

Asia-Pacific

# Prevention of Parent-to-Child Transmission of HIV Task Force



## 10<sup>th</sup> Meeting Report

15-17 September 2015  
Beijing, China



Asia-Pacific Prevention of Parent-to-Child  
Transmission of HIV Task Force – 10<sup>th</sup> Meeting Report

© UNICEF East Asia and Pacific Regional Office, August 2016

ISBN: 978-974-685-152-7

Published by UNICEF East Asia and Pacific Regional Office

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**Asia-Pacific**

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# ACRONYMS AND ABBREVIATIONS

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ANC	antenatal care	NVC	National Validation Committee
ARV	antiretroviral	NVT	National Validation Team
ART	antiretroviral therapy	PAHO	Pan American Health Organization
CBO	community-based organization	PEPFAR	President's Emergency Plan for AIDS Relief
CD4	T lymphocyte cell count	PITC	provider-initiated testing and counselling
CDC	Center for Disease Control and Prevention	PLHIV	people living with HIV
CSO	civil society organization	PNG	Papua New Guinea
EAPRO	East Asia and Pacific Regional Office of UNICEF	PrEP	pre-exposure prophylaxis
EID	early infant diagnosis	PWID	people who inject drugs
EPTCT	elimination of parent-to-child transmission	POC	point-of-care
HBsAG	HBV surface antigen	PPTCT	prevention of parent-to-child transmission
HBV	hepatitis B virus	PNG	Papua New Guinea
HIV	human immunodeficiency virus	ROSA	Regional Office of South Asia (UNICEF)
HMIS	health management information system	RVC	Regional Validation Committee
HTC	HIV testing and counselling	RVS	Regional Validation Secretariat
iPMTCT	integrated prevention of mother-to-child transmission	RVT	Regional Validation Team
GARPR	Global AIDS Response Progress Reporting	SEARO	South East Asia Regional Office of WHO
GVC	Global Validation Committee	SDG	Sustainable Development Goal
GVS	Global Validation Secretariat	SRH	sexual and reproductive health
MCTS	Mother and Child Tracking System	STI	sexually transmitted infection
MDGs	Millennium Development Goals	UHC	universal health coverage
MMR	maternal mortality ratio	UNAIDS	Joint United Nations Programme on HIV/AIDS
MNCH	maternal and neonatal child health	UNFPA	United Nations Population Fund
MSM	men who have sex with men	UNICEF	United Nations Children's Fund
NGO	non-governmental organization	WHO	World Health Organization
NHSO	National Health Security Office, Thailand	WPRO	Western Pacific Regional Office of WHO



# EXECUTIVE SUMMARY

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The 10<sup>th</sup> Asia-Pacific United Nations Prevention of Parent-To-Child Transmission (PPTCT) of HIV and Syphilis Task Force meeting was held from 15 to 17 September 2015 in Beijing, China. More than 230 participants from 19 Asia-Pacific countries, including 90 participants from provinces in China, as well as civil society and United Nations partners attended the meeting. The meeting focused on steps towards achieving and validating the elimination of parent-to-child transmission (EPTCT) of infectious diseases, and the integration of services to contribute to improving maternal and child health (MCH) outcomes.

There has been significant progress towards EPTCT of HIV and syphilis in the Asia-Pacific region. The majority of countries are committed to and have adopted policies towards the dual elimination goal. A total of 12 out of the 19 countries have set an elimination deadline of 2020 and two thirds of the countries have integrated EPTCT of HIV and/or syphilis interventions into maternal, neonatal and child health (MNCH) services. The slow decline in new HIV infections among children (aged 0-14), 27 per cent between 2000-2014, signifies that the agenda is still unfinished regarding HIV transmission to infants. Increasing testing coverage of pregnant women, access to antiretroviral therapy (ART) and syphilis treatment, retention in care of mother-baby pairs, early infant diagnosis (EID) and ART coverage for children with HIV and treatment for syphilis-exposed children remain compelling priorities for post-2015 sustainable development. Elimination of HIV and syphilis in children is possible if bold actions are taken now to contain transmission to the next generation.

The meeting concluded that high burden countries in the region are progressing towards EPTCT of HIV and syphilis, while advances in other countries are varied. Thailand has initiated preparation towards validation, and China is embarking on a pre-validation exercise. In order to achieve EPTCT goals, universal HIV and syphilis testing as part of a standard antenatal care (ANC) package is essential. Several countries are also offering universal hepatitis B virus (HBV) screening as part of the standard ANC package, and there is potential to expand it to include screening for other infectious diseases such as tuberculosis. Participants learned that dual platforms for HIV/syphilis point-of-care (POC) testing are showing promise in the field. Likewise, novel technological methods for tracking women and babies are available to aid retention in care.

Several gaps still persist in the region. Many women are still diagnosed late in pregnancy, during labour and delivery. Pregnant women from key populations, who are at higher risk for HIV and syphilis, remain hidden. Male partner involvement is lacking, and there are poor mechanisms to retain women and babies in care beyond delivery. Viral load testing is unavailable in some settings and too few infants have access to EID services, while the ART coverage of children remains low.

Key recommendations for countries are to incorporate the EPTCT goals into national strategic plans and integrate universal HIV and syphilis testing into essential ANC packages; develop strategies to increase early ANC attendance; decentralize testing services and scale up the use of POC platforms for the testing of HIV and syphilis; and scale up control programmes to prevent HBV transmission in all high burden countries. Lifelong ART for all HIV-positive pregnant women is now implemented in all countries, but careful consideration must be given to retain mothers and babies in care and strengthen EID services. Task shifting and enlisting the support of civil society are actions that need to be continued in order to scale up services in situations where resources are limited. Private sector engagement needs to be accelerated to share data on pregnant women accessing private care for MNCH and PPTCT.

In order to maximize outcomes, partner organizations will work in a more focused manner to continue to assist countries in the region to achieve the EPTCT goals. This will include: monitoring progress, supporting the validation process, documenting and sharing experiences, encouraging cooperation between countries in the procurement of diagnostics and drugs, and continuing to facilitate strong participation of civil society. Participants agreed that the Task Force would no longer operate in its current form. However, partner organizations remain firmly committed to assisting countries through more focused individual country support, and meetings on more specific themes will be organized to achieve the elimination goal of HIV and syphilis and the control of HBV in the region.

# MEETING PROCEEDINGS

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## Meeting organization

More than 230 international participants from 19 Asia-Pacific countries, including 90 participants from provinces in China, civil society and United Nations partners, attended the 10th meeting of the PPTCT Task Force on HIV and syphilis in Beijing on 15-17 September 2015. The meeting focussed on reviewing progress and next steps towards achievement and validation of EPTCT of HIV and syphilis in the Asia-Pacific region. 2015 marked the transition from the conclusion of the millennium development goals (MDGs) to a new set of sustainable development goals (SDGs) adopted by the United Nations and member states.

## Meeting objectives

The objectives of the meeting included:

- Reviewing progress, goals, targets and action plans towards EPTCT of HIV and syphilis in selected countries in Asia and the Pacific;
- Informing countries of the regional mechanism for the validation of EPTCT of HIV and syphilis and discussing plans for validation; and
- Discussing priority actions for the future.

# DAY ONE: 15 SEPTEMBER 2015

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## Opening session

*Dr Isiye Ndombe, Deputy Regional Director, UNICEF East Asia Pacific Regional Office, Bangkok, Thailand, Dr Bernard Schwartlander, Representative, WHO, and Dr Qin Geng, Director General Maternal and Child Health, National Health and Family Planning Commission, PR China*



Dr Isiye Ndombe highlighted the importance of 2015 as the transition point between the MDGs and the new SDGs. Progress toward the EPTCT of HIV and syphilis in the region had been made, but the rate of progress remained slow. HIV continues to be an unfinished agenda and required the intensification of efforts to test and treat up to 90 per cent of adults and children by 2020. Evidence from the region showed that rapid gains towards elimination are possible. Thailand has led the way in demonstrating rapid and steady progress and has added syphilis and HBV control to the programme. China has demonstrated similar gains. Fiji has included HIV, syphilis and HBV testing and treatment in its ANC programme. Dr Isiye Ndombe noted that opportunities to advance the programme included: building on the high ANC coverage, taking advantage of the contact between women, babies and skilled birth attendants, improving efforts towards monitoring the programme and retaining women and babies in care using mobile and biomedical technology to improve planning and systems.



Dr Bernard Schwartlander welcomed participants on behalf of the Task Force. Elimination of HIV and syphilis is critical to the region as it transitions to the SDGs, which include universal health coverage (UHC). In the region, 21,000 babies were newly infected with HIV in 2014. Both HIV and syphilis infections among infants could be prevented through simple interventions. These strategies must be linked to the control of HBV to further protect mothers and new-borns. He commended China on integrating HBV testing with HIV and syphilis testing. A new UNAIDS strategy was in the final stages of development and included five important action areas. He urged countries to provide inputs based on experiences in the field. Cuba's achievement of validation for EPTCT of HIV and syphilis earlier in the year served as a precedent for the Asia-Pacific region to follow.



Dr Qin Geng welcomed all the participants to Beijing. China has a population of 1.36 billion people, and the Chinese Government had prioritized EPTCT of HIV and syphilis. Over the past few years experience was gained and evidence generated from scaling up interventions nationwide in an incremental manner. Authorities developed an integrated approach to include syphilis and HBV and there was a sizeable increase in the allocation of funding for the programme. Screening for pregnant women was provided free of cost. Rates of PTCT of HIV fell from 34.8 per cent before 2005 to 6.1 per cent in 2014, and a 30 per cent reduction in congenital syphilis cases from 2011 to 2014 was noted. China remained committed to the elimination of HIV by 2030 and to the validation process for EPTCT of HIV and syphilis. The large delegation of Chinese representatives at the meeting was testament to the Government's commitment to exposing provinces to global strategies. Dr Qin Geng thanked the partners for their technical support.

A video jointly prepared by the Chinese Government and UNICEF China was shown, depicting the commitment and progress made towards EPTCT of HIV and syphilis in the country.

# Review of the 9<sup>th</sup> Task Force Meeting recommendations

*Annefrieda Kisesa, UNICEF ROSA, and Razia Pendse, WHO SEARO*

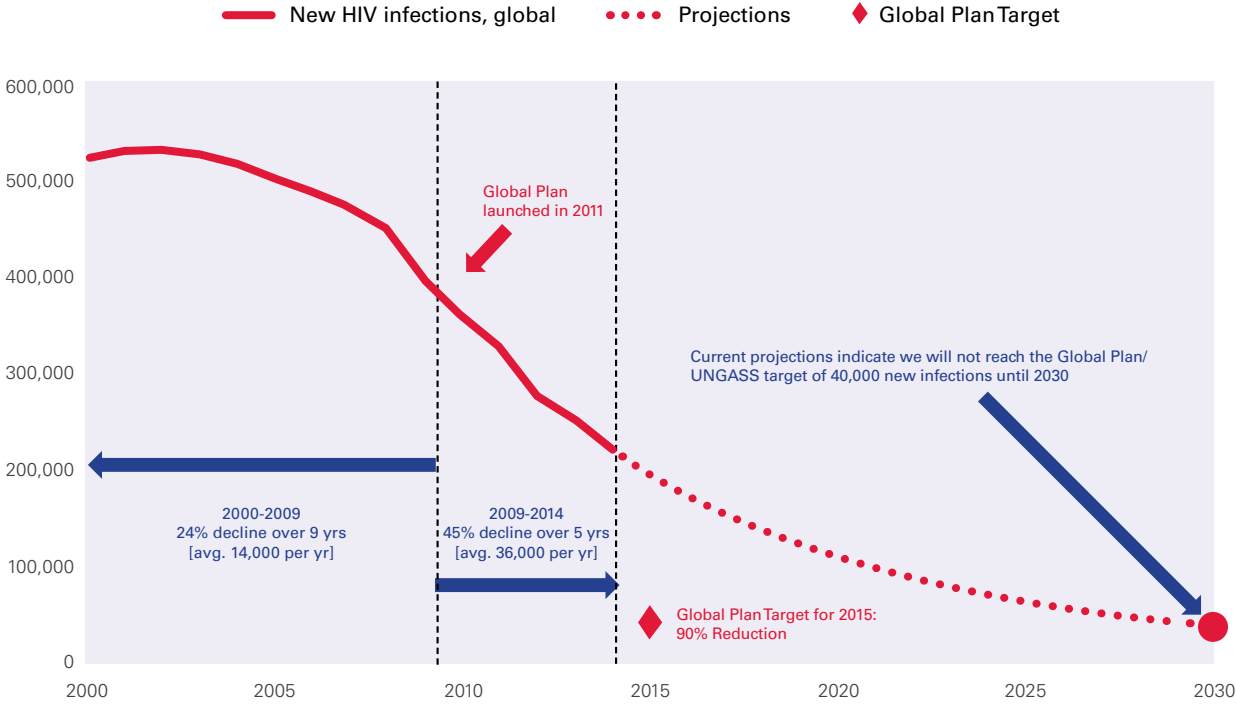
The conclusions and recommendations arising from the 9th Asia-Pacific PPTCT Task Force Meeting, 2013, which took place in Kathmandu, Nepal, were presented to review the progress made. The goal of the EPTCT of HIV at that time was deemed a real possibility, while plans for the integration of EPTCT programmes into routine ANC care were developed. The meeting also called for strong political commitment, the engagement of civil society and the development of a validation mechanism to evaluate EPTCT in the region (see Annex 2).

## Global updates on EPTCT of HIV and syphilis

*Shaffiq Essajee and Melanie Marie Taylor, WHO Geneva*

Globally, there was a 45 per cent drop in new HIV infections in children between 2009-2014, nearly double the 24 per cent decline between 2000-2009.

**Figure 1 Declines in new HIV infections among children – Global**



Source: UNICEF analysis of UNAIDS 2014 HIV and AIDS estimates, July 2015.

More than 80 per cent of countries across the globe recommended lifelong treatment for pregnant women living with HIV (i.e. Option B+). Updated guidelines from WHO recommended early ART for all people living with HIV (PLHIV), and lifelong treatment for all HIV-positive pregnant women was now the recommended strategy.<sup>1</sup> WHO HIV testing guidelines, released in July 2015, recommended the increased use of rapid POC tests.<sup>2</sup>

More than 1 per cent of women attending ANC services in one third of countries globally had syphilis. Between 2008-2012 there was a reduction in estimates of maternal syphilis infections and related adverse pregnancy outcomes,<sup>3</sup> particularly in the Asia-Pacific region, most notably in India and Indonesia. Syphilis screening was cost-effective in all settings, and combined HIV and syphilis screening was substantially more cost-effective than HIV testing alone.<sup>4</sup>

### Discussion

- Improvements in syphilis estimates in India and Indonesia between 2008-2012 were attributed to improved data quality from the countries.
- The risks of late initiation of ART in pregnant women were discussed. A high maternal viral load enhances the risk of HIV transmission. If a woman becomes pregnant while on ART, the risk of transmitting HIV would be very low. Women who are diagnosed as HIV-positive should be initiated on ART as early as possible, ideally even before they become pregnant.

## Regional progress and impact of PPTCT of HIV and syphilis

*Vladanka Andreeva, UNAIDS RSTAP, Wing-Sie Cheng, UNICEF EAPRO and Ying Ru-Lo, WHO WPRO*

The UNAIDS Fast-Track HIV targets for 2020 support advances towards the EPTCT goal.<sup>5</sup> The targets are: 90 per cent of PLHIV should know their status, 90 per cent should receive treatment, and 90 per cent of those on ART should be virally suppressed. These targets increase to 95 per cent to attain elimination of the pandemic by 2030.<sup>6</sup> If the current approach to EPTCT of HIV were continued, there would be a shortfall in achieving the targets of an estimated 12,000 children. Testing coverage among key populations was often below 50 per cent. Improved and simpler POC diagnostics were required. The average cost of preventing one new case of HIV transmission is USD 130 for one year, 40 cents per day, and this was found to be affordable.

Most countries in Asia had very low HIV prevalence and the identification of HIV-positive pregnant women remained a challenge. Syphilis prevalence was low, whereas the HBV burden was high in Asia, particularly in China. The PPTCT cascade was shown (*see Figure 2*), highlighting the gap between the estimated number of pregnant women with HIV and those diagnosed as HIV-positive, as well as the number of infants receiving EID in the region.

<sup>1</sup> WHO Guidelines on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV, WHO, 2015 at <http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/>

<sup>2</sup> WHO HIV Testing Guidelines, at <http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/>

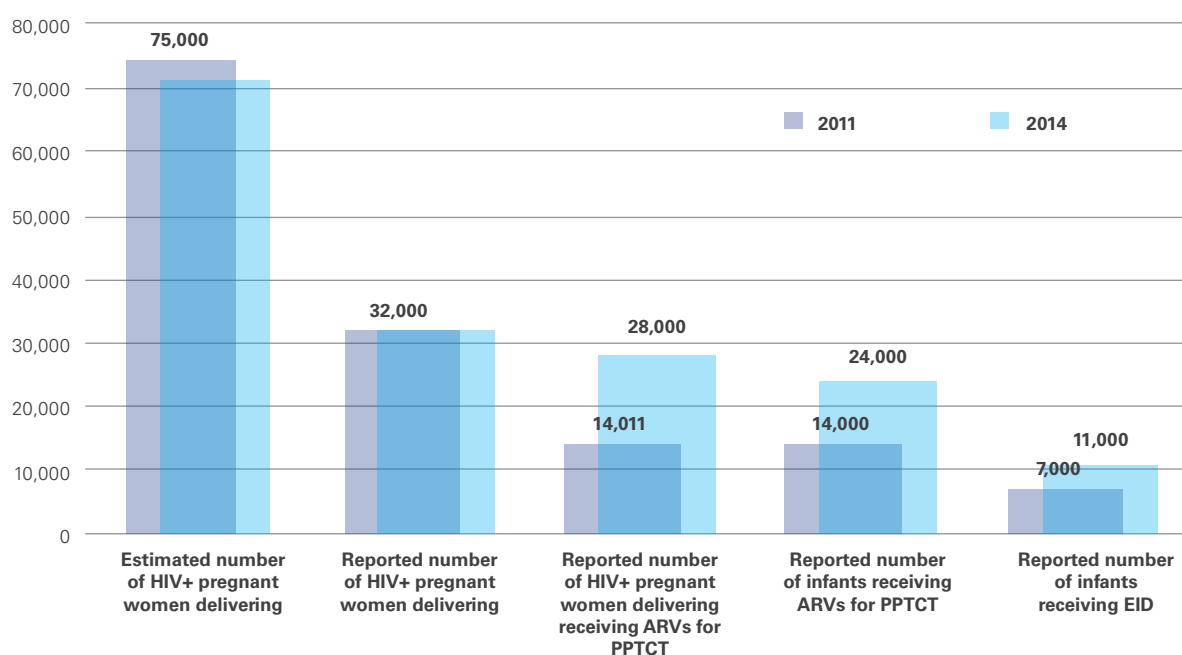
<sup>3</sup> Wijesooriya, N.S., Rochat, R.W., Kamb, M.L., Turlapati, Temmerman, M., Broutet, N., Newman, L.M., Unpublished data.

<sup>4</sup> Owusu-Eduesei, K., Tao, G., Gift, T., et al., *Sex Trans Dis.*, 2014.

<sup>5</sup> The elimination of new HIV infections among children will require very high levels of coverage of ART among pregnant women, exceeding the overall 90-90-90 targets for treatment.

<sup>6</sup> [http://www.unaids.org/sites/default/files/media\\_asset/JC2686\\_WAD2014report\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf)

**Figure 2: PPTCT cascade of services in the Asia-Pacific region: Progress from 2011-2014**



Source: Data provided by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on UNAIDS, *How AIDS Changed Everything. MDG 6: 15 Years and 15 Lessons of Hope from the AIDS Response*, WHO, Geneva, 2015; and 2011 historical data.

There was a near universal uptake of Option B+ in the region. However, pregnant women were tested very late in pregnancy or during labour and delivery. Access to syphilis testing and treatment in the region lagged behind that for HIV. In the Western Pacific Region of WHO (WPRO), 20 countries had reached less than 1 per cent HBV infection rates in 5-year-old children. Elimination of HIV and syphilis is the end game. Achieving UHC and integration of MCH, sexual and reproductive health (SRH) services, hepatitis and HIV programming is required.

## Triple EPTCT of HIV, syphilis and hepatitis B

*Lance Rodewald, WHO China, Shi Ying and Song Li, NHFPC, PR China*

Approximately 2 billion people have been infected with HBV globally, almost 75 per cent of whom were in the Asia-Pacific region,<sup>7</sup> including 258 million who were chronically infected.<sup>8</sup> There are 686,000 annual deaths globally from the disease. Great progress has been made in preventing HBV, with 7 million deaths averted, half a million deaths in 2014 alone. In 2013 a resolution was passed to reduce HBV surface antigen (HBsAg) seroprevalence to less than 1 per cent in 5-year-old children in the WPRO by 2017.<sup>9</sup> China has reached the seroprevalence target among 5-year-olds in the 2012 birth cohort. A HBV birth dose vaccine is critical to prevent chronic infection in children. Vaccination rates in the region have increased over the last two decades although in several countries they remained low. Regional HBV prevalence among children was estimated to be 0.96 per cent among the 2012 birth cohort. However, even when vaccination birth coverage was high, substantial numbers of new infections occurred annually.

<sup>7</sup> GBD 2013 Mortality and Causes of Death Collaborators, 'Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013', *Lancet*, vol. 385 no. 9963, 10 January 2015, pp. 117-71.

<sup>8</sup> Schweitzer, A., et al., 'Estimations of worldwide prevalence of chronic hepatitis B virus infection: a systematic review of data published between 1965 and 2013', *Lancet*, 28 July 2015, <doi:10.1016/S0140-6736(15)61412-X>

<sup>9</sup> The 64<sup>th</sup> Session of the WHO Regional Committee of the Western Pacific, October 2013. <http://www.wpro.who.int/mediacentre/multimedia/photos/features/rcm64gallery/en/>

## HIV, syphilis and hepatitis B virus control in China

*Shi Ying, PR China*

There were approximately 810,000 reported cases of HIV (prevalence 0.06 per cent) in China in 2013. The epidemic was highly diverse across the country. Increasing numbers of new HIV cases among key populations, especially older men and young students, were reported. There were 455,818 reported cases of syphilis (33.64 per 100,000 population) and the HBV incidence was 69 per 100,000 people in 2014. The Chinese Government had committed politically and financially to HIV control and supporting community organizations in delivering vital prevention services. There is high prevention coverage among female sex workers and men who have sex with men (MSM). In almost all service delivery sites for HIV and MNCH, screening for syphilis was included. HBV control had increased with universal vaccination, including birth dose. Improvements were made to ensure the safety of blood products, infection control, treatment and management of chronic infections and health promotion and education.

Challenges and next steps include:

HIV

- Controlling sexual transmission among MSM, older men and young people;
- Improving case finding;
- Health education; and
- Community participation.

HBV

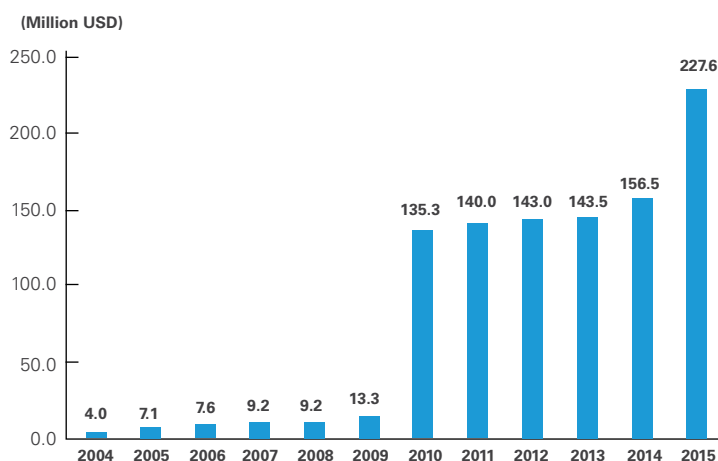
- Sustaining high vaccination coverage for infants and high-risk adults;
- Increasing availability of drugs and standardized treatment for hepatitis; and
- Improving health education.

## China national PPTCT programme of HIV, syphilis and hepatitis B virus

*Song Li, PR China*

PPTCT is a key priority in China. PPTCT started as a pilot project in 2002 in one county, by 2010 it had developed into the integrated prevention of mother-to-child transmission (iPMTCT) programme implemented in 1,156 counties. As of 2015 China had universal coverage of PPTCT, which is funded domestically. The Government's investment towards zero HIV infections in children has grown exponentially over the past decade.

**Figure 3: Financial investment in PPTCT, China**

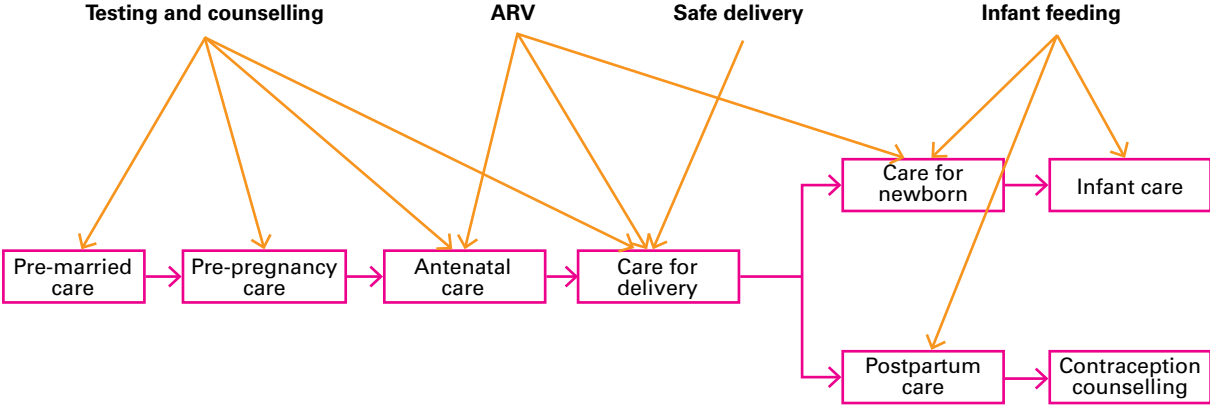


Premier Li Keqiang visits You'an Hospital on World AIDS Day 2014  
"PMTCT expanded nationwide for Zero infection in Children"

Source: Department of Women and Children's Health, National Health and Family Planning Commission, China.

The national programme provides a free essential ANC package covering the iPMTCT of HIV, syphilis and HBV, which is fully integrated into routine MCH services (See Figure 4). In the past decade, the coverage of testing and treatment had increased and mother-to-child transmission rates for HIV had decreased dramatically from 34.8 per cent before 2005 to 6.1 per cent in 2014. China had also adopted Option B+, initiating and providing lifelong treatment to HIV-positive pregnant women.

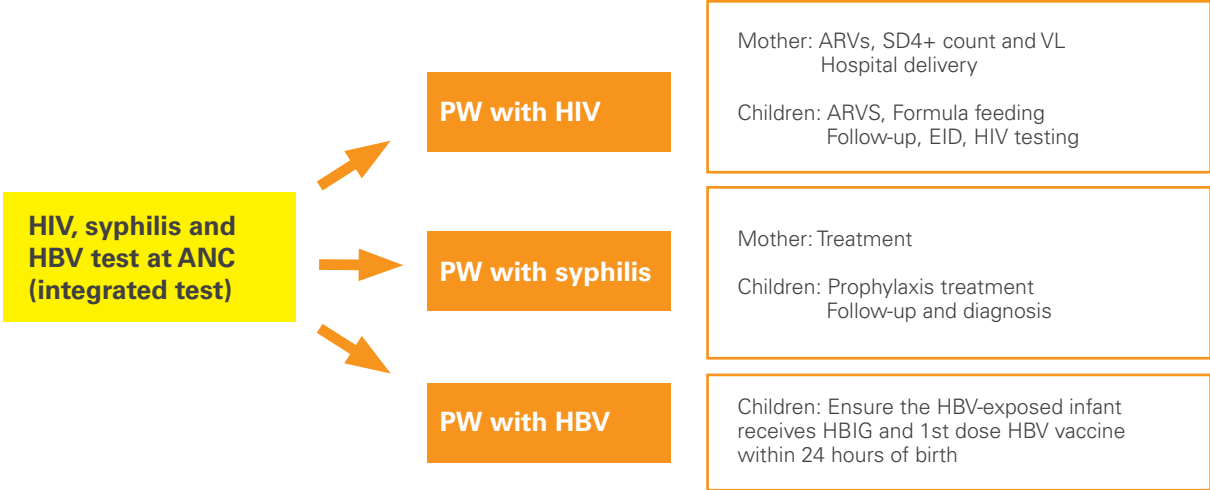
**Figure 4: Integration of PPTCT in routine MCH services**



Source: Department of Women and Children’s Health, National Health and Family Planning Commission, China.

Testing and treatment coverage of syphilis also increased. Hepatitis immunoglobulin intervention reached 98.7 per cent of HBV exposed infants in 2014.

**Figure 5: Package of iPMTCT services in China**



**All services listed above are free for HIV-syphilis/HBV positive pregnant women and their children**

Source: Department of Women and Children’s Health, National Health and Family Planning Commission, China.



Large gaps nevertheless remain for EPTCT of HIV and syphilis:

- Regional disparities
- Lack of MNCH services especially for migrants and minority populations
- Variations in quality of services

Next steps include:

- Improving quality of services;
- Implementing iPMTCT more widely;
- Strengthening equity and access to services; and
- Working more closely with civil society and adoption of social mobilization approaches.

## Discussion

Governments needed to fund surveys for HBV as well as HIV, which help to monitor the impact of programmes. In China, HBV serosurveys were conducted in 1992 when the sample size was 270,000. In 2006 there were 81,000 samples, and in 2014, 31,000. These serosurveys were difficult to carry out but they provided useful information, indicating that China had reached the WPRO goal of reducing HBsAg seroprevalence to less than 1 per cent in 5-year-old children.

## The PPTCT cascade: Scaling up HIV and syphilis testing in antenatal care and community-based programmes

*Kyoko Shimamoto, UNICEF EAPRO, Naoko Ishikawa, WHO WPRO*

ANC attendance in most countries (at least one visit) was high, but with variation across the region. About 60 per cent of the countries in Asia and the Pacific had integrated HIV counselling and testing (HCT) into ANC. Some countries also provided HIV and syphilis testing prior to delivery for mothers who missed the test during ANC.

Universal versus targeted HIV testing in low prevalence settings so as to reach the majority of people who needed HIV testing services had been the subject of debate. Modelling analysis based on country data revealed that offering universal HIV testing for pregnant women in antenatal services was cost-saving and/or cost-effective even in low HIV prevalence settings.<sup>10</sup> Integrated routine HIV and syphilis testing was substantially more cost-effective than providing HIV testing alone.

## Country experiences

*Lukas C. Hermawan, Indonesia, Mohd Nasir Abd Aziz, Malaysia, Htun Nyunt Oo, Myanmar, Gehanath Baral Nepal, Lilani Rajapaksha, Sri Lanka*

Strategies to increase coverage of HIV and syphilis testing among pregnant women were shared by Indonesia, Myanmar, Sri Lanka, Nepal, and Malaysia. HBV screening was not commonly provided in these countries. Key issues discussed included:

- The importance of the availability of a national strategy or policy to guide scale up.
- Task shifting of HIV and syphilis testing to non-laboratory personnel. Myanmar shared that syphilis testing coverage was low because testing could only be conducted by trained laboratory personnel.

<sup>10</sup> WHO, Consolidated guidelines on HIV testing services, 2015. WHO, Geneva, 2015: [http://apps.who.int/iris/bitstream/10665/181060/1/WHO\\_HIV\\_2015.25\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/181060/1/WHO_HIV_2015.25_eng.pdf?ua=1)

- Indonesia highlighted that local government commitment was critical in a country with decentralized policy and programme implementation. Demonstration sites in four different provinces showed widely varied coverage of testing for HIV and syphilis.
- Experiences were shared by Nepal and Myanmar on community HIV testing.
- Rapid tests facilitated scale up of HIV and syphilis testing.
- High ANC coverage in Malaysia and Sri Lanka had facilitated HIV and syphilis testing for pregnant women. Sri Lanka reported reaching the elimination target for congenital syphilis.
- There were public health challenges that hampered service delivery such as high healthcare costs and disparities in access to health services (e.g. among migrants and the urban poor). Loss to follow-up was invariably high among this population.

## Option B+: Implementation within maternal and child health platform, including transition from Option A/B to B+ and lessons learned, strategies to improve programme implementation and service delivery coverage

*Nathan Shaffer, Consultant for EMTCT and HIV, WHO WPRO*

All countries in the region have adopted the Option B+ strategy. Many were transitioning or had recently transitioned to this strategy. Lessons from African countries demonstrated that careful planning was required for rolling out Option B+ to ensure that high-risk women access care early rather than showing up only at labour and delivery, and are retained in care after delivery. The key to programmatic success was careful planning, integration of HIV testing with syphilis and other routine tests, use of rapid POC diagnostics, and partner testing. Aspects of assuring quality of services included: maintaining the quality of the HIV test, availability of counselling and support, ensuring continuous access to drugs, enhanced interventions for high-risk infants, ability to track mothers and babies for retention in care, access to viral load monitoring, and support for achieving and maintaining viral suppression.

### Overview and country experiences

*Dinesh Baswal and R. S. Gupta, India, Htun Nyunt Oo, Myanmar, Lahui Geita, Papua New Guinea, Nguyen Mai Huong, Viet Nam, Sunee Talawat, Thailand (CSO)*

For most countries reporting in this session, Option B+ was recently rolled out. Challenges in implementing Option B+ and innovative strategies were shared by India, Myanmar, Papua New Guinea, Viet Nam and Thailand.

#### Challenges described by countries included:

- The gap between the number of pregnant women diagnosed as HIV-positive and the estimated number of HIV-positive women is large in the region and attention to increasing testing coverage is important. India shared that despite this gap, once pregnant women were identified, ART coverage of HIV-positive pregnant women and EID levels were quite high (94 per cent and 85 per cent respectively).
- Late testing and access to treatment for women: In Viet Nam over 50 per cent of women were tested for the first time at labour and delivery.
- Hard-to-reach areas and transportation problems resulted in poor access to services. In Viet Nam, this was compounded by high rates of home delivery. Natural disasters, as mentioned by Myanmar, also disrupted services.
- Language barriers made it difficult for marginalized populations such as immigrants and ethnic minorities to access care.
- Fear of stigma and discrimination often deterred people from accessing services.

- Even in successful countries such as Thailand, women still struggled to negotiate safe sex with their partners.
- Out-of-pocket expenses for pregnant women: In Viet Nam, HIV testing was supported by donors on a project basis and was therefore not universally available. In Thailand, free testing was unavailable for undocumented immigrants.
- Health workers had limited knowledge of, and counselling skills on, HIV testing for pregnant women at the primary healthcare level where ANC was provided, such as at the commune level in Viet Nam.
- Reporting systems for retention in care, accessing data from private care services, and supply chain management were weak in many countries.
- Laboratory quality assurance mechanisms needed improvement.
- There were long turnaround times for EID, and services were not aligned with the integrated management of childhood illnesses and the expanded programme on immunization.

#### **Innovative strategies:**

- Thailand emphasized the importance of involving members from civil society in the healthcare team to increase understanding and collaboration between staff and PLHIV.
- Task shifting was also mentioned as a strategy that could increase health-care delivery.
- Civil society members from the Thai Positive Women's Network assisted with ART counselling, running support groups, partner tracing and testing, active case management, family-centred HIV care and developing adolescent-friendly services.
- Mother mentors were effectively adopted in Papua New Guinea for peer education.

### **Option B+: Strategies to reach women from key populations, including migrants and late presenters (late diagnosis during 3rd trimester/labour/postnatal period)**

*Marama Pala, ICWAP (CSO), Ayu Oktariani, Indonesia Positive Women's Network (CSO), Anisur Rahman and Lima Rahman, Bangladesh, Tayyaba Rashid, Pakistan, Ly Penh Sun, Cambodia, Chaweewan Tonputsas, Thailand*

**"We should end this epidemic, but we can only do this if we put women living with HIV at the centre."**

*Teresia Njoki Otieno, ICW Global Chair at UN 2014*

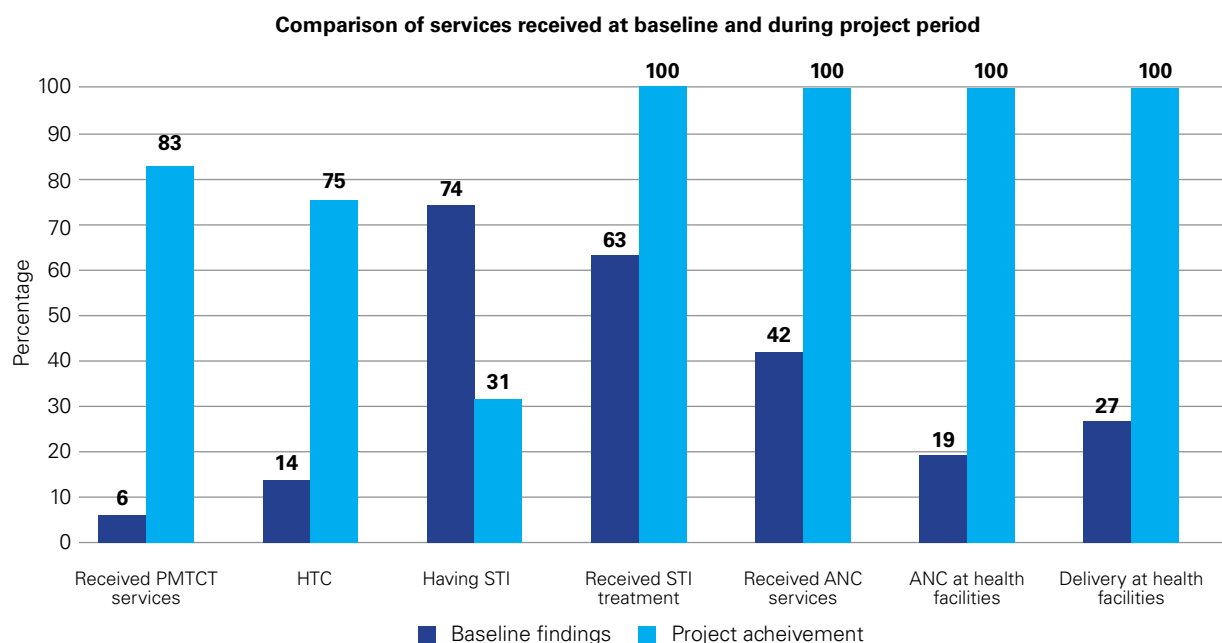
Indonesia, Bangladesh, Pakistan, Cambodia and Thailand reported on strategies to reach women from key populations.

Real progress towards reducing vertical transmission and achieving viral load suppression could only be made by upholding the human rights of women living with HIV, including meaningful involvement of the women themselves, non-discriminatory care, and informed choices. Investment should be made in community-based responses: developing networks of women living with HIV, providing peer-to-peer support and ensuring universal access to quality healthcare. Only then would the opportunity of accessing lifelong treatment result in improving the health, dignity and the lives of women living with HIV and those of their children and families.

The Indonesia Positive Women's Network/Ikatan Perempuan Positif Indonesia provided a framework for meaningful participation from the community while promoting MCH and HIV programmes, supporting HIV-positive pregnant women and discordant couples, and tracking follow-up mechanisms for loss to follow-up.

Bangladesh, Pakistan, Cambodia and Thailand shared their experiences with targeted versus universal models for PPTCT services. Bangladesh had seen an increase in new HIV cases, of which one third were women and 40 per cent migrants, with a big gap in availability of services. Targeted services for women from key populations had been used and recently a model for universal PPTCT services for pregnant women in high HIV prevalence areas was introduced. Data for the first phase of providing universal PPTCT services in high burden areas in Bangladesh were shared, demonstrating improvements in access to PPTCT and ANC services from the baseline assessment.

**Figure 6: Services received or provided at baseline and during provision of universal PPTCT services in high-burden areas in Bangladesh**



Source: Programme report of PMTCT project for women in special population group and draft report of baseline assessment of PMTCT project, Save the Children, 2015.

In Pakistan, HIV infections were increasing in most key populations, particularly among people who inject drugs (PWID) (pregnant women). PPTCT services were provided in a targeted fashion and risk assessment was performed to identify the women that should be offered these services. A two-pronged approach was introduced, strengthening facility-based identification and referral of high-risk women, along with a community outreach programme using home visits to provide home-based HIV testing and counselling (HTC) for women at risk and referrals, with promising results in three districts in Punjab.

Universal HIV testing for pregnant women was recommended for Cambodia and Thailand. In Cambodia, an active case management programme had been scaled up to facilitate the tracking of mother-baby pairs. HIV testing at birth and treatment for all children under 15 years of age was now recommended in the updated guidelines. Decreased funding coverage could limit programmatic success beyond 2017. During 2009-2012, about 40 per cent of HIV-positive mothers were lost to follow-up postpartum in Thailand. Strategies to address loss to follow-up and long-term retention in care among postpartum HIV-positive women in Thailand included:

- Policy advocacy and partnership collaboration.
- Updating HIV treatment and care guidelines, tools and materials such as the benefits package (ART, viral load, T lymphocyte cell count (CD4)) provided by the National Health Security Office.
- Improving treatment literacy, management guidance for women who presented late or in labour and delivery.
- Help for migrants to obtain health insurance.
- Improvements in data reporting had been instituted, including new indicators to assess retention and viral load suppression in women.

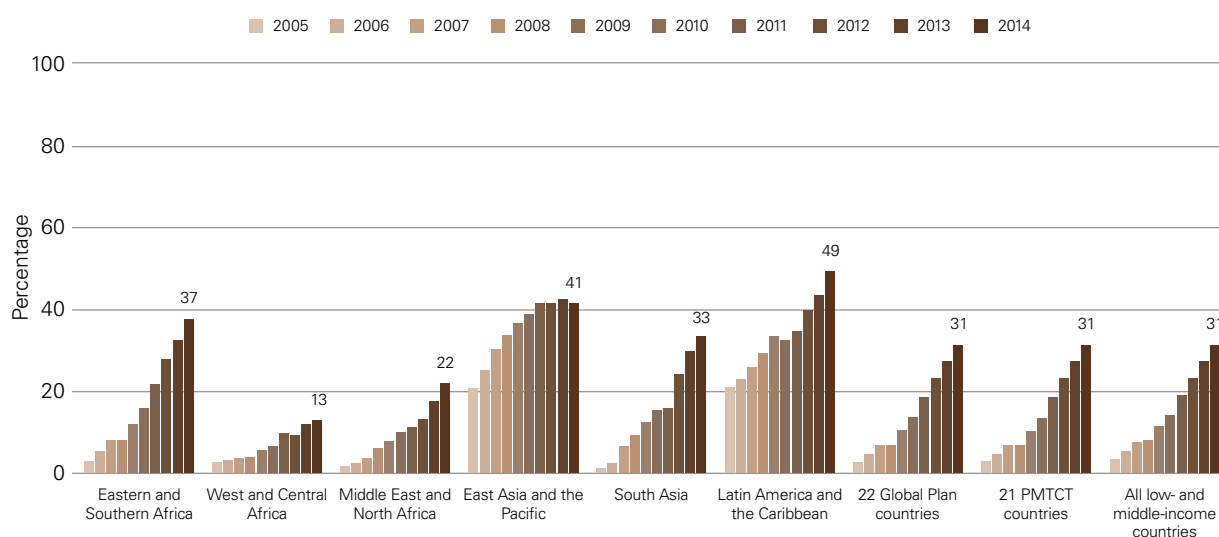
# DAY TWO: 16 SEPTEMBER 2015 (MORNING)

## Increasing paediatric HIV treatment coverage in Asia-Pacific: Early infant diagnosis, strategies to address loss to follow-up and outcomes of treatment coverage for infants and children

Shaffiq Essajee, WHO Geneva

In 2014, access to ART for children lagged behind that for adults (32 per cent versus 41 per cent, respectively) in all regions except the Americas.

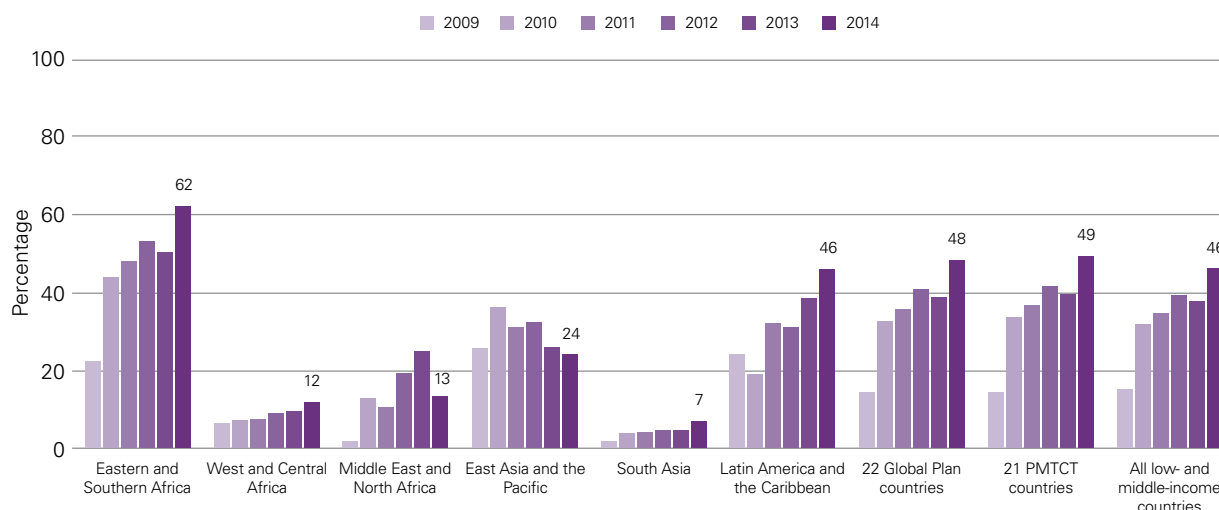
**Figure 7: Access to ART among children, 2005-2014, by UNICEF region**



Source: UNAIDS estimates derived from GARPR 2015 data.

Access to EID is relatively low, and is apparently declining in East Asia and the Pacific.

**Figure 8: Coverage of early infant diagnosis, 2009-2014, by UNICEF region**



Source: UNAIDS estimates derived from GARPR 2015 data.

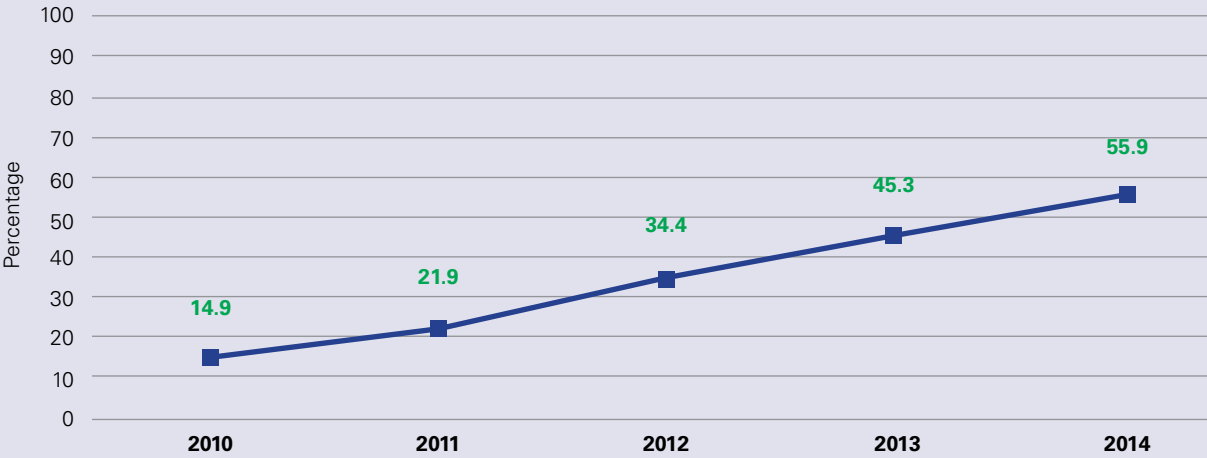
Mortality from HIV infection is highest in the first few months of a child’s life, making early diagnosis and access to treatment urgent for infants. Some countries were beginning to recommend birth testing. If this strategy were to be adopted, a second test would be necessary for those who test negative, as birth testing would likely miss babies infected during the peri-partum period. POC diagnostics for EID were under development. Treatment regimens for babies and young children were more complex than for adults, but new medicines in the pipeline might make treatment for children simpler.

**Country experiences**

*Wang Ailing, PR China, Sigit Prihutomo, Indonesia, Rangsim Lolekha, Thailand, Nguyen Thi Lan Huong, Viet Nam*

EID and ART coverage for children were implemented to varying degrees in the region. China, Indonesia, Thailand and Viet Nam commonly reported that centralized laboratories and long turnaround times resulted in low numbers of children receiving EID. There were 22 EID sites in Indonesia to date, too few to cover the number of infants needing EID. China was previously in a similar situation but in 2013, regional laboratories were set up and a standardized procedure was initiated, with procurement plans put in place and increased training. These measures had markedly reduced turnaround time, while EID coverage almost quadrupled, from 14.9 per cent in 2010 to 55.9 per cent in 2014 (see Figure 9).

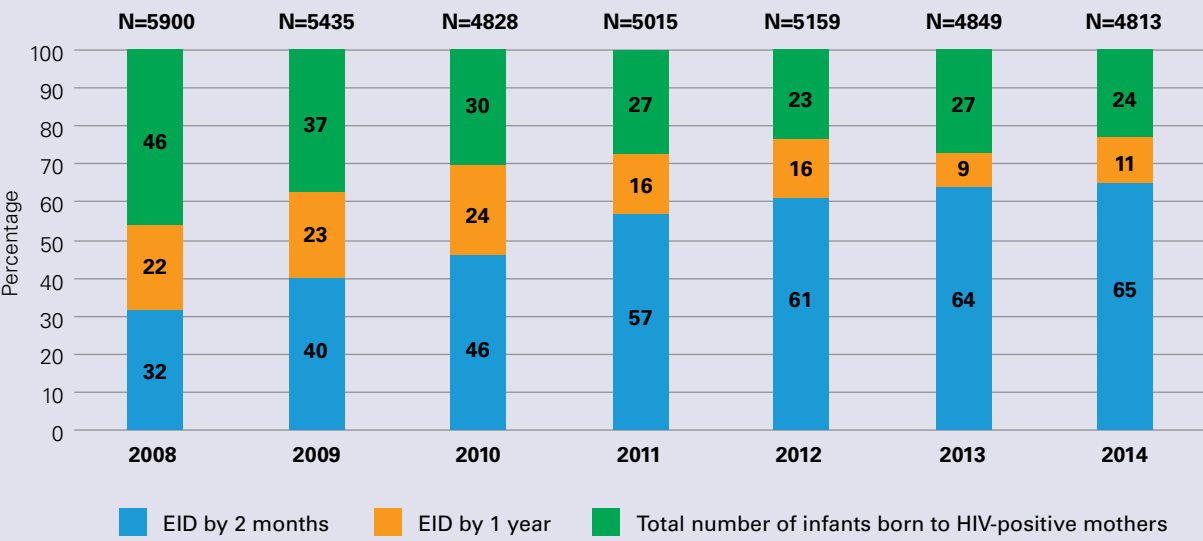
**Figure 9: Early infant diagnosis rates of HIV-exposed infants younger than 2 months old in China, 2010-2014**



Source: National Centre for Women and Children’s Health, China Center for Disease Control and Prevention (CDC).

An increased number of provinces and sites in Viet Nam were collecting dried blood spot samples for EID, with more children being tested in the first two months after this measure was introduced. In Thailand, EID was conducted at birth for HIV-exposed infants and an increasing proportion of children received EID by their second month, with coverage increasing from 32 per cent in 2008 to 65 per cent in 2014. Indonesia has committed to scaling up EID services and announced the policy of integrating PMTCT of HIV, STI and syphilis services into MCH as part of its standard ANC package.

**Figure 10: Proportion of HIV-exposed infants receiving EID in Thailand by 2 months and 1 year of age**

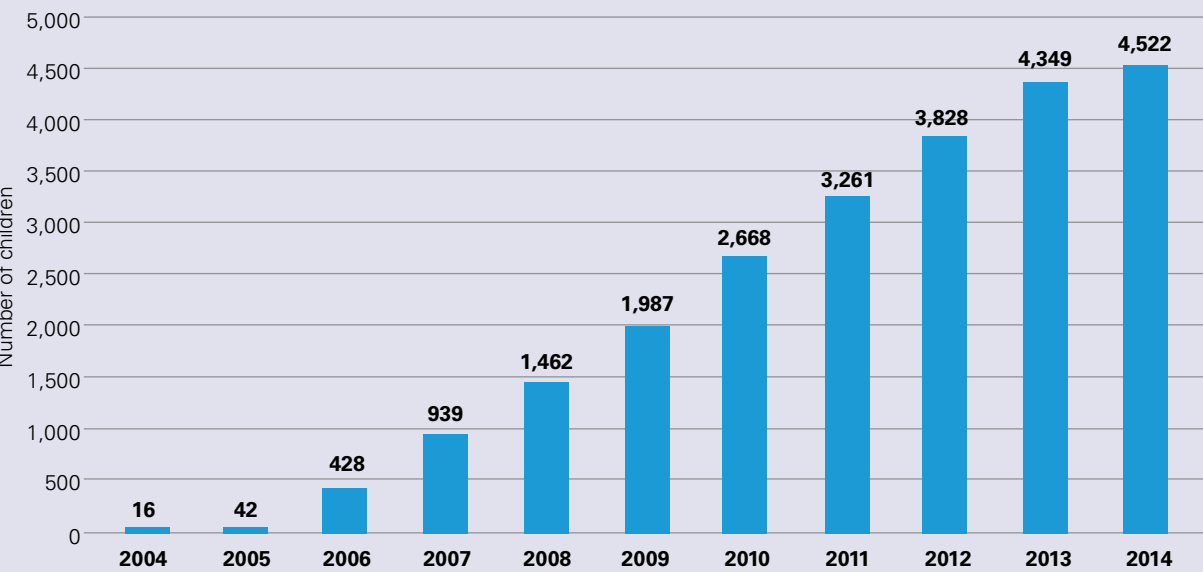


Source: Estimated number based on data from the Thailand Ministry of Interior and HIV prevalence among pregnant women.

Note: N refers to the estimated number of infants born to HIV positive mothers.

The treatment cascade for Thai children in 2013-2014 showed that 67 per cent of the estimated number of infected infants were started on ART, with 64 per cent of patients who started ART having a viral load of <1,000 cells/mm<sup>3</sup>, and 47 per cent a with a viral load of <50 cells/mm<sup>3</sup>. In Viet Nam, there were 4,650 children on ART as of June 2015, with ART coverage of 62 per cent (denominator: estimated number of HIV-positive children under 15 years).

**Figure 11: Number of children accessing ART by year in Viet Nam, 2004-2014**



Source: Viet Nam Administration of HIV/AIDS Control (VAAC) – Ministry of Health.

## Strengthening strategic information systems along the cascade towards EPTCT and universal health coverage

*Derek Ritz, ecGroup, Canada, Rakesh Kumar and R. S. Gupta, MOHFW, India, Kechi Achebe, Save the Children – USA, Xiang-Sheng Chen, NCSTDC, PR China*

Development of client registries, using unique identifiers that supported health information sharing between various silos of information sources, could help promote coordinated service delivery and support continuity of person-centred care. Client registries could also be leveraged to support related initiatives like UHC and civil registration and vital statistics. Data systems to support long-term tracking of mothers and children, especially in the context of widespread adoption of Option B+, were essential for monitoring outcomes. Innovative tracking and costing tools could support policy makers and programme managers for the estimation of results, planning interventions, advocating for resources and monitoring the quality of services.

## Point-of-care diagnostics for PPTCT

*Lori Newman, President's Emergency Plan for AIDS Relief (PEPFAR), Cambodia, Dipendra Raman, Nepal*

Rapid POC tests were an important tool for ensuring that all pregnant women have access to services. They could also address health disparities for hard-to-reach populations. Access to high-quality HIV-related testing is a human right for all residents in the South-East Asia and Western Pacific regions.<sup>11</sup> Several single tests for either HIV or syphilis were commercially available and WHO-prequalified; dual rapid HIV and syphilis testing platforms were proving highly sensitive and specific in the laboratory. Countries were urged to plan to evaluate these in the field and share best practices. Triple rapid tests, including HBV, were also in the pipeline.

In Nepal, a dual HIV and syphilis test was piloted and tested against the national algorithms for HIV and syphilis. Results were 100 per cent concordant for HIV tests and 95.45 per cent sensitive and 99.87 per cent specific for syphilis tests.

## Validation of EPTCT of HIV and syphilis regional mechanism and strategies for Asia-Pacific

*Dr Ying Ru-Lo, WHO WPRO*

The regional mechanism for validation of EPTCT was presented by Dr Ying Ru-Lo (WPRO). WHO released global criteria for validation in June 2014.<sup>12</sup> PPTCT Task Force Core Group members met in November 2014 to discuss the regional process for validation of EPTCT of HIV and syphilis and subsequently a regional validation mechanism and terms of reference for regional validation teams were formulated. These were shared with participants and agreed upon. Three validation tools were to be used for the process: a data quality checklist and impact assessment tool; a laboratory quality assessment tool; and a human rights and community engagement tool were also shared (*see Annex 3*).

<sup>11</sup> [https://aslm.org/stay-informed/press-room/news-articles/new-phnom-penh-statement-gaining-momentum-to-end-aids-by-2030/?utm\\_source=Phnom+Penh+Statement&utm\\_campaign=Phnom+Penh+Statement&utm\\_medium=email](https://aslm.org/stay-informed/press-room/news-articles/new-phnom-penh-statement-gaining-momentum-to-end-aids-by-2030/?utm_source=Phnom+Penh+Statement&utm_campaign=Phnom+Penh+Statement&utm_medium=email)

<sup>12</sup> WHO, Global guidance on criteria and processes for validation: elimination of mother-to-child transmission (EMTCT) of HIV and syphilis, 2014, at <http://www.who.int/reproductivehealth/publications/rtis/9789241505888/en/>



## **EPTCT of HIV and syphilis in the Americas – Progress and achievements: Cuba validation experience**

*Massimo Ghidinelli, WHO PAHO*

Latin America and the Caribbean was the first region to articulate the elimination of PTCT strategy. Coverage of testing and treatment in the Pan American Health Organization (PAHO) region was high; the estimated PTCT rate was 5 per cent in 2013, and the number of new infections in children had declined steeply. Cuba has offered free universal health access in a primary healthcare-based system since the 1970s, and services were strongly integrated. Routine syphilis and HIV screening have been available since 2003. Option B+ was fully implemented and HIV-exposed infants were followed up (PCR 1 and 4 months after birth). An outreach programme to engage male partners was also introduced. These strong interventions led to efficient reduction of PTCT, which enabled Cuba to become the first country to be validated for EPTCT on 30 June 2015. In the PAHO region, 12 more countries were reporting data consistent with EPTCT of HIV and syphilis goals.

## **Thailand national EPTCT of HIV and the syphilis validation process**

*Petchsri Sirinirund, Senior Advisor, MoPH and Rangsim Lolekha, Global AIDS Program/Asia Regional Office US CDC, Thailand*

Following the Regional Core Group Meeting for the Validation of the Elimination of Parent-to-Child Transmission of HIV and Syphilis in Asia and the Pacific on 10 November 2014 in Bangkok,<sup>13</sup> Thailand was invited to consider proceeding to validation of EPTCT. Thailand reported high levels of syphilis testing and treatment of pregnant women (97.5 per cent and 95 per cent respectively) in 2014-2015. HIV testing of pregnant women was 99.7 per cent and partner testing 40.6 per cent, with almost 30 per cent of couples receiving counselling. The PTCT of HIV rate in 2014 was 2.1 per cent. In 2015, the Department of Health set up a national validation committee as well as four working groups, with defined roles and accountabilities. The national validation committee and working groups had started regular meetings (with funding support from UNICEF and the Thailand Ministry of Public Health-US and CDC collaboration).

The four working groups are:

Group 1: Data validation working group

Group 2: Human rights working group

Group 3: Lab validation working group

Group 4: Subnational EPTCT working group

### **Next steps for the Thailand EPTCT process:**

A proposal was being prepared for submission to UNICEF Thailand for funding EPTCT activities for full-year 2016. The Government had taken steps to inform all major hospitals and facilities about the validation exercise, including those in the private sector, urging them to share data. Fieldwork for data collection would also be conducted. A report would be developed and the Ministry of Public Health would write to the WHO South-East Asia Regional Office to apply for validation of EPTCT of HIV and syphilis.

<sup>13</sup> Meeting Report, Regional Core Group Meeting for the Validation of the Elimination of Parent-to-Child Transmission of HIV and Syphilis in Asia and the Pacific, 10 November 2014, Bangkok, Thailand, at <http://iris.wpro.who.int/handle/10665.1/10903>

# DAY TWO (AFTERNOON) AND DAY THREE (MORNING): 16-17 SEPTEMBER 2015

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Participants were divided into four groups to discuss and plan around four topics in a musical chair arrangement (with each group taking turns to cover all four topics). Provincial representatives from China were organized into three other groups for Chinese language discussion of all the topics in the context of China's iPMTCT roll out.

## **Discussion Group A: PPTCT cascade: the 90-90-90 and 95-95-95 targets**

Good progress towards EPTCT of HIV and syphilis was noted. The remaining gaps were highlighted for addressing if the Fast-Track targets were to be met:

Testing 90 per cent:

- Measurement of the indicator for HIV testing of pregnant women was not standardized.
- No specific approach existed to reach HIV-positive pregnant women except in Pakistan and Bangladesh.
- The consent process could be lengthy and a deterrent for testing pregnant women.

Treating 90 per cent:

- Option B+ is recommended in most countries. However, many countries had vertical systems for treating PLHIV.
- Late presentation in ANC was common in many settings.

Viral suppression 90 per cent:

- Retention mechanisms postpartum were not clearly defined for many countries.
- EID was highly centralized, and the long turnaround times for results meant that opportunities for identifying and treating infants early were missed.
- Viral load testing was not available at all in 20 per cent of the countries. In other countries, viral load use was variable; some used it to diagnose treatment failure only; some used it for treatment monitoring; and very few offered viral load testing pre-delivery.

## **Some recommendations to achieve these targets:**

- HIV and syphilis testing must be integrated with ANC services.
- To reach 90 per cent treatment coverage, focus should be placed on early testing.
- Countries should develop specific strategies to deal with late presenters.
- Viral load testing for pregnant women should be integrated.
- Countries should consider specific adherence support and mechanisms to retain women in care after delivery.
- EID services should be strengthened.

## Discussion Group B: HIV testing and counselling in antenatal care

- 17 out of 19 countries include HIV and syphilis in their routine ANC package, but were at various levels of implementation.
  - 10 out of 19 countries included HBV testing in the current ANC package, the rest were planning to include HBV screening.
- Most countries provided HIV and syphilis testing and treatment free of charge.
- All countries encourage the notification and testing of partners of ANC attendees found to be HIV-positive or with STIs.
- Nepal and Thailand were the only countries conducting retesting of HIV prior to the initiation of ART.
- 15 out of 19 countries had plans to use a dual HIV and syphilis test kit.
- Most of the countries conducted symptomatic tuberculosis screening for ANC attendees with HIV.

### Recommendations:

- Support scale up of integrating HIV, syphilis and HBV testing into ANC.
- Retesting of HIV-positive women prior to initiation of ART, taking into consideration the HIV testing algorithm at the country level.
- Start country processes to introduce dual rapid tests for HIV and syphilis.
- Encourage partner notification and testing.
- Support adaptation of the new WHO guidelines on HIV testing services.
- Step up symptomatic screening for tuberculosis among ANC attendees and proper referral when needed with emphasis on strengthening tuberculosis/HIV collaboration.
- Strengthen quality assurance of HIV and syphilis testing.

## Discussion Group C: Late presenters

Late presenters usually include marginalized women. Suggestions for interventions to trace these women included:

- Using mobile phone reminders;
- Use of labour register, PPTCT case manager for follow-up; and
- Couples counselling and community or midwife involvement in tracking.

Recognizing high-risk pregnant women was challenging; many women did not identify themselves as high risk (such as PWID, sex workers, etc.); neither did health workers identify these women as high risk. ANC staff were usually overstretched, it was difficult to make special efforts to identify pregnant women at high risk of HIV, especially in low prevalence settings. Risk assessment was discouraged as an inefficient approach.

## Recommendations to identify pregnant women earlier included:

- Use of peer educators to identify high-risk women during outreach.
- Tracing female partners of high-risk males, providing home-based and community-based HIV counselling and testing for spouses of key affected populations.
- Using community health systems that are linked to health services systems.
- Referrals from other non-health systems – police, social services, etc.
- Harmonization of PPTCT and ANC registers.
- Pre-exposure prophylaxis (PrEP) for sero-discordant couples.

**Table 1: Countries considering promoting PrEP for sero-discordant couples**

Yes	Not yet
Bhutan	Bangladesh
Malaysia	Cambodia
Maldives	China
Nepal	Fiji (trying to prioritize 90-90-90, no funding)
Thailand (in guidelines but not in practice)	Indonesia
	Lao PDR
	Myanmar
	India
	Philippines (but considering for future for PWID, no funding)
	Maldives
	Mongolia
	Sri Lanka
	Papua New Guinea
	Pakistan (TasP)
	Viet Nam

## Discussion Group D: Validation of elimination

All countries were interested in the validation process, seeking opportunities to strengthen MCH services and integrating HIV, syphilis and HBV screening into ANC services.

**Table 2: Elimination targets as set by countries**

Country	EPTCT of HIV (target, year)	EPTCT of syphilis (target, year)
Afghanistan		
Bangladesh		
Bhutan		
Cambodia	2020	2020
China		
Fiji	2020	2020
India	2020	2020
Indonesia	2020	2020
Lao PDR	2020	2020
Malaysia	2018	2018
Maldives		
Mongolia	2020	2020
Myanmar	2020	2020
Nepal		
Pakistan		
Philippines		
Papua New Guinea		
Sri Lanka	2017	2017
Thailand	2015	2015
Viet Nam	2020	2020

In summary, 12 out of 19 countries committed to undertake validation by 2020, if not before, and many countries hoped to use it to galvanize political support and ensure that EPTCT was a goal in national strategic plans. There was also a consensus that subnational validation processes (validation processes in geographic regions with a high disease burden) could serve as a starting point towards reaching national coverage and the national elimination goals.

Some countries requested technical support. South-South collaboration to exchange experiences was increasingly recognized as useful. Regional mechanisms should continue to support every country and support lesson sharing about EPTCT between countries.

Group discussions are summarized in Annex 4.

# CONCLUSIONS AND RECOMMENDATIONS

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## Conclusions

### **High burden countries in the region are progressing towards EPTCT of HIV and syphilis while advances in other countries are varied**

- Thailand is committed to EPTCT and has initiated preparations towards validation.
- China is initiating a pre-validation exercise, building on the Government's political and financial commitment towards EPTCT of HIV/syphilis and integrating control of HBV. Free HIV, syphilis and HBV testing has been scaled up and is available at POC in all provinces as of 2015. By 2020, China plans to reduce PTCT of HIV to under 5 per cent and congenital syphilis to less than 15 cases/100,000 live births.
- Indonesia announced a policy to integrate PPTCT of HIV, syphilis and HBV into MNCH services, including ANC, in recognition that children have a right to be born free of these preventable diseases.
- India is scaling up a PPTCT response, integrated into MNCH services, and plans to provide universal testing for all pregnant women.
- Most countries have scaled up routine provider initiated testing and counselling (PITC); 17 out of 19 countries include HIV and syphilis testing in their ANC packages.
- Nepal and Thailand include retesting of HIV prior to ART initiation.
- 15 out of 19 countries plan to include dual rapid POC testing and Nepal has already piloted use of dual rapid HIV/syphilis testing.
- The majority of countries in the region have committed to EPTCT of HIV and syphilis and to integrating these services in MNCH programmes
- At the meeting, 12 out of 19 countries committed to EPTCT of HIV and syphilis by 2020 (see country 'next steps' below).
- Many countries agree that validation of EPTCT opens up opportunities for political advocacy and resource mobilization and in particular, the inclusion of EPTCT goals in their national strategic plans.
- Many also agree that subnational validation processes serve as a starting point to reach national goals, especially where targeted testing is a national policy or currently recommended.
- All countries have adopted Option B+ (lifelong ART for all pregnant HIV-positive women), but with the recognition that careful planning is vital, and that the retention of women and babies in care is essential to ensure health benefits as well as the prevention of HIV drug resistance.
- Improved technology for tracking women and babies is becoming increasingly available to facilitate integration of services across platforms and increase the retention of women and babies in care.
- Most countries provide testing free of charge; one country provides free HIV screening with some costs for the other tests in outpatient care.

### **Universal testing for HIV and syphilis as part of the standard ANC package is important for EPTCT of HIV and syphilis because:**

- A universal approach to HIV and syphilis testing is cost-saving even in low burden settings.
- Integrated provision of HIV and syphilis testing, as well as other tests for pregnant women, is more cost-effective than providing a single test alone.
- All children have the right to be born free of preventable, communicable diseases, and all women have a right to improved maternal health.

### **New technologies are being developed for dual HIV/syphilis point-of-care (POC) testing and tracking of women and infants to assist with retention**

- Promising results with POC or rapid dual platform tests are noted, which enables expansion of testing in hard-to-reach areas and populations.
- Novel methods for tracking women and babies are now available that show promise towards retention in care.
- Tools are available to estimate syphilis disease burden to help countries forecast and plan for EPTCT programmes.

### **Countries are offering universal HBV screening as part of the standard ANC package, and there is potential to expand the package of care to include screening for other infectious diseases such as tuberculosis**

- Control of HBV through vaccination has been successful in the Western Pacific Region.
- 10 out of 19 countries include HBV screening for pregnant women.
- The advantages of screening mothers and babies for tuberculosis and other co-infections as part of the MCH care package were discussed, and most of the countries do screen for tuberculosis symptoms of pregnant women living with HIV.

### **Gaps remaining in progress towards EPTCT**

- Many pregnant women are identified with HIV and/or syphilis late, often at labour and delivery.
- Male partner involvement needs to be strengthened.
- Vertical programmes for ART still exist in most places.
- ART retention mechanisms for pregnant women after pregnancy are not clearly defined.
- Viral load testing is not available in 20 per cent of the countries, and few countries offer viral load testing for women before delivery.
- EID services are highly centralized, some countries send specimens outside the country for diagnosis and turnaround times are a challenge for most settings.

## **Recommendations for countries**

- Advocate for the highest level of political commitment to EPTCT and ensure that this goal is stated in national strategic plans.
- Reinforce calls for universal testing and treatment of HIV and syphilis for pregnant woman as part of an essential ANC package to improve maternal and child health outcomes and reach EPTCT goals.
- Advocate for, and ensure that HIV/syphilis testing and treatment are included in, UHC, both as part of care delivery systems and a health insurance/benefits package.
- Develop specific strategies to increase early ANC attendance (1st trimester) for implementation of early testing and treatment.
- Make PPTCT programmes more inclusive of vulnerable and key populations.
- Adapt WHO recommendations on HIV testing as recommended in the WHO consolidated HIV testing services guidelines updated in July 2015.
- Decentralize testing services to maximize coverage. Opportunities accorded by new POC technologies should be harnessed.
- Scale up rapid POC testing platforms including dual HIV and syphilis tests and integrate them into MNCH services. Reduce gaps in couples or intimate partners' counselling and testing.
- Integrate viral load assessment for pregnant women living with HIV into the overall implementation of WHO antiretroviral (ARV) guidelines.
- Plan and develop strategies to retain women and children in care in order to maximize the benefits of lifelong ART and prevent HIV drug resistance:
  - Improve tracking mechanisms of mother-baby pairs through active case management and optimizing the use of technology through maternal health.
  - Improve follow-up services, including EID and routine immunization for HIV-exposed infants/children, within the MNCH programme.
- Strengthen and scale up EID services to measure the impact of the PPTCT programme, and to ensure that infants and children are not excluded from efforts to initiate ART as soon as possible.
- Improve tuberculosis screening and treatment of pregnant women and their exposed infants and HBV immunization efforts in MCH services.

- Strengthen the client-centred approach by fostering integration of MNCH, SRH and immunisation services.
- Strengthen surveillance and programme data, including interlinking patients' records to reduce loss to follow-up, and invest in interoperability of disparate health/disease information systems.
- Define clearly the testing denominator to reach the elimination goal based on WHO global guidance, and jointly evaluate both the transmission risk and case rate even in low prevalence settings.
- Engage with the private sector to share data on pregnant women accessing private care for MNCH and PPTCT.
- Develop national processes to strengthen the quality of services, laboratory services, data management systems, protection of human rights and links with civil society (for countries considering validation of EPTCT of HIV/syphilis).

## Recommendations for partner organizations

- Implement and notify Member States of regional mechanisms to support the EPTCT and national validation process.
- Monitor progress towards EPTCT in the region and document experiences and lessons learned in implementing EPTCT programmes.
- Provide platforms for the sharing of best practice and information exchange. Encourage cooperation between countries on the technical procurement of diagnostic test kits and ARV drugs.
- Continue to facilitate stronger participation of civil society and the community of women living with HIV in the drive to EPTCT of HIV and syphilis.

Each country at the meeting committed to a series of 'next steps' in order to advance towards the elimination goals (*see Table 3*). The meeting was concluded with an announcement that the Asia-Pacific United Nations Regional Task Force for the Prevention of Parent-to-Child Transmission of HIV and Syphilis would no longer operate in its current form. However, partner organizations remain firmly committed to supporting countries towards the EPTCT of HIV and syphilis goals and plan to hold smaller meetings around specific topics as the need arises.



**Table 3: Country next steps towards EPTCT of HIV and syphilis**

Country	EPTCT target – HIV	EPTCT target – syphilis	Preparation toward validation	Improving HIV and syphilis testing in concentrated epidemics	Addressing late presenters	Male partner testing – increase male involvement
<b>Afghanistan</b>						
<b>Bangladesh</b>						
			<ul style="list-style-type: none"> <li>- Advocate for commitment from policy makers on inclusion of HIV, syphilis, HBV into ANC package into the new National Health Sector Plan 2017-2022.</li> </ul>	<ul style="list-style-type: none"> <li>- Organize a coordination meeting among directorates of HIV, MCH and family planning and establish a working group.</li> </ul>	<ul style="list-style-type: none"> <li>- Improve overall access to ANC through increased advocacy/ community awareness of importance of ANC.</li> <li>- Increase MCH mobile outreach to promote early testing.</li> <li>- Strengthen village health volunteer programme to identify pregnant women to access ANC and get tested.</li> <li>- Develop PLHIV database.</li> <li>- Use of mobile phone ICT for tracking and bringing mothers in.</li> </ul>	<ul style="list-style-type: none"> <li>- Organize social mobilization to encourage male participation in ANC/MCH.</li> </ul>
<b>Bhutan</b>						
				<ul style="list-style-type: none"> <li>- Include EPTCT of HIV and syphilis goal into national strategic plan for 2016.</li> </ul>	<ul style="list-style-type: none"> <li>- Develop Internet/ cloud-based mother tracking systems using an electronic recording system.</li> </ul>	<ul style="list-style-type: none"> <li>- Institute couples counselling.</li> <li>- Hire male MCH counselling staff to engage male partners.</li> <li>- Include peer counsellors to encourage male testing.</li> <li>- Social mobilization to encourage male participation in ANC/MCH.</li> </ul>
<b>Cambodia</b>						
	2020	2020	<ul style="list-style-type: none"> <li>- Advocate for the validation goals to be incorporated into the National Strategic Plan, create a validation sub committee.</li> </ul>	<ul style="list-style-type: none"> <li>- Scale up testing.</li> <li>- Request WHO and CDC assistance to advocate for MOH focal point for HBV.</li> <li>- Plan to cost dual HIV/ syphilis test vs. two single tests.</li> <li>- Plan to hold discussion on how to reach the syphilis screening target (dual test might help) and reduce burden on providers</li> </ul>	<ul style="list-style-type: none"> <li>- Institute ANC outreach through community involvement to increase HIV/syphilis testing at ANC.</li> <li>- Increase efforts for remote provinces.</li> <li>- Scale up labour/ delivery HIV testing to catch those missed at ANC or not attending ANC.</li> </ul>	<ul style="list-style-type: none"> <li>- Scale up partner notification, tracing and testing approach.</li> <li>- Community advocacy for male participation in ANC and encourage testing.</li> </ul>

Country	EPTCT target – HIV	EPTCT target – syphilis	Preparation toward validation	Improving HIV and syphilis testing in concentrated epidemics	Addressing late presenters	Male partner testing – increase male involvement
<b>China</b>	2020	2020	<ul style="list-style-type: none"> <li>- Set up national validation committee, collect data, announce elimination plan in 2017.</li> </ul>	<ul style="list-style-type: none"> <li>- More proactive health promotion of specific high-risk populations.</li> <li>- Strengthen capacity building at grass-roots level.</li> <li>- Communication and information exchange between MCH and CDC, and within MCH system.</li> <li>- Decentralize testing services, make testing services available at township level.</li> <li>- Strengthen ANC services and management of pregnant women using maternal and children handbook.</li> <li>- Continue providing services for infant follow-up based on MCH platform.</li> <li>- Health education to encourage male partner testing.</li> </ul>	<ul style="list-style-type: none"> <li>- Conduct community campaign and mobilization to encourage pregnant women to attend ANC early and to deliver at health facility.</li> <li>- Community mobilization.</li> <li>- Pre-marriage testing.</li> <li>- Advocacy to reduce stigmatization to improve testing.</li> <li>- Improve accessibility and acceptability of testing facilities and ANC.</li> </ul>	<ul style="list-style-type: none"> <li>- Advocate for policy and increased funding/resources for male partner testing.</li> <li>- Health promotion and stigma reduction to increase partner testing.</li> </ul>
<b>Fiji</b>	2020	2020	<ul style="list-style-type: none"> <li>- Add HBV to ANC package of services.</li> </ul>	<ul style="list-style-type: none"> <li>- Build capacity of service providers in providing POC testing both at the divisional and sub-divisional levels.</li> <li>- Enhance reporting and recording systems for MCH, HIV, syphilis and hepatitis.</li> </ul>	<ul style="list-style-type: none"> <li>- Offer triple testing: HIV, syphilis, HBV.</li> <li>- Train healthcare workers to promote attendance at ANC.</li> <li>- Launch safe motherhood initiative.</li> <li>- Aim to target younger populations, single mothers and adolescents.</li> <li>- Early ANC booking.</li> <li>- Provide two HIV tests during ANC.</li> </ul>	<ul style="list-style-type: none"> <li>- Increase testing access for males.</li> </ul>
<b>India</b>	(2020)	(2020)	<ul style="list-style-type: none"> <li>- Plan for subnational validation, advocate for efforts to expand screening to all 22 million pregnant women.</li> </ul>	<ul style="list-style-type: none"> <li>- Step up HIV and syphilis testing for mothers presenting in labour to increase coverage of prenatal testing.</li> <li>- Advocate for dual HIV and syphilis test introduction.</li> </ul>	<ul style="list-style-type: none"> <li>- Mapping and delivery points and ICTC couples mapping.</li> <li>- Provide transport support to pregnant women at ANC/post antenatal to minimize loss to follow-up/improve adherence.</li> <li>- India SSH (short stay home) scheme for all pregnant women including high risk.</li> <li>- Different colour cards are issued for those at high risk.</li> <li>- Mother and Child Tracking System (MCTS) also captures various parameters where they can be identified as high risk.</li> </ul>	

Country	EPTCT target – HIV	EPTCT target – syphilis	Preparation toward validation	Improving HIV and syphilis testing in concentrated epidemics	Addressing late presenters	Male partner testing – increase male involvement
<b>Indonesia</b>	2020	2020	<ul style="list-style-type: none"> <li>- Integrate HIV services into MCH services.</li> </ul>	<ul style="list-style-type: none"> <li>- Universal testing of pregnant women for HIV, syphilis and HBV.</li> <li>- Review and update guidelines.</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthen the information system through a technical assistance programme to better capture late presenters and improve follow-up.</li> <li>- Engage the private sector.</li> </ul>	<ul style="list-style-type: none"> <li>- Integrate male involvement approach into ANC programme.</li> <li>- Bring in expert technical assistance to review and propose strengthening measures for male involvement programme in ANC.</li> </ul>
<b>Lao PDR</b>	2020	2020	<ul style="list-style-type: none"> <li>- Push implementation of universal testing and expanded pre-natal care.</li> <li>- Raise the priority of MCH within government and donor planning.</li> </ul>	<ul style="list-style-type: none"> <li>- Hold dissemination meeting upon return.</li> <li>- Work with external and internal counterparts to expand PMTCT services nationwide and integrate HIV, syphilis, and HBV into routine services.</li> </ul>	<ul style="list-style-type: none"> <li>- Share recommendations from PPTCT meeting to stakeholders to get buy in.</li> </ul>	<ul style="list-style-type: none"> <li>- Conduct advocacy meetings to get additional support and involvement with community, mobile outreach, and better data recording and reporting.</li> </ul>
<b>Malaysia</b>	2018	2018	<ul style="list-style-type: none"> <li>- Advocate for higher levels of political commitment for EPTCT of HIV and syphilis.</li> </ul>	<ul style="list-style-type: none"> <li>- Prepare for validation of EPTCT of syphilis and HIV with support from regional partners.</li> <li>- Conduct a site visit to Cuba to learn from their experience on the validation.</li> <li>- The government requests regular support and consultative progress reviews with UNICEF country office to ensure they remain on track.</li> </ul>	<ul style="list-style-type: none"> <li>- More efforts to identify high-risk mothers and their partners.</li> </ul>	<ul style="list-style-type: none"> <li>- Make clinics partner-friendly to encourage participation and testing.</li> </ul>
<b>Maldives</b>			<ul style="list-style-type: none"> <li>- Develop strategy and evaluate current systems.</li> </ul>	<ul style="list-style-type: none"> <li>- Work on information systems. Patients all have a national ID card, MoH is working on a new system to register patients on a general practice system so that all citizens fall into the catchment area of a General Practitioner. Have an online HIV and STI reporting system.</li> <li>- Validation of EPTCT of syphilis (no reported HIV). Want to use validation as a chance to strengthen the programme. Will connect with regional WHO and UNICEF focal points to discuss.</li> </ul>	<ul style="list-style-type: none"> <li>- Capacity strengthening for primary healthcare workers to identify and track late attendees and motivate them to stay in HIV care</li> <li>- Expand and strengthen youth- friendly health services to ensure adolescent/ unplanned pregnancies are brought into ANC and continuum of care.</li> </ul>	

Country	EPTCT target – HIV	EPTCT target – syphilis	Preparation toward validation	Improving HIV and syphilis testing in concentrated epidemics	Addressing late presenters	Male partner testing – increase male involvement
<b>Mongolia</b>	2020	2020	<ul style="list-style-type: none"> <li>- Develop a strategic plan to include syphilis and HIV testing in ANC.</li> </ul>	<ul style="list-style-type: none"> <li>- Integrate MCH, HIV, STIs and hepatitis at the policy and service delivery level.</li> <li>- Expand throughout the country the one-stop shop where there is integrated service delivery that includes MCH, HIV, STI and hepatitis.</li> <li>- Strengthen recording and reporting systems for MCH, HIV, STIs and hepatitis.</li> </ul>	<ul style="list-style-type: none"> <li>- Develop operational plan for PPTCT.</li> <li>- Develop a student health programme with HIV/syphilis PITC in universities for students who are at higher risk and not accessing services.</li> </ul>	<ul style="list-style-type: none"> <li>- Advocacy and availability of male health services (which are currently very weak).</li> <li>- Family/couples counselling.</li> <li>- Family visits.</li> </ul>
<b>Myanmar</b>	2020	2020	<ul style="list-style-type: none"> <li>- Pre-assessment in 2016 and scale up of screening.</li> </ul>	<ul style="list-style-type: none"> <li>- Step up couple counselling, awareness-raising and community mobilization.</li> <li>- Scale up community-based HIV testing to reach more key populations.</li> <li>- High-level advocacy and funds mobilization for the country to move from focused HTC to a universal HTC approach.</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthen coordination at township level with rural health centre.</li> <li>- Strengthen EID monitoring.</li> <li>- Link health management information system (HMIS) data to HIV data to improve tracking.</li> <li>- Strengthen the involvement of community and CSOs in the tracking process.</li> <li>- Promote HCT coverage with basic health services and CSOs.</li> <li>- Use PLHIV network to follow up mother-baby pairs.</li> </ul>	<ul style="list-style-type: none"> <li>- Improve the quality of data recording for male partners, move towards e-Health systems.</li> <li>- Need to include PrEP and learn from neighbouring countries about the implementation process.</li> </ul>
<b>Nepal</b>			<ul style="list-style-type: none"> <li>- Include EPTCT goals in new the National Strategic Plan.</li> </ul>	<ul style="list-style-type: none"> <li>- Conduct cost-effectiveness analysis of universal HIV testing.</li> <li>- Scaling up dual HIV and syphilis rapid tests to increase the coverage of ANC clients with both of these services.</li> <li>- Include HIV, syphilis and HBV in the basic healthcare package then roll it out at all levels of the health facility.</li> <li>- Include universal HIV testing in the new HIV and AIDS strategy 2016-2021 (on-going review).</li> <li>- Set up referral laboratory for polymerase chain reaction (PCR) testing so that dried blood spot samples are tested in-country.</li> </ul>	<ul style="list-style-type: none"> <li>- Mobilize the following community groups and the awareness of their existence: <ul style="list-style-type: none"> <li>- Female community volunteers.</li> <li>- Community MCH workers.</li> </ul> </li> <li>- Counselling and awareness through media.</li> <li>- Tracking through community groups.</li> <li>- Tracking through mobile information technology.</li> <li>- Increasing accessibility of birthing facilities.</li> <li>- Institute universal coverage with an incentive programme for insurance coverage.</li> <li>- Strengthen HMIS for community-based tracking.</li> </ul>	<ul style="list-style-type: none"> <li>- Awareness through community health networks and media.</li> <li>- Involvement of civil society and health management committee.</li> </ul>

Country	EPTCT target – HIV	EPTCT target – syphilis	Preparation toward validation	Improving HIV and syphilis testing in concentrated epidemics	Addressing late presenters	Male partner testing – increase male involvement
<b>Pakistan</b>			<ul style="list-style-type: none"> <li>- Add HIV and HBV to routine testing, build infrastructure to provide universal testing and include it in national policy.</li> </ul>	<ul style="list-style-type: none"> <li>- Conduct cost analysis of the various HIV and syphilis testing approaches.</li> <li>- Advocate for the most appropriate testing approach based on the recommendations from the cost analysis.</li> <li>- PWID and expatriates are key populations. Develop approaches for accessing them with services.</li> <li>- Linkages and partnerships with the private sector as they manage a significant (30 per cent) number of ANC clients.</li> <li>- Improve equitable access to MCH services. Advocate with NGOs providing services for vulnerable populations like urban poor and slum dwellers for the EPTCT of HIV and syphilis as part of the ANC package.</li> </ul>	<ul style="list-style-type: none"> <li>- Awareness campaign at ANC clinics to encourage female partners of male PLHIV to present early at ANC.</li> </ul>	<ul style="list-style-type: none"> <li>- Increase male involvement through the improved counselling of HIV-positive males.</li> </ul>
<b>Philippines</b>			<ul style="list-style-type: none"> <li>- Plan to have an administrative order on EPTCT of HIV and syphilis by 2016.</li> </ul>	<ul style="list-style-type: none"> <li>- Meet with STI and HIV programme managers to discuss and make a plan.</li> <li>- Integration of syphilis and HIV tests into the maternity care package (social health scheme: philhealth).</li> <li>- Fast track of HIV testing results (geographic prioritization – region 7 and metro manila).</li> <li>- High five (high burden areas) 60 per cent HIV testing coverage; 50 per cent syphilis testing coverage among pregnant women.</li> <li>- Expanding testing facilities (procurement of commodities to address the problem).</li> </ul>	<ul style="list-style-type: none"> <li>- Have a joint meeting of MCH, HIV and surveillance programmes to determine how to better track late presenters and high-risk women and improve this gap.</li> </ul>	<ul style="list-style-type: none"> <li>- The Philippines lacks a strong PPTCT programme, and has a wide geographic variation, especially with HIG male PWID and females that are uninfected. Many PWID are not on ART, even considering PrEP.</li> </ul>

Country	EPTCT target – HIV	EPTCT target – syphilis	Preparation toward validation	Improving HIV and syphilis testing in concentrated epidemics	Addressing late presenters	Male partner testing – increase male involvement
<b>Papua New Guinea</b>			<ul style="list-style-type: none"> <li>- Build infrastructure over the next five years to expand testing.</li> </ul>	<ul style="list-style-type: none"> <li>- Address stock-out issues from the periphery.</li> <li>- Explore options to make both HIV and syphilis test kits in the same facility at the same time.</li> <li>- Strengthen the capacity of service providers in the health facilities in adhering to the guidelines.</li> <li>- Strengthen coverage of ANC 1st booking and increase facility delivery.</li> </ul>	<ul style="list-style-type: none"> <li>- Increase ANC accessibility through increased MCH mobile outreach and awareness of the importance of ANC services.</li> <li>- Strengthen the identification of high-risk HIV-positive pregnant women through the strengthened skills of village health volunteers.</li> </ul>	<ul style="list-style-type: none"> <li>- Train healthcare workers in couples counselling.</li> </ul>
<b>Sri Lanka</b>	2017	2017	<ul style="list-style-type: none"> <li>- Programme strengthening to improve services.</li> </ul>	<ul style="list-style-type: none"> <li>- Conduct programme review and identify areas of improvement.</li> <li>- Apply for validation of EPTCT of HIV in 2017. Will use the existing steering committee to double as the country validation team.</li> <li>- Provide feedback to MCH counterparts who were not able to participate in this meeting.</li> <li>- Advocate for subsidized or free HIV and testing services.</li> </ul>	<ul style="list-style-type: none"> <li>- Scale up ANC HIV testing to 95 per cent by the end of 2015.</li> <li>- Address late testing at delivery, but still offer it to make sure those who were not tested at ANC get tested.</li> <li>- Identify mothers who may need a 2nd HIV test during the 2nd trimester.</li> <li>- Improve the content of counselling training to STI staff and ANC nurse counsellors to better encourage partner testing.</li> </ul>	<ul style="list-style-type: none"> <li>- Need to introduce HIV testing in partners at parent meetings in ANC settings.</li> </ul>
<b>Thailand</b>	2015	2015	<ul style="list-style-type: none"> <li>- Pre-validation for EPTCT of HIV underway.</li> </ul>	<ul style="list-style-type: none"> <li>- Discuss the issues of HBV and tuberculosis screening for pregnant women.</li> <li>- Strengthen partner counselling and testing and encouragement for early ANC (1st trimester).</li> <li>- Move forward to quality births.</li> </ul>	<ul style="list-style-type: none"> <li>- Areas to improve: develop standard operating procedures for follow-up; better monitoring and evaluation.</li> <li>- Involve HIV-positive women from ANC clinics in peer community support groups and set up mothers' groups for sharing information, experience and providing social support to other HIV-positive pregnant women.</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthen training of staff to encourage partner testing.</li> </ul>

Country	EPTCT target – HIV	EPTCT target – syphilis	Preparation toward validation	Improving HIV and syphilis testing in concentrated epidemics	Addressing late presenters	Male partner testing – increase male involvement
Viet Nam	2020	2020	<ul style="list-style-type: none"> <li>- Pre-assessment for validation at the country level.</li> </ul>	<ul style="list-style-type: none"> <li>- Development of national guidelines on linkages of SRH and HIV and national guidelines on reproductive health services (integrating HIV, syphilis and HBV into ANC).</li> <li>- Ensure health insurance coverage of HIV, syphilis and HBV at ANC.</li> <li>- Include HIV, syphilis and HBV testing into HMIS under an MCH component.</li> <li>- Capacity building for MCH workers on HIV, syphilis and HBV testing.</li> </ul>	<ul style="list-style-type: none"> <li>- Expand services to community level</li> <li>- Provide outreach service for mobile/marginalized populations.</li> <li>- Develop national and sub-national policy for these hard-to-reach groups.</li> <li>- Improve data collection for the private sector.</li> <li>- Develop operational plan for PPTCT</li> <li>- Classify high-risk groups geographically, including residents versus migrants.</li> </ul>	

# ANNEXES

## Annex 1. Agenda

### The 10<sup>th</sup> Asia Pacific United Nations Prevention of Parent-to-Child Transmission Task Force Meeting

15-17 September 2015  
Beijing, China

Day 1: 15 September 2015 (Tuesday)			
Time	Topic	Speaker	Chairpersons
08:30 – 09:00	Registration		
09:00 – 09:25	Opening remarks		Chairpersons: Rakesh Kumar, India and Gita Maya Koemara Sakti, Indonesia
	Opening and welcome address by UNICEF (7') <sup>14</sup>	Isiye Ndombi Deputy Regional Director, UNICEF EAPRO	
	Address by WHO (7')	Bernhard Schwartländer, WHO Representative, PR China	Note taker: Robin Nandy, UNICEF Indonesia
	Key note address by the Chinese Government, followed by a video (10')	Dr Qin Geng, Director-General, MCH Department, National Health and Family Planning Commission, PR China	
09:25 – 09:35	Security briefing by UNDSS	UNDSS	UNDSS
09:35 – 09:45	Introduction: Objectives and expected outcomes Presentations (10')	Ying-Ru Lo, WHO WPRO	Note taker: Bolorchimeg Dagva, UNICEF Mongolia
09:45 – 10:00	Review of 9th Task Force Meeting recommendations (TF Secretariat) Presentation (15')	Annefrida Kisesa, UNICEF ROSA and Razia Pendse, WHO SEARO	

<sup>14</sup> Please note that the prime symbol indicates the number of minutes the speaker had to talk (e.g., 7' indicates the speaker had 7 minutes).



<b>10:00 – 10:30</b>	Global updates on Elimination of Parent-to-Child Transmission of HIV and Syphilis (EPTCT)		Chairpersons: Song Li, PR China and Craig McClure, UNICEF New York
	Presentations (20') - Global progress on EPTCT and paediatric HIV - Updates on global guidance and guidelines	Shaffiq Essajee and Melanie Marie Taylor, WHO Geneva	Note taker: Mukta Sharma, WHO Thailand
	- WHO 2015 Consolidated guidelines on HIV testing services and the use of antiretrovirals (ARV), Global Guidance for Validation		
	- Discussion (10')		
<b>10:30 – 10:45</b>	Group photo		
<b>10:45 – 11:00</b>	Tea/coffee		
<b>11:00 – 11:30</b>	Regional progress and impact of PPTCT of HIV and syphilis		Chairpersons: Song Li, PR China and Craig McClure, UNICEF New York
	Fast tracking the response for EPTCT (10')	Vladanka Andreeva, UNAIDS RSTAP	Note taker: Mukta Sharma, WHO Thailand
	Progress update (20')	Ying Ru-Lo, WHO WPRO and Wing-Sie Cheng, UNICEF EAPRO	
<b>11:30 – 12:00</b>	Triple EPTCT of HIV, syphilis and hepatitis B		Chairpersons: Saiasi Caignidaveta, Fiji and Abdul Hameed, Maldives
	Control of hepatitis B among children through vaccination in the region (including certification of Hep B elimination) (10')	Lance Rodewald, WHO China	Note taker: Polin Chan, WHO China
	HIV, syphilis and HBV prevention and control in China (10')	Shi Ying, PR China	
	China national PPTCT programme of HIV, syphilis and HBV (10')	Song Li, PR China	
<b>12:00 – 13:00</b>	Lunch		

<b>13:00 – 14:30</b>	The PPTCT cascade: Scaling up HIV and Syphilis Testing in antenatal care (ANC) and community-based programmes		Chairpersons: Oyuntsetseg P, Mongolia and Petchsri Sirinirund, International expert
	Standard ANC packages for better maternal and child health (15') Strategic HIV and syphilis testing approaches for use in low and concentrated epidemics (15')	Kyoko Shimamoto, UNICEF EAPRO Naoko Ishikawa, WHO WPRO	Note taker: Justine Nankinga, UNICEF PNG
	Country experiences (panel discussion with short presentation 10' each) Indonesia Malaysia Myanmar Nepal Sri Lanka	Lukas C. Hermawan, Indonesia Mohd Nasir Abd Aziz, Malaysia Htun Nyunt Oo, Myanmar Gehanath Baral, Nepal Lilani Rajapaksha, Sri Lanka	
	Discussion (10')		
<b>14:30 – 15:45</b>	Option B+: Implementation within maternal and child health (MCH) platform, including transition from Option A/B to B+ and lessons learned, strategies to improve programme implementation and service delivery coverage		Chairpersons: Khampiou Syhakhang, Lao PDR and Siti Nadia Tarmizi, Indonesia
	Overview and country experiences (panel discussion with country presentations) (15') Field implementation within MCH Linkages to care and treatment Adherence and loss to follow-up	Overview: Nathan Shaffer	Note taker: Saba Moussavi, UNICEF EAPRO
	Panellists: Overview presenter and four country programme managers and civil society - India, Myanmar, Papua New Guinea, Viet Nam and a CSO (10' each)	Dinesh Baswal and R. S. Gupta, India Htun Nyunt Oo, Myanmar Lahui Geita, PNG Nguyen Mai Huong, Viet Nam Sunee Talawat, Thailand (CSO)	
	Discussion (10')		
<b>15:45 – 16:00</b>	Tea/coffee		

<b>16:00 – 17:15</b>	Option B+: strategies to reach women from key populations, including migrants and late presenters (late diagnosis during 3rd trimester/labour/postnatal period)		Chairpersons: Jonathan Neil Erasmo, Philippines and Nathan Shaffer, international expert
	Country experiences (panel discussion with short presentation) (10') each Panellists: Civil society organizations (CSOs) Four national programme managers: Bangladesh and Pakistan (key pops) Cambodia and Thailand (late presenters/late diagnosis/testing and ARV at labour)	Marama Pala, ICWAP (CSO) Ayu Oktariani, Indonesia Positive Women's Network (CSO) Anisur Rahman and Lima Rahman, Bangladesh Tayyaba Rashid, Pakistan Ly Penh Sun, Cambodia Chaweewan Tonputs, Thailand	Note taker: Birendra Pradhan, UNICEF Nepal
	Discussion (15')		

**18:30** Official reception

### Day 2: 16 September 2015 (Wednesday)

Time	Topic	Speaker	Chairpersons
<b>08:30 – 09:45</b>	Increasing paediatric HIV treatment coverage in Asia-Pacific: early infant diagnosis (EID), strategies to address loss to follow-up and outcomes of treatment coverage for infants and children.		Chairpersons: Ly Penh Sun, Cambodia and Reapi Mataika, Fiji
	Early detection and treatment – routine testing of children, integration of EID in routine immunization and other settings, and WHO guidance on vaccinating HIV-exposed children (15')	Shaffiq Essajee, WHO Geneva	Note taker: Narantuya Jadambaa, WHO Mongolia
	Country experiences (10' each) China Indonesia Thailand Viet Nam	Wang Ailing, PR China Sigit Prihutomo, Indonesia Rangsima Lolekha, Thailand Nguyen Thi Lan Huong, Viet Nam	
	Discussion (20')		

<b>09:45 – 10:45</b>	<p>Strengthening strategic information systems along the cascade toward EPTCT and Universal Health Coverage</p> <p>Leveraging eHealth and mHealth for better outcomes, including interoperability of systems and ID management (15')</p> <p>Technology innovations in tracking of mother and child and opportunities for EPTCT, India (10')</p> <p>'PedTrack' – an innovative technology to follow-up mother-baby pairs beyond 18 months (10')</p> <p>Estimation of disease burden of maternal and congenital syphilis and costing tools (15')</p> <p>Discussion (10')</p>	<p>Derek Ritz, ecGroup, Canada</p> <p>Rakesh Kumar and R.S.Gupta, India</p> <p>Kechi Achebe, Save the Children – USA</p> <p>Xiang-Sheng Chen, NCSTDC, PR China</p>	<p>Chairpersons: Genesis Samonte, Philippines and Lori Thorell, UNICEF EAPRO</p> <p>Note taker: Paul Prabhakar Francis, WHO India</p>
<b>10:45 – 11:00</b>	Tea/coffee		
<b>11:00 – 11:35</b>	<p>Point-of-care diagnostics for PPTCT</p> <p>Quality of HIV and syphilis testing, including the use of dual rapid test (10')</p> <p>Country experience - a pilot in Nepal (10')</p> <p>Addressing TB/HIV co-infections for children and pregnant women (10')</p> <p>- Discussion (5')</p>	<p>Lori Newman, PEPFAR, Cambodia</p> <p>Dipendra Raman, Nepal</p> <p>Sun Yanni, WHO China</p>	<p>Chairperson: Chen Xiang-Sheng, International expert</p> <p>Note taker: Beatricia Iswari, WHO Indonesia</p>
<b>11:35 – 12:00</b>	<p>Validation of eMTCT of HIV and Syphilis: Regional Mechanism and Strategies for Asia-Pacific, followed by Q&amp;A (25')</p>	<p>Ying-Ru Lo, WHO WPRO</p>	<p>Chairpersons: Wing-Sie Cheng and Razia Pendse</p> <p>Note taker: Xiaona Huang, UNICEF China</p>
<b>12:00 – 13:00</b>	Lunch		

<b>13:00 – 13:50</b>	Validation of EPTCT of HIV and Syphilis:  - Experience in Latin America and the Caribbean region (10')  - Validation process in Cuba (10')  - Thailand (20') Rationale on national EPTCT validation process  Setting up of national validation committee and working groups  Challenges and recommendations  - Discussion (10')	Massimo Ghidinelli, WHO PAHO  Massimo Ghidinelli, WHO PAHO  Petchsri Sirinirund  Rangsima Lolekha	Chairpersons: Sisira Liyanage, Sri Lanka and Mohd Nasir Abd Aziz, Malaysia  Note taker: Yang Yuning, UNICEF China
<b>13:50 – 14:00</b>	Explanation of Group Work – participants to proceed to breakout rooms		
<b>14:00 – 17:15</b>	Group discussions (60 min per station) – Four breakout rooms; one hour per session  PPTCT cascade: The 90-90-90 and 95-95-95 programme and operational opportunities and challenges  HIV and syphilis testing in ANC in low and concentrated epidemics  Addressing the common issue of late ANC: pregnant women who show up late – at labour – with delayed ART initiation, diagnosis and treatment of infants  Validation of elimination – in-country preparations and next steps  All four topics – Chinese participants (plenary room with simultaneous translation)	Facilitators:  Group 1: Vladanka Andreeva Annefrida Kisesa-Mkusa Nicole Seguy  Group 2: Lori Newman Chen Xiang-Sheng Naoko Ishikawa  Group 3: Shaffiq Essajee Rangsima Lolekha Nguyen Thi Thuy Van  Group 4: Razia Pendse Massimo Ghidinelli Petchsri Sirinirund  Group 5: Ying-Ru Lo Wing-Sie Cheng Polin Chan Robert Scherpbier Nathan Shaffer Guo Sufang	Note takers: Mukta Sharma, WHO Thailand and Beena Kuttiparambil, UNICEF Thailand  Note takers: Justine Nankinga, UNICEF PNG and Madeline Salva, WHO South Pacific  Note takers: Saba Mousavvi, UNICEF EAPRO and Zhang Lan, WHO China  Note takers: Patchara Benjarattanaporn, UNAIDS Thailand and Melanie Marie Taylor, WHO Geneva  Note takers: Xu Tao, WHO WPRO Yang Yuning, UNICEF China and Zhang Lei, UNICEF China

<b>15:30 – 15:45</b>	Tea/coffee in between
<b>15:30 – 17:15</b>	Group discussions continue (day 2 covers three rounds; the 4 <sup>th</sup> round to continue the following morning)
<b>Evening</b>	Free shuttle service to downtown Beijing

### Day 3: 17 September 2015 (Thursday)

Time	Topic	Speaker	Chairpersons
<b>08:30 – 09:30</b>	Group discussions continue (the 4 <sup>th</sup> and final round)		
<b>09:30 – 11:00</b>	Group work synthesis – preparation in groups for PowerPoint presentation	Group work rapporteurs	
<b>10:30 – 10:45</b>	Tea/coffee (in between preparing synthesis)		
<b>11:00 – 12:30</b>	Group work presentation and discussion (15' per group)  Discussion (15')	Group work rapporteurs	Chairpersons: Chador Wangdi, Bhutan and Peniel Boas, Papua New Guinea  Note takers: Nasir Sarfraz, UNICEF Pakistan (Groups 1 & 2)  Nguyen Huy Du, UNICEF Viet Nam (Groups 3 & 4)
<b>12:30 – 13:30</b>	Lunch		
<b>13:30 – 14:00</b>	Future of the Asia-Pacific PPTCT Task Force, review of achievements and role in the post-2015 sustainable development agenda	Joint Secretariat	Chairpersons: Petchsri Sirinirund  Note taker: Ziya Uddin, UNICEF Bangladesh
<b>14:00 – 15:00</b>	Key recommendations from the meeting and discussion  Closing remarks	Joint Secretariat	Note taker: Shirley Mark Prabhu, UNICEF EAPRO
<b>15:00 – 15:30</b>	Tea/coffee		
<b>15:30 – 17:30</b>	Side meeting: China consultation meeting on elimination of HIV, syphilis and hepatitis B (by invitation only)	China National Centre for Women and Children's Health, NHFPC, PR China	

## **Annex 2. Key conclusions and recommendations from the 9<sup>th</sup> Meeting of the Asia-Pacific United Nations Task Force for the Prevention of Parent-to-Child Transmission**

“A generation of children free of HIV/AIDS and congenital syphilis is possible and achievable”

27-29 August 2013  
Kathmandu, Nepal

### **Conclusions**

Based on the rich discussion, wealth of information, experiences and evidence shared during the PPTCT Task Force Meeting, 27-29 August 2013 among 16 countries in the Asia-Pacific region, participants concluded that:

- (1)** The goal of eliminating new paediatric HIV infections and congenital syphilis is now a real possibility and the drive to attain it is gaining momentum in Asia and the Pacific. With political commitment, evident progress in PPTCT interventions as well as advances in treatment and testing technologies, the Asia-Pacific region is in a position to translate the aspirational goal of an HIV and AIDS-free and syphilis-free generation into reality.
  - Eight countries – Cambodia, China, Fiji, Indonesia, Malaysia, Sri Lanka, Papua New Guinea and Thailand – have committed to the dual goal of EPTCT of HIV and syphilis.
  - China and Fiji have included HBV in the elimination initiative.
  - Myanmar has committed to eliminating new paediatric HIV infections.
  - Bangladesh will issue its 2013 National Guidelines for the Prevention of Vertical Transmission of HIV and Congenital Syphilis before the end of 2013.
  
- (2)** The Asia-Pacific Conceptual Framework for the Elimination of New Paediatric HIV and Congenital Syphilis 2011-2015 and other tools have provided the targets and thrust for country actions. The vision, goal and targets of the framework are reflected, in various degrees, in all of the National Strategic Plans for HIV and AIDS in the region.
  
- (3)** The meeting has noted significant progress in scaling up testing and counselling of pregnant women for HIV and syphilis, and in some instances HBV as well. Although this progress is uneven across the region, universal screening for HIV and syphilis (and combined testing where possible) is increasingly recognized as crucial and beneficial to maternal and child health. This would be a step forward from geographic prioritization and phased, strategic scale-up of screening – the approach currently adopted by the majority of countries – to detect HIV-positive, syphilis and HBV-infected pregnancies. Antenatal care settings have, almost throughout the region, served as a vital entry point for screening to prevent transmission of these life-threatening diseases to new-borns, demonstrating the increased commitment, ownership and co-leadership of maternal, neonatal and child health programmes, in partnership with national AIDS programmes, in eliminating new infections in children.

- (4)** Countries in the region have begun to adopt the new WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection released in July 2013. However, understanding of the new guidelines varies across implementers. The meeting noted the time and processes needed to adapt and implement the guidelines, especially in countries with large populations and weaker health system capacities.
- All countries in the region have made the switch to the recommended PPTCT Programme Option of B or B+, and a majority has already phased out single-dose Nevirapine. The switch to a simplified, harmonized treatment option of a fixed-dose triple ART combination for all HIV-positive pregnant women has been swift and positively received. There are, however, many responsibilities involved in planning rollout and strategic expansion, with decisions on financing, task shifting/sharing, improved community engagement, organization, training and management, including examination of MNCH's role in ART management for mothers.
  - The new recommendations for early and immediate treatment for all HIV-positive mothers also call for the improved quality of MNCH care and long-term retention in care, and efforts to address on-going concerns of high loss to follow-up.
- (5)** A concerted effort is needed to improve access by children to paediatric ART, which has substantially lagged behind that of adults. The meeting has noted that implementation bottlenecks in EID, whose coverage remains low in most countries of the region, along with long turnaround times for test results, low levels and/or delayed ART initiation and the high rate of loss to follow-up, are issues that require urgent attention. It is also recognized that despite advances in paediatric treatment efficacies, there remain challenges in dispensing the recommended regimen to infants and children younger than 3 years due to requirements for cold-chain storage and the palatability (bitter taste) of boosted lopinavir that could affect adherence.
- Nearly half the countries indicated the intention to adopt the new WHO paediatric guidance of initiating ART in all HIV-positive children under 5, regardless of clinical or immunological criteria.
  - Most other countries are planning national consultations before the end of 2013 to decide on new paediatric treatment policies.
- (6)** There is greater appreciation in countries of the importance of linkages or integration between HIV/STIs and maternal, child and reproductive health programmes, especially recognizing that high ANC attendance coverage and a low rate of unmet need for family planning are the critical starting points in the PPTCT cascade:
- All countries have implemented various models and approaches for linking or integrating these programmes and services using ANC as the entry point.
  - Additional and substantive investment in ANC and MCH care capacity, service quality, human resources, programme management and partnerships with communities are needed to attain the elimination goal.
  - Almost all countries face challenges related to policy, quality, health systems, programmes and social issues.
  - Low prevalence and concentrated epidemiology poses a challenge for the MCH programme to accord high priority to PPTCT, with other competing priorities.
  - Greater efforts are needed to ensure that contraceptive use is increased and unmet need for family planning is reduced among women of reproductive age in general, and among HIV-positive women in particular. Concerted efforts towards meeting the unmet need for family planning will need to be a priority.



**(7)** All countries recognize that increasing uptake early in the PPTCT cascade is critical, and that achieving a high retention in care for both HIV-positive pregnant women and HIV-positive children on ART and viral load suppression, are the ultimate aims of monitoring PPTCT through the cascade approach.

- The meeting noted that a number of countries have already expanded or refined existing indicators to better analyse the levels of uptake of interventions – from attending ANC to voluntary HIV testing, ARVs or ART for pregnant women, EID and HIV-positive children starting and continuing ART as well as linkages to chronic care – for both mothers and children.
- PPTCT services for key populations, including female sex workers, women injecting drugs, spouses/intimate partners of men injecting drugs, men who have sex with men, migrants and adolescent girls etc. have not been adequately addressed. Targeted HIV prevention programmes for key populations implemented in most countries do not provide necessary information on PPTCT. Existing efforts to offer PPTCT services to women among key populations in some countries have also remained inadequate and donor-driven, and thus unsustainable.

**(8)** The expansion of ANC-based screening, in particular by offering a package of tests, has contributed to the detection of more HIV-positive cases among women, with reduced fear of HIV-exclusive stigma.

- Two countries, China and Fiji, have stated that HIV testing, offered as part of a package of antenatal screening that includes syphilis and HBV, is cost-saving, normalizes HIV testing and strengthens an integrated MCH approach.
- Pakistan focuses on high-risk men and their families, and high-risk women with HIV testing and linkages to care.
- Countries have concluded that a strategic expansion of antenatal HIV testing with initial geographic prioritization based on HIV burden and readiness of MCH services ultimately aiming at universal HIV testing would be feasible. There is a general recognition that risk-based screening is not useful.
- Considerations should also be given to the use of a single test kit for diagnosing both HIV and syphilis. India holds that the availability of a single test kit can be highly beneficial, and will contribute to the operationalization of the EPTCT of HIV and syphilis.

**(9)** Within ANC settings, the poor disclosure of HIV test results, a low level of male partners' engagement and couples testing and counselling, as well as the overall stretched capacity of MNCH programmes still pose many challenges on prevention between sero-discordant couples.

- Couples testing and counselling, offering counselling to couples to test together and learn their status together or recommending testing for the partner of the HIV-positive pregnant women is, the meeting noted, now a national policy in nine countries.

**(10)** Data management is vital to improving PPTCT cascade management at every stage. Countries are investing in data management and some have begun the early adoption of robust, innovative information technology. All of this is in recognition that improved data contributes to strengthening operational linkages, referral management, follow-up and monitoring of results as countries move towards the elimination goal. There is also a need to improve capacity on data analysis and data utilization for decision-making in programme management, rapid adjustments and resolving operational bottlenecks.

- (11)** Countries increasingly recognize the usefulness of the costing tool developed by the PPTCT Task Force to cost the national response to eliminating new paediatric HIV cases and congenital syphilis. Lao PDR reported that it has helped in building consensus on the need for a national testing strategy for PPTCT, a phased scale-up of PPTCT and a stronger case for resource mobilization informed by a costed PPTCT plan. Use of this tool can help budget the response, examine operational linkages, pool resources, forecast, procure and supply ARVs and above all, make the political and business case for investment in PPTCT.
- (12)** The meeting notes that countries' political commitment towards the elimination of paediatric HIV and congenital syphilis has generated increased investment in the national PPTCT response.
- In China, Thailand, Malaysia and Fiji, national universal testing of HIV and syphilis is fully funded from the domestic budget. China and Fiji have also funded HBV screening from their domestic budget.
  - In most countries of the region, however, PPTCT interventions were primarily financed by development partners such as GFATM and in Viet Nam, by PEPFAR, raising concerns about future financial sustainability and domestic ownership.
  - Concerns were raised in regards to the sustainability of the PPTCT response, and challenges in ensuring increasing investments from domestic resources to replace decreasing external financial support.
- (13)** CSOs are stakeholders and continue to play a central and dynamic role in the HIV/AIDS response across all key areas of prevention, treatment, care and support. There has been significant input to the body of knowledge on HIV service delivery from civil society through studies carried out at community level.
- Findings from these studies will assist in redesigning approaches that will allow for increased coverage with improved quality of services.
  - CSOs have been critical in outreach efforts that have worked to simultaneously increase demand for HIV prevention services, influence political decisions through informed advocacy, and reach more people in need of services, particularly in underserved areas.
  - CSOs strive to increase their level of involvement in the areas of policy formulation and service delivery, and are seeking support for institutional strengthening so that their contributions can become increasingly effective and sustainable.
- (14)** Global processes and criteria for the validation of elimination of PTCT of HIV and syphilis have been established, and there is now a need to establish a regional structure for external validation. In order to measure validation targets, countries expressed the need for technical support especially in the area of strengthening surveillance and monitoring systems.
- (15)** The Asia-Pacific PPTCT Task Force has continued to serve a useful role in galvanizing actions and commitment to the goal of eliminating new paediatric HIV, congenital syphilis and HBV infections. The Task Force has played a critical role in facilitating thinking and consensus on the development of an effective regional response to HIV, HBV and syphilis in women, their partners and children. While its linkage to global-level developments is important, the Task Force will continue to focus on unique regional needs, and will expand focus on the dual elimination of paediatric HIV and congenital syphilis.

## Recommendations

The 9<sup>th</sup> Asia-Pacific PPTCT Task Force Meeting has recognized that a number of areas identified in the 8<sup>th</sup> Meeting in Lao PDR in 2010 still require further strengthening. The earlier recommendations made remain valid, especially in maintaining political commitment, leadership, financial investment and partnership.

Based on the conclusions, the 9<sup>th</sup> Meeting recommends that countries undertake the following:

- (1)** Galvanize more urgently than ever high-level political support and leverage domestic investment in PPTCT of paediatric HIV and congenital syphilis towards 2015 and beyond in the face of an overall decline in external funding for HIV and AIDS.
- (2)** Make the business case for greater investment in eliminating new paediatric HIV and congenital syphilis cases by tapping into technical expertise in health economics, in collaboration with public health and MNCH experts. This will further enhance political and programmatic recognition of the cost-benefits of PPTCT of HIV and congenital syphilis. The fact that one third of infants do not survive beyond their first birthday, and more than half die before they reach 2 years of age without ART intervention, make PPTCT a compelling investment. In addition, countries could consider undertaking:
  - Cost-benefit analysis of the current service delivery system versus an integrated services approach at the country level to inform decisions about the service delivery model that would best fit country needs.
  - Country-specific analysis of current and future resource needs to reach the elimination goal, with suggested options (increase of domestic budget, re-programming of Global Fund grants and/or new submissions) and plans for ensuring the sustainability of the HIV response should be developed.
  - Organizing country-based dialogues with key partners, including the Ministries of Finance, Planning and Development, as reported by Malaysia, with communities and development partners to ensure political commitment and scale-up of domestic financial contributions towards the agreed goal.
- (3)** Consider the transition to the universal testing of pregnant women for the long-term elimination of HIV, HBV and syphilis in children:
  - The region should strive towards the strategic expansion of antenatal testing with initial geographic prioritization – based on HIV and syphilis burden and readiness of MCH services – ultimately aiming at universal testing in ANC.
  - Concurrent efforts to strengthen HIV testing at labour and delivery for pregnant women who do not attend ANC.
  - Risk assessment to selectively test pregnant women is widely recognized as ineffective. Provision of HTC as part of an ANC package (ideally combined with syphilis and/or HBV testing) and their normalization and regularization help reduce associated stigma and discrimination.
  - Strategic approaches that actively recommend HIV testing for families of key populations (such as partners of PWID, sex workers or spouses of men who have sex with men) and refer high-risk and vulnerable pregnant women to ANC will help detect HIV-positive pregnant women in need of interventions.
  - Countries should further expand couples testing and counselling for couples to test and learn their results together. If partners of HIV-positive pregnant women are offered HIV testing, healthcare worker-guided support for mutual disclosure should be offered. Innovative solutions to encourage male participation in testing should be explored. ART should be offered to the positive partner (whether male or female) in a sero-discordant relationship.
  - Demand for HIV testing and counselling services for ANC attendees should be created and strengthened using innovative approaches, including community-based POC testing.

- (4)** Sustain and strengthen the current commitment towards linkages and integration between HIV/STI and maternal, child and reproductive health programmes and the Expanded Programme on Immunization at all levels, from policy to management to service delivery:
- Strong linkages/collaboration between MCH, reproductive health, STI and HIV programmes from national policy level to service delivery level are crucial. The challenges for effective linkages in each county need to be analysed with greater intensity and rigour. This will help identify remedial measures and the benefits to, and increasing the commitment of, the maternal, child and reproductive sectors.
  - Cross-programme collaboration could include jointly working on development of work plans and monitoring/programme review between MCH and HIV, as well as paediatric, reproductive health and other related programmes.
  - Engagement of communities could be strengthened through task shifting, decentralization of testing, counselling, case management, and outreach services. Midwives, for instance, can provide testing/birth doses of vaccines in communities where there is a high rate of home delivery.
- (5)** Institute appropriate monitoring to report on scale-up and early experiences on acceptability, adherence, retention and integration both within ART programmes and MCH, paediatric, reproductive health and STI programmes. In view of the rapid adoption in the region of Option B and B+ for HIV-positive pregnant women as recommended in the new 2013 WHO ARV guidelines.
- (6)** Support the adoption of paediatric treatment guidelines and treatment programme expansion. The meeting noted that national consultations and paediatric treatment guidelines review processes are being planned in many countries of the region. It endorses these efforts and encourages focused attention to address bottlenecks in children's treatment access, including EID, late turnaround of test results, loss to follow-up and procurement and provision of appropriate medicines. The meeting also recommends the development of global guidelines on diagnosis and management of syphilis, including the management of penicillin allergies and the diagnosis and management of congenital syphilis, as well as training.
- (7)** Promote increased involvement of CSOs In order to promote a client-centred, demand-driven and quality-based response. Involvement of CSOs must be meaningful and encouraged at all levels, including policy formulation, programme design, service delivery and monitoring to ensure accountability.
- (8)** Develop and support key linkages between PPTCT and other programmes that focus on HIV prevention, treatment and care for populations at high risk of HIV exposure, including adolescents and migrants. Ensure that ANC, labour, delivery, and postpartum services (including access to ARV drugs both for the mother's health and to prevent transmission to their baby during pregnancy, delivery and breastfeeding) provide a user-friendly environment for women living with HIV among key populations at high risk of HIV exposure. These include PWID, people engaging in transactional sex, spouses of men at high risk for HIV exposure, migrant women and adolescents who are living with or at high risk for HIV.

**(9)** The meeting recommends that the Asia-Pacific PPTCT Task Force should:

- Promote and facilitate South-South knowledge and experience sharing, information exchange and technical assistance.
- Document positive experiences and lessons learned in implementing new PPTCT programme Options, in particular Option B+, including the role of MNCH in ART of HIV-positive mothers, treatment adherence, and long-term retention in care.
- Establish and run a bi-regional validation committee for elimination of PTCT of HIV, HBV and syphilis as one of its core tasks.
- Facilitate stronger participation of members of civil society in future task force meetings to cultivate healthy debate on critical issues of access and programme quality, in recognition that CSOs and key populations are vital to PPTCT success, and that they play a crucial role in the elimination of paediatric HIV and congenital syphilis.

## Annex 3. Asia Pacific regional validation mechanism for elimination of parent-to-child transmission of HIV and syphilis

### 1. Background

Elimination of parent-to-child transmission (EPTCT) of HIV and syphilis contributes to better maternal and child health. It is estimated that there are approximately 72,000 pregnant women living with HIV in Asia and the Pacific region in 2014, of those 38 per cent received antiretroviral drugs (ARVs) to prevent parent-to-child transmission of HIV.<sup>15</sup> It is also estimated that the Asia Pacific region has high burden of congenital syphilis with more than 200,000 adverse outcomes associated to syphilis in pregnancy.<sup>16</sup>

The Asia Pacific United Nations Prevention of Parent-to-Child Transmission (PPTCT) Task Force was established in 1998. The members of the Task Force include the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), and the Joint United Nations Programme on HIV/AIDS (UNAIDS), Member States, and technical partners. In 2010, the Task Force developed the conceptual framework for EPTCT of HIV and syphilis in the Asia Pacific by 2015.<sup>17</sup> The regional goal of EPTCT of HIV and syphilis was endorsed at the 8<sup>th</sup> PPTCT Task Force Meeting held in November 2010 at Vientiane, the Lao People's Democratic Republic.

There is a commitment for the elimination of mother-to-child transmission of HIV and syphilis, globally and regionally. An initiative for the global elimination of congenital syphilis which was launched in 2007 by WHO<sup>18</sup> and the global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive was launched by UNAIDS and the President's Emergency Plan for AIDS Relief (PEPFAR) in June 2011.<sup>19</sup>

As Member States progress towards EPTCT, there is a need to establish a mechanism to validate elimination. WHO in collaboration with UNICEF, UNFPA, and UNAIDS developed a Global guidance on criteria and processes for validation: elimination of mother-to-child transmission (EMTCT) of HIV and syphilis.<sup>20</sup> This guidance outlines minimum processes and criteria for validation in a country; provides a description of global EPTCT validation targets and indicators; explains the operation of validation committees and secretariats; and reviews the validation procedure.

### 2. Regional mechanism of validation in Asia and the Pacific

The regional validation mechanism will be operated through the Regional Validation Secretariat (see Figure 1). Below is a brief description of roles and structures of the mechanism. A detailed description of criteria for validation will be found in Global guidance on criteria and processes for validation.<sup>6</sup>

- **Regional Validation Secretariat**

The Regional Validation Secretariat (RVS) coordinates and supports the regional validation process. The RVS is provided by the WHO regional offices for South-East Asia and the Western Pacific and its functions will be performed in partnership with UNICEF and UNAIDS. The RVS establishes and convenes the regional validation team (RVT). The RVS will develop, maintain and regularly update a roster of independent experts, which will be used to identify RVT members.

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<sup>15</sup> UNAIDS 2015. How AIDS changed everything - MDG6: 15 years, 15 lessons of hope from the AIDS response [http://www.unaids.org/en/resources/documents/2015/MDG6\\_15years-15lessonsfromtheAIDSresponse](http://www.unaids.org/en/resources/documents/2015/MDG6_15years-15lessonsfromtheAIDSresponse)

<sup>16</sup> Newman L, Kamb M, Hawkes S, Gomez G, et al. Global Estimates of Syphilis in Pregnancy and Associated Adverse Outcomes: Analysis of Multinational Antenatal Surveillance Data. *PLoS Med* 10(2): e1001396. doi:10.1371/journal.pmed.1001396, 2013.

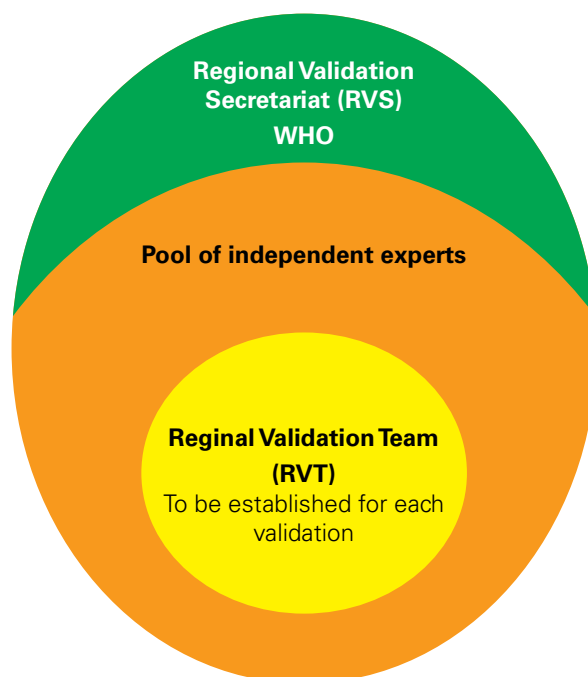
<sup>17</sup> [http://www.unicef.org/eapro/PPTCT\\_CF\\_and\\_ME\\_guide\\_17Aug11.pdf](http://www.unicef.org/eapro/PPTCT_CF_and_ME_guide_17Aug11.pdf)

<sup>18</sup> WHO 2007. Global elimination of congenital syphilis: rationale and strategy for action.

<sup>19</sup> UNAIDS 2011. Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.

<sup>20</sup> WHO 2014. Global Guidance on Criteria and Processes for Validation: Elimination of Mother-to-Child Transmission of HIV and Syphilis <http://www.who.int/reproductivehealth/publications/rtis/9789241505888/en/>

**Figure 1: Regional mechanisms of validation in Asia-Pacific**



- **Regional Validation Team**

A RVT will be formed each time a country submits a validation request. The RVT advises the RVS on whether candidate countries' achievements in the EPTCT of HIV and syphilis can be recommended for global validation.

A RVT will review the national validation report; conduct in-country validation visits with the National Validation Team (NVT) and the National Validation Committee (NVC); and prepare a regional validation report.

**1) Functions:**

- 1.1. Review national validation reports.
- 1.2. Conduct in-country validation mission and determine national compliance with global criteria for validation in consultation with the NVC.
- 1.3. Prepare a regional validation report that will advise RVS whether the country meets the global criteria for validation and submit to the RVS.
- 1.4. Ensure that the regional report includes clear explanations and suggestions for the areas requiring improvement if a candidate country does not meet the validation criteria.
- 1.5. Advise RVS to improve validation tools.

## 2) Members of RVT:

- 2.1. Independent experts with following expertise shall be nominated through the RVS after consultation with countries and stakeholders to create a roster of experts:
  - Epidemiologists and/or statisticians;
  - Public health practitioners including national managers and programme officers for maternal and child health, HIV and sexually transmitted infections (STI);
  - Laboratory scientists;
  - Representative of civil society and non-governmental organizations including and women, and men living with HIV, and community members;
  - Experts on HIV and other STIs; and
  - Human rights expert.
- 2.2. Members of a RVT shall be appointed by the RVS for each country validation.
- 2.3. A team consists of six or seven independent experts. The team's activities are supported by the RVS and regional partners.
- 2.4. Optimum diversification in terms of professional background, gender, geographical representation, international standing and affiliations will be considered.
- 2.5. A team leader will be appointed by the RVS, who will lead and coordinate the RVT.
- 2.6. Each member will be asked to sign a confidentiality and conflict of interest statement. The members should not have any salary, bonuses or other compensatory elements tied to their membership or actions.

## 3) Frequency and cost of activities:

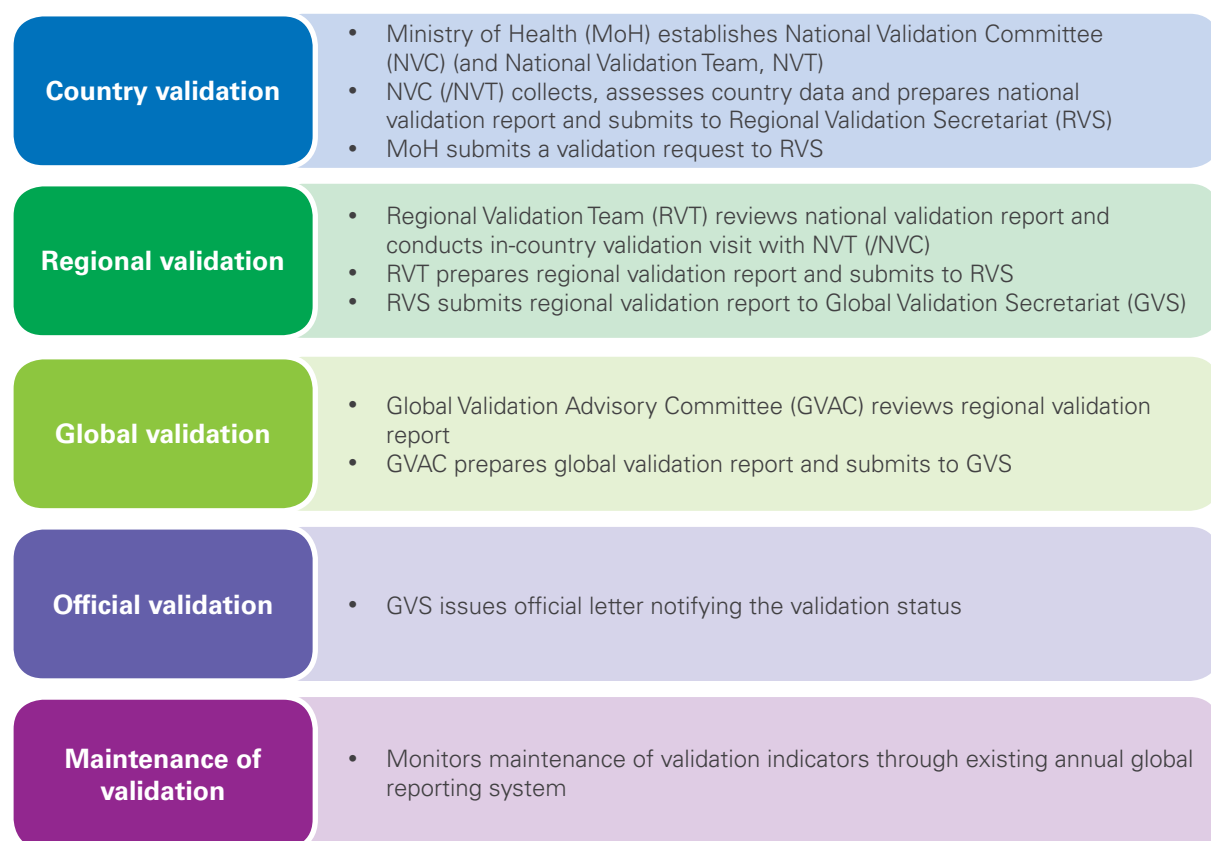
- 3.1. The frequency of activities will depend on the progress made by countries and the number and timing of validation requests submitted by countries.
- 3.2. WHO, UNICEF, UNAIDS, and the other partners will mobilize resources to support operational costs for the validation, including travel costs of the RVT members.

### • National Validation Committee and Team

Countries preparing for validation will establish a National Validation Committee (NVC). The NVC is responsible for the national validation process. The NVC is convened, chaired and led by the Ministry of Health. The NVC gathers evidence and prepares the national validation report; coordinates internal validation processes; and ensures strong communication with the Ministry of Health and stakeholders. The NVC may convene a national validation team (NVT as a subset of the NVC membership to perform its tasks.



### 3. Process of validation



A more detailed description of each step is available in *Global guidance on criteria and processes for validation: elimination of mother-to-child transmission (EMTCT) of HIV and syphilis*.

## Annex 4. Group discussions

### Group A: PPTCT cascade: the 90-90-90 and 95-95-95 programme and operational opportunities and challenges

Countries have made significant progress, with most having implemented the national scale-up of routine HIV testing as part of the ANC package. Many countries have also added syphilis and HBV testing to the ANC package. There was significant variability across countries in the measurement of this indicator, with some using all estimated pregnancies, or those registered in ANC. In general, countries had no specific approaches for high-risk pregnant women with the exception of Pakistan and Bangladesh.

There was variability in the integration of HIV testing into the MNCH platform. Some countries were still delivering services as part of a vertical HIV programme. In some countries, HIV testing required specific consent, presenting challenges to full national scale-up. Lengthy pre-test counselling fuelled delays. In most countries ART was delivered as part of the vertical programme, with patients being referred to specific sites. Due to low HIV prevalence in the region, the need to integrate treatment into MCH platforms was not seen as cost-effective. Option B+ rollout coverage in most countries has been recent while reported coverage of ART was high. However, some countries did not provide ART during labour (first dose) or at the delivery health facility. In most countries ART retention mechanisms for pregnant women after pregnancy were not clearly defined and there was no system in place for tracking and data collection.

EID is highly centralized, with two countries still sending specimens abroad for diagnosis. Turnaround time was still a challenge in most settings and viral load testing was not available in 20 per cent of the countries. In others, use of viral load was variable; some countries only used it to diagnose treatment failure, others only for treatment monitoring, and very few offered viral load testing pre-delivery and at baseline. There was a strong commitment to annual viral load testing and many countries include it in their national guidelines, but resources and implementation/logistical challenges persisted.

### Recommendations

- Testing must become routine and implemented through the MCH platform (including procurement, training etc.) if elimination goals are to be met.
- Countries should develop specific strategies to deal with late presenters and ensure earlier ANC. This requires strong leadership by the MCH programme. Specific attention for migrants and other ethnic minorities or other under-served groups is needed.
- For elimination purposes, countries need to use the testing denominator as 'all estimated pregnancies'.
- As syphilis testing is lagging behind that for HIV, countries should explore the use of dual testing to facilitate an integrated approach.
- Countries should consider specific adherence support during and after the end of pregnancy, including monitoring retention in Option B+. In order to achieve 90 per cent treatment coverage and earlier treatment, countries need to focus on earlier testing and diagnosis strategies.
- Viral load testing for pregnant women should be integrated in the overall implementation of WHO guidelines for ART monitoring. Countries should utilise the opportunities provided by new POC technologies (2016) and GeneXpert wherever possible.
- EID services need to be urgently strengthened in order to measure the impact of the PPTCT programme and 'fast track' paediatric treatment.

## **Group B: HIV and Syphilis Testing in ANC in low and concentrated epidemics**

### **Summary of discussion**

- 17 out of 19 countries included HIV and syphilis testing in their routine ANC package but they are at various levels of implementation.
- 7 out of 19 countries included HBV testing in the current ANC package, with the remaining countries planning to include HBV screening.
- With regards to cost, most countries offered testing free of charge; one country provided free HIV screening while charging for the other tests if conducted on an out-patient basis. If done in-patient, all tests were free.
- All countries encouraged notification and testing of partners of ANC attendees found positive for HIV and STIs; usually part of the HIV testing policy.
- Nepal and Thailand were the only countries to conduct retesting of HIV prior to initiation of ART.
- Nepal was the only country to complete a pilot study testing the dual HIV and syphilis test kit in a scale-up phase with government approval.
- 15 out of 19 countries had plans to use HIV and syphilis test kits following government approval and revision/updating of national policy.
- Most countries conducted symptomatic tuberculosis screening for ANC attendees with HIV.

### **Recommendations**

Support scale up of integration of HIV, syphilis and HBV testing in ANC through:

- Conducting of cost-effectiveness analysis.
- Advocating for establishment of coordination mechanism at the country/subnational level.
- Reviewing of programmes; preparation for validation of ePTCT for countries that are ready.
- Advocacy for inclusion in national health insurance package and government recurrent funds to ensure access and scale up of services to reach key populations and other vulnerable populations.
- Start country processes to introduce dual rapid test for HIV and syphilis.
- Encourage partner notification and testing on an ongoing basis.
- Retesting of those who are HIV-positive prior to initiation of ART, taking into consideration the HIV testing algorithm at the country level.

## **Group C: Practical suggestions to address late presentation in pregnancy and male partner involvement**

Reasons pregnant women skipped ANC or presented late:

- Migrants or highly mobile populations.
- Key affected populations including female drug users, female sex workers.
- Partners of high-risk males/HIV-positive males.
- Conflict/insurgent areas.
- Ethnic minorities.
- Socially disadvantaged women.
- Multi-parity.
- Geographically remote and/or women not living close to services.
- Adolescent pregnant women.
- Unemployed/poor.
- Unaware of services.
- Unwanted pregnancies/stigmatized pregnancy.
- Private sector health service users.

Suggestions for approaches to improved tracking:

- Mobile phone reminders.
- ICT approaches, such as using applications like V-chat, Viber, WhatsApp, etc.
- Home and community-based HCT for spouses of key affected populations.
- Use of labour register.
- PPTCT case manager follow-up.
- Couples counselling.
- Community involvement in tracking.
- Linkage of midwives at township level with PPTCT sites.
- Decentralize services will make it easier to track.
- Link to and utilize PLHIV networks for tracking.
- Contact tracing.

Channels to track mother-baby pairs:

- Record as pair (mother and baby) in PPTCT register.
- EID at Expanded Programme on Immunization first visit.
- EID monitoring conducted by HIV/STI teams.
- Follow-up at district level until infant diagnosis established then referred to MNCH clinics.
- Have case management system which tracks mother-baby pair (Philippines started this month).
- Follow up through home visits.
- Use mother-infant follow-up tool.
- Refer from maternity before mother discharge to paediatric AIDS care for EID.

Strengthening capacity of healthcare providers:

- Improve through technical and financial support to community-based organizations (CBOs).
- NSP incorporates HIV training for MCH for CBO/CSO.
- Postpartum network that is run by civil society.
- PLHIV network follows up those lost to follow-up, however this is project-based and not institutionalized and nationwide.
- Capacity strengthening through continuum of care framework for case managers, community support groups and health worker cadres.
- Using and scaling up active case management.

Identifying high-risk pregnant women:

- Use peer educators to identify during outreach.
- Public health clinic registers that record high-risk behaviours and pregnancy.
- Through high-risk male partners – male tested first and then female partner.
- Take complete history including that of male partner and then perform a risk assessment.
- Using community health systems that are linked to health services systems (Maldives).
- Referrals from other non-health systems – police, social services, etc.
- Harmonization of PPTCT and ANC registers.
- Home and CBO-based HCT for spouses of key affected populations.
- Algorithm exists for identifying and tracking high-risk women in MCH minimum package of services.

Suggested steps to identify and track late presenters:

- Internet-based mother tracking systems using an electronic recording system.
- Offer triple testing: HIV, syphilis, HBV.
- Train healthcare workers to promote attendance at ANC.
- Launch safe motherhood initiative.
- Target younger populations, single mothers and adolescents.
- Capacity strengthening for primary healthcare workers to identify and track late attendees and motivate them to stay in HIV care.
- Develop an operational plan for PPTCT.
- Develop a student health programme with HIV/syphilis PITC in universities for students who are at higher risk and not accessing services.
- Strengthen coordination at the township level with rural health centres.
- Strengthen the identification of high-risk HIV-positive pregnant women through strengthened skills of village health volunteers.
- Improve data collection for the private sector.

Suggestions to improve male partner involvement:

- For each HIV-positive pregnant woman, partner is encouraged to come in for testing.
- Training healthcare workers in couples counselling and awareness on the importance of partner involvement.
- Strengthen counselling for HIV-positive women to improve partner notification.
- Male partners of HIV-positive women are traced and tested, then linked to a continuum of care if they are found to be positive.
- Include male partner in counselling and male partner involvement in PPTCT.
- Referral of both HIV-positive woman and male partner for voluntary confidential counselling and testing.
- Encourage family testing.
- Incentive programme for male involvement.
- Provide partner friendly services – service site accommodates male partners.
- HTC policy has a partner notification policy within two weeks (Fiji).
- Address cultural barriers to males accompanying their partners to ANC (Fiji).
- Partner Notification Testing and Tracking in Cambodia in 15 operational districts, with an aim to scale up to all districts.
- Have counsellors for sero-discordant couples.
- Improve the quality of data recording for male partners.
- Awareness of partner testing services through community health networks and media.
- Social/community mobilization to encourage male participation in ANC/MCH.
- Hire male MCH counselling staff to engage male partners.
- Include peer counsellors to encourage male testing.

## **Group D: Validation of elimination**

Ensure *no country is left behind*...

Main themes:

- Variable situations reported in each country (prevalence).
- Every country was interested in the validation process.
- Validation was viewed as an opportunity to strengthen MCH services.
- Opportunity to integrate HIV, syphilis, and HBV screening into ANC services.

By 2020:

- 12 out of 19 countries committed to the validation process by 2020.
- Many countries committed to use the process to stimulate advocacy by putting goals in national strategic plans.
- Subnational validation processes were suggested as a starting point for national goal.
- Some countries requested technical support.
- Group participants reiterated the importance of promoting South-South collaboration.

Regional support is required to:

- Provide practical clarity for assessment.
- Country dialogue.
- Regional mechanism to continuously support every country.

**Table 4: Elimination targets by country**

Country	EPTCT of HIV (target, year)	EPTCT of syphilis (target, year)	What are the next steps at this point to prepare and move forward towards validation? Please list:
<b>Afghanistan</b>	.....	.....	
<b>Bangladesh</b>			Political commitment to add HIV, syphilis, HepB, to the national strategic plan
<b>Bhutan</b>			Add goal to the national strategic plan for 2016
<b>Cambodia</b>	2020	2020	Strategic plan, create sub-committee, scale up testing
<b>China</b>	2020	2020	National committee, collect data, announce elimination plan in 2017
<b>Fiji</b>	2020	2020	Add HepB to ANC package of services
<b>India</b>	2020	2020	For subnational validation, efforts to expand screening to all 22 million pregnant women
<b>Indonesia</b>	2020	2020	Integration between HIV and MCH is critical to process
<b>Lao PDR</b>	2020	2020	Push implementation of universal testing and expanded pre-natal care. Raise the priority of MCH within government and donor planning
<b>Malaysia</b>	2018	2018	High level political commitment
<b>Maldives</b>			Develop strategy and evaluate current systems
<b>Mongolia</b>	2020	2020	Development of a strategic plan to include syphilis and HIV testing in ANC
<b>Myanmar</b>	2020	2020	Pre-assessment in 2016 and scale up screening
<b>Nepal</b>			Include in new National Strategic Plan
<b>Pakistan</b>			Opportunity to add HIV and HepB to routine testing, build infrastructure to provide universal testing and include in national policy
<b>Philippines</b>			Plan to have administrative order by 2016
<b>Papua New Guinea</b>			In next 5 years build infrastructure to expand testing
<b>Sri Lanka</b>	2017	2017	Programme strengthening to improve services
<b>Thailand</b>	2015	2015	
<b>Viet Nam</b>	2020	2020	Pre-assessment at country level

## Group E: China discussion

Four topics were discussed:

1. PPTCT Cascade: the 90-90-90 and 95-95-95 targets
2. HIV testing and counselling in ANC
3. Late presentation in ANC
4. Validation of elimination

### PPTCT cascade: the 90-90-90 and 95-95-95 targets

In 2014, HIV testing coverage among pregnant women who attended ANC was 98 per cent and the syphilis testing rate 99 per cent. As of 2015, free HIV, syphilis, and HBV testing was available throughout the country. Free testing was already fully covered in high burden HIV areas before 2015. Other relatively low prevalence areas were included in 2015.

In 2014, ARV prophylaxis coverage of pregnant women was 83 per cent, and the proportion of pregnant women with syphilis who received treatment was 68 per cent (it was above 80 per cent in some provinces). There was variation among provinces.

In China, the follow up of mother-infant pairs was conducted through the MCH platform to provide a series of services, including ART and the monitoring of viral load and CD4 count, etc. In MCH hospitals, healthcare workers were assigned to be responsible for the management of mother-infant pairs. This model has been effective in terms of reducing loss to follow-up, maintaining confidence and increasing adherence.

**Gaps:**

In China, ART coverage for both HIV-positive and syphilis-positive pregnant women was relatively low. The main reasons for this included: late presentation of HIV-positive women at ANC, who thus missed the chance to receive treatment, and in some areas, a lack of access to treatment (e.g. treatment for syphilis) and a lack of capacity to provide services. There were different HIV and syphilis epidemics in different areas, and an uneven distribution of resources, such as laboratories offering viral load testing.

**Next steps:**

- Strengthen capacity building at grass roots level
- Communication and information exchange between MCH and CDC, and within the MCH system

**HIV testing and counselling in ANC**

- Promote universal testing
  - Increasing diagnosis of HIV-positive cases
- Integrated testing in the ANC package
  - Standard content of ANC services
  - Provided at first ANC visit
  - HIV, syphilis and HBV should be tested at the same time
- Services provided free of charge for pregnant women

**Gaps:**

- Although the testing rate was high, the proportion of pregnant women tested during the 1st and 2nd trimester was relatively low in some areas
  - Newly expanded area
  - Poor, remote, and minority group area
  - ANC coverage, MCH network
  - Areas with more migrant populations
  - Border areas
- Barriers for implementing free testing
  - Lack of motivation at some general hospitals due to limited subsidies
- Key populations access to services
  - HIV-positive pregnant women hesitated or avoided testing
  - Migrant pregnant women struggle to access ANC services
  - Cross border women also struggle to access ANC

**Next steps:**

Decentralize testing services to make testing services available at the township level. Strengthen ANC services and the management of pregnant women using maternal and children booklet.

**Late presentation in ANC**

Services for children born to HIV-positive mother within the MCH system

- At birth
  - ARVs as early as possible (6-12 hours)
- 6 weeks
  - First EID
- 3 months
  - Second EID, HIV-positive infant referred to ARV centres
- 6, 9, 12, 18 months
  - Follow-up
- ARV prophylaxis for children born to HIV-positive pregnant women
 

- Institutional delivery rate	91.7 per cent
- National Essential Public Health Programme	99 per cent
- The rate of EID testing at 2 months	56 per cent
- EID laboratory network within the MCH system	
- Male partner testing
  - Inform and suggest to test, or refer to CDC for free testing
  - Free testing available in MCH hospital

**Next steps:**

- Continue to provide services for infant follow-up based on MCH platform
- Health education to encourage male partner testing

**Validation of elimination**

- China set the goal in the 2015 technical guidelines by 2020:
  - Reduce MTCT rate to under 5 per cent
  - Reported congenital syphilis incidence under 15/100,000 live births
- Government commitment has been achieved
- China situation:
  - Large population and area
  - Regional disparity
  - Different epidemics: low, high prevalence
  - Different progress of PMTCT programme
- Preparation:
  - Adopt international validation guideline
  - Develop China guideline and plan
- Initiate a pre-elimination evaluation study
- Start from several provinces as pilot:
  - Go through the validation process
  - Analysis of weak points that need to be strengthened
  - Prepare for validation
- Experience from pilot studies should be used to advocate for other provinces to use the evaluation tool for self-evaluation



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