronger bargaining power, it often calls the shots and controls the purse. It is critical for the government to accelerate its resource allocation decisions in support of NGOs in recognition of direly needed partnership. It must be understood that BONASO is not managing the global fund; BONASO assumes an implementing function.

Can we share experiences about enrolment levels in VCT programmes and why there is a disparity between women and men? What lessons can Botswana share with us with regards to VCT programmes?

The disparity that emerges between women and men in enrolling VCT programmes can be attributed to the fact that those who appear for testing are not necessarily those who need it. They are often those who are in steady relationships who have made a conscious decision to abstain. There is a need to create awareness among those who really need these services.

Routine testing is done on pregnant women; a slight increase has occurred but latest figures are not readily available. 60 per cent uptake of routine testing has occurred, moving up to 83 per cent.

WORKSHOP SESSION ONE: NATIONAL RESPONSES

SUBJECT AREA 1: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTC)

Objective: To share experiences and lessons learned on PMTCT programmes in participants' respective countries.

Lead facilitator: Dr. Siriporn Kanshana

Team members: Dr. Somsak Paltarakulwnich, Mrs. Achara Eksaengsri

Dr. Siripon Kanshana started the discussion and highlighted the following **aspects of PMTCT** in Thailand:

- The magnitude of the mother-to-child transmission of HIV infection;
- Information on health indicators, major components of the programme, anti-natal care, HIV testing and counselling;
- Development of PMTCT ART and infant formula policies,
- Issues such as short courses on ZDV, a pilot programme to evaluate national implementation, monitoring and evaluation; and
- Conclusions, lessons learned and approaches to sustainability.

During the discussion, representatives from South Africa and Botswana gave presentations on PMTCT experiences in their own countries in order to share success stories, challenges and strategies. They were interspersed with a plenary session. The two presentations are summarized below.

South Africa's experience

Depending on the report or model used, national prevalence differs and ranges from 11-17%. For example, HSRC estimates national HIV prevalence at 16%. There are one million births per annum in South Africa, and prevalence among pregnant women is 29.6%, which differs from province to province.

PMTCT is offered in all hospitals and community health centres. Currently, the coverage stands at 70% and the uptake for testing is 50%. Testing is routinely offered to pregnant women, who are offered the option to opt-in or opt-out. The opt-out option is preferred by most women.

The initial programme was piloted in a few areas with the intention of evaluating the programme before scaling up at the national level; however, scaling up was done before evaluation due to political pressure.

Other key points that emerged include:

- 50% of pregnant women are given nevirapine;
- There is a missed opportunity to implement PCR testing in 15-18 month-old children. It is difficult to follow up as infants are often not brought back for further assessment.
- Instant feeding choices are made available to mothers, enabling them to make informed choices between breast and formula feeding. Infant feeding is provided freely for 6 months but the Nestle formula used always runs out.
- On-going training for service providers relies on community service providers managed by NGO stipends of approximately R500-R1,000 per month.
- A Cohort Study for the 3 initial pilot facilities was begun to ensure the efficacy of the programme; however, due to a constitutional court order, the programme had to go full-scale before evaluation was completed.

Botswana's experience

In Botswana, PMTCT has been integrated into MCH services, and the under-five growth-monitoring card has been revised to include PMTCT information. This was initiated to resolve problems related to PCR missing results due to the fact that mothers were bringing their children to the under-five MCH clinic to get immunizations without having PCR tests performed.

Due to political pressure associated with the HIV/AIDS, PMTCT programmes did not take into consideration involvement of the community and community structure, including involvement of traditional birth attendants, community and civil society organizations.

The following issues were raised in discussion:

- Common PMTCT protocols in the region. For instance, Botswana is using dual therapy, which is similar to Thailand.
- Issues of nevirapine resistance were raised. How does it affect future treatment options for mothers and children? While researchers are advocating for the WHO-recommended regime, how does this compare to the Thailand approach in terms of increasing efficacy?
- The failure to combat the spread of HIV/AIDS is often attributed to failure to reach hard-to-reach populations. How do we reach the so-called hard-to-reach populations, including farm workers, those in very remote areas, migrant labourers, etc? Suggestions are to develop pro-poor strategies.
- Why are people unable to access HIV/AIDS services? Interventions developed should strategically addresses society at all levels, including those with special needs.

- Male involvement in PMTCT programmes is lagging behind within the region.
- How do we deal with home delivery, which is still prevalent within the region?
- South Africa's PMTCT programmes are included under HIV/AIDS programming, not MCH programmes. Most countries within the region are still keeping MCH and PMTCT programmes running parallel. Why is this?
- Eligibility of mothers covered under the PMTCT programme to enrol in the ART programme. Most countries are now considering PMTCT mothers under ART programmes.
- How many children have been saved from infection through PMTCT programmes? How effective is PMTCT? This raised issues of data management and the need for managers to have balanced information.

Lessons learned and best practices

- PMTCT is routinely offered as part of the package for ANC services within the region.
- Botswana has successfully integrated PMTCT into MCH. Other countries are in the process of doing this.
- Under-five growth-monitoring card data has been revised to include PMTCT data through a pilot project ongoing in Botswana.

Challenges

- Difficulty in following-up with mother/child pairs enrolled under PMTCT programme through testing at 15-18 months as many do not come back for the re-assessment as required.
- Uptake for voluntary testing is still low in some countries due to stigma and inappropriate approaches to counselling.
- Husbands and male partners often do not want to be seen in health facilities.
- Community participation and involvement in PMTCT has been very minimal.
- PMTCT is not fully integrated into MCH in many countries, though efforts are being made to do so.
- Problems of access to PCR testing. For instance, there is only one testing centre in Botswana that provides PCR testing.
- High level decision-making on the ART regime.
- Poor data collection and management which makes it difficult for programme mangers to assess outcomes.
- Some countries are still experiencing high numbers of home deliveries which pose logistical problems of administering the prescribed ART regimen for PMTCT.
- In addressing these obstacles, countries like Lesotho, Swaziland and Zimbabwe resorted on take-home treatment measures. Women are given nevirapine tablets and syrup to take home and are given instructions on how to administer these at the time of the delivery if they deliver at home. However, in case of hospital delivery, they have to bring the drugs to the hospital.
- There is a high chance of drugs losing their potency, especially because of the conditions in which these drugs are often stored in the home. Furthermore, PMTCT effectiveness depends on mothers remembering to take the drug and administer the syrup to newborns and infants. Reliability of the results is therefore questionable.

Way forward

- Advocating for meaningful engagement of the community on PMTCT;
- Strengthening capacity building for all service providers;
- Developing strategies for reaching out to the hard-to-reach populations; and
- Full integration of PMTCT into MCH.

SUBJECT AREA 2: CONDOM PROGRAMMES

Objectives: To exchange experiences and lessons learned in each country on condom promotion programmes for prevention of HIV and STI infections and to identify approaches and methods for further improvement for different target groups.

Lead facilitator: Dr. Sombat Thaenprasertsuk

Team members: Dr. Somsak Pattarakulwanich, Ms. Achara Eksaengsri

The session started off with a presentation on the condom programme in Thailand, including detailed statistical break-downs of condom use and HIV/AIDS prevalence rates in various demographic groups in Thailand. After sharing experiences, the participants were divided into two groups and instructed to select a group chairperson to moderate the discussion and a rapporteur to undertake the recording and preparation of summaries for presentation.

Questions and answers

A question-and-answer session followed the presentation on Thailand's programme. Key issues raised are included below.

The definition of consistency means different things to different people. Can this concept be further elaborated on?

The results on consistency are population-based and should not be considered as perfect use.

Are condom vending machines different where there is no electricity?

Are there any objections on vending machines from religious institutions?

Religious institutions have accepted the concept of Vending Machines.

Is condom marketing done as a package for family planning?

5% of women are using "the Pill" as a family planning method. The strategic approach would be to intensify condom use among women as a family planning method.

In addition, with the growing phenomenon of multiple/non-regular sexual partners, married women are more at-risk than commercial sex workers. Condoms should therefore also be promoted as a partner protection mechanism.

Group discussions

The participants converged into two groups and were required to discuss the following topics:

- The experiences and lessons learned from each country in the implementation of condom programmes, in terms of the level of risky sexual behaviour and current status of condom use practices in different groups of people and their access to condoms.
- How condom use practices can be further promoted, considering the following aspects:
  - How to resolve resistance from the public sector to disseminate condom promotion messages;
  - Methods to further promote condom use among different target populations; and
  - How condom use practices are monitored.

Specific cross cutting issues included:

- How condom use practices and promotion can be integrated into health programmes such as comprehensive treatment and care programmes for PLWHAs, including ARV programmes; and
- Access by other hard-to-reach groups.

Discussions on commercial sex work environments

SADC

Cross-border initiatives exist in high-transmission sites.

South Africa

Although the sex trade concept is not legalized in South Africa, educational programmes exist that target truck drivers, which also indirectly targets commercial sex workers. The government is not sensitive to commercial sex workers, and there is a need to lobby the government to legalize sex work.

Swaziland

To a certain extent, sex work prevails, but it is neither recognized nor legalized.

Thailand

Sex work in is not legal in Thailand, but the country has developed pragmatic strategies to include sex workers into HIV/AIDS programming successfully – strategies which could be emulated by SADC nations.

Zimbabwe

Commercial sex work is not legalized in Zimbabwe. Condom use among non-regular sexual partners is high, including commercial sex workers. However, regular sexual partners are more at risk; marriage is no longer protection from HIV/AIDS. In commercial sex work, it is the client who dictates whether or not a condom will be used. The poverty situation influences the decision and commercial sex workers have no option but to concur with the client's decision, which puts them at even more risk.

Discussions on access to condoms for commercial sex workers

Botswana

Condom dispensers are placed in female toilets.

Lesotho

People in Lesotho are not proactive in purchasing condoms; instead, they are dependent on government distribution, thus there is a problem of accessibility.

Madagascar

Condom use by girls in the rural areas is culturally accepted. However, there is limited knowledge and access to condoms is a challenge; therefore, STIs are common in some areas. There is 30% condom use among commercial sex workers in urban areas. At the national level, 3% condom use has been recorded; the question of affordability comes into play.

Mozambique

Female condom use is problematic because of re-use, increasing the possibility of tears and breakage. Also, "free" condoms are often perceived to be less effective because of the belief that better quality is more expensive. More people in urban areas have been reported to use condoms consistently but surveillance does not support this result.

South Africa

In South Africa, female condoms are not popular. In addition, the female condom is not affordable for most people. Females take the lead in the general use of condoms as men feel that it is not their responsibility.

Thailand

Female condoms are inclusive in the 100% condom use programme.

Zambia

The female condom is unpopular in Zambia. Education on its use is limited; hence, commercial sex workers will often use the same condom all night with multiple partners.

Zimbabwe

In Zimbabwe, females report irritation/itch when using the female condom, hence they are unpopular.

Discussions on condom programming among youth

Botswana

Condom use among youth has been measured, but the results are too good to be true, based on the survey.

Lesotho

Procurement and distribution occurs, but statistics on utilization levels do not exist; therefore, the effectiveness of programming in youth cannot yet be determined.

Madagascar

Condoms are not used for family planning, nor is there a strategy for increasing condom use under the guise of family planning.

Mozambique

The World Bank, government and UN agencies support life skills programmes in schools, including out-of-school youth, but in the longer term, regular partners tend to stop using condoms.

South Africa

In using the ABC message, there is a need to ensure which audience is being targeted. In primary schools, for example, the emphasis is on abstinence. In secondary schools, it is the ABC "love life" programme. The tertiary level poses no problems. Distribution of condoms can be measured easily, but statistics on utilization are a challenge to gather.

Swaziland

Youth are extensively targeted through awareness raising and education programmes.

Zimbabwe

Youth awareness raising and education is limited and needs to be accelerated.

Discussions on general condom use promotion

Thailand

Success in condom promotion is assisted by the general absence of cultural barriers which are often stumbling blocks.

South Africa

Resistance has emerged from the public sector. Unemployment also works against promoting condom use. It is therefore imperative for the government to provide social grants to address the situation of successful condom promotion. The fact that pregnancy is still rife amongst at-risk groups and youth means that resistance to condom use is still problematic.

Zimbabwe

Myths and misconceptions still exist in promoting the use of condoms. Dispelling these myths is critical. A challenge also exists in supporting certain groups because of the persistence of cultural barriers. Governments in Sub-Saharan Africa must overcome their cultural orientation and accept the reality of the epidemic. Strategies should be developed to protect the lives of all people, including those who are often bear the brunt of socio-cultural stigma such as prisoners, MSMs and commercial sex workers.

Zambia

No condom distribution has been afforded for youth, but the prevalence rate has declined, which is an indication that young people are procuring condoms for themselves. There is a need for the government to re-align its policies to support such behavioural change in young persons.

Discussions on PLWHAs

HIV-positive couples must use condoms for life even when they have the desire to have children. The risks with unprotected sex should be explained to these couples.

Conclusions and challenges

- Condom use is largely inconsistent throughout all demographic groups across all countries, particularly in long-term relationships.
- Sex work is not legalized – and thus not regulated – in most countries.
- Transgenerational sex poses additional problems in the region.
- The uptake of female condoms is low.
- Awareness on HIV/AIDS is high, but the perception of risk is low, encouraging resistance to condom use.
- People in rural areas lack access to condoms.
- Government disapproval of supplying condoms to prisoners works against reversing the epidemic.
- Myths and misconceptions about condom use are still rife in many countries.
- There is resistance from some religious groups to condom use.

Recommendations

- Policies should be realigned to match with current epidemiological trends.
- Sex workers should be acknowledged and groups should lobby and advocate for the legalization of sex work.
- Training materials should be developed to dispel misconceptions, misunderstandings and myths.
- Condom use should be promoted as a family planning method.
- Policies supporting condom use by prisoners should be advocated for and health workers should not be silent about it.
- Governments that do not have budget lines for condom distribution should be encouraged to take the issue into serious consideration.
- In certain countries, religious institutions are opposed to condom use and lobbying should be increased to effect change.
- Condoms can be included in pay-slips to encourage their use.
- Door-to-door education and distribution of condoms should be intensified to enable users to make it a consistent practice.
- Vending machines should be installed at workplaces – a good lesson shared by Thailand.
- Data collection should be accurate and reflective, and monitoring mechanisms should be put in place to measure utilization levels.
- Companies that manufacture condoms should be proactive and design motivational messages as an implementation tool and social responsibility.

SUBJECT AREA 3: ANTIRETROVIRAL PROCUREMENT AND MONITORING SYSTEMS

Objective: To share lessons and experiences on national ARV programme management in Thailand with southern African countries.

Lead facilitator: Ms. Achara Eksaengsri

Team members: Dr. Somsak Pattarakulwanich, Dr. Sombat Thaenprasertsuk

Two presentations were shared in this session, covering the topics of generic ARV production in Thailand and related issues of patent Law and intellectual property rights, as well as the procurement and monitoring of ARVs.

The key issues that emerged from the presentations are summarized below.

Generic production of ARVs in Thailand

This presentation gave an overview of generic production of ARV drugs in Thailand by the Government Pharmaceutical Organization (GPO), a state enterprise under the Ministry of Health.

To contextualize the need for Thailand's efforts, statistics were shared on infection rates and deaths related to HIV/AIDS.

The presentation then outlined the general role of the GPO, the products they manufacture, and their mandate, which is not only research in developing new drugs but also in complementing existing pharmaceutical research and technology.

The Research and Development Institute of the GPO has been involved in formulation development and bioequivalence studies of HIV/AIDS-related drugs since 1992 and started manufacturing and piloting production of the first product (100 mg AZT capsules) in 1995 for 5,000 patients.

Thailand managed to increase production of ARVs tenfold to treat 50,000-100,000 patients and reduced the cost 30-50% by 2001.

Government funding to ensure availability, accessibility and affordability of ARVs in Thailand are issues considered when formulating policies.

The GPO, in conjunction with the Department of Communicable Diseases, is charged with implementing the Vendor-Managed Inventory System (VMI), which is responsible for the management of ARV medication stock and distribution in the country.

TRIPS, patent law and intellectual property rights

The presenter also discussed requirements of the Agreement on TRIPs, the WTO's Doha Declaration (2001), the Decision of August 2003 (Paragraph 6), and the Thai Patents Act.

These agreements, which relate to international drug licensing, patenting, manufacturing, import and export of drugs have a significant effect on the expansion of production and access to ARV drugs, especially in developing countries. They have a direct impact on the affordability, sustainability and accessibility of ARV programmes.

Most participants agreed that they were not very cognizant with issues covered in this presentation and could therefore not comment nor ask a lot of questions on the subject. This implies that there is a need for further information and education on this crucial topic.

A question was asked regarding the availability or existence of herbal medicines or treatments offered in Thailand. The response was that herbal medication also plays an important part in the ARV programme.

Consensus was also reached by the group that more consultation and information sharing on this topic should occur between countries including exploring ideas on how Thailand can assist in this regard.

ARV procurement and monitoring system

Mr. S. Mapiki, principal pharmacist for Central Medical Stores under the Ministry of Health in Botswana presented on the subject of ARV procurement in Botswana. The presentation covered the following key areas:

- Resource situation analysis and needs;
- Ministry of Health guidelines with regards to patient priority groups, drugs for 1st, 2nd and 3rd line treatment and pilot sites;
- Procurement, forecasting principles and quantification processes;
- Drug distribution and security;
- Monitoring and treatment protocol;
- Capacity building and training;
- Statistics on health facilities;
- Inherent challenges and scale-up strategies.

That procurement of ARV drugs in Botswana is financed by the government, with the support of private donors such as the Bill and Melinda Gates funds and others. Central Medical Stores (CMS), under the Ministry of Health, is responsible for all public sector procurement and distribution of ARV drugs in the country.

Drugs are purchased directly from the suppliers in bulk to gain price advantage and no generic drugs or unlawful procurement is allowed,

The CMS purchasing process is based on a competitive bid process. Funds are requested from the National AIDS Coordinating Agency (NACA). Once funds are available and procurement authority is received, an annual order is made with the selected supplier.

In terms of monitoring, CMS has developed a national database to record the number of patients and stock quantities of drugs at all sites. Forecasting principles to determine order quantities are based on 90% adult patients and 10% children and on monthly enrolment rates of 1,000 to 2,000 patients.

CMS is also responsible for safe transportation, secure storage and recordkeeping of ARV drugs. Monthly physical stock taking and reporting is mandatory for all sites for monitoring purposes. CMS also undertakes the training of doctors, pharmaceutical officers and nurses involved in the programme.

Mr. Mapiki also went on to detail the progress made so far in ARV procurement and monitoring in Botswana, statistics of available health facilities, challenges and scale-up strategies, detailed below.

Progress made

- From 2002 to date, 32 sites have been opened from an initial 4 sites, including:
  - 3 referral hospitals
  - 12 general hospitals
  - 17 primary hospitals
- 261 district clinics, as well as private surgeries and chemists will be included in the roll-out programme;
- 37,000 patients are currently receiving treatment, with an estimated 70,000 as of December 2005;
- The monthly enrolment rate is 1,000 to 2,000 patients;
- That the amount spent of the ARV programme in 2004/05 was US$45 million.

Challenges

- Lack of adherence by the private sector;
- Resistance to ARV treatment as new strains emerge;
- Pilferage of ARV drugs;
- Affordability and long-term sustainability;
- Patients often present themselves for treatment when it is too late;
- Co-infection of HIV/AIDS and tuberculosis;
- Lack of capacity to scale up the programme to rural areas;
- Worldwide shortage of ARV drugs and unreliable suppliers, resulting in late delivery and adversely affecting adherence;
- Issues of patent rights (TRIPs);
- In some countries procurement of drugs is difficult due to lack of financial resources;
- Procurement of drugs is over centralized in some countries.

Future strategies and recommendations

- Strengthen local, national, sub-regional and international capabilities to enhance strategies of dealing with procurement issues and supplies;
- Use district resources to make ARVs available to rural areas;
- Engage the private sector in public-private partnerships (PPP) to scale up the ARV programme;
- Engage private physicians for consultation purposes and engage retail pharmacists to dispense ARVs so that the programme can reach more people.

Questions and answers

A question-and-answer session followed the presentation. Key issues raised and responses follow below.

How are private practitioners monitored and how does CMS intend to address the issue of pilferage?

The government has appointed a Drug Monitoring Company to distribute drugs to the private sector from a central distribution point. Cases of pilferage are referred to the police for investigation.

Are patients diagnosed in the hospital and then referred to the private practitioners?

Currently, all patients are diagnosed at government facilities only.

How does CMS differentiate between the drugs they issue and the drugs bought by the private practitioners?

Differentiation of drugs issued by CMS and those that are bought by private practitioners for sale is a challenge which needs to be addressed.

How is data collected from the private practitioners to be added to the national database?

The government collects data from the private sector for input into the national database.

SUBJECT AREA 4: NATIONAL ANTIRETROVIRAL PROGRAMMES

Objective: To share experiences and lessons in national ARV programme management, including the involvement of PLWHAs, and discuss the challenges.

Lead facilitator: Dr. Sombat Thaenprasertsuk

Team members: Dr. Siriporn Kanshana, Dr. Somsak Pattarakulwanich, Ms. Achara Eksaengsri and Mr. Kamon Upakaew

ARV national policy management in Thailand

Due to the scale of the HIV/AIDS epidemic in Thailand, a national policy on ARVs was developed to respond effectively and halt the spread and prevalence of the disease. This policy was divided into two phases: the introduction of ARVs (1992-1997) and subsequent local generic production of ARVs.

During this period, the following **activities** were undertaken:

- Projection and forecasting, through compilation of statistics indicating cumulative infections, deaths, PLWHAs and new HIV cases and infections;
- Addressing issues of national access to HIV/AIDS medical care for PLWHAs;
- Local generic production of ARVs, with a view to lowering costs;
- Training for healthcare professionals;
- Strengthening CD4 cell count facilities; and
- Capacity building of participating hospitals.

The **components of the national programme** were to look into issues of:

- Enrolment criteria;
- Infrastructure development and capacity building;
- Drug procurement;
- Monitoring and evaluation;
- Laboratory networks for monitoring purposes; and
- The role of civil society, PLWHAs, and family caregivers.

Challenges

- Cost and sustainability of the ARV programme;
- Resistance to drugs, requiring alternative drugs;
- Lack of proper adherence; and
- Drop-outs due to severe side effects or death.

Successes

- Reached a target enrolment of 80,000 in 2005;
- Formed networks to assist with adherence and care-giving; and
- Made efforts to encourage people to come for treatment at an early stage.

Future direction

- Developing an ART benefit package through programmes of universal health assurance, social security fund and co-payment by patients, with the government to ensure sustainability;
- Developing monitoring and adherence programmes;
- Maintaining drug resistance surveillance;
- Development of services relevant to ART, like VCT, and monitoring of CD4 counts in symptomatic HIV infections;
- Addressing issues of a second-line regimen of choices and their associated costs;
- Strengthening NGOs, PLWHAs and caregiver groups; and
- Continuing with capacity-building activities.

Questions and answers

After the presentation, the participants were given an opportunity to ask questions and comment on the content. These are summarized below:

How often are viral loads tested?
Viral load testing is currently not being done due to costs inhibitions.

How is training conducted?
Guidelines for professional training are used and efforts to develop modules for training are being made.

Are nurses considered to prescribe ARVs?
Nurses are currently not prescribing ARVs because they need to acquire more knowledge and training before they can do so.

Is there a problem of transmission by people on ART?
The assumption is that there is no sexual activity during treatment. Patients on ART are educated and prescribed condoms in order to avoid transmission.

What are the side effects and complications of ART?
There are currently no reports available to indicate the exact side effects of ARVs; however, it should be noted that all drugs have side effects.

How is adherence monitored and what is the role of social workers?
Adherence is monitored by using ad hoc questionnaires, surveys and by asking the patients themselves. Social workers are part of the counselling process.

How accessible are ART and CD4 count centres throughout Thailand's provinces?
There are 76 provinces in Thailand, and hospitals send samples to the CD4 centres on a daily basis. Software has also been developed for monitoring, including the use of the internet. The centres are linked to the government computer network.

Are there lower level health institutions in Thailand?

There are health stations which are manned by approximately four health staff, but there are no nurses, doctors or laboratory technicians in these health stations, hence they are not included in the ART programme. There is a hospital in every province.

PLWHA involvement at national and community levels

Over 60,000 patients are currently being cared for in hospices in Thailand. Adherence to ART programmes is quite good in Thailand – approximately 90% of patients return to refill their drug prescriptions. Once patients are enrolled, stringent follow-up is carried out to ensure adherence. In addition, regular meetings are held to discuss relevant lifestyle issues, including coping mechanisms, safe sex, individual responsibility and resistance. Through education, patients understand the issues surrounding ARV treatment and learn of the benefits, therefore encouraging them to practice adherence.

There are currently 160 PLWHA networks in Thailand. Information and training on PLWHA involvement is provided to team leaders of PLWHA networks. Courses are conducted at hospitals on counselling for ART patients and on encouraging adherence. Information is shared with them about the drugs used and their possible side effects, and emphasis is on adherence to the treatment. There is also an emphasis on collaborating with other member networks for transparency purposes.

After the presentation, the participants divided into two groups for discussions. They were asked to discuss and identify common problems and barriers in scaling up the ARV programme in their countries and to propose means to solve the problems and overcome the barriers in order to make the ARV programme sustainable and achievable. The following key issues emerged.

Common problems and barriers

- Overwhelming numbers of people in the region are in need of ARVs, but only a few are able to access them, particularly the marginalized or hard-to-reach groups.
- Due to the overwhelming number of people enrolling into ART programmes, quality is compromised.
- Stigma and discrimination is still rife in many countries, and this affects access to treatment.
- There is a general lack of appropriate infrastructural development, equipment and facilities that could enhance service delivery.
- There is a lack of integration of the various programmes in some countries.
- Capacity of human resources is low in many countries, which is partly attributed to high attrition rates. Follow-up therefore becomes difficult.
- Collection of data and exchange of information is slow between many countries of the region. Countries can learn from each other through evidence-based data and reliable information.
- Voluntary testing facilities are often skewed to urban centres. Rollout and distribution is not uniform.
- Lack of funding and, therefore, programme sustainability concerns arise in most countries.
- Funding is also not uniform in the region since, in some countries, the governments are solely responsible for funding, and in others, other sources like the World Bank support the countries. This has a negative impact on access to ARVs and procurement.
- Countries in the region are at different levels in their ARV programmes.

- ART programmes have difficulty reaching the hard-to-reach areas and populations such as youth and immigrants.
- Supply delays are being experienced in some countries and this impacts negatively on adherence.
- Poor follow-up and monitoring mechanisms exist throughout the region.
- There is a general lack of adherence to medication.
- The role of PLWHAs is not recognized and they are often not involved in the programmes.
- There is poor dissemination of information, especially to the critical mass in the rural areas.
- ART-related training programmes in the region are inadequate.
- Political interference for campaigning purposes disrupts ART programmes in many countries.

Proposed solutions and recommendations

- Offer training, capacity building and support for health workers involved in ART programmes in the region;
- Increase financial assistance to sustain ART programmes;
- Target high-risk groups such as highly mobile people, illegal immigrants, commercial sex workers and homosexuals;
- Decentralize ART services to rural areas, develop mobile centres and install community-based facilities;
- Engage in campaigns to actively encourage enrolment to ART programmes to prolong and improve the quality of life;
- Let people know that ARVs help to reduce stigma and that adherence is key;
- Address legal systems at the appropriate level; harmonize policies with laws;
- Enrol and engage community health workers to educate on adherence;
- Link the various ART programmes with home-based care, PMTCT. VCT and others;
- Intensify mobilization of funding and other resources for infrastructural development and installation of facilities;
- Utilize other trained healthcare cadres like nurses to support doctors;
- Train CBOs and PLWHAs in peer counselling;
- CD4 screening machines are essential and must be obtained;
- Emulate countries like Zimbabwe, which has created trust funds to help sustain ART programmes.

WORKSHOP SESSION TWO: COMMUNITY RESPONSES

SUBJECT AREA 1: COMMUNITY PARTNERSHIPS AND THE ROLE OF FAITH-BASED ORGANIZATIONS

Objectives: To share experiences and lessons on community interventions and inherent challenges, as well as to discuss the role of faith-based organizations in their efforts to deal with the epidemic.

Lead facilitator: Ms. Nonglak Boonyabuddhi

Team members: Dr. Anthony Pramualratana, Mr. Kamon Upakaew, Rev. Dr. Chuleepran S. Persons and Mr. Sompong Chareonsuk

The discussion began with an animated exercise in which the participants had to show, through imagery, the characteristics and situation of communities before the epidemic, shifts and behaviours during the epidemic, and situations (or projected situations) occurring in communities after the epidemic, including strategies required to reverse its spread.

These scenarios are outlined below.

Communities before the epidemic

Before the epidemic, communities were described as largely cohesive, with people living close to each other in harmony. Extended family connections and desirable support mechanisms knitted families together and there was an intact social capital which respected value systems and traditional expectations.

Law and order was maintained through traditional systems, and traditional leaders generally earned respect from their communities.

Participants also described idyllic scenes of favourable natural conditions, i.e. flowing rivers, rainfall and good harvests, which meant less poverty.

Communities during the epidemic

Participants then described some of the issues and situations widely occurring in communities during the epidemic. These included:

Stigma, belief and attitude issues

- Lack of awareness, denial, stigma and discrimination, misconceptions and misunderstandings on the magnitude of the HIV/AIDS epidemic;
- HIV/AIDS deaths blamed on witchcraft and superstitious philosophies, increasing the blame mentality;
- Lack of community support for those affected and infected;
- Silence, fear, confusion and disoriented communities;
- Myths and misconceptions emanating from culture, tradition and customs.

Family issues

- Hiding sick relatives for fear of stigmatization;
- Rising stress levels in individuals and families;
- Mistrust among individuals and families;
- Continuation of gender-based violence originating from the patriarchal system;
- The emergence of an orphan population;
- Speculation about the disease, conspiracies and disintegration of extended family relations.

Economic development issues

- Perceptions of HIV/AIDS as strictly a health issue, rather than a development issue;
- Shifting of already scarce resources from productivity to containing the epidemic;
- Increasing poverty, particularly in rural areas, working against the reversal of the epidemic; Thailand's OTOP programme and its success as an income generation strategy is a lesson learned which could be applied.
- Rising unemployment rates, particularly among young persons and women.

General response issues

- Inadequate initial interventions to deal with the epidemic head-on in its early phases;
- Initial lack of political will to provide holistic strategies to reverse the epidemic;
- Slow response from government and communities;
- Fragmented, uncoordinated response structures which work against a common purpose;
- Mushrooming of CBOs/NGOs and other village structures all groping in the dark to develop strategies to reverse the epidemic.

Communities after the epidemic

After the onset of the epidemic, participants agreed that ideally, communities would acknowledge the epidemic and its impending realities and establish the relevant structures necessary to deal with its spread. They also called for political will and leadership to lead the reversal of the epidemic. In their ideal scenario, strategic linkages would be formed to reverse the epidemic in a coordinated manner. NGOs and CBOs will have stepped up their efforts to focus their programming on combating the epidemic. Funding sources and expenditure budgets will have been put in place to support HIV/AIDS programmes.

The specific **strategies** suggested by the group **to reverse the epidemic** emerged as follows:

- Community empowerment based on participatory methodologies/approaches that enhance community capacity, rather than using the expert-only approach;
- Identification of cultural barriers, religious beliefs and traditional structures and addressing them head-on when facilitating conversations with communities;
- Coordination of the response based on government and civil society structures and consultations;
- Continuous sharing of experiences and best practices across communities, regions, nations, government organizations, NGOs and donors;
- Design of home-grown, implementable programmes through community-friendly dialogue;
- Design and development of simple, participatory evaluation tools that consider the input of communities in order to address the emerging challenges and development of corrective measures;
- Training core groups of facilitators in participant-driven methodologies for them to transfer knowledge and skills to a critical mass and, in particular, community members and youth cohorts;
- Improved allocation of resources based on budgetary processes that consider a joint approach to reversing the epidemic and support NGOs and CBOs in assisting their target groups;
- Creation of HIV/AIDS-competence communities by demystifying the epidemic in an effort to address stigma, denial, secrecy and discrimination;
- Involving, engaging and enrolling PLWHAs in all processes;
- Informed interventions based on research that is shared with the communities;
- Interventions which are not medicalized, but addressed through multi-sectoral approach;
- Developing advocacy strategies to inspire political will and elicit the support of governments and international partners;
- Increasing education and awareness at all levels to include the public sector, private sector, NGOs, CBOs and community stakeholders;
- Regenerating the communities to restore value systems;
- Mainstreaming HIV/AIDS in all sectors to create an understanding of HIV/AIDS as a development issue;
- Lobbying for the review of laws to be in concert with the policies and programmes implemented;
- Mainstreaming gender into HIV/AIDS programmes;
- Fostering understanding of the crucial issue of ART and nutritional supplements to support PLWHAs;

- Encouraging open dialogue on the issue of HIV/AIDS to reduce stigma, spread awareness and share valuable lessons learned, based on the experience of Thailand;
- Ensuring that often-marginalized groups such as gays and lesbians are included in the response;
- Recognition of PLWHAs as an important group in the community, while keeping in mind issues of confidentiality;
- Considering hard-to-reach groups that comprise the informal sector when developing HIV/ AIDS programmes; and
- Emulating Thailand's ASO concept, which has opened up communication between Thailand and African countries.

The contribution of faith-based organizations

After discussions on general community response and intervention methods, Thailand shared its unique experience and success with faith-based organizations. A video was presented which detailed the various approaches, missions, structures, networking aspects, activities and achievements of Buddhist, Islamic and Catholic faith-based organizations in Thailand.

Concern was raised on the common use of the word "victim". A consensus was reached that the word should be avoided when dealing with HIV/AIDS.

In addition, participants sought clarity on the Catholic Church in Thailand's views on the use of condoms. The response was that the Catholic Church in Thailand seemed not to have a problem with this issue.

SUBJECT AREA 2: PARTICIPATION OF PEOPLE LIVING WITH HIV/AIDS

Objectives: To share experiences and lessons learned by PLWHA networks in Thailand and southern African countries; to discuss key factors supporting positive partnerships in HIV/AIDS prevention and care at the community level.

Lead facilitator: Ms. Nonglak Boonyabuddhi

Team members: Mr. Kamon Upakaew, Dr. Anthony Pramualratana, Rev. Dr. Chuleepran S. Persons and Mr. Sompong Chareonsuk

Thailand Network of People Living with HIV/AIDS (TNP+)

Mr. Kamon Upakaew, Chairman of TNP+ began by contextualizing the work of his successful PLWHA organization, sharing background information including the number of HIV/AIDS-related deaths in Thailand. He also discussed the country's previous lack of social acceptance, which led to the establishment of TNP+ in 1997. Today, TNP involves 908 groups and has approximately 70,000 members.

Mr. Kamon elaborated on the goals of TNP+ and its network structure, mentioned issues regarding access to care and resulting policy and advocacy actions by government and civil society. He also detailed the capacity-building efforts of TNP+ to enhance its membership networks and outlined the services provided and participation of members in care services.

Achievements, challenges and lessons learned by TNP+ were the basis for a discussion which followed. Questions and responses are documented below.

Is HIV/AIDS care subsidized for those who are unemployed? Are nutritional supplements included HIV/AIDS care?

National care is guaranteed. In addition, there are scholarship opportunities for education, and an amount is provided for social security. No direct nutritional programme is provided under this scheme, but income-generating activities play a key role in providing economic survival.

Has stigma against HIV/AIDS been combated effectively in Thailand?

Stigma has been reduced, but this took decades to achieve. It is important to note that success in stigma reduction has only been recorded in the northern and central provinces. Thailand's southern provinces still present a challenge in terms of stigma, but people are gradually opening up.

Is there still stigma against core groups such as homosexuals and sex workers? Have these groups gained acceptance in Thailand?

Progress has been made, and homosexuals and sex workers are gaining greater acceptance and support in Thai society; however, misconceptions still continue to cloud people's understandings, particularly on the legal front.

How accessible are ARVs nationwide? Who finances their provision and what role does civil society play?

The ARV programme is supported by the government of Thailand. Civil society assists the hospitals in offering counselling sessions and outreach activities and work to motivate patients to continue taking medications. They also assist with administrative procedures and paperwork to ease the burden on doctors.

Have Thailand's more affluent populations joined in the advocacy movement with other community organizations?

Due to the level of stigma, the affluent shy away from joining active groups that deal with HIV/AIDS. Lack of openness and acceptance from the wealthy still serve as barriers to their participation.

Botswana Network of People with HIV/AIDS (BONEPWA)

Mr. David Ngele of the Botswana Network of People with HIV/AIDS followed the presentation from TNP+ to share his organization's experiences with Thailand and other participating African countries on the subject of PLWHA networks in Botswana.

BONEPWA's work with the PLWHA community adheres to the principle of "Nothing for us without us". This means promoting greater involvement and empowerment of PLWHAs, and embracing the principles of transparency, accountability and confidentiality.

The main objectives of the BONEPWA network are promotion and strengthening of support groups for PLWHAs, information sharing and dissemination, lobbying and advocating for human rights, and capacity building.

The presentation generated a few key questions and comments from the participants, which are included below with their responses

How does the network deal with issues of confidentiality?

Confidentiality is a very broad-based concept. For example, it cannot be guaranteed with health workers. In addition, there are a number of people who are associated with PLWHAs, including direct family members, domestic workers and others. Confidentiality thus becomes a dilemma in terms of deciding who should be involved and determining the appropriate level of confidentiality.

Are there any public personalities openly involved in the operations of the network?

People at the higher levels and in public life often feel inhibited to open up and get involved in the programmes of the network. The issues of stigma, secrecy and denial are still rife among public personalities, particularly those with high social status. More still needs to be done to encourage and motivate people to accept the epidemic.

SUBJECT AREA 3: HIV/AIDS AND EMPLOYMENT: ISSUES IN THE WORKPLACE

Objectives: To exchange views and discussion on best practices and lessons learned from HIV/AIDS workplace organizations in Africa and Thailand.

Lead facilitator: Dr. Anthony Pramualratana

Team members: Mr. Kamon Upakaew, Mr. Sompong Chareonsuk and Ms. Nonglak Boonyabuddhi

Botswana Business Coalition on HIV/AIDS (BBCA)

Mr. Kabelo Ebneng of BBCA discussed his organization's establishment, strategic objectives, national principles, linkages with national programmes and the driving force. He also shared examples of achievements made by BBCA, which involved stakeholder involvement and capacity development. He emphasized the role of the private sector in fighting HIV/AIDS.

Mr. Ebneng shared the results of a recent needs assessment of BBCA which provided valuable feedback, revealing challenges and making recommendations for future improvement.

A question-and-answer period followed the presentation. Issues discussed are documented below.

To what extent does BBCA respond to the informal sector?

Existing structures, such as District Multi-sectoral AIDS Committees (DMSACs), BOCCIM Business Councils and the Chamber of Commerce, are in place and support the informal sector.

Why has the membership drive of the coalition been so slow?

Membership growth is slow, but the coalition depends on its partners, such as the Chamber of Commerce, to support its endeavours.

How does the coalition lobby government support?

The coalition is represented at the National AIDS Council (NAC) level, which is chaired by the President of Botswana. It therefore has an opportunity to influence policy at the highest level.

Do companies in Botswana have programmes for non-office employees?

Some companies do have programmes for non-office employees, but transport companies should be the main focus of immediate interventions.

The steering committee of BBCA seems to exclude trade unions. Why is this?

The Botswana Federation of Trade Unions (BFTU) is on the BBCA membership list. The organization has previously supported the formulation and development of policies, but they seem to have lost interest and need follow up.

In addition to the above questions, Thailand made reference to the hard-to-reach population. BBCA agreed that strategies to reach these groups should be adopted, and lessons from Thailand will be a valuable contribution.

AIDS-Response Standard Organization (ASO) Thailand

Dr. Anthony Pramualratana of followed with a presentation on the ASO concept in Thailand. He shared the six objectives of ASO, covering issues of policy, confidentiality, education on HIV/AIDS in the workplace and promotion of participation and cooperation with the community at-large in AIDS prevention and management.

Implementation methods of various programmes were also shared, including the activities undertaken by ASO.

Questions and answers from the discussion that followed are documented below.

Is it compulsory for a company to have an AIDS policy in place to get involved in the ASO concept?

The strategic move is to put your product line in the market, sell the product for free and engage in awareness creation and training.

Are HIV/AIDS-affected employees often discharged from work, and how does this reconcile with issues of basic human rights?

It is very dependent on the companies that employ people living with HIV/AIDS and those who contract the disease during employment with them. Some companies care and some do not.

There is some ambiguity regarding the statistics on increasing condom usage. Is there an explanation?

Condom usage increase can be confidently reported in the sex worker population; however, success with other groups is uncertain.

How do you ensure that standards are being met in the various workplace programmes?

Surveys are undertaken regularly and the findings inform any corrective actions that may need to be undertaken.

How do local populations respond to instruction on condom usage?

The impact is dependent on who you use to deliver the curriculum. For example, it is easy to talk to young people about sex, but the older generation is more conservative. It therefore depends on the methodology. Peer education strategies are valuable and success factors have been documented.

In addition to the questions above, South African representatives shared a brief example of their nation's own workplace programmes. Workplace programmes exist in South Africa, including in conjunction with health institutions. Interaction occurs with transport companies; for example, roadside clinics are open 24 hours daily. These services provide healthcare access for truck drivers and commercial sex workers. This interaction has helped to strengthen workplace programmes.

It was concluded that the ASO approach is one that could serve as a useful model for the BBCA and other African workplace programmes.

ILO/USDOL International Workplace HIV/AIDS Education Programme

Ms. Marianyana Selelo was the final presenter, sharing the experiences of the ILO/USDOL International Workplace HIV/AIDS Education Programme. She emphasized that HIV/AIDS must also be recognized as a workplace issue, affecting the livelihoods of a large number of people worldwide.

Ms. Selelo shared the programme's strategies and interventions at the enterprise level and reported on achievements, challenges and lessons learned.

Questions and comments raised in the discussion that followed are documented below.

Is there any linkage between the ILO/USDOL programme and the church?

The church does play a major part in HIV/AIDS issues in general, and the workplace should develop strategic linkages in this regard.

People living with HIV/AIDS are often unfairly discharged from the food industry. What is being done to discourage these lay-offs?

Terminating employment of HIV/AIDS-affected employees in the food industry does indeed happen; however, because policies and laws are not harmonized, many challenges exist.

Have the transport, agricultural and mining sectors been excluded from involvement in the programme? Why is this?

The exclusion of other sectors is due to inadequate resources; however, programme is working on ways to involve these and other sectors in some way.

Has the loss of income on the workers' side been effectively measured?

The loss of worker income cannot be easily measured because a cost-benefit analysis has not yet been undertaken.

How does the programme respond to reports of unfair treatment of workers in particular regions and areas?

The presenter noted that issues of unfair treatment need further investigation.

SUMMARY OF CLOSING REMARKS

Mr. Kittiphong na Ranong
Director-General
Department of International Organizations
Ministry of Foreign Affairs, Thailand

The Director-General closed the workshop by explaining that this forum was about sharing experiences with African countries and not an intention to lecture to them. He emphasized the importance of reinforcing South-South partnerships and said that further partnerships between Thailand and southern Africa should be promoted through further networking visits.

Prevention, care, the issue of orphans, reaching vulnerable groups, home-based care and nutritional aspects should be considered as key when implementing programmes, he explained. Distinction must also be made between levels of the epidemic and appropriate strategies developed for specific target groups and groupings of SADC countries.

Lessons can be learned from Thailand's experiences with PMTCT programmes, and communication channels to exchange information are necessary. Information management systems thus become key.

Inter-faith strategies and programmes can also be shared as valuable lessons, and a task force on inter-faith strategies can be established and information forwarded to SADC countries through UNDP.

Networking on condom programmes and study visits should occur, on all strategic components of the programme. Information dissemination and lesson exchange between Thailand and African countries can also occur in the following areas: clinical research, youth-friendly ARV services, behavioural change strategies, development of generic drugs and related issues with TRIPs and the Doha Declaration, and capacity-building initiatives.

Income-generating activities are further lessons that can be shared between Thailand and African countries, the Director-General said, citing Thailand's OTOP project, which has been received with much success in Thailand's more remote provinces.

Innovative strategies can also be shared on combating the spread of HIV/AIDS among particularly at-risk groups such as MSMs, prison inmates and sex workers.

The Director-General cited the issue of sustainability of ARV programmes as critical to ensuring that people already on treatment can continue receiving it. He cited the need to identify specific sources of ARV drugs which are affordable for people in the region.

Comprehensive and similar strategies towards combating the epidemic are required across entire regions to ensure effective impact; HIV/AIDS knows no borders. The Director-General thus recommended harmonizing differing protocols because of the high mobility of populations in SADC countries. The need for monitoring of intergenerational transmission is also critical.

Private sector participation in prevention and care is a critical step, and the best approach is to advocate for comprehensive workplace programmes. In addition, adopting the concept of "nothing for us without us" will help to ensure the full participation of PLWHAs in all policy making and programming.

The Director-General closed by reminding the participants that all the strategies to reverse the epidemic will need high-level political involvement to mobilize national resources; thus, negotiation with national leadership should be a priority.

Ms. Viola Morgan
UNDP Resident Representative, a.i. for Botswana

In her closing remarks, the UNDP Resident Representative, a.i. confirmed the success of the workshop in making significant inroads into the South-South cooperation. The experiences shared and commitment demonstrated is evidence of an effort to collectively overcome common challenges, she said.

She praised the emerging recommendations as valuable, but reminded the participants that they require further refinement by policy-makers and partners in order to see them to full implementation. The challenge now, she stated, is to take the lead and continue to work towards translating the recommendations into concrete actions.

Sharing of experiences is key to generating win-win strategies, she said, as similarities prevail across the region, and resources are limited. "Re-inventing the wheel", she explained, or constantly having to develop new interventions from the ground up defeats the purpose.

Ms. Morgan said that the workshop proceedings clearly demonstrated that behavioural change is key to turning the tide of the HIV/AIDS epidemic in Southern Africa. The statistics have always given a human face to the pandemic, she said, and thus involving people should be at the heart of any response.

In this regard, Ms. Morgan closed by emphasising that partnering is a brilliant idea which must be sustained. "Let us involve communities in responding to the epidemic," she said. She reminded the participants that the next generation – today's children – are going to judge us, and that therefore, "We should be determined to leave behind an AIDS – free generation."

Mr. R. Dimbungu
Director
National AIDS Coordinating Agency (NACA), Botswana

In bringing the workshop to a close, the NACA director thanked the participants for an exceptional and successful workshop. This success, he explained, was drawn from the lessons and experiences shared, which will generate future innovative strategies that can be sustained.

The valuable dialogue that occurred, he said, encourages the involvement of communities to turn the tide – a lesson for all participants to take back home and implement.

The idea of bringing together experts from various backgrounds is phenomenal in itself, he added, praising the Thai government for its offer to share its valuable lessons and experiences combating the HIV/AIDS epidemic. The efforts of the Thai government should be greatly acknowledged and commended, he said, and expressed thanks for their offer to collaborate with African countries.

The Director also acknowledged UNDP as a vital partner and commended its collaborative efforts in making the workshop a success. He also extended gratitude to all the delegates from the African countries represented and expressed the hope for sustained partnership with Thailand, which will hopefully lead to development, implementation and sustainability of programming.

CONCLUSIONS AND RECOMMENDATIONS

The following conclusions and recommendations emerged during the final wrap-up session. This session brought together all the participants after the two workshop sessions on national and community interventions in order to synthesize the information gleaned from both, and draw conclusions and recommendations upon which new strategies can be based.

Strengthening partnerships

- The most strategic move is to sustain dialogue and partnership amidst struggles and face challenges collectively to find the possible solutions.
- When the next South-South meeting occurs, each country should be given an opportunity to share experiences during presentations.
- Countries should continue sharing appropriate creative behavioural change strategies through appropriate participatory methods.
- An Inter-faith information-sharing forum between religions and between countries, such as Zingo inter-faith in Zambia, is a good approach to emulate.
- Comprehensive reporting and documentation of findings in the region must be strengthened and shared.

Eliminating stigma

- Stigma and misconceptions surrounding the epidemic and on prevention measures such as condom usage are widespread throughout SADC countries and must be eliminated.
- The challenges of behavioural change are paramount, and countries should endeavour to develop focused programmes to motivate behavioural change.
- The media should be engaged to encourage objective reporting, prevention awareness raising, and eliminate stigma and discrimination.

Strengthening community and private sector involvement

- Civil society programmes, particularly preventive efforts among young people, effective treatment and care, adherence to medication and ART management are of paramount importance.
- Standardized training for the workplace is important. The evaluation and accreditation of workplaces is an important strategy and providing incentives for companies to keep improving their work environment is a step in the right direction.
- Financial management training for NGOs is a critical factor towards ensuring sustainability.

Encouraging government involvement

- Governments should endeavour to decentralize their budgets to achieve community capacity enhancement.
- There is currently no legislation in place to enforce national workplace policies. Policies should be enforced through legislation. For example, governments should use tax exemption or appropriate incentives for companies implementing workplace programmes.
- Income generation activities should also be regular activity for all NGOs and PLWHA networks – a lesson that can be learnt from Thailand.
- There is a need for the involvement and participation of communities and PLWHAs from the initial stages through to implementation and monitoring.

Enhancing programming strategies

- A comprehensive tool kit should be provided to programme organizers as a starter kit. Collect other tool kits and share these between countries.
- Condom promotion and distribution should take into consideration prevalence of pregnancy, STDs, and condom use by those on ART as indicators of evaluation.
- Evidence-based strategies must be used rather than programmes based on generalization.
- Increased involvement of those already working in the field, such as child care-givers and health workers should be encouraged.
- Existing regional structures should be used to move programming agendas forward. Marginalized communities currently not provided with services need the development of messages and communication tools to reach them.
- Incorporation of 1st-, 2nd- and 3rd-line ARV regiments into programming guidelines is key.

Reaching out to marginalized groups

- Concrete strategies to reach hard-to-reach groups must be developed, based on experiences shared through the Zimbabwe E-forum.
- More youth representation should be ensured in next forum for more experience sharing.
- Promoting gender equality is critical. Current sexual dynamics are fuelling the spread of the epidemic.
- In the next forum, more PLWHAs should be included, as well as core groups such as youth, gays, people with disabilities and sex workers.
- More men should be engaged and enrolled in programming and advocacy measures.
- PLWA involvement in patient management; adherence, compliance and hospital support is an important approach.

ANNEX I
WORKSHOP PROGRAMME

Wednesday, 16 November 2005

08:30-09:00	Registration
09:00-09:45	**Opening Ceremony** Welcome address by Dr. T.L. Moeti, Deputy Permanent Secretary, Ministry of Health, Botswana Welcome address by Ms. Viola Morgan, UNDP Resident Representative, a.i. for Botswana Welcome address by H.E. Dr. Virachai Virameteekul, Vice Minister for Foreign Affairs, Thailand Welcome address by Lt. Gen. Mompati S. Merafhe, Minister of Foreign Affairs and Internal Cooperation, Botswana
10:00-12:00	**Expert Panel Discussion: HIV/AIDS Policy Responses and Challenges** *The Overall Situation and Challenges for HIV/AIDS Prevention and Care in Africa* by Mr. Kwame Ampomah, UNAIDS Country Coordinator, Botswana and representative of the National Aids Coordinating Agency (NACA) *Botswana's HIV/AIDS Situation: Challenges for Prevention and Care* by Mr. Peter Stegman, TITLE, ORGANIZATION *Thailand's Policies and Challenges on HIV/AIDS* by Dr. Siriporn Kanshana, Inspector-General, Ministry of Public Health *Civil Society Response to HIV/AIDS in Botswana* by Mr. D. Motsatsing, Botswana Network of AIDS Organizations (BONASO)
13:30 - 17:30	**SESSION I: NATIONAL RESPONSES** *Prevention of Mother-to-Child Transmission* **Facilitator**: Dr. Somsak Pattarakulwanich **Team members**: Dr. Siriporn Kanshana, Mrs. Achara Eksaengsri *Condom Programmes* **Facilitator**: Dr. Sombat Thaenprasertsuk **Team members**: Dr. Somsak Pattarakulwanich, Mrs Achara Eksaengsri **SESSION II: COMMUNITY RESPONSES** *Community Partnerships and the Role of Faith-based Organizations* **Facilitator**: Ms. Nonglak Boonyabuddhi **Team members**: Dr. Anthony Pramualratana, Mr. Kamon Upakaew, Rev. Dr. Chuleepran S. Persons, Mr. Sompong Chareonsuk
18:30	**Delegate Reception** Hosted by H.E. Vice Minister for Foreign Affairs of Thailand

Thursday, 17 November 2005

09:00 - 12:30	**SESSION I: NATIONAL RESPONSES (continued)** *Antiretroviral Procurement and Monitoring Systems* **Facilitator**: Mrs. Achara Eksaengsri **Team members**: Dr. Sombat Thaenprasertsuk, Dr. Somsak Pattarakulwanich **SESSION II: COMMUNITY RESPONSES (continued)** *Participation of People Living with HIV/AIDS* **Facilitator**: Ms. Nonglak Boonyabuddhi **Team members**: Mr. Kamon Upakaew, Dr. Anthony Pramualratana, Rev. Dr. Chuleepran S. Persons, Mr. Sompong Chareonsuk
13:30 - 17.30	**SESSION I: NATIONAL RESPONSES (continued)** *National Antiretroviral Programmes* **Facilitator**: Dr. Sombat Thaenprasertsuk **Team members**: Dr. Siriporn Kanshana, Dr. Somsak Pattarakulwanich, Mrs. Achara Eksaengsri, Mr. Kamon Uppakaew **SESSION II: COMMUNITY RESPONSES (continued)** *HIV/AIDS and Employment: Issues in the Workplace* **Facilitator**: Dr. Anthony Pramualratana **Team members**: Ms. Nonglak Boonyabuddhi, Mr. Kamon Upakaew, Mr. Sompong Chareonsuk
17:30	Discussion and Wrap-up among Team Members from Thailand

Friday, 18 November 2005

09:00-10:30	**Wrap-up Presentation & Discussion: National and Community Responses on HIV/AIDS** **Co-Moderators**: Mr. Sompong Chareonsuk, UNAIDS Thailand; ARR and Focal Point on HIVAIDS, UNDP Botswana
10.45-12:00	**Plenary Discussion: The Way Forward for Cooperation Among Thailand and African Countries** **Co-Moderators**: Mr. Sompong Chareonsuk UNAIDS Thailand; Mr. Peerasak Chantavarin, Department of International Organizations, Ministry of Foreign Affairs of Thailand
12:00 - 12.30	**Closing Ceremony** Closing remarks by Mr. Kittiphong na Ranong, Director-General, Department of International Organizations, Ministry of Foreign Affairs of Thailand Closing remarks by Ms. Viola Morgan, UNDP Resident Representative, a.i. for Botswana Closing remarks by Mr. R. Dimbungu, Director, National AIDS Coordinating Agency (NACA), Botswana

ANNEX II
OPENING ADDRESS

Opening Address by
H.E. Dr. Virachai Virameteekul
Vice Minister for Foreign Affairs of Thailand

Excellencies,
Distinguished guests and participants,
Ladies and gentlemen,

First of all, I wish to thank the Deputy Permanent Secretary of the Ministry of Health for being with us today, and express my appreciation to Botswana for co-hosting the "Workshop on Comprehensive Response to HIV/AIDS Prevention and Care". My special thanks also go to the offices of the United Nations Development Programme in Thailand and Botswana for co-organizing this Workshop with Thailand.

Please allow me to welcome the participants from Botswana, Lesotho, Madagascar, Mozambique, South Africa, Swaziland, Zambia and Zimbabwe. The high-level representation of top policy-makers and key actors is not only an encouragement, but also a blessing for future implementation of policies that will be born out of this workshop. Your representation offers hope to those who are hopeless.

Ladies and gentlemen,

Thailand attaches high priority to Africa. Under "Forward Engagement" policy, Thailand is determined to expand our partnership with African countries. It is our conviction that the Year 2005, which is our "Year for Africa", would pave the way for a long journey towards productive partnership.

The cooperation with the African region is based upon our firm commitment to the Eighth Millennium Development Goal, namely Global Partnership for Development. In this connection, Thailand and UNDP jointly organized a forum called the *"Consultation on Africa-Thailand Partnership for Development"* in Bangkok last year. The forum was aimed at defining the scope and priority of Thailand's development cooperation with Africa.

Earlier this year, Thailand and UNDP also co-organized the first workshop on HIV/AIDS prevention and care in Nairobi. During the workshop, participants from ten central and northern African countries sincerely exchanged experiences and deliberated over the way forward. The earlier workshop and the one today are a testimony to our effort to promote the South-South cooperation. Let us do our best to ensure that this process continues with a strong momentum.

Ladies and gentlemen,

We are now standing before a struggle of historic proportion. 70 million lives would be lost by the year 2010. This is more than a statistic. This is tragedy. In the face of new advance in medicine and science this is unacceptable. We must do more, much much more, to reinforce our solidarity in the fight against HIV/AIDS.

And this is precisely why we are here today. To supplement the international endeavors already pursued by governments around the world and UN agencies. Thailand has learned a painful lesson on how to cope with the deadly disease, and we would humbly like to share our experiences in the next few days.

In our battle with the disease, we have found it useful to build a caring society. In short, there must be community responses to HIV/AIDS. We must allow participation of people living with HIV/AIDS. We must incorporate them into the workplace. All these issues are to be fully discussed. Learn with us the lesson of grace and compassion.

We would also like to discuss our experiences with the ARV National Programme, and the ARV Procurement and Monitoring System. We must find ways to make it affordable to all, not only for the few, because so many precious lives depend on it. We no longer have the luxury to be patient.

Ladies and gentlemen,

Thailand, in our capacity as the Chairman of the Human Security Network, has established partnerships with NGOs, civil societies and the private sector to involve multi-stakeholders in this important process. Recognizing that HIV/AIDS is not only a health concern but also a threat to human security, the Network has now developed a medium-term plan, in order to raise awareness on preventing the spread of the disease.

The Network, whose members and observers are from all continents, aims at creating a world where people are free from fear, free from want and are able to live in dignity.

Ladies and gentlemen,

In closing, I challenge everyone in this great hall to make sure that the second workshop will be as successful as the first one, if not more. I challenge you to make suggestions and recommendations, however ambitious. So that there would be less suffering outside this great hall.

For we are now a world at risk. HIV/AIDS has claimed more lives than any weapons of mass destruction. WE must mean what we say, when we say the fight against HIV/AIDS is a race against time. And we must all fight it as a team. Together. Asia, Africa, and the world.

Thank you.

ANNEX III
LIST OF PARTICIPANTS

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