REPORT OF THE JOINT FORUM INCORPORATING THE
Consultation on
Integrating Prevention
& Management of STI/HIV Into
Reproductive, Maternal
& Newborn Health Services

AND THE

6th UN Asia-pacific PMTCT Task Force Meeting

KUALA LUMPUR, MALAYSIA
6-10 November 2006

CONVENED BY
Table of Content

List of Abbreviations 1
Executive Summary 5
Background 8
Presentation Summaries 10
Annex 1: Agenda 34
Annex 2: List of Participants 35
Annex 3: Evaluation Summary 62
## LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFRH</td>
<td>Adolescent-friendly reproductive health (services)</td>
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<td>AFS</td>
<td>Adolescent-friendly services</td>
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<td>AH</td>
<td>Adolescent Health</td>
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>ARV</td>
<td>Anti-retroviral (drugs)</td>
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<td>ART</td>
<td>Anti-retroviral treatment</td>
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<td>ASEAN</td>
<td>Association of South East Asian Nations</td>
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<td>ASRH</td>
<td>Adolescent sexual and reproductive health</td>
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<tr>
<td>AZT</td>
<td>Zidovudine (ZDV, Retrovir)</td>
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<td>BCC</td>
<td>Behavior change communication</td>
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<td>BSS</td>
<td>Behavioral surveillance surveys</td>
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<td>CDC</td>
<td>Centers for Disease Control</td>
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<td>CMV</td>
<td>Cytomegalovirus</td>
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<td>CST</td>
<td>UNFPA Country Support Team</td>
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<tr>
<td>CSW</td>
<td>Commercial sex worker</td>
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<td>CTX</td>
<td>Cotrimoxazole</td>
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<td>DBS</td>
<td>Dry blood spot</td>
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<td>DNA</td>
<td>Deoxyribonucleic Acid</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>EAPRO</td>
<td>Unicef East Asia and Pacific Regional Office</td>
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<td>ELISA</td>
<td>Enzyme-linked immunosorbent assay</td>
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<td>ESEA</td>
<td>UNFPA Regional Office for East and South East Asia</td>
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<td>EVA</td>
<td>Especially vulnerable adolescents</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>FSW</td>
<td>Female sex worker</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>GIPA</td>
<td>Greater Involvement of People with AIDS</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>IDU</td>
<td>Injecting drug user</td>
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<td>IEC</td>
<td>Information, education, communication</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>IPR</td>
<td>Intellectual Property Rights</td>
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<td>IRIS</td>
<td>Immune reconstitution inflammatory syndrome</td>
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<tr>
<td>KAPB</td>
<td>Knowledge, attitudes, practices and behavior</td>
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<tr>
<td>MAC</td>
<td>Mycobacterium avium complex</td>
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<tr>
<td>MARA</td>
<td>Most at risk adolescents</td>
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<tr>
<td>MCH</td>
<td>Maternal and child health</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MNCH</td>
<td>Maternal, newborn and child health</td>
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<td>MNH</td>
<td>Maternal and newborn health</td>
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<tr>
<td>MoE</td>
<td>Ministry of Education</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSM</td>
<td>Males who have sex with males (or men who have sex with men)</td>
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<td>MTCT</td>
<td>Mother-to-child transmission</td>
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<tr>
<td>NAC</td>
<td>National AIDS Committee</td>
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<td>NAP</td>
<td>National AIDS Program</td>
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<td>NGO(s)</td>
<td>Non-governmental organization(s)</td>
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<td>NNH</td>
<td>Neonatal health</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>NSP</td>
<td>National HIV Strategic Plan</td>
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<tr>
<td>OI</td>
<td>Opportunistic infections</td>
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<td>OVC</td>
<td>Orphans and vulnerable children</td>
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<tr>
<td>PCP</td>
<td>Pneumocystis jiroveci pneumonia (formerly Pneumocystic carinii pneumonia)</td>
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<tr>
<td>PCR</td>
<td>Polymerase chain reaction</td>
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<tr>
<td>PED</td>
<td>Peer education</td>
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<tr>
<td>PLWHA</td>
<td>PLWHA People living with HIV and AIDS</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
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<tr>
<td>PNG</td>
<td>Papua New Guinea</td>
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<tr>
<td>PPTCT</td>
<td>Prevention of parent-to-child transmission</td>
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<tr>
<td>Prong 1</td>
<td>Primary HIV prevention in girls/women and their partners</td>
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<td>Prong 2</td>
<td>Prevention of unintended pregnancies in girls/women who are HIV-infected</td>
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<tr>
<td>Prong 3</td>
<td>Prevention of mother to child transmission (during pregnancy, delivery, breast feeding)</td>
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<td>Prong 4</td>
<td>Follow-up, care and support for HIV-positive mothers, their children and partners</td>
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<td>PSA</td>
<td>Public service announcement</td>
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<td>PSM</td>
<td>Procurement supply management</td>
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<td>QI</td>
<td>Quality improvement</td>
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<tr>
<td>RH</td>
<td>Reproductive health</td>
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<tr>
<td>ROSA</td>
<td>Unicef Regional Office for South Asia</td>
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<tr>
<td>RNA</td>
<td>Ribonucleic Acid</td>
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<tr>
<td>RST</td>
<td>UNAIDS Regional Support Team</td>
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<tr>
<td>SAARC</td>
<td>South Asia Association for Regional Cooperation</td>
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<tr>
<td>SEARO</td>
<td>WHO South East Asia Regional Office</td>
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<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>SW</td>
<td>Sex worker</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TG</td>
<td>Transgender</td>
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<tr>
<td>ToT</td>
<td>Training-of-trainers</td>
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<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>TRIPS</td>
<td>Trade-related aspects of intellectual property rights</td>
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<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Programme on HIV</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNESCO</td>
<td>Nations Education, Scientific and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV/AIDS</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crimes</td>
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<tr>
<td>UNTG</td>
<td>United Nations Theme Group on HIV</td>
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<tr>
<td>VCCT</td>
<td>Voluntary and confidential counseling and testing</td>
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<tr>
<td>VCT</td>
<td>Voluntary counseling and testing</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>WPRO</td>
<td>WHO Western Pacific Regional Office</td>
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<td>WTO</td>
<td>World Trade Organization</td>
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WHO, UNICEF, UNFPA and UNAIDS co-convened a Joint Forum in Kuala Lumpur, Malaysia, between November 6th – 10th 2006. The joint forum consisted of two linked meetings:

- The Consultation on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services, and

150 participants from 20 Asia and Pacific countries attended the Joint Forum, consisting of members of government and non-governmental organizations, young people, people living with HIV, academia and donors, UN professionals from headquarters, regional and country offices from WHO, UNICEF, UNFPA, UNAIDS and UNDP. The countries represented were Afghanistan, Bangladesh, Bhutan, Cambodia, China, India, Indonesia, Kiribati, Lao People’s Democratic Republic, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, Papua New Guinea, Philippines, Sri Lanka, Thailand, Timor Leste and Vietnam. Also in attendance were representatives from the ASEAN and SAARC Secretariat.

The interlinked meetings jointly addressed three agendas:

1. to achieve better integration of HIV and STI interventions with Sexual and Reproductive Health, Mother and Child Health and Family Planning
2. to strengthen the comprehensive approach to PPTCT,
3. to expand access to treatment and care for HIV positive pregnant adolescent girls and women, their partners, and their children.

The objectives of the Consultation on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services were to share country experiences in integrating these programs and services; to discuss guidelines for pregnancy, childbirth, postpartum and newborn care and propose a framework to integrate prevention and management of STI/HIV into reproductive, maternal and newborn health service; and to develop recommendations for UN agencies, through UN Theme Groups on HIV and AIDS to collaborate with Member States for integrating prevention and management of STI/HIV into the aforementioned services. Discussion revolved around a draft framework on integration developed by Dr. Wendy Holmes of the Burnett Institute in Australia. This framework will continue to be developed and refined during the coming months, incorporating comments and suggestions made by participants at the Consultation.

The key recommendations from the Integration Consultation had two parts:

1) For the revision of the draft framework, the general comments are:
   - The framework to be shorter and a more user friendly format
   - A clear statement to be made on the target that the framework is meant for, i.e. programme managers and service providers
   - To consider having separate sections to deal with technical issues, non-technical issues and policy matters
   - To ensure that the framework will be useful to all countries and to meet the needs of countries at different stages.

2) The recommendations for the “next steps” are:
   - All countries will undertake broader national level consultation, to reach consensus on the Framework, and develop plans to implement the Framework, once the draft is finalized, incorporating the participants’ suggestions for revisions.
   - Notwithstanding this effort, some countries have already started, and others are ready to develop guidelines on integration of HIV/STI prevention into reproductive, maternal and newborn health.
   - Almost all countries will need to harness or further strengthen political commitment and formulate a clear policy on prevention of STI/HIV for pregnant adolescent girls.
and women, their partners, and their children, and in doing this, to ensure that services are integrated.

- Advocacy will go beyond policy makers and national leadership, and will engage the media more actively and effectively reach the communities.

- Partnership and intersectoral/interagency collaboration was a common theme among all countries, and many of the countries have indicated the mechanism and identified the partners to be engaged.

- Most countries emphasized the issue of lack of resource as a major constraint, and recommendations were made to secure resources, which include human resource in all related disciplines such as clinical, laboratory, counselling, (numbers, knowledge, skills, expertise), equipment, drugs.

- In respect to lack of resources, many countries mentioned the role of donor agencies in fragmenting or integrating services, either in the effort to initiate a programme or in scaling up, and the need to ensure coordination among donors.

- Capacity strengthening was emphasised by many countries, especially by those countries where programmes to prevent STI/HIV have not begun or have only just begun.

- Some countries recommended activities to include or to reach out more to marginalized groups such as sex workers, injecting drug users and men who have sex with men.

- Information and data management was identified as an area of concern for further action to be taken by almost all countries. One specific activity suggested related to this was to conduct a facility mapping.

The PMTCT Task Force components on prong 1 (primary prevention of HIV) and 2 (prevention of unintended pregnancies in adolescent girls and women living with HIV) were incorporated in the first half of the Joint Forum, during the Consultation on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services. The remaining 2.5 days of the PMTCT Task Force meeting examined recent global knowledge and progress in the region on PMTCT and Paediatric HIV and AIDS, with the aim of scaling up coverage and intensifying action on the four-pronged comprehensive approach to PPTCT (primary prevention of HIV, prevention of unintended pregnancies in HIV positive girls/women, prevention of mother to child transmission, care and support for children and mothers of HIV-positive adolescent girls and women without any consent. Participants specifically recognized the importance of protecting the reproductive rights of HIV-positive adolescent girls and women in making informed decisions on family planning.

The key elements discussed in 2006 PMTCT Task Force meeting were integration of PMTCT into MCH, FP/RH, STI services, technical updating and new tools on PMTCT and Paediatric AIDS, practical experiences across all 4 prongs and across countries, importance of procurement, supply chain management for basic PMTCT packages, and intellectual property law and rights, monitoring and evaluation (M&E) – ‘a part of the whole’, HIV and Infant Feeding, and involvement of male partners. Due to the efforts made by many countries in the region, PMTCT and paediatric HIV and AIDS are firmly entrenched in Universal Access and there is a recent greater global commitment to children.

3 Greater involvement of males in Sexual Reproductive Health and Maternal and Neonatal Health

All participants agreed on the need for greater male/partner involvement in the sexual and reproductive health of adolescent girls and women, and the health of their children. It was also agreed that male STI patients should be asked whether their wives are pregnant, breastfeeding, planning pregnancy, and encouraged to bring their wives for assessment and treatment. Participants recognized the importance of male partners being counseled on the increased susceptibility of girls and women to HIV during pregnancy, and on the risk of mother to child HIV transmission.

4 PPTCT programming should be targeted, evidence-based and result orientated

The meeting made a strong call for PPTCT programming to be evidence-based with measurable indicators. Innovative ways need to be found to reach adolescent girls, women and families at increased risk of HIV-infection based on a country’s epidemic situation and capacity to respond such as through non-test dependent primary prevention services provided at MCH/ANC centers or out-reach VCT services in selected areas. It is important that one particular PPTCT model does not fit all countries in the region.

5 Have a broad approach to comprehensive PPTCT

In countries and areas with low prevalence of HIV and early epidemics it is important to prioritise primary prevention of HIV, assisting girls, women and couples that want to avoid pregnancy, and population level interventions including promotion of exclusive breastfeeding for all mothers and babies. Special efforts need to be made through outreach and referral to enable marginalized pregnant girls, women and their partners to access HIV prevention and care services, including counseling and testing, with antiretroviral prophylaxis and safer infant feeding counselling for those who test positive.
6 Ensure a continuum of care

Prevention, treatment, care and support services need to be seen as a continuum. Depending on the HIV-status of a person, and if asymptomatic or symptomatic, the types of services he or she needs will change. Effective referral systems have to be developed to ensure that people living with and affected by HIV, especially HIV infected pregnant adolescent girls and women can benefit from the variety of services at the community and institutional levels throughout the course of infection and disease. PMTCT services need to be harmonized and effectively linked with the overall national continuum of care services so that HIV infected pregnant adolescent girls and women who need treatment for her own health can benefit.

7 Follow-up and diagnosis of the HIV-exposed child

Participants recognized that follow-up is a weak component of PPTCT in most countries. Different entry points for pediatric HIV testing have been identified through the course of the meeting. Better diagnostics such as DNA PCR as well as guidelines for pediatric HIV diagnosis are now available. However, the technology and costs are major obstacles for countries in the region (except Thailand) to implement at national level. New technologies (such as the dried-blood-spot technique-DBS) need to be assessed at country-level to see how they can enhance programming i.e. having a regional reference laboratory where countries can send their DBS and get the results back instead of installing expensive DNA PCR in countries with a lower HIV case load.

8 Build capacity at country level within rollout plans to manage Paediatric ART

Country-level capacity to manage paediatric HIV is weak. Participants recognized a need for estimations and projections, developing national guidelines, developing training manuals, training health care workers and counselors, as well as workers from relevant NGOs and organizations of PLWHA, and developing a procurement and supply management system. Countries should come up with a strategic plan with how to rollout Paediatric HIV management, which will be extremely helpful for resource mobilization and achieving set targets at different levels.

9 Identify TRIPS flexibilities

Availability and affordability of ARVs at country-level is crucial for comprehensive HIV programming. The Agreement on Trade-Related aspects of Intellectual Property rights (TRIPS) contains provisions that allow a degree of flexibility for governments to accommodate their own patent and intellectual property systems and developmental needs, including the need of affordable access to existing medicines. These flexibilities need to be reviewed at country-level and, if applicable, enacted into national law in order to allow for access to cheaper medicines.

10 Universal Access covers prevention, treatment, care and support of which ARVs (Anti Retro Viral drugs) are only one part. Consider a “package” of supplies

Program planning needs to be closely coordinated with procurement planning. Efficient and sustainable procurement and supply management should coordinate supplies needed for HIV prevention, treatment, care and support, reproductive health, maternal and child health, preventing and treating sexually transmitted infections, tuberculosis, malaria and other related diseases.

11 Consider incorporating additional PPTCT prongs 1, 2 and 4 process indicators into National HIV Monitoring and Evaluation Frameworks

Global indicators for PMTCT mainly reflect process in prong 3 interventions; suitable process indicators for prongs 1, 2 and 4 need to be derived. Examples could be “number of condoms distributed at ANC sites”, “number of HIV-positive pregnant adolescent girls/women referred to Family Planning from ANC”, as well as “number of PMTCT services that refer to care and support” and “number of mothers who receive free counselling on infant feeding at the first post-natal infant follow-up”.

12 Incorporate PPTCT monitoring into the National Health Management Information System

At present, many countries have a specific PPTCT reporting, monitoring and evaluation system separate from the National Health Management Information System. Incorporating PPTCT reporting and monitoring into the National Health Management Information System ensures sustainability and consistent use of the data nation-wide.

13 Recommendation on the future of Asia Pacific UN PMTCT Task Force

At the conclusion of the meeting, participants discussed the future direction of the Task Force and agreed upon the following recommendations:

• The Task Force mandate will formally include PPTCT and Paediatric HIV and AIDS
• Membership of the Task Force should be leaner, with a maximum of three to four participants from countries to be formally led by the National PMTCT/ PPTCT Manager/Focal Point and Paediatric Manager/Focal Point.
• Task Force meetings will continue to focus on: technical updating; programming scale-up progress and action plans; review of progress on key recommendations from previous Task Force meetings.
• Monitoring of progress on key recommendations will be followed up every six months at national level jointly by UNICEF/WHO (including ensuring availability of technical assistance) to countries.
• Given the upcoming ICAAP meeting (Sri Lanka, August 2007), and other regional consultations foreseen for 2007, the next UN Asia Pacific PMTCT Task Force meeting will take place in 16-18 months time (late February 2008).
Background

Approximately 39.5 million people were living with HIV in 2006, 2.6 million more than in 2004; nearly half of all people living with HIV are now female.1

Over the past year there have been increasing commitments to the goal of universal access to HIV prevention, treatment, care, and support interventions in the Asia Pacific region. Universal access to comprehensive prevention services is an urgent priority, both as a goal in itself and as a means to ensure the affordability and sustainability of treatment in the long term.

As the UN Secretary-General’s report to the 2006 High Level Meeting on HIV and AIDS highlights, the target of universal access is premised on the need for strengthened integration of HIV and AIDS responses with broad-based strengthening of health, education, and other social services. Critically within this is the need to integrate and link efforts to prevent HIV infection and STIs (Sexually Transmitted Infections) into the broader health system of preventive, promotive and curative aspects of Sexual and Reproductive Health (SRH), Maternal and Child Health (MCH), Adolescent Friendly Sexual Reproductive Health (ASRH), and Newborn Health (NBH) Services which has long been acknowledged and widely advocated.2,3,4,5,6,7,8 Yet, progress towards integration and linkages has been slow. Most policy and technical advice and support continue to come from different directions; programme funding and management responsibilities differ; and as a result prevention interventions and services often remain separate.

Prevention of HIV-infection in boys, men, girls and women of reproductive age (PPTCT prong 1) is the long-term solution for preventing HIV in newborns and children. To date, however, action to prevent HIV infection in children has largely been focused on preventing vertical transmission from an HIV-infected mother to her newborn during delivery (prong 3) and during lactation. Statistical modeling shows that, even with much higher coverage in antenatal care, HIV testing, provision of antiretroviral prophylaxis prior to and during delivery, and with counseling on infant feeding, the United Nations’ General Assembly Special Session on HIV’s goal of reducing HIV infection among children by half by 2010 will not be achieved. There is an urgent need to reach adolescent girls, women of reproductive age, and their partners in healthcare and community settings for primary HIV prevention interventions, and to prevent unintended pregnancies in HIV-infected adolescent girls and women.

With the growing emphasis on increasing access to treatment in many countries, there is potential for both using PMTCT as a major entry point for prevention, early care, support and treatment of mothers, fathers/partners, and children identified through the program, and integrating PMTCT into existing ARV treatment programs.

Based on the need for a coherent approach for program and service integration in countries in the region, WHO, UNICEF, UNFPA and UNAIDS co-convened a Joint Forum in Kuala Lumpur, Malaysia, between November 6th – 10th 2006. The Joint Forum consisted of two linked meetings:

- The Consultation on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services, and

Delegations from 20 countries attended the Joint Forum, consisting of approximately 150 members of government and non-governmental organizations, young people, people living with HIV, academia, donors, UN agency personnel from headquarters, regional and country offices from WHO, UNICEF, UNFPA, UNAIDS and UNDP. The countries represented were Afghanistan, Bangladesh, Bhutan, Cambodia, China, India, Indonesia, Kiribati, Lao People’s Democratic Republic, Malaysia, Myanmar, Mongolia, Nepal, Pakistan, Papua New Guinea, Philippines, Sri Lanka, Thailand, Timor Leste and Vietnam. Also in attendance were representatives from the ASEAN (Association of South East Asian Nations) and SAARC (South Asian Association for Regional Cooperation) Secretariat.

The interlinked meetings jointly addressed three agendas: (1) to achieve better integration of HIV and STI interventions with Sexual and Reproductive Health, Mother and Child Health and Family Planning (2) to strengthen the comprehensive approach to PMTCT, (3) to expand access to treatment and care for HIV positive pregnant girls, women, their partners and their children.

The Asia Pacific UN PMTCT Task Force components on prongs 1 and 2 were incorporated in the Consultation on

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1 UNAIDS, WHO, AIDS Epidemic Update, December 2006
Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services. The remaining 2.5 days of the Asia Pacific UN PMTCT Task Force meeting, progress in the region on PMTCT and Paediatric HIV and AIDS were examined, with the aim of scaling up coverage and intensifying action on the four-pronged comprehensive approach to PMTCT (primary prevention of HIV, prevention of unintended pregnancies in HIV positive girls/women, prevention of mother to child transmission, care and support for children and mothers living with HIV). Participants engaged in reviewing the policy environment, technical tools and guidelines, and program progress and challenges. Experiences were shared, followed by vibrant discussion and debate.

Objectives of the meetings were:

1. To share country experiences and lessons learnt in integrating prevention and management of STI/HIV into reproductive, maternal and newborn health services;

2. To discuss the guideline for pregnancy, childbirth, postpartum and newborn care (PCPNC) and propose a framework to integrate prevention and management of STI/HIV /AIDS into reproductive, maternal, and newborn health services; and

3. To develop recommendations for WHO and partner agencies to collaborate with Member States for integrating prevention and management of STI/HIV into reproductive, maternal and newborn health services.

4. To strengthen evidence-based approaches to programming comprehensive PMTCT interventions in Asia and the Pacific countries;

5. To review programmatic implications of comprehensive PMTCT, and recommend strategies and action plans to ensure all HIV positive pregnant girls, women, their children and their partners have access to care, treatment and support;

6. To update technical knowledge on latest PMTCT and Paediatric ART guidelines, HIV testing for diagnostics, monitoring and quality improvement issues and other relevant studies; and

7. To develop draft individual country action plans for accelerated scaling up of services in order to achieve global commitments on PMTCT.
SESSION 3 For reasons related to the schedules of guests, the Opening Ceremony was held on the afternoon of November 6 and was designated as the third session of the meeting. For the purposes of this report, it is being placed at the beginning while retaining its chronological designation as Session 3.

OPENING REMARKS – 1
Delivered by Dr. Han Tieru, WHO Representative, Malaysia, Singapore and Brunei, on behalf of the Regional Director, WHO WPRO.

"Children must also be a special focus in our efforts to prevent and control HIV and AIDS."
– Dr. Han Tieru

We must take advantage of the window of opportunity available for intervention by integrating the prevention and treatment of sexually transmitted infections and HIV into basic reproductive, maternal and newborn health services, said Dr. Han Tieru in his opening remarks. Experience has shown that efforts to prevent HIV infection in pregnant girls and women and newborns are most effective if they are fully integrated into existing health services, including family planning, antenatal care, obstetrics, delivery services and postpartum and newborn care.

Additional points made by Dr. Han Tieru included:

• Effective management of sexually transmitted infections is one of the cornerstones of HIV control.
• Adequate STI management will also reduce adverse outcomes of pregnancy, such as congenital syphilis in newborns.
• Integration of STI and HIV and AIDS prevention and management into reproductive, maternal and newborn health must become a reality in order to achieve the Millennium Development Goals.
• We must maximize resources, increase utilization of health services and reduce the social stigma associated with these diseases.

• It is important to remember the vulnerability of women and girls, both biologically and socially, to sexually transmitted infections and HIV and AIDS.

OPENING REMARKS – 2
Delivered by Richard Bridle, Deputy Regional Director, UNICEF EAPRO.

“To assure children a future unclouded by HIV, we must safeguard women from HIV now.”
– Richard Bridle

Scaling up HIV prevention in children and women can’t be done by any one agency alone, said Richard Bridle of UNICEF. But as UN agencies strive towards integration they must bear in mind the reality of cost. Prevention must be prioritized for those who need it most – women and girls in high-risk, high-prevalence pockets in each country. PMTCT services also need to recognize women’s inherent rights to reproductive health treatment, knowledge and support services, which are not dependent on their test results.

Other points made by Mr. Bridle included:

• Cultural factors and sexual behaviours of boys and men during women’s pregnancy period can greatly exacerbate the risk of HIV infection among women.
• In achieving greater integration and convergence of services, engaging men is essential.
• A “couple” antenatal visit can contribute to maternal and perinatal health.
• Other issues are: stepping up effective measures to prevent HIV among girls and women, prioritizing the package of services in high risk areas to those who need them most, and integrating PMTCT with broader measures to improve women and children’s health.

Mr. Bridle closed with a quote from Stephen Lewis, UN Special Envoy on AIDS: “Maternal mortality, between 500 and 600 thousand deaths per year, has not changed for 30 years. You can bet that if there was something called
paternal mortality, the numbers wouldn't be frozen in time for three decades.”

OPENING REMARKS – 3

Delivered by Dr. Chaiyos Kunanusont, HIV Advisor, UNFPA CST ESEA (East and South East Asia)

“We must scale up existing prevention techniques and programs that are known to work.” – Dr. Chaiyos Kunanusont

Despite advances in technologies related to HIV and STI prevention, the key to safeguarding people is to scale up existing prevention techniques and programs that already exist and that are known to work, said Dr. Chaiyos Kunanusont of UNFPA. One proven technique is PMTCT. And one way to integrate services is through recommendations contained in the draft framework that will be presented at this consultation. A manual is being developed to guide everyone on implementing the framework. However, experience shows that integration has never been easy. We have to learn more. We have to try harder. But we can all learn from each other’s experiences. We must work together, not only during this workshop, but after we leave and return to our countries. We have to find the right way to implement services in our countries so we can scale up and truly be effective.

OPENING REMARKS – 4

Delivered by Dr. Prasada Rao, Regional Director, UNAIDS Regional Support Team for Asia and the Pacific

“Integrating STI/HIV services into Reproductive and Maternal and Newborn Health Services is a natural marriage.” – Dr. Prasada Rao, Regional Director, UNAIDS RST

In the last couple of years there have been an increasing number of concerted efforts to integrate reproductive and sexual health and HIV services, said Dr. Prasada Rao of UNAIDS. Coverage remains the key to reversing the epidemic. If 80% of most-at-risk populations can be reached with services, the tide can be turned on the epidemic.

Dr. Rao said some of the areas where services could be integrated are:

For HIV-negative women
• Detect and treat STIs, especially syphilis, as part of antenatal and postnatal care (more than 340 million people contract a curable STI each year, with women having greater vulnerability to infection than men).

• Offer information and supplies of male and female condoms
• Provide HIV prevention counselling during routine “couple” visits
• Refer pregnant girls/boys/women/couples at higher risk, or with symptoms/signs suggestive of HIV for counselling and testing and follow up PMTCT interventions if positive

For HIV-infected women
• Prevention of transmission from mother to her infant
• Ensure infants receive co-trimoxazole prophylaxis, follow-up care and early HIV diagnosis.
• Refer HIV positive girls/women and children for assessment and ARV (anti-retroviral) treatment and OI (opportunistic infections) and treatment as required

For children
• Offer paediatric ARV treatment for HIV-positive children for their survival

OPENING REMARKS – 5

Delivered by the Honourable Dato Seri Dr. Chua Soi Lek, Minister of Health, Malaysia

“No effort should be spared to prevent women from being infected with HIV.” – Hon. Dato Seri Dr. Chua Soi Lek

The Honourable Dato Seri Dr. Chua Soi Lek, Malaysia’s Minister of Health, began his remarks by congratulating UNICEF, WHO, UNFPA and UNAIDS on convening a meeting to deal with such broad and complex agendas. Not only is cooperation being evidenced between different agencies, but between two different regions, East Asia and the Pacific and South Asia. One of the major global agendas for human development is the Millennium Development Goals, and everyone is working hard to achieve these. In the Malaysian context, the minister said, the country is on track to meet the first three goals of eradicating poverty, providing primary education and ensuring gender equality.

Malaysia has already achieved the fourth and fifth MDGs by reducing child mortality by two thirds and maternal mortality by three quarters. Progress is being made on environmental sustainability, the seventh goal, with safe drinking water available in almost every part of the country. For the eighth goal of a global partnership for development, Malaysia will continue to contribute as a partner.

The sixth goal of reducing HIV and STI are particularly challenging for Malaysia, although the country has had less difficulty in fighting tuberculosis and malaria. Malaysia has a concentrated epidemic, mainly among groups engaged in high risk behaviours, such as commercial sex workers, men who have sex with men and injecting drug users. The epidemic has progressed, however, to the point where heterosexual sex is now an important mode of transmission. Another mode of transmission is vertical, from HIV positive mothers to their children. While mother to child transmission is a small problem in Malaysia, the country is committed to reducing it. We must go beyond tackling maternal health, however, and improve the quality of life and reproductive and sexual health services, along with an agenda for gender equality. Services should be provided in a holistic manner, and PMTCT is a good entry point for services. But PMTCT is only one component of HIV prevention in the context of reproductive health, and we must do more to expand. No effort should be spared to prevent women from being infected with HIV, and to prevent women living with HIV from having unintended pregnancies. These are challenging issues and they will require strong, sustained commitment.
PRESENTATION 1

INTEGRATION OF PMTCT INTO MATERNAL AND CHILD HEALTH CARE SERVICES: AN OPPORTUNITY FOR IMPROVING MATERNAL AND CHILD HEALTH
Presented by Dr. Monir Islam, Director, Department of Making Pregnancy Safer, WHO Headquarters, Geneva, Switzerland.

“No more poor options for poor people. Let’s have equal options for everyone.” – Dr. Monir Islam

Harmonization of health services is important because resources are not being maximized at the country level, said Dr. Monir Islam of WHO. One health care worker may have to deliver all services, so everyone needs to work together. In striving for integration, it is necessary to consider the rich-poor divide. The poor are malnourished, make fewer visits to antenatal clinics and give birth unattended. In most countries women will come to antenatal clinics for care, but not for delivery. It is important to use that ANC (antenatal consultation) visit to offer and provide as many appropriate services as possible.

The low status of women in many societies is an obstacle to delivering health care services. If women don’t have the power to decide for themselves what is good for them, then national programs won’t improve the situation. Women are more than reproductive machines. They need care and support. Another factor to consider is whether or not the health care system is adequate. If the quality of services does not improve then they won’t reach the people who need them. Dr. Islam said that harmonized health programs should have the following objectives:

- Keeping HIV negative mother negative and preventing future undesired pregnancy in HIV positive girls/women
- Preventing HIV transmission to the newborn
- Follow up and care for HIV positive mothers
- Follow up for HIV positive newborns

In conclusion, Dr. Islam said it was imperative to ensure that all people have the same rights and options.

PRESENTATION 2

SETTING THE CONTEXT: LINKING SEXUAL, REPRODUCTIVE, MATERNAL AND NEWBORN HEALTH – THE CIRCLE OF LIFE
Presented by Dr. Wendy Holmes, Deputy Director, Technical Programs, Centre of International Health, Macfarlane Burnet Institute, Australia.

“We need to do much more to prevent women from becoming infected during pregnancy and during breastfeeding.” – Dr. Wendy Holmes

The response to HIV is marked by inequality, said Dr. Wendy Holmes of the Macfarlane Burnet Institute. In developed countries, only 1% of children born to mothers living with HIV become infected with the virus. In the developing world the percentage is much higher. A human rights approach is needed. Vulnerable groups, such as sex workers, don’t live in separate compartments from the rest of society. Our aim is not simply to prevent mother to child transmission of HIV but to promote child survival – this means it is important to prevent mothers becoming infected with HIV, to treat those mothers that are already infected with HIV, and to support safer infant feeding to prevent infant deaths through formula feeding. Roughly 90% of children living with HIV became infected during pregnancy, delivery or breastfeeding.

The UN Interagency Task Force has a four prong approach to PMTCT. Prong 1 is primary HIV prevention in parents to be, Prong 2 is prevention of unintended pregnancies in girls and women who are HIV-positive, Prong 3 is prevention of transmission from an HIV-infected woman to her infant, and Prong 4 is care and support for HIV-positive mothers and their infants. But the focus to date has largely been on Prong 3. This is in part because using a drug to block transmission is straightforward, attractive, and measurable, while it is more difficult to measure the numbers of babies saved from HIV infection through Prongs 1 and 2. But broader, population approaches are needed because:

- Prong 1 and 2 interventions can make a great contribution to reducing the numbers of children with HIV
- Antenatal screening PMTCT cannot prevent MTCT from women that become infected late in pregnancy or during breastfeeding
- Population-based strategies that take into account that most women with HIV infection are unaware of their status are also important
- Antenatal screening PMTCT does not reach those who do not have access to or do not attend antenatal care services

Efforts to prevent HIV infection in mothers and children should strengthen general reproductive, maternal and child health care and prevention services. The responsibility for primary prevention has not been clear.
It is dispersed and so everyone thinks everyone else is doing it. All countries need to focus more on Prongs 1 and 2.

**PRESENTATION 3**

**PRIMARY PREVENTION OF HIV IN THE PRE-PREGNANCY PERIOD: ACCELERATING EFFORTS TOWARDS UNIVERSAL ACCESS OF HIV/STI PREVENTION, TREATMENT AND CARE IN WOMEN AND CHILDREN IN ASIA AND THE PACIFIC**  
Presented by Dr. Stephen J. Atwood, Regional Advisor, Health & Nutrition, UNICEF EAPRO

“The uncomfortable truth is that women's status in this region isn’t all that good, and that is contributing to all these problems.” – Dr. Stephen Atwood

Targeting pre-pregnant girls and women for HIV prevention services makes sense as a strategy for accelerating universal access to HIV/STI prevention, treatment, care and support, said Dr. Stephen Atwood. Most women visit antenatal clinics during their second or third trimester. Pre-pregnancy is the period of weeks or months between a couple’s decision to become pregnant and conception. Conception and the first trimester are crucial and sensitive for growth and development of the fetus. Targeting pre-pregnant women, if they can be identified, gives government a more manageable and affordable alternative than targeting all women of reproductive age.

Evidence shows that targeting pre-pregnant women will result in a reduction of low-birth weight, reduction of childhood stunting, improved maternal survival, and a reduction of birth defects. Pre-pregnant women should be tested for TB, malaria, haemoglobin, urinary tract infections, STD, HIV. Arguments for a routine package of pre-pregnancy tests include:

- Allows a woman to be tested for HIV status without her having to ask and hence reduces stigma – the right to decline the test always applies –
- Offers a woman a choice before she becomes pregnant.
- Gives both members of a couple a chance to discuss issues before becoming pregnant.
- Increases understanding of the epidemiology of STIs and HIV in a given population.
- If a girl/woman is HIV positive, therapy can be started, including micronutrients; if she is HIV negative then efforts to protect her during pregnancy can be enhanced.

Dr. Atwood suggested girls/women planning to marry be given a “wedding basket” consisting of coupons for health tests, including HIV tests, and other items to improve maternal and child health.

**Questions and Answers**

A participant said that stigma and discrimination were big issues and asked how to deal with them. Dr. Holmes agreed that it is a major issue, especially when it comes to testing. She said it is necessary to address people’s fears, especially the fears of health care workers. Otherwise they will never come to accept people living with HIV. Dr. Atwood added that tuberculosis, STI and HIV tests should be carried out on both members of the couple. For discussion purposes, he asked if these tests should be required to obtain a marriage license, as a syphilis test is in the United States, as it may remove stigma if the whole population is subjected to it. One doctor commented that integration is a big and complex subject, and so it is important to clarify exactly what is meant by integration. Is it integration of programmes or services? People feel threatened by programme integration as they are concerned about their turf. Dr. Holmes agreed it is a complex subject and integration is defined differently in different regions. She mentioned the “supermarket approach” where, when a woman visits a health care facility for any reason she is offered a range of other services (i.e., when a mother attends a health facility with her baby for immunisation she will be offered family planning advice, provided with breastfeeding support, offered condoms, asked about STI symptoms etc.). But it can also involve linking clinic care with community support. There is also gender integration, involving men in sexual and reproductive health and in maternal and child health, so integration has different dimensions.

A participant commented that family planning programs had barely been discussed, and asked if there are lessons to be learned from their past successes for prongs 1 and 2. Dr. Atwood noted that many family planning clinics go beyond offering contraception. Failures often occur in other areas of prevention because of a lack of resources. Another participant said that until there is commitment from national leaders to raise the issue, male involvement in family planning issues would be minimal.
CAMBODIA

Presented by Dr. Koum Kanal, Director, National Maternal and Child Health Centre, Ministry of Health, Cambodia.

PMTCT began in Cambodia with a pilot project in 2001, and began to expand in 2003. There are an estimated 461,000 live births each year in Cambodia, and about 10,000 newborns are exposed to HIV. PMTCT is integrated into existing MCH services. Cambodia’s strategy is to promote HIV testing at antenatal clinics, provide antiretroviral prophylaxis to HIV-infected mothers and their children, and to collaborate with other institutions. The following challenges, however, remain:

- Drugs (supply, re-supply, channel)
- Health infrastructure problem: Not all health centres in Cambodia are functional. There is a need to build, equip with staff and medical supplies more health centres and health posts.
- Human resources: Lack of qualified health staff at functioning health centres, due to staff movement.
- Health planners at all levels have limited knowledge on Family Planning/Reproductive Health, PMTCT.
- Functioning health centres provide Family Planning services and counselling, but no special sessions for HIV-infected women.
- Poor coordination and collaboration between FP/RH and HIV prevention activities.
- Donor commitment to the linkage between RH and PMTCT

INDIA

Presented by Dr Jotna Sokhey, Additional Project Director, National Aids Control Organisation, New Delhi, India

India is fortunate that HIV prevalence among pregnant women is still very low. Out of 27 million pregnant women in the country each year, 216,000 would be HIV positive and 30% would be expected to pass the infection to their babies. In the absence of a prevention programme, an estimated 64,800 children are added to the HIV pool per year. An operational research project with a sample size of 100,000 pregnant women is planned in 10 sites to test the feasibility of implementing a multi-drug regimen, determine drug resistance to single dose nevirapine (NVP) and address operational issues. Challenges that remain include:

- Increasing the number of institutional deliveries for the general population
- Scaling up of testing at PPTCT centres through an ‘opt out’ approach
- Expansion of PPTCT services to the private sector – Currently 88 private health facilities offer PPTCT services in the country
- Prophylactic nevirapine coverage for 80% of mother-baby pairs tested positive for HIV
- Covering un-booked emergency cases

CHINA

Presented by Dr. Wang Linhong, M.D., Professor, National Centre of Maternal and Child Health, Centre for Disease Control, China.

In its response to HIV and AIDS, China has implemented a policy called “Four Frees and One Care” which consists of:

- Free antiviral treatment to groups with financial difficulties in rural, township and urban areas.
- Free anonymous blood test in the highly affected areas.
- Free schooling for the orphans who parents suffered HIV/AIDS
- Free counselling, testing, and treatment to HIV positive pregnant women
- Provide special relief to AIDS patients who have financial difficulties.

In the area of primary prevention of STI and HIV among young women, China has launched a mass campaign for the general public, is providing comprehensive reproductive health services through its Maternal and Child Health and Family Planning networks, establishing sentinel surveillance sites that include surveillance of pregnant women, adolescents, sex workers and STIs patients (552 sites as of May 2006), and conducting screening of high-risk groups all over the country. Remaining tasks and needs include:

- Coordination between various networks needs to be strengthened and make it more effective overall
- Improving coverage to ensure universal access to PMTCT services
- Increasing awareness among the general public and eliminating discrimination about HIV
- Capacity building is needed especially on VCT, PMTCT, infant feeding
Follow up of babies delivered to HIV positive mothers – challenge of testing infants with DNA PCR.

MYANMAR

Presented by Dr. Win Mar, Assistant Director and PMTCT Programme Manager, National AIDS Control Programme, Department of Health, Ministry of Health, Yangon, Myanmar

More than 70% of Myanmar’s population lives in rural areas. About 80% of deliveries take place at home. In 2006, there were 8,200 children up to the age of 14 years living with HIV. Health authorities have decided to adopt a community-based approach to PMTCT with services delivered at township health centres and antenatal clinics. It was first launched in areas where the potential of a target population exists as evidenced by epidemiological data and the existing infrastructure and manpower was feasible to implement the PMTCT programme. The community-based approach has certain:

Advantages:
• It can cover home deliveries
• Increases the knowledge and experience in HIV of Basic Health Staff
• Easy access to voluntary counselling and testing (VCT) for pregnant women
• Good follow up after delivery

Challenges:
• Logistical challenge of transporting blood samples/reports
• Technical challenges include the difficulty of supervising a large number of Reproductive Health Clinics, and improving counselling skills of midwives

THAILAND

Presented by Dr. Nipunporn Voramongkol M.D., Bureau of Health Promotion, Department of Health, Ministry of Public Health, Bangkok, Thailand

In Thailand, antenatal clinic coverage reaches 96.5% of women, and most women, even if they don’t visit an ANC know they should deliver in a hospital. Health care coverage is universal in Thailand, and its PMTCT program includes pre- and post-test counselling, antenatal/intrapartum HIV testing, short-course antiretroviral drugs and replacement feeding. The country’s STI prevention and control program includes:

• Promotion of safer sex and condom use (intervention among risk groups and 100% condom use)
• Promotion of health seeking behaviours
• Health education
• Community participation
• Promotion of comprehensive STD case management
• Strengthen STD surveillance system

Some barriers and problems remain, including not enough male involvement, difficulties with disclosure, counselling and testing for couples, and stigma and discrimination.

Questions and Answers

One participant noted that syphilis is still more prevalent than HIV, so wanted to know more about how it could be incorporated into PMTCT programs, along with sexual health. Participants from several countries responded that they had attempted, or were attempting, to incorporate STI screening in family planning or antenatal clinics, but were facing difficulties, often because of a lack of resources.
PRESENTATION 1

INTRODUCTION OF THE DRAFT INTEGRATION FRAMEWORK
Presented by Dr. Wendy Holmes, Deputy Director, Technical Programs, Centre of International Health, Macfarlane Burnet Institute, Australia.

"Working towards integration can strengthen health care systems. At the same time, integration won’t work unless there is a strong health care system.

– Dr. Wendy Holmes.

Dr. Wendy Holmes introduced participants to the draft integration framework “Linking Sexual, Reproductive, Maternal and Newborn Health – the Circle of Life.” The framework is intended to help policy makers, planners and managers understand the rationale for integration and stronger links between sexual and reproductive health (SRH) services, maternal and newborn health (MNH) services, and HIV prevention and care. While the framework is intended as a guide to integration that can be used by all of the countries in the region, despite their diversity, it is a work in progress and feedback is encouraged, particularly on barriers to integration. The framework also suggests steps to make services more accessible to groups which are marginalized or poor, as these groups are often more vulnerable to HIV.

A strong case for integration exists. The region suffers from a huge burden of unnecessary morbidity, mortality and disability from problems associated with Sexual Reproductive Health, Maternal and Newborn Health, and Adolescent Health (AH). Common causes and risk factors mean that SRH, MNH, AH, problems and HIV can be prevented together. This will provide a greater return on investment for HIV prevention as it can also improve SRH, MNH and AH. Governments will need to make strategic choices.

Integration needs to be achieved on two levels: vertical and horizontal. Vertical integration relates to the need for strong referral links between services at community level, health centre and the referral hospital – a continuum of care approach. Horizontal integration means that a variety of services are offered at the same facility during the same operating hours.

The Framework document is built around a matrix with four components, based on the ‘UNFPA Framework for priority linkages’:

- Maternal and child health
- Family Planning
- Sexual health
- Counselling and testing for HIV

Dr. Holmes also said that in many resource-constrained settings, PMTCT programmes have not paid adequate attention to services for women who test HIV-negative. Primary prevention activities are important for these women and their partners, especially during pregnancy and lactation, because both biological and behavioural factors may increase a woman’s risk of acquiring HIV at these times.

Questions and Answers
A participant commented that in most countries it would be necessary to map who is delivering which services and to involve all stakeholders in the process of integration, and that it is important for integration to be seen not as an end in itself, but as a means of delivering comprehensive care. Another participant said they would like to see more details on services for HIV-negative people, and perhaps a fifth component in the matrix: HIV care and support. One doctor noted that many people never visit health facilities and only receive health care through outreach visits, and so it would be necessary to also define what integrated services could be delivered through outreach. Another participant said that as most countries already have national plans on these issues, the Framework should not be presented as a new plan, but as guiding principles to strengthen existing national plans.
FOLLOWING THE PRESENTATION OF THE DRAFT FRAMEWORK, REPRESENTATIVES PARTICIPATED IN TWO GROUP WORK SESSIONS. Attendees assembled into 13 groups by country, with smaller country delegations paired together. In the first session participants reviewed the context and challenges to integration in each country and how the draft framework addresses them or needs to be modified.

Participants were asked to consider five questions:

- What are the key reasons for integrating services in your country?
- What is the current state of integration and what are some of the challenges?
- How much access do marginalized girls/women and boys/men have to MCH services, family planning, STI treatment, and HIV prevention counselling?
- How strong are the referral links to clinical services?
- To what extent are men involved in sexual, reproductive, maternal, newborn and child health?

Participants were also asked to review the matrices of essential services in the draft framework, comment upon them and offer suggestions.

As countries presented the results of their group work deliberations, some general comments were made about the Framework, including:

- The Framework should be shorter
- The Framework should have a more user friendly format
- There may be an argument for changing the title of the Framework
- A clear statement should be made that the Framework is meant for programme managers, public health officials, and service providers, and to have a separate accompanying document (policy brief) for policy makers
- Consider having separate sections to deal with technical issues, non-technical issues and policy matters
- Ensure all statements and recommendations are based on evidence, and avoiding subjective statements
- Ensure that the framework will be useful to all countries, bearing in mind that they are at various levels/stages of programme maturity and integration, and to meet the needs of countries at these different stages
- Have a section on the role of international organisations and donor agencies

The following is a brief summary of key points made by each group during the presentations of the first group work. Full results from each group can be found in the attached CD Rom.

AFGHANISTAN/CAMBODIA Maternal mortality in Afghanistan is among the highest in the world, while Cambodia is already taking steps toward integration through its national plans. Afghanistan’s challenges include lack of health care infrastructure and low level awareness among the population. Cambodia faces similar problems and is adopting a sector-wide approach to health care, but progress has been slow.

BANGLADESH / PAKISTAN Maternal mortality rates are very high in both countries. Services are delivered by different ministries and there is duplication and overlap. Integration should reduce turf wars and increase access to a range of services, particularly as many villagers live great distances from clinics and so need to get the most out of a single visit.

BHUTAN/INDIA An integrated approach is already a part of government policy in both countries. Targeted interventions are being given priority as a part of national programs. Health workers are, however, overburdened with too many activities, and so there is a need for additional health workers or more resources.

CHINA High risk groups are not sufficiently covered in the framework matrix. It needs to be more specific about the interventions for sex workers [male and female] and their clients, injecting drugs users, and persons with multiple sex partners. This is important because there are many governments, NGOs and others providing these services.

FIJI/KIRIBATI/SRI LANKA All three countries have large populations of young people, and also significant numbers of people engaged in high risk behaviours. To improve the situation they recommended a program of better education on parenting, facilities and services be made more father friendly, and efforts be made to address and break down cultural taboos that result in false beliefs and foster stigma and discrimination.

INDONESIA/TIMOR LESTE Indonesia and Timor Leste cited challenges in the areas of health care infrastructure, human resources and training. In many areas, the only person delivering services is a midwife. Integration will increase her workload and necessitate expanding and improving her knowledge, skills and capabilities.
LAOS PDR  Access of marginalized groups to health prevention and care services is still very low, as is access for women in remote communities. Outreach activities in communities are limited and need to be improved. The health care system needs strengthening at the district level.

MALAYSIA  Integration had been initiated in stages into the MCH services since the early 1980s (Malaria, TB and STIs); comprehensively from the 1990s (Family planning since the early 1990s, PMTCT since 1998). A health management information system was established in 1989.

MONGOLIA / PHILIPPINES  Both Mongolia and the Philippines have reasonably good levels of services in urban areas, but the same is not true in rural areas. Mongolia’s strength is its high literacy level, which should assist in educating the populace, while in the Philippines health care workers have shown they are capable of multi-tasking.

MYANMAR  Myanmar also has weak health care infrastructure. Significant numbers of people live in remote areas, and so most deliveries are at home and knowledge about health issues is low because of lack of education. Male involvement is also low. The team recommended a community mobilization strategy to address these issues.

NEPAL  Nepal cited low quality of services, lack of training of health care workers, poor infrastructure, weak logistics and supply management, weak referrals and intersectoral collaboration, and sustainability issues as impediments to integration. On a positive note, NGOs and organisations of people living with HIV are involved in decision making on these issues.

PAPUA NEW GUINEA  Papua New Guinea relies heavily on a network of health clinics. In Provincial Hospitals the clinics are within the hospital grounds (but with their own screened access) and provide easy referral pathways to other hospital services. These clinics are referral clinics for the province.

THAILAND  Thailand has relatively advanced health care infrastructure, yet challenges to integration include the attitudes of health care workers towards marginalised groups and female STI patients, the difficulties in reaching migrant sex workers, inadequate youth-friendly services, insufficient male involvement in female reproductive health.

VIETNAM  Resources are a challenge in Vietnam, both human and material. The quantity and quality of training, facilities and equipment needs improvement. Stigma is still an obstacle. Mass media and peer education are strategies that should be adopted to reduce this.

THE SECOND GROUP WORK SESSION ASKED PARTICIPANTS TO MAP OUT WHAT NEXT STEPS NEED TO BE TAKEN TO PROMOTE, ADVANCE AND ACHIEVE INTEGRATION. FROM THE COUNTRY PRESENTATIONS, IT WAS CLEAR THAT THE 20 COUNTRIES ARE AT VARIOUS STAGES OF INTEGRATION, WITH NO COUNTRY EITHER WITHOUT ANY INTEGRATION IN PROGRAMS AND SERVICES OR TOTALLY INTEGRATED. Most are somewhere between these two extremes. Therefore, the activities that are suggested as “next steps” depend to a large extent, on the current stage of integration in each country. Nonetheless, most countries produced remarkably similar sets of steps to be taken to advance the agenda of integration. In general it was suggested that:

• For countries at the very early stages of weaving HIV and AIDS prevention into reproductive health and MNCH, including PMTCT, the next steps consisted mainly of obtaining the political commitment and policy decisions to begin putting these activities in place. Countries that fell into this category included Afghanistan, Bangladesh, Laos PDR, Mongolia, Nepal, and Timor Leste.
• For countries that have achieved a good programme performance in prevention of HIV and AIDS, reproductive health and MNCH, and are already well on their way towards integration, the suggested next steps focused on expansion of programmes and services, such as introducing the services in the private sector. Countries in this category include Malaysia and Thailand.
• The majority of countries have begun initiatives in prevention of HIV and AIDS in reproductive health and MNCH, especially PMTCT. The next steps consist largely of scaling-up and strengthening of services. Countries in this group include Cambodia, China, India, Indonesia, Philippines, and many others.

Questions and Answers

• One participant commented that no one had mentioned how they would use epidemiological research into HIV and STI to prioritize and target their responses. Facility mapping should be tied to epidemiology.
• Other factors not mentioned were cancer of the cervix, costing of various plans and communications issues.
• One participant urged others to be realistic about what they can actually
achieve at the country level based on the strength of their health care systems.

- Another participant said the consultation was too short to go into detail on complex issues such as STI prevention management, but it is important that this is in the Framework.
- A participant called on donors to give more funding to the HIV sector in order to expand and integrate services.
- Another doctor added that coordinating donors was essential to ensure sustainability. It was noted that all four UN agencies and programmes want to work together. The key question was how. While integration is already taking place, ways and means need to be found to deepen integration.

In concluding the meeting, Dr. Ardi Kaptiningsih of WHO/SEARO said that participants agreed that a framework is needed. There is a spectrum in the region where some countries are beginning to integrate, many are in the middle of it, and a few are ahead. The document needs amending and shortening. Basically, the framework is a set of guiding principles and concepts. The hope is that our suggestions and comments will be taken into consideration when the final product is being prepared.

Taking all countries together, the following are the next steps recommended by the consultation:

- All countries reported that they will implement the Framework once the draft is finalized which should incorporate the suggestions for the revision.
- Notwithstanding this effort, by which the framework will be revised and the next draft will be disseminated to member states, some countries are ready to develop guidelines on integration of HIV/STI prevention into reproductive, maternal and newborn health.
- Almost all countries will need to harness or to further strengthen political commitment and formulation of a clear policy on prevention of STI/HIV for pregnant women and their babies, and in doing this, to ensure that comprehensive services are provided in an integrated approach.
- Advocacy as the next step will go beyond the policy makers and national leadership, and efforts will be made to engage the media more actively, and to effectively reach the communities.
- Partnership and intersectoral/interagency collaboration was a common theme among all countries, and many of the countries have indicated the mechanism and identified the partners to be engaged.
- Most countries emphasized the issue of lack of resource as a major constraint, and recommendations were made to procure resources, which include human resource in all related disciplines such as clinical care, laboratory, counseling, (numbers, knowledge, skills, expertise), equipment, drugs.
- In this respect of insufficient resources, many countries mentioned the role of donor agencies, either in the effort to initiate a programme (Nepal) or in scaling up (Indonesia), and to ensure coordination among donors.
- Similarly, capacity strengthening was emphasized by many countries, especially those countries where programmes to prevent STI/HIV have not begun or have only just begun.
- Some countries recommend activities to include or to reach out more to marginalized groups such as sex workers, people who inject drugs and men who have sex with men.
- Information and data management was identified as an area of concern for further action to be taken by almost all countries. One specific activity suggested related to this was to conduct a facility mapping.
THE CONSULTATION ON INTEGRATION ENDED ON THE AFTERNOON OF 8TH NOVEMBER WITH REMARKS FROM DR. ARDI KAPTININGSIH, REGIONAL ADVISOR FOR REPRODUCTIVE HEALTH, REPRESENTING THE REGIONAL DIRECTOR OF WHO/SEARO, DR. MONIR ISLAM DIRECTOR OF DEPARTMENT OF MAKING PREGNANCY SAFER, WHO/HEADQUARTERS, WING-SIE CHENG REPRESENTING UNICEF AND DR. CHAIYOS KUNANUSONT REPRESENTING UNFPA. Dr. Chaiyos re-emphasized the need to strengthen all four prongs of the UN strategy. Dr. Islam urged participants to demand UN agencies follow through on the consultation outcomes so real changes can take place at the country level.

Conclusion
The Consultation on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services was concluded on a positive note, its objectives were met, with participants giving a positive evaluation on the consultation.

WHO (HQ, WPRO and SEARO) as the lead agency for the development of the framework on integration will confer with the other co-organisers (UNICEF, UNFPA, UNAIDS) at a later date to further revise the Regional Framework on Integrating Prevention and Management of STI/HIV into Reproductive, Maternal and Newborn Health Services. A small Working Group will be formed to carry out this function, and the second revised draft will be circulated to member countries for final comments.

OPENING REMARKS
“The vast majority of roughly half a million children under the age of 15, who die from HIV-related illnesses every year, become infected through mother to child transmission.” – Toshiyuki Niwa

The meeting began with remarks from Toshiyuki Niwa, Deputy Executive Director of the United Nations Children's Fund (UNICEF), New York. Toshiyuki Niwa stressed that prevention of mother-to-child transmission of HIV hinges on preventing HIV infections in women in the first place. Involving men in the response to HIV was also crucial, as they often have decision making power over whether or not women can access reproductive health services and HIV testing. As of now, only 6% of women in the Asia Pacific region have access to drugs to prevent mother-to-child transmission. Newborns who escape infection are often orphaned at a young age because their mothers have no access to follow-up care, treatment and support.

Toshiyuki Niwa emphasized that three points need to be addressed in order to create an enabling environment to prevent mother to child transmission:

• Women's rights must be respected. The dominant role of men in societies must be challenged, and an end put to the impunity of violence against women.
• Stigma and discrimination hinders HIV prevention efforts and so must be reduced. Counseling and testing needs to apply to couples, not just women, and should be part of any discussions and services relating to starting a family.
• Treatment must be readily available to those who need it. An estimated 660,000 children living with HIV are in need of Anti-Retroviral Therapy, and 2.1 million HIV infected children are in need of cotrimoxazole. The numbers of those actually receiving these treatments are tragically low.

Toshiyuki Niwa called for a comprehensive, rather than a piecemeal approach to achieve these goals. Such an approach would require creative thinking, as well as the right incentives to ensure those most in need are reached and served, especially marginalized groups in high prevalence areas.
PRESENTATION 11

OVERVIEW OF THE UN ASIA PACIFIC PMTCT TASK FORCE MEETINGS
Presented by Dr. Aye Aye Mon, Program Officer, HIV and AIDS, UNICEF Philippines.

“The challenges we addressed in the beginning, are still being addressed today.” - Dr. Aye Aye Mon

As one of the founding members of the Asia Pacific UN PMTCT Task Force, Dr. Aye Aye Mon was asked to provide a historical perspective. The first Task Force meeting took place in Cambodia in March 2000. It was convened by UNICEF and WHO, and originally covered only Southeast Asia. Country delegations led by representatives of national HIV programs participated along with nongovernmental organizations working on issues pertaining to PMTCT. In 2004, the Task Force was expanded to cover South and Southeast Asia, with 15 countries represented. The objectives of Task Force meetings are to review program and project implementation in selected countries, share information and lessons learned, and to update and share the latest technical developments related to PMTCT. Dr. Aye Aye Mon said that many of the issues raised, and recommendations made at the first Task Force meeting were still being discussed today. Among previous Task Force meeting recommendations were:

- Human, financial and organizational resources presently focusing on prong 3 and 4 should be reassessed and increasingly made available for prongs 1 and 2.
- Build country level capacity for readiness for supply chain management: assessments, forecasting, supply chain system development and management.
- There is a need for globally agreed upon core indicators for PMTCT prongs 1, 2 and 4 which can be used at country levels. UNICEF, WHO and UNFPA regional and global levels need to provide more support to ensure that prongs 1 and 2 are incorporated in measuring progress towards UNGASS targets.
- Linking PMTCT to Care, Support and Treatment.
- The strategic intent of PMTCT needs to be improved maternal and child survival and the importance of placing it within a Child (and maternal) Survival and Development approach.
- Involvement of men in PMTCT.
- Interventions should focus on safe sexual practices and will require active involvement of male partners.
- Increase funding, for example through the Global Fund to fight AIDS, Tuberculosis and Malaria.

A participant shared the experience of his country where it took 16 years from the moment the first HIV case was identified until PMTCT and pediatric AIDS programs were integrated into the national health care program; however, even if the process might be not as rapid as desired, eventually PMTCT and pediatric treatment programs were effective. Even for resource limited settings, tools and guidelines were now available, based on clinical observations alone even if advanced testing facilities were not available. Implementing pediatric treatment was a tremendously rewarding task since the progress was so striking. Strengthened advocacy efforts could support rapid scale up.

PRESENTATION 12

PREVENTION OF MOTHER TO CHILD TRANSMISSION: IMPLEMENTATION STATUS IN ASIA AND PACIFIC
Presented by Dr. Myo Zin Nyunt, Regional HIV Officer, UNICEF ROSA.

“If I were a policymaker, where would I put my money? This is a serious question when we deal with decision makers.” - Dr. Myo Zin Nyunt

Significant efforts have been made in the Asia-Pacific region to provide PMTCT services to pregnant women, according to Dr. Myo Zin Nyunt. However, because the focus of PMTCT efforts have been limited to Prong 3 and because of low rates of ANC coverage and few skilled birth attendance, only a small percentage of women are actually receiving PMTCT services. In East Asia as a whole, only 2% of women are accessing PMTCT services, while in Southeast Asia the figure is 5%. Compounding the problem is the geographic variation of different morbidities: in India the areas which have the highest levels of under-five mortality are not the same areas with the highest rates of HIV infection, indicating that AIDS is far from being the biggest killer of children under five. These figures needed to be kept in mind when
negotiating with policymakers to allocate more money for PMTCT. A recommended basic package of services for a low-prevalence, low-resource setting with low service uptake would include information, education, communication materials on HIV and AIDS directed at pregnant girls and women and their partners; group education strategies; prevention counseling including dual protection (to prevent unintended pregnancy and STIs); counseling on infant feeding; condom programming (male and female); referral linkages for VCT, STI services, tuberculosis screening, malaria prevention and treatment, PMTCT services, and treatment care and support services. Dr. Myo Zin Nyunt concluded that:

- There is no single approach for all countries in Asia Pacific.
- Countries should adopt strict evidence-based and result-oriented programming.
- A prioritized, targeted approach is required for scale-up, with close referral linkages with NGOs.
- Infant feeding needs to be an integral part of national PMTCT scale-up plans.
- In order to reduce vertical transmission, we must move from vertical programming to horizontal programming – “Integration.”
- Strengthen primary prevention, prevention of unintended pregnancies, referral linkages, infant feeding and follow-up.

One participant commented that it was important to consider the gaps in health care coverage before attempting integration. An important aspect of this was counseling, as there is a shortage of counselors in most countries. Another consideration is the complexity of multi-drug regimens. They need to be administered by people with training, while the single dose nevirapine regimen could be administered by any health care worker. Dr. Myo Zin Nyunt said NGOs had been useful and supportive when it came to counseling, and Wing-Sie Cheng of UNICEF said Indonesia had positive experiences in producing greater numbers of counselors. Another participant said it was necessary to develop guidelines which were country appropriate and should consider cultural concepts and traditions of local ethnic groups, for example when it came to infant feeding.

STI Adviser, UNFPA CST ESEA.

“Even the UN as a whole can not do it alone. Neither can government. We need all partners involved.” - Dr. Chaiyos Kunanusont

We need to make the distinction between service integration and linkages between services, said Dr. Chaiyos Kunanusont of UNFPA. For some settings, linkages could be more appropriate than integration. He also cautioned that an evidence-based approach should be followed when integrating services, and only those interventions be scaled up which have proven to be feasible and effective.

To reduce the incidence of mother-to-child transmission, we cannot work alone, Dr. Chaiyos Kunanusont said. We need all the partners, including civil society, communities and people working together.

In countries with a generalized epidemic, integrated services become very cost-effective. Dr. Chaiyos Kunanusont said integrating HIV and AIDS prevention, care, treatment and support with Maternal and Child Health required:

**Advocacy:**
- Develop policies to provide HIV and AIDS prevention, care and treatment for pregnant girls, women, mothers, their partners, babies and families.
- Ensure and monitor that all four prongs of PMTCT are in place and funded

**Services:**
- Provide a basic package of HIV and AIDS in ANC.
- Integrate antenatal syphilis screening and treatment with PMTCT services.
- Strengthen maternal health services for women living with HIV and AIDS.
- Provide counseling on reproductive choices for people living with HIV and their partners.

For concentrated HIV epidemics, integration might not be superior to specific programmes for targeted high-risk populations.

One participant registered concern about the quality of integrated services. If health care workers were asked to do too much, the result could be poor quality services. Dr. Chaiyos said that we have to understand community needs, as well as the cultural context in which we implement services. This understanding will guide us to the appropriate answer for programming. Another participant responded that stigma and discrimination among health care workers was discouraging many women from making use of hospital-based HIV programs.

PRESENTATION 13

**LINKING THE “INTEGRATION” WITH THE “PMTCT TASK FORCE” MEETINGS**

Presented by Dr. Chaiyos Kunanusont, HIV/
ANTIRETROVIRAL DRUGS FOR TREATING PREGNANT WOMEN AND PREVENTING HIV INFECTION IN INFANTS IN RESOURCE-LIMITED SETTINGS. WHO RECOMMENDATIONS

Presented by Dr. Tin Tin Sint, Medical Officer, PMTCT, Department of HIV, WHO Headquarters.

“We are providing better services … but we need to find a way to reach women who are not coming to health facilities.” – Dr. Tin Tin Sint.

While more people living with HIV than ever are receiving antiretroviral therapy, in every region except Latin America, a large percentage of those who need ART are still not receiving it. From 2003 through 2005, ART coverage has tripled globally. Sadly, the same can not be said for ARV prophylaxis for HIV-infected mothers. Only 9% of women have access to PMTCT. While better services are being provided, those services are not reaching most women, especially those who do not attend antenatal clinics or go to health facilities in general. In 2006, WHO issued revised guidelines for PMTCT. The guiding principle calls for improving maternal and infant mortality by integrating PMTCT into Maternal and Child Health services at the population level.

WHO’s revised Comprehensive Continuum of Care includes:

For Mothers

- HIV services need to be integrated into MCH care
- Counselling and care related to nutrition, infant feeding, and psychosocial support
- Cotrimoxazole prophylaxis
- Access to sexual health and family planning services
- HIV care, treatment and support services
- Primary prevention services for HIV-negative women

For Children

- Immunization
- Growth Monitoring
- Cotrimoxazole prophylaxis
- Postnatal longitudinal follow up, including diagnosis: Early diagnosis of HIV for HIV-exposed children and nutritional support as necessary
- HIV care, treatment and support services, including ART

In addition, the guidelines recommend that all pregnant women eligible for antiretroviral therapy should receive ART. All HIV-infected pregnant women not needing ARV treatment should ideally receive ARV prophylaxis with the following regimen:

<table>
<thead>
<tr>
<th>PREGNANCY</th>
<th>LABOUR</th>
<th>POSTPARTUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZT (&gt;28 wks)</td>
<td>SINGLE DOSE-NVP + AZT/3TC</td>
<td>AZT/3TC X 7 DAYS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SINGLE DOSE NVP + AZT/3TC X 7 DAYS</td>
</tr>
</tbody>
</table>

One participant asked what should be done when an HIV-positive mother delivered, but the status of the baby was unknown. Dr. Tin Tin Sint said that the recommendation is to give a single dose of nevirapine no later than 12 hours after delivery. After that, the efficacy of nevirapine and AZT decreases. She also responded to a question about allergic reactions to nevirapine by noting that they were extremely rare and unlikely to be brought about by a single dose.

One person asked if the mother presents during labour, if there were any recommendation to give a slightly prolonged course of ARV prophylaxis when she was breastfeeding. Dr. Tin Tin Sint replied that the recommendation at the moment was not to prolong the course of ARV prophylaxis, but there were studies on this subject underway and we could expect updated recommendations mid next year. A participant asked if there was any advantage to adding a third drug in ARV prophylaxis, as this was more difficult for health centres. Dr. Tin Tin Sint replied that with Combivir two of the drugs (AZT and 3TC) were available in a single pill, and that the reason for adding a third drug was to guard against resistance to nevirapine.
PRESENTATION 15

HIV COUNSELING AND TESTING
Presented by Dr. Nguyen Van Kinh, Vietnam Administration of HIV/AIDS Control, Ministry of Health, Vietnam

“In most countries male involvement and support is critical in improving women's uptake of PMTCT services.” – Dr. Nguyen Van Kinh

From 1987 through 1995, Vietnam established a laboratory system for HIV testing in 20 sentinel provinces. During 1995 through 2000, the government passed ordinances on AIDS control, VCT guideline and started VCT programs in 20 provinces. Since then, there has been continued scaling up VCT activities in 64 provinces and the start of VCT at the district level with the support of the CDC, Global Fund, UNICEF and other organizations. VCT has been integrated with antenatal clinics in seven obstetric hospitals. Meanwhile, integration is being piloted at the district level in 40 sites. Provider initiated routine offer of VCT is intended to enable people to benefit from HIV prevention, care and treatment services by knowing their HIV status as early as possible. It must abide by the “ 3 Cs” : Consent, Counseling, and Confidentiality. Clients retain the right to refuse testing or “opt-out.” It provides “shorter” pre-test counseling to obtain informed consent, and intensive post-test counseling for positive clients, plus referral to, or provision of PMTCT, care, treatment and support services.

Routine offer of HIV testing at ANC has advantages. It enables more pregnant women, their infants and partners to benefit from available services, such as knowing their HIV status and contributing to primary prevention, PMTCT and HIV care, treatment and support. Possible disadvantages are that it’s not cost-effective in low prevalence countries or that PMTCT, care and treatment services may not be easily accessible after diagnosis, clients may not exercise their rights to “opt-out,” and an increased burden for laboratories for testing and shipping specimens. Vietnam reached the following conclusions:

- Political support (Law on HIV/AIDS control, National strategy on HIV/AIDS control) is required.
- Country guidelines must include confidentiality, counseling and consent principles.
- VCT is the most common approach in the region, while provider-initiated routine testing has been introduced to ANC in some countries.
- Policy/program decisions for routine testing in ANC should be made taking into account pros and cons.
- ANC provides a potentially effective opportunity for primary prevention interventions. It could be strengthened based on the best practices.
- Partner involvement is vital to promote PMTCT while creative and careful strategies are needed.

A delegate inquired about the IEC (information, education, communication) and BCC (behaviour change communication) activities conducted in Vietnam before counseling. Dr. Nguyen said that mass information campaigns had been developed in partnership with NGOs and mass organizations, such as women's organizations. It was also important that services were available before launching the information campaigns. Another participant asked how Vietnam was able to improve the quality of its VCT services as it scaled up. Dr. Nguyen replied that Vietnam followed the “Three Ones” principle of one country program, one governing body and one monitoring and evaluation system. From the beginning, Vietnam set up a monitoring and evaluation system and it was centralized. For testing, only certain laboratories can do confirmatory testing, so it is easier to monitor the quality of these specific labs. Also, academics from the country’s universities helped to evaluate the program. An attendee asked if Vietnam had any problems with tracing partners. Dr. Nguyen said that from the program’s beginning it stressed male involvement, as men were first affected by the epidemic. At the district level, getting men to attend counseling was difficult because usually the centers were a single room. At the provincial level, where centers are larger and there is more capacity, there is more male involvement.

PRESENTATION 16

PREVENTION OF MOTHER-CHILD TRANSMISSION OF HIV (PMTCT) IN PAKISTAN
Presented by Dr. Ayesha Khan, Infectious Diseases and HIV/AIDS Specialist, National AIDS Control Program, Ministry of Health, Pakistan

“There is no room for complacency.” – Dr. Ayesha Khan

The time to act on HIV and PPTCT is now, said Dr. Ayesha Khan of Pakistan. The health and social costs of the HIV epidemic are tremendous, and so there is no room for complacency. Pakistan is facing concentrated epidemics among groups engaged in high-risk behaviors, such as people who inject drugs and men who have sex with men. At
the present time, the epidemic is spreading to female sex workers, long-distance truck drivers and migrant men. With a population of 160 million, there are about 4.8 million births each year. Data from antenatal clinics is scarce, and the estimated prevalence among pregnant women is assumed to be anywhere in-between 0.1% and 1%, resulting in 1,750 – 17,500 HIV-infected newborns annually in the absence of PMTCT interventions.

Pakistan's main focus at this point in time is Prong 3, and the country is setting up centers to carry this out. By its very nature, this is closely linked to Prong 4, or providing care and support for HIV-infected women, their infants and their families after delivery. With Prong 1, or primary prevention, Pakistan is linking up with national HIV media. The country is still in the process of trying to integrate Prong 2. A major challenge is targeting high risk groups who usually do not access health services. But at the present time the strategy is to strengthen Prong 3 and work out from there. Next steps include:

- Operationalizing pilot sites
- Training of health care workers
- Roll out of PPTCT interventions
- Building linkages and support systems with NGOs
- Research and information for program scale up
- Future direction: Review our existing model and pilot community based approaches

One person asked for more details about Pakistan's support program for women who choose not to breast feed. Dr. Ayesha Khan responded that the program was not yet fully operational because so few women had chosen to be tested, or not to breastfeed, and Pakistan was reluctant to fully launch a program if it was not sustainable. In response to a question about stigma and discrimination preventing high-risk groups from coming to ANC and other health centers, Dr. Ayesha Khan said Pakistan was still searching for good answers to this problem. One was to ask organizations that represent or reach out to high-risk groups to take a more active role in bringing people to PMTCT centers. Another is to train health care workers to be more sensitive to members of high risk groups. She added that new HIV policies in Pakistan were more receptive to high risk behavior groups such as sex workers.

Presented by Dr. Wang Linhong, M.D., Professor, National Center of Women and Children Health, China CDC

“Evidence-based research is lacking in Asia and the Pacific on HIV and infant feeding.” – Dr. Wang Linhong

Dr Wang Linhong reported back from the Technical Consultation on HIV and Infant Feeding held in Geneva, October 25–27, which she had attended.

As the epidemic progresses, more studies on MTCT are providing new evidence on the various risks associated with different types of infant feeding. Studies in Africa found that exclusive breastfeeding reduced risk of HIV transmission compared to non-exclusive breastfeeding during the 3-6 months period after delivery. Non-exclusive breastfeeding, however, carries a 2-4 fold increased risk of transmission of HIV compared to exclusive breastfeeding. The Mashi-trial, Botswana, 2006, found that breastfeeding with zidovudine prophylaxis was not as effective as formula feeding in preventing postnatal HIV transmission, but was associated with a lower infant mortality rate at 7 months. Both strategies had comparable HIV-free survival at 18 months. These results demonstrate the risk of formula feeding to infants in sub-Saharan Africa, and the need for studies of alternative strategies. In Asia and the Pacific there are different national guidelines on infant feeding and different cultural practices. Evidence-based research is lacking on HIV and infant feeding, the relationship between patterns of infant feeding and MTCT rates, infant feeding and infant morbidity and mortality and their influencing and risk factors. This raises the question of whether African studies are applicable to Asia and the Pacific.

Dr. Wang Linhong shared the following recommendations from Technical Consultation which included researchers, programme implementers, infant feeding experts and representatives of the Interagency Task Team on Prevention of HIV Infections in Pregnant Women, Mothers and their Children, and six WHO departments:

- Assess the gap between country existing guidelines on infant feeding and UN advocated guidance (HIV and infant feeding: Framework for priority action), to formulate and revise national strategies and measurements.
- Follow WHO criteria for replacement feeding: Exclusive breastfeeding for the first 6 months of life is recommended, unless replacement feeding is Acceptable, Feasible, Affordable, Sustainable, Safe (AFASS).
- At 6 months, if AFASS criteria are not met, HIV-infected women should continue to breastfeed their infants, give complementary foods in addition and return for regular follow up assessments.
- Breastfed infants and young children who are found to be HIV-infected should continue to be breastfed according to infant feeding recommendations for the general population.
- All HIV-exposed infants and their mothers should receive the full package of maternal health and child survival interventions.
- Strengthen training on knowledge and counselling skill of HIV and infant feeding to improve quality of service and counselling.
- Conduct evidence-based researches and evaluate safe interventions to reduce postnatal transmission of HIV in our region.

A participant asked if there were positive experiences with heating breast milk. A doctor from Thailand said this option had been tried and found to be very impractical, as elimination of the virus was not always complete and many vital nutrients were lost in the heating process. Another participant asked if it might not be wiser for low prevalence countries to spend some of their HIV budgets on finding out why women from high-risk behaviour groups don’t come to health centers where they can learn about HIV prevention. Dr. Ayesha Khan said that Pakistan was in fact addressing this issue and found there were many reasons why both men and women did not come for HIV-testing. A major reason was that HIV-related treatment was not available, so why risk stigmatization? One doctor asked the UN to give a clearer policy on breast feeding vs formula feeding, as the presentation suggested that after six months there was not much difference between the two, and that some NGOs that are opposed to breast feeding are accusing doctors who support it of harming children. Dr. Linghong agreed that clear guidelines were needed.

**PRESENTATION 17**

HIV AND INFANT FEEDING: MESSAGE AND CONSIDERATION FROM WHO TECHNICAL CONSULTATION
PRESENTATION 18

INTRODUCTION TO SOUTH AND SOUTH-EAST ASIA REGIONAL PAEDIATRIC ART GUIDELINES
Presented by Dr. Sudhansh Malhotra, Regional Adviser, Child Health and Development, WHO/SEARO

“Less than 1% of children who need treatment were receiving ART in South-East Asia in 2005.” – Dr. Sudhansh Malhotra

Regional guidelines on pediatric ART have been developed with two objectives in mind, said Dr. Sudhansh Malhotra of WHO. The first is to strengthen national capacity for providing universal access to quality treatment and care to children exposed to or infected with HIV. The second is to provide guidance for appropriate ART in resource-limited settings of South and South-East Asia. He cautioned that as more research is done, the guidelines could become out of date, and so he urged participants to provide feedback.

The guidelines were developed because it was apparent there was a need for a user-friendly clinical manual containing concise and practical information. The purpose is to provide guidance for national clinical guidelines and to assist national policy makers/programme managers in strategy formulation. The manual deals with five key areas: (1) Diagnosis of HIV infection, HIV staging, CTX (cotrimoxazole) prophylaxis and treatment; (2) Treatment failure and second line therapy; (3) Immune reconstitution inflammatory syndrome (IRIS); (4) Opportunistic infections; and (5) Pediatric formulations. Attention is also given to growth and nutrition, counseling and social support, and adherence support, with weak adherence being the main reason for treatment failure.

A participant asked if the manual defined treatment failure and adherence. Dr. Sudhansh Malhotra said that it did, and some of the benchmarks for treatment failure were loss of neurological development and care to children exposed to or infected with HIV. The second is to provide guidance for appropriate ART in resource-limited settings of South and South-East Asia. He cautioned that as more research is done, the guidelines could become out of date, and so he urged participants to provide feedback.

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The Dry Blood Spot (DBS) Technique can be used as a mechanism to send blood samples for virological testing to a central laboratory. Advantages of DBS include:
- Small blood volume required
- Ease of sample collection, storage and shipment
- Noninfectious transport medium
- Safety of handling
- Stability of sample – stable in room temperature for more than 1 month
- Allows for centralization of testing facilities

and doctors to be alert to potential signs of HIV. Though some of these symptoms were non-specific, a pattern of symptoms could indicate HIV infection. Dr. Sudhansh Malhotra acknowledged that paternal history was a good and valid point and would be included in the next edition of the guidelines.

PRESENTATION 19

DIAGNOSIS OF HIV INFECTION IN CHILDREN
Presented by Associate Professor Kulkanya Chokephaibulkit, Department of Pediatrics, Faculty of Medicine, Siriraj Hospital, Mahidol University, Thailand

“Incorporating everything in a one-stop service is helpful in getting mothers to bring their infants back for testing.” – Dr. Kulkanya Chokephaibulkit

Diagnosing infants for HIV can be complicated, but it is very important for efficient management of pediatric HIV, improving the outcome for the child through PCP (pneumocystis carinii pneumonia) prophylaxis and ART. Early diagnosis also contributes to efficient monitoring of the PMTCT program, which can lead to improvements in the program. Early diagnosis can be an immense relief for the family in the case of a negative test result. If the test is positive, it allows families to make proper plans for the child and caretakers. In children older than 18 months, diagnosis can be done by anti-HIV serology. In children under 18 months, diagnosis is more difficult because maternal antibodies may persist in the child. Clinical symptoms can be a guide, but are not reliable, and may overlap with other problems. To diagnose children under 18 months, but older than six weeks, virological methods are recommended, including DNA-PCR (deoxyribonucleic acid polymerase chain reaction), RNA-PCR (ribonucleic acid polymerase chain reaction) and p24 antigen. The caveat is that a virological test should be confirmed with serology. Some non-subtype B or group “O” can give false negative PCR (polymerase chain reaction) results (newer assays are better).

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- Small blood volume required
- Ease of sample collection, storage and shipment
- Noninfectious transport medium
- Safety of handling
- Stability of sample – stable in room temperature for more than 1 month
- Allows for centralization of testing facilities
Disadvantages include:

- Live viral isolates cannot be determined from DBS
- Sample processing is more difficult, requires more steps
- Lymphocytes subsets cannot be measured
- It is difficult to obtain long PCR fragment, (>1.2 kb) DBS – based genet-ic screening

Dr. Kulkanya Chokephaibulkit added that an ideal entry point for pediatric HIV testing would be at ‘well baby clinics’ that include: immunization, growth monitoring, feeding centers, anticipatory guidance and educational activities.

A participant asked about how to transport Dry Blood Spot samples, and how to protect them against heat and humidity. Dr. Kulkanya Chokephaibulkit answered that DBS samples were put in plastic bags and shipped in a variety of ways, including courier services, postal services and motorcycle messengers. India said it had contracted a company to transport them to regional centers for testing. Both agreed that heat and humidity had not affected the samples in any way.

**PRESENTATION 20**

**CHALLENGES OF PROVIDING HIV CARE FOR INFANTS AND CHILDREN IN RESOURCE LIMITED SETTINGS**

Presented by Dr. Tripti Pensi, Consultant, UNICEF, National Convener HIV/AIDS, Indian Academy of Pediatricians

"Our policy is to never give up." – Dr. Tripti Pensi

In India’s population of 1.028 billion people, each year there are approximately 27 million pregnant women. Only about 3.9% avail themselves of PPTCT services, and as much as 59% deliver at home. Overall, infant and maternal mortality have been decreasing, but in rural areas more progress needs to be made. These indicators need to improve if India is to make progress on children surviving with HIV. India has a system of health centers for vaccinations. If these could be expanded to provide more holistic health care, they could serve as a good network to deliver PPTCT. Many women only show up at a health center or hospital for delivery. Most hospitals are not set up to provide counseling and testing in emergency room settings. The Clinton Foundation is supporting ARV for 10,000 children for three years in 36 centers by September. The difficulty is knowing where these children are. Partnerships are being forged with NGOs to screen children. Guidelines are still lacking on how to tell children they are infected, and also nutritional guidelines, which are the backbone of support for HIV infected children.

Among the next steps India plans to take are:

- Launch of a pediatric initiative on World AIDS Day 2006
- Pilot new PPTCT regimens
- Pilot pediatric M&E indicators
- IAP-NACO-Pharma – AZT Ped FDC, ABC
- Scale up comprehensive pediatric care to sub-district level.
- Develop guidelines for Pediatric counseling, disclosures, consent and confidentiality for the young.

A participant asked what second line treatments India was using, and what experiences India had with adherence in children. Dr. Tripti Pensi responded that India did not have second line treatments at this point in time, but they were working with a company to develop a second line alternative. Dr. Wendy Holmes added that India had changed its PPTCT regimen from a short course of ZDV to single dose nevirapine in 2002. Indian PPTCT counselors had said that while single dose nevirapine was easier to administer, the short course of ZDV had the advantage of requiring the mother to come back several times to the health center. This allowed doctors and health care workers to develop a rapport with the woman and follow up was improved. However, other counselors had said that another advantage of single dose nevirapine was that mothers liked to see the baby getting medicine too. It had a positive psychological effect upon the mother. It is worth thinking about these aspects when countries change their PPTCT regimen.

**PRESENTATION 21**

**“THE PLUS” – REFERRAL, LINKAGES AND COMMUNITY-BASED CARE AND SUPPORT TO CHILDREN HIV INFECTED AND AFFECTED BY HIV**

Presented by Dr. Mean Chhi Vun, NCHADS Director, Cambodia

"The question is how to follow up mothers and children after ANC so they can get PPTCT Plus and pediatric AIDS care.” – Dr. Mean Chhi Vun

PMTCT is making a difference in Cambodia, according to Dr. Mean Chhi Vun. Under the PMTCT program, the government estimates that about 300 children each year are born infected with HIV. Without PMTCT, the number would be 2,540. Cambodia began VCCT in 1995, and has been scaling up slowly since that time. In 2003, an estimated 1.9% of the population was living with HIV. That same year, Cambodia instituted a Continuum of Care approach to HIV and AIDS, which is essentially a one-stop-shop approach to providing prevention, treatment, care and support. Partnerships were crucial to making this happen. Linkages were important. Included in the approach were a pediatric HIV and AIDS program, and expansion of PMTCT and VCT centers outside the capital Phnom Penh. Other aspects of the Continuum of Care approach include:

- Partnerships between medical services, PLWH groups, the public health system and NGOs
- Strong referral mechanisms between the home, the community and the institutional care levels.
- Effective involvement of PLHA in all aspects of the continuum of care – MMM (RIPA).
- Reinforcement of health care facilities to provide quality care services to PLHA.
- Development of care packages at each level of the health care system.

Challenges still remain. Among them are:

- Limited access to pediatric AIDS care (shortages in human resources, facilities, laboratories, etc.).
- Poor coordination and collaboration between home based care and Health Facility to increase PMTCT uptake.
- Slow extension and expansion of the model of good referral mechanisms and linkages between Home Based Care and Health Care Facility, as well as relevant services within the Continuum of Care (PMTCT, Pediatric AIDS Care, OI/ART, etc.).
- Limited capacity of integrated monitoring and data management of Continuum of Care (PMTCT, Pediatric AIDS Care, etc.).
**PRESENTATION 22**

**OPPORTUNITIES AND CHALLENGES IN ENSURING RELIABLE ACCESS TO SUPPLIES**

Presented by Dr. Helene Moller, Field Support Officer, HIV AIDS and PMTCT, UNICEF Supply Division

“If any one component of the supply chain breaks down, there will be chaos.” – Dr. Helene Moller

All programs are vulnerable to shortages of supplies. All interventions use and depend upon supplies, said Dr. Helene Moller of UNICEF’s Supply Division. Planning for supplies must be done from the onset of planning for any program or intervention. Access to essential supplies depends on effective supply chain management. If any one component of the supply chain breaks down, there will be chaos. Many country representatives are talking about scaling up programs. If that happens, then supplies have to be scaled up, and so it is important that supplies be considered from the start. When it comes to PMTCT ARV formulations, collaboration with industry is required, to develop and obtain better formulations. More appropriate formulations then need to be phased in, as there are program and cost implications to be considered. And until testing is scaled up, it is difficult to negotiate with industry over costs and availability because the volume is still low. While the ELISA (enzyme-linked immunosorbent assay) test is still the most reliable and widely used, the technology of simple and/or rapid tests are constantly improving:

- Rapid, whole blood tests with 100% sensitivity and 100% specificity
- Tests with 14 – 18 months guaranteed shelf life on arrival in country
- Test that can stand temperatures up to 30°C

Dr. Helene Moller left the participants with the following questions to consider in the area of access to medicines:

- Do patients in your country have access to a basic package of care?
- Can they afford accessing treatment?
  - do they pay for medicines
  - do they pay to access the services
  - transport costs, etc
- How closely is your programme planning coordinated with procurement planning?

**PRESENTATION 23**

**ENSURING SECURE AND RELIABLE SUPPLY AND DISTRIBUTION SYSTEMS IN DEVELOPING COUNTRIES IN THE CONTEXT OF HIV AND PMTCT: A JOINT ASSESSMENT OF THE PHILIPPINES HIV SUPPLY CHAIN MANAGEMENT SYSTEMS**

Presented by Dr. Jabulani Nyenwa, Consultant, UNICEF Headquarters Supply Division

“We need to look at countries’ capacities for supply support, particularly in relation to their capacity for scaling up.” – Dr. Jabulani Nyenwa

Although the final report from the Joint Philippine DOH - UNICEF - WHO technical assessment (September 2006) upon which this presentation was based has not yet been released, Dr. Jabulani Nyenwa said that sharing some of its lessons could be valuable for the Task Force. The objective of the Philippine assessment was to ascertain the Procurement and Supply Management (PSM) capacity in the country and provide recommendations to effectively support scale-up of HIV prevention, treatment and care, and also to provide specific recommendations on supply distribution and monitoring.

While the epidemic in some countries in the region can be characterized as “low and slow” it is nonetheless increasing. Most countries recognized the urgent need to strengthen capacity to scale up towards universal access of HIV prevention, treatment, care and support. Effective supply management is essential for successful scale-up. Many commodities have to be considered in the HIV supply system, and various factors need to be taken in account when managing the chain of HIV supplies. Among these is that ARV therapy entails life-long, uninterrupted treatment with a combination of three to four products. An interruption in the supply of any one of the ARVs has serious implications for the successful management of the ARV programme and the HIV epidemic. ARVs are relatively expensive supplies. Many HIV- and STI-related test kits and some ARVs need cold storage, and both ARVs and test kits have short shelf lives.

In conclusion, Dr. Nyenwa made the following recommendations:

- Closer collaboration between implementers and supply managers to improve forecasting and quantification
- Establish a mechanism for redistribution of ARVs
- Develop ordering, distribution and reporting system for ARVs, with training
PRESENTATION 24

TRIPS, TRADE AND LEGISLATION: ENSURING ACCESS TO MEDICINES IN ASIA AND THE PACIFIC

Presented by Cecilia Oh, Trade Policy Adviser, UNDP Asia and Pacific Regional Centre, Colombo

"When governments use TRIPS flexibilities, prices of medicines have fallen." – Cecilia Oh

Cecilia Oh’s presentation dealt with three areas:

1. The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS, 1995), which introduced global minimum standards for protecting and enforcing nearly all forms of intellectual property rights (IPR), including those for patents. The TRIPS Agreement now requires all WTO members, with few exceptions, to adapt their laws to the minimum standards of IPR protection. TRIPS also contains provisions that allow a degree of flexibility for countries to accommodate their own patent and intellectual property systems and developmental needs, including the need for affordable access to existing medicines.

2. The Doha Ministerial Declaration (2001) which sought to clarify ambiguities between the need for governments to apply the principles of public health and the terms of the TRIPS Agreement. The Doha Declaration affirms that “the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health.” In this regard, the Doha Declaration enshrines the right of WTO Members to make full use of the flexibilities of the TRIPS Agreement in order to protect public health and enhance access to medicines for poor countries.

3. Current challenges to access to ART.

Many countries have already used TRIPS flexibilities with a very positive effect on ARV availability and affordability. TRIPS flexibilities are the following:

- Compulsory licences permit 3rd parties to use an invention without consent of patent holder. Under a compulsory licence, a drug company can locally produce generic versions of medicines patented in the country or import generics from foreign producers.
- Government use licences permit government agencies to make use of an invention for public, non-commercial purposes. Under a govt use licence, local production of generic versions of patented medicines or import of generics may take place for public, non-profit purposes.
- Exceptions to exclusive patent rights allow limited use of a patent in specific circumstances. For example, a Bolar exception allows generics to be manufactured for the purpose of testing and approval, such that the generic product is ready for marketing as soon as the relevant patent expires.
- Parallel import is the import and resale of a patented product in another country. This TRIPS flexibility permits a patented drug, sold at US$5 in one country, to be imported and re-sold in on a different country, where the same product is being marketed at a higher price (e.g., US$10).

Doha Declaration principles and TRIPS flexibilities are not self-executing. They are not automatically applicable in national context and require enactment into national law.

In conclusion, Cecilia Oh said the following measures needed to be taken:

- Policy and technical guidance: UNDP-WHO remuneration guide, model provisions
- Training and capacity building: UNDP-WHO Asia-Pacific regional workshops, multi-agency cooperation on IPRs and public health issues
- Country support: legislative review and amendment, technical assistance on options for TRIPS implementation
- Monitoring and analysis: patent information on ARVs and HIV-related drugs
- Raise the awareness of public health community and civil society

PRESENTATION 25

ASEAN Cooperation on Increasing Access to ARV and HIV-Related Supplies

Presented by Bounpheng Philavong MD, MPH, DrPH, Senior Officer for Health, ASEAN Secretariat

"ASEAN has commitment at the highest levels, especially from heads of government, and that is its comparative advantage." – Dr. Bounpheng Philavong

The Declaration on HIV and AIDS adopted by the 7th ASEAN Summit in 2001 acknowledged that prevention is the only effective way to combat the spread of HIV. ASEAN Members Governments pledged to “lead and guide the national responses to the national responses to the HIV epidemic as a national priority … by integrating HIV prevention, care, treatment and support and impact mitigation priorities into the mainstream of national development planning…” An ASEAN Task Force on AIDS (ATOFA) has been established in 1993. ATOFA is preparing a key outcome documents for the 12th ASEAN Summit Special Session on HIV and AIDS scheduled for December 2006 in Cebu, Philippines. This is the second time national governments are convening a Special Session on HIV.

The ASEAN Secretariat works with the Rockefeller Foundation to review IPRs and conduct capacity-building activities to enhance access to ARVs by reviewing countries’ patent laws, identifying options to enhance access to drugs; building local, legal capacity in ASEAN countries on IPR and access to medicines through workshops at national and regional levels.

At two regional workshops held in June 2002, government representatives agreed to work towards joint negotiation between ASEAN Member Countries and pharmaceutical sector to: Enhance understanding of TRIPS and its implications for access to drugs, including options available to improve access; and compile baseline information from all ASEAN countries. Government representatives also adopted the ASEAN Regional Framework on Increasing Access to Antiretrovirals and Diagnostic Reagents. It consists of nine strategies:

Strategy 1: Establish national and regional committees of experts for regional cooperation
Strategy 2: Strengthen communication and Information Management
Strategy 3: Promote: a) the adoption of TRIPS safeguards into national legislation (based on review of intellectual property rights laws), and b) the actual use of safeguards that already exist in the law.
Strategy 4: Develop a regional action plan to include different options for drug procurement
Strategy 5: Establish fast track registration mechanism of ARV drugs
**Strategy 6:** Advocate selected, specific issues related to increasing access to antiretrovirals

**Strategy 7:** Establish and make use of an effective monitoring and evaluation system

**Strategy 8:** Build capacity on: a) IPR and access to medicines, b) logistics management of medicines and diagnostics, and c) ethical aspects of the use, prescription and trade in medicines

**Strategy 9:** Surveillance of ARVs and Research (this additional strategy is proposed by Group I and will be written in detail by Indonesia and ASEAN Secretariat for further agreement)

Due to lack of time, there was no question and answer segment for this session.

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**SESSION 15**

**PRESENTATION 26**

Impact of Monitoring and Evaluation of PMTCT
Presented by Dr. Sun Gang, Monitoring and Evaluation Adviser, UNAIDS Regional Support Team, Asia Pacific

"It is behavior that drives the epidemic, not the populations." – Dr. Sun Gang

Certain cofactors can explain what drives the HIV epidemic, said Dr. Sun Gang of UNAIDS. A country may have a small number of sex workers, but if those sex workers have a large number of clients each day, then that will be a gateway for the virus to spread to low- or no-risk females and children. Studies show that across the region, female sex workers are 0.2 – 0.8% of the adult female population. Prevention of mother-to-child-transmission must start with prevention for most-at-risk populations, which in turn will protect women and children. Therefore, behavior change is the key, combined with coverage.

In support of the various goals for universal access to prevention, treatment, care and support as expressed in the Millennium Development Goals and the UNGASS targets, the following set of core indicators can be used to gauge progress on PMTCT:

1. Existence of guidelines for prevention of HIV infection in infants and young children
2. Number of health workers newly trained or retrained in the last 24 months on interventions for prevention of HIV infections in infants
3. Percentages of all possible public and private venues (family planning, primary health care, antenatal care/ maternal and child health services, etc) providing minimum package of service for prevention of HIV infections in infants in the past 12 months
4. Percentage of pregnant women who access ANC services and counseling and testing; includes
   - Attend at least one ANC visit in a site for the prevention of HIV infection in infants
   - Accept testing for HIV
   - Receive HIV results and post-test counseling
5. Percentage of pregnant women receiving a complete course of ARV prophylaxis to reduce mother-to-child transmission of HIV in accordance with nationally approved treatment protocol in the last 12 months
6. Estimated percentage of HIV-infected infants born to HIV-infected mothers

**PRESENTATION 27**

**Process Monitoring**
Presented by Dr. Lata Bajracharia, Senior Consultant, Maternity Hospital Kathmandu, on behalf of the Nepal Country Team

"The goal is to improve the quality of services delivered." – Dr. Lata Bajracharia

The Nepalese government established hospital-based PMTCT services in three hospitals in 2005 and four more in 2006. National guidelines for PMTCT and paediatric care have been developed. Paediatric ARV therapy is scheduled to begin at one site in December 2006. As far as monitoring and evaluation is concerned, the overall goal is to improve the quality of service delivery at specialized PMTCT sites. Information is collected, data analyzed and feedback provided to sites with this primary goal in mind. Secondary objectives include identifying problems in providing quality PMTCT service; assessing the performance of the clinical team; reviewing the quality and adequacy of the ARV drug management, laboratory testing and counseling; and reviewing the quality of record keeping on patient visits and related HIV and AIDS clinic reporting.

Monitoring and Evaluation activities include:

- Monitoring tools have been developed for use in ongoing reporting of activities and every supervisory visit
- Monthly reports are generated at each PMTCT site
- Monthly/bimonthly supervisory visits are conducted to each site
- Comprehensive country-wide PMTCT review scheduled for Nov/Dec 2006

While Nepal’s monitoring tools have been helpful in identifying areas where improvements need to be made, it also has displayed some limitations. For one, they are time consuming. Also, observations are made on only one clinic/clinical team at a time, and capacity does not yet exist to evaluate the activities of other clinics or clinical teams.

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**PRESENTATION 28**

A National Assessment for Preventing HIV in Mother and Children: An Indonesian Story
Presented by Dr. Lukman Hendro Laksmono, Directorate of Maternal Health, Ministry of Health, Indonesia

"..." – Dr. Lukman Hendro Laksmono

Indonesia is aiming to integrate PMTCT into national health programs in 2007. To that end, it is conducting a rapid assessment,
capacity building workshops, training of health professionals and other activities. The epidemic in Indonesia was first discovered in the community of sex workers. When it spread among IDUs, however, it increased rapidly because of the more efficient transmission of HIV through contaminated injecting equipment. In 2006, the Ministry of Health conducted its rapid assessment at seven sites across the country. It found that the epidemic is not spreading rapidly, but health officials are concerned about accepting that conclusion without more solid evidence. The goal of the assessment was to identify the conditions which support or constrain broad PMTCT interventions.

The assessment found that many people were knowledgeable about HIV, including the risk of transmission from mothers to children. However, the depth of knowledge on prevention was limited even among health care workers. Health care workers also had many fears related to HIV, and pregnant women were rarely given information on MTCT in either hospitals or clinics. Obstacles to improving and integrating coverage include the lack of trained health care workers, there are few places which provide sexual and reproductive health care services to unmarried youths, and exclusive breastfeeding is not promoted. Nonetheless, there are health centers and NGOs who have experience providing services to PLWHA and reaching groups with at-risk behaviors.

In conclusion, Dr. Lukman said Indonesia had learned the following lessons from its rapid assessment:

- Building capacity among health care workers is possible.
- Assessment tools/processes are replicable and can assist as monitoring and evaluation methods.
- Potential entry points for PMTCT messages include community-based maternal and child health clinics, immunization clinics and the workplace.
- Male partners, who often hold decision-making powers over women's reproductive health, were uninformed about PMTCT.
- There is evidence that health care workers adopt a more empathic and positive attitude towards PLWHA, and have developed a better understanding of the ways HIV is transmitted and how to prevent transmission.

**PRESENTATION 29**

**Quality Improvement in PMTCT and Pediatric HIV Care: Thailand Experiences**

Presented by Dr. Rangsima Lolekha, Team Leader, Pediatric and Family Team, Global AIDS Program, Thailand Ministry of Public Health - US CDC Collaboration

“Having good policies and guidelines doesn’t mean, however, that health care workers are implementing them.” – Dr. Rangsima Lolekha

As one of the first countries in the region affected by the HIV epidemic, Thailand has developed good policies and guidelines. PMTCT and ART are available in many health care settings in Thailand. Having good policies and guidelines doesn’t mean, however, that health care workers are implementing them. A monitoring and evaluation system needed to be designed to ensure that they are. Thailand adopted HIVQUAL-T, a model from the New York State Department of Health. HIVQUAL-T is an HIV care and treatment quality improvement (QI) initiative designed to build capacity for performance measurement and quality improvement in Thai ambulatory care clinics. Its goals are to develop a sustainable QI program structure that supports ongoing improvement in the quality of HIV care; promote reporting of HIV care performance data by hospitals; and improve the quality of care for PLHAs.

Core indicators for pediatric care used in the HIVQUAL-T model are HIV status monitoring (clinical and CD4 monitoring), OI prophylaxis (PCP), antiretroviral therapy and TB screening. Optional indicators include HIV status monitoring (viral load monitoring), OI prophylaxis (MAC – mycobacterium avium complex – prophylaxis and CMV – cytomegalovirus – retinitis screening), immunization, growth and development, dental health and psychosocial issues. Among the next steps that need to be taken are emphasizing the concept of using performance measurement data to improve quality of services; establish a QI (quality improvement) group learning workshop among hospitals; Pediatric HIVQUAL-T manual and tool kit development; and site expansion (regional and provincial hospitals) by integrating pediatric module into national HIVQUAL-T.

In summary, Dr. Rangsima made the following points:

- The magnitude of the HIV epidemic and the complexity of treatment make quality assessment of HIV care essential.

**Questions and Answers**

After observing the four presentations on monitoring and evaluation, several participants commented that the various programs are only monitoring Prong 3. They said that was too narrow a focus and it would be better to gauge the MTCT situation if tools were developed to also monitor the other prongs. Dr. Sun Gang replied that PMTCT has to be put in an overall context and the key word is integration. It has to fit into the national monitoring system. Another participant asked the representative from Indonesia if their monitoring and evaluation program is capturing pregnant women who inject drugs, as the epidemic is still concentrated among those who inject drugs in that country. Indonesia replied that there are small programs doing that, but the next step is to focus on a plan that will bring in the groups reaching injecting drug users so data can be gathered. A participant asked Nepal how they deal with pregnant women who do not wish to participate in MTCT, and how Thailand reaches women who do not attend ANCs. Nepal said that only one out of 25 women refused PMTCT services, and Thailand replied that the problem of women not using ANCs is mainly in border areas, and so there are plans to develop more hospitals there and also outreach programs for hill tribe people.
SESSION 7

Presentation of Group Work, Summary and Discussions
Chaired by Ian Macleod, HIV Adviser, UNICEF ROSA

At the end of the second day of the conference, country teams were asked to assemble in groups and formulate an action plan for scaling up either PMTCT or pediatric care and treatment in their countries. Groups were instructed to detail the current situations, strengths and weaknesses in their countries and look at opportunities for scaling up through integration. Each group was asked to present three recommendations and five tasks for each recommendation. On the third day, the groups presented their work.

After all groups presented, chairperson Ian Macleod of UNICEF ROSA observed that there were common themes raised by most countries:

- First was the stress on integration of programs into the larger health care infrastructure as a means of scaling up HIV prevention, care, treatment and support.
- Second was that many countries felt a need to begin a review process of their existing national guidelines, strategies, linkages and operating procedures.
- Third, there are continuing issues of stigma and discrimination among the general population and also health care workers.
- Fourth, the skills capacity and confidence of health care workers needs to be improved, especially in relation to counseling about issues such as infant feeding options.
- Fifth, community mobilization needs emphasis.
- Sixth, better coordination is needed among all stakeholders, including UN agencies.

- Seventh, promotion of male involvement, especially around ANC and post-partum care is required but lacking.
- Eighth, challenges remain and need to be addressed regarding uptake of ANC and other services.
- Ninth, the desire to work more closely with organizations of PLWHA.

In summary, no one model fits all. There are great geographic and economic differences, differences in health system capacities and coverage, as well as differences in the stage of the epidemics: Low prevalence, concentrated and generalized. The differences are vast within and between countries. Even if no one model of PMTCT and pediatric treatment, care and support fits all, a number of guidelines and approaches presented over the last week have sparked some thoughts and debate.

SESSION 8

Synthesis of the PMTCT Task Force and Key Agreements and Recommendations
Chaired by Ian Macleod, HIV Adviser, UNICEF ROSA

The proceedings and results of the 6th PMTCT Task Force meeting were analyzed and synthesized. A number of new issues were raised at the meeting. In the area of policy environment, comprehensive PMTCT and paediatric HIV and AIDS are now firmly entrenched in Universal Access, and there is a greater global commitment to children. As far as technical guidelines and tools were concerned, developments discussed included new PMTCT and paediatric AIDS guidelines (global); a South and Southeast Asia Clinical Manual on Management of paediatric HIV infection. In addition, new developments include a greater focus on access to ART for pregnant women; improved diagnostics – better rapid testing, use of DBS; ARV price reductions; and research evidence on impact of infant feeding options on child survival, which concluded that there is no difference in 18-month HIV-free survival between formula-fed and breastfed + AZT infants.

Most of the countries in Asia-Pacific have commenced PMTCT programs with different levels of implementation status: two countries have national coverage, two countries provided ARV prophylaxis for more than 50% of HIV infected pregnant women. Guidelines and training manuals have been developed, and capacity building processes are on-going. Also, some countries have developed national scale-up plans as part of National Strategic Plan for HIV and AIDS.

Bettina Schunter, HIV and AIDS project officer for UNICEF in Islamabad, Pakistan, read the following policy and program recommendations of the Asia Pacific UN PMTCT Task Force, as a synthesis of the 5 days discussion:

Policy

1. Integrate PMTCT components into existing service delivery points

The most effective way to increase coverage was seen to integrate PMTCT components into existing services. As an example, messages related to PMTCT prong 1 and 2 could be integrated in services related to family planning and reproductive health, maternal health, sexually transmitted infections, adolescent health and possibly in traditional medicine. Likewise, pediatric HIV-related treatment should be integrated into existing child health structures and/or adult treatment hubs.

Programming

2. Ensure reproductive rights of women, and of HIV-positive women in particular

Choices relating to pregnancy, antenatal, delivery, postnatal care as well as choices of being tested or treated for HIV or sexually transmitted infections have rested with the male head of the household for generations. Unless women are empowered to make decisions related to their own bodies and reproductive health, maternal mortality and infant mortality rates will not improve. Participants specifically recognized the reproductive rights of HIV-positive women in making informed decisions on family planning.
3. PMTCT programming should be targeted, evidence-based and result-oriented

The meeting made a strong call for PMTCT programming to be evidence-based with measurable indicators. Innovative ways need to be found to reach women and families at increased risk of HIV-infection, such as through out-reach VCT.

4. Ensure a continuum of care

Prevention, treatment, care and support services need to be seen as a continuum. Depending on the HIV-status of a person, and if asymptomatic or symptomatic, the types of services he or she needs will change. Effective referral systems have to be developed to ensure that people living with and affected by HIV can benefit from the variety of services at the community and institutional levels throughout the course of infection and disease. PMTCT services need to be harmonized and effectively linked with the overall national continuum of care services.

5. Follow-up on and diagnosis of the HIV-exposed child

Participants recognized that follow-up is a weak component of PMTCT in many countries. Different entry points for pediatric HIV testing have been identified through the course of the meeting. Better diagnostics as well as guidelines for pediatric testing are available and can be used at country-level. New technologies (such as the dried-blood-spot technique) need to be assessed at country-level to see how they can enhance programming.

6. Build the capacity at country level within rollout plans to manage Paediatric ART

Country-level capacity to manage paediatric HIV is weak. Participants recognized a need for estimations and projections, developing guidelines, developing training manuals, training health care workers and counselors, as well as representatives from relevant NGOs and organizations of PLWH, and developing a procurement and supply management system.

Supply

7. Review TRIPS flexibilities

Availability and affordability of ARVs at country-level is crucial for comprehensive HIV programming. The Agreement on Trade-Related aspects of Intellectual Property rights (TRIPS) contains provisions that allow a degree of flexibility for countries to accommodate their own patent and intellectual property systems and developmental needs, including the need to affordable access to existing medicines. These flexibilities need to be reviewed at country-level and, if applicable, enacted into national law in order to allow for access to cheaper medicines.

8. Universal Access is wider than ARVs only. Consider “package” of supplies

Program planning needs to be closely coordinated with procurement planning. Efficient and sustainable procurement and supply management should coordinate supplies needed for HIV prevention, treatment, care and support, reproductive health, maternal and child health and preventing and treating sexually transmitted infections.

Monitoring and Evaluation

9. Consider incorporating additional PMTCT prong 1, 2 and 4 process indicators into National HIV Monitoring and Evaluation Frameworks

Global indicators for PMTCT mainly reflect process in prong 3 interventions; suitable process indicators for prong 1, 2 and 4 need to be derived. Examples could be “Number of condoms distributed at ANC sites” “Number of HIV-positive pregnant women referred to Family Planning from ANC”, as well as “Number of PMTCT services that refer to care and support” and “Number of women who receive free counselling on infant feeding at the first post-natal infant follow-up.”

10. Incorporate PMTCT monitoring into the national Health Management Information System

At present, many countries have a separate PMTCT monitoring and evaluation system. Incorporating PMTCT monitoring into the national Health Management Information System ensures sustainability and consistent use of the data.

In conclusion, the following blueprint for the future of the Task Force was presented, based on discussions with members and participants:

• The Task Force mandate to formally include comprehensive PMTCT and Paediatric HIV and AIDS
• Membership of the Task Force to be leaner, with a maximum of three to four participants from countries to be formally led by the National PMTCT Manager/Focal Point and Paediatric Manager/Focal Point.
• Task Force meetings to continue to focus on: technical updating; programming scale-up progress and action plans; review of progress on key recommendations from previous Task Force meetings.
• Monitoring of progress on key recommendations to be followed up every six months at regional level jointly by UNICEF/WHO (including ensuring TA availability) to countries.
• The next UN Asia Pacific PMTCT Task Force meeting to take place in 16-18 months time (late February 2008).
## Annex 1: Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday, 6 November</th>
<th>Tuesday, 7 November</th>
<th>Wednesday, 8 November</th>
<th>Thursday, 9 November</th>
<th>Friday, 10 November</th>
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| 08:30 - 10:00 | Registration                                           | 4. Introduction of the draft Framework (Dr. Holmes, Burnet) | 6. Group work: country plans for next steps
a. Guidelines for group work (Dr. Awin, Malaysia)
b. Country team work on planning for the next step | 10. New WHO PMTCT Guidelines (Dr. Sint, WHO)
a. Procurement and Supply Management (Dr. Molles, UNICEF)
b. TRIPS, trade and legislation (UNDP)
c. Action in ASEAN on ensuring sustainable access (Dr. Philavong, ASEAN) |
| 10:00 - 10:30 | COFFEE BREAK                                          |                                                         |                                                       |                                                       |                                                       |
| 10:30 - 13:00 | 1. b. Pre-pregnancy comprehensive prevention (Dr. Atwood, UNICEF)
   2. Presentations on best practices, experiences and lessons learnt (Cambodia, China) | 4. Introduction of the draft Framework (continued) 5. Group work: reviewing, revising and commenting on the Framework
   a. Guidelines for group work (Dr. Ionita, UNICEF) | 6. b. Country team work on planning for the next steps
c. Presentation for the next steps | 11. b. ARV Prophylaxis (Dr. Khan, Pakistan)
c. Infant Feeding (Prof. Wang, China) | 15. Panel Presentation: Monitoring, Evaluation and Quality Assurance
a. Impact Monitoring and Evaluation (Dr. Sun, UNAIDS)
b. Process Monitoring (Nepal)
c. PMTCT Program Assessment (Indonesia)
d. Quality Improvement (Dr. Joleah, Global AIDS Program, Thailand MOPH-US) |
| 13:00 - 14:00 | LUNCH BREAK                                            |                                                         |                                                       |                                                       |                                                       |
| 14:00 - 16:00 | 2. Presentations on best practices, experiences and lessons learnt (continued) (PNG)
   3. Opening ceremony (WHO, UNICEF, UNFPA, UNAIDS, HE Minister of Health
      Dato’ Dr. Chua Soi Lek)
   Group Photo | 5. b. Group work | 6. c. Presentation for the next steps (continued)
a. New Asia Pacific Tools and Guidelines on Paediatric HIV and AIDS (Dr. Malikova, WHO)
b. Diagnosis (Dr. Kulkanya, Thailand)
c. Treatment (Prof. Persi, India)
| 16:00 - 16:30 | Presentations on best practices, experiences and lessons learnt (continued) (Myanmar, Thailand, India) | 8. Opening (Mr. Toshi Nwa, UNICEF Deputy Executive Director)
   9. Panel presentation PMTCT
   a. PMTCT in Asia and the Pacific: Overview of the PMTCT Task Force (Dr. Mon, UNICEF)
   b. PMTCT status in Asia and the Pacific (Dr. Nyunt, UNICEF)
   c. UN Asia Pacific PMTCT Task Force Review and Endorsement of Framework (Dr. Usmani, UNFPA) | 13. Group work on Scale up | 17. Synthesis of the PMTCT Task Force key Agreements and Recommendations (Rapporteurs)
   Decision on next meeting: country and month |
| 16:30 - 18:00 | COFFEE BREAK                                           |                                                         |                                                       |                                                       |                                                       |
| 19:00         | Official reception                                      | Movie Night                                             | Sight Seeing of Kuala Lumpur                         | Movie Night                                           |                                                       |
## Annex 2: List of Participants

<table>
<thead>
<tr>
<th>Country</th>
<th>Team</th>
<th>Participant</th>
<th>Organisation / Designation</th>
<th>Contact Details</th>
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<tbody>
<tr>
<td>Afghanistan</td>
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Annex 3: Evaluation Summary

A) Quantitative part:

- Ratings are positive: on a scale from 1 (lowest) to 5 (highest rating), sessions all ranged in between 3.7 (testing, ARV prophylaxis, Infant Feeding) and 4.0 (PMTCT Guidelines).
- A break-down into the different sub-questions shows that “relevance” of the different sessions scored 4 on average, with the Guidelines session and the M&E session with the best ratings.
- Presenters and technical resource people have received good ratings, as did the conference arrangement.

B) Qualitative part:

- Overall very positive “The second half of the Joint Forum is very suitable and useful,” “good participation,” “The Task Force (TF) has met expectations and objectives”

Some specific feedback for improvement (next meeting):

- Some messages should have been clearer, such as for integration, infant feeding, scaling PPTCT in low prevalence contexts
- Discussions on the integration framework should have taken place in a smaller group
- First 3 days have not been specific enough for prongs 1 and 2
- More “how-to” required, i.e. support for programming, not only technical updates
- Some participants commented on interagency issues: “speaking with one UN voice” and “miscommunication among Regional Offices before the meeting”
- Too much lecture type sessions; need for more innovative interactive training methodologies

Expectations towards the future of the TF

- Great demand for a more detailed session on infant feeding
- Great demand for recent studies and more evidence based recommendations
- Demand for continuation of TF
- Divided feedback regarding membership of TF
- Demand for more expert speakers with specialized technical expertise
- Some asked for a newsletter