

Report

Towards eliminating new HIV infections in children and congenital syphilis in Asia-Pacific

The 8th Meeting of the Asia-Pacific UN Task Force for the Prevention of Parents-to-Child Transmission of HIV



World Health Organization

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The 8th Meeting of the Asia-Pacific United Nations Task Force for the Prevention of
Parents-to-Child Transmission of HIV

The proceedings of the meeting were recorded by Robert Horn

Cover photograph: A newborn grasps his mother's hand in the maternity ward of the
Charoenkrung Pracharak Hospital in Bangkok, Thailand: Roger LeMoyne/UNICEF
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Acronyms

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
APN	Asia-Pacific Network of People Living with HIV/AIDS
ART	antiretroviral therapy
ARV	antiretroviral
BCC	behaviour change communication
CDC	Center for Disease Control
CS	congenital syphilis
CSO	civil society organization
EAPRO	East Asia and Pacific Regional Office
ECS	elimination of congenital syphilis
EID	early infant diagnosis
GF	Global Fund
FCH	Family and Community Health
FHI	Family Health International
GSM	Global System for Mobile Communications
HAART	highly active antiretroviral therapy
HIV	human immunodeficiency virus
HMIS	Health Management Information System
IATT	Inter-Agency Task Team
ICT	information and communication technology
IDU	injecting drug user
IPPT	International Planned Parenthood Federation
KAP	key affected population
LHW	lay health workers
MARP	most-at-risk population
MBB	Marginal Budgeting for Bottlenecks
MCH	maternal and child health
MDG	Millennium Development Goal
MNCH	maternal, neonatal and child health
MPS	Making Pregnancy Safer
M & E	monitoring and evaluation
MSM	men who have sex with men
NCGM	National Center for Global Health and Medicine
OI	opportunistic infection
OPC	Outpatient Centre
PCR	polymerase chain reaction
PEP	post-exposure prophylaxis
PHIMS	Perinatal HIV Intervention Monitoring System
PHOMS	Perinatal HIV Outcome Monitoring System
PLHA	people living with HIV and AIDS
PLHIV	people living with HIV

PMTCT	prevention of mother-to-child transmission
PNC	postnatal care
PPTCT	prevention of parents-to-child transmission
PTCT	parents-to-child transmission
RH	reproductive health
ROSA	Regional Office for South Asia
RSTAP	Regional Support Team for Asia and the Pacific
SEARO	South East Asia Regional Office
SOP	standard operating procedure
SRH	sexual reproductive health
STI	sexually transmitted infection
TF	Task Force
ToR	Terms of Reference
UA	universal access
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VCT	voluntary counselling and testing
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organization
WLHIV	women living with HIV

Executive Summary

The HIV epidemic in Asia-Pacific is growing rapidly, although most countries have low HIV prevalence while some have concentrated epidemics. AIDS is increasingly feminized through intimate partners' transmission with gradual increase of new HIV infections among low-risk women and consequent mother-to-child transmission. In 2008, an estimated 1.4 million women and 161,000 children aged 14 years and under were infected with HIV in the region. The estimated number of HIV-positive pregnant women was 85,000. New infections in children totalled 19,700, while 11,700 children died of causes related to AIDS.

Prevention of mother-to-child-transmission (PMTCT) coverage in the region has increased steadily, albeit slowly, from 9 per cent in 2004 to 32 per cent in 2009, with Thailand surpassing 90 per cent. For other countries, coverage ranges from 3 per cent in Nepal to 55 per cent in Myanmar. Region-wide, the impact of PMTCT services preventing children from acquiring HIV are not yet clearly determined (8th Asia-Pacific UN PPTCT Task Force Meeting Concept Note).

The region is confronted with a number of issues. Wide disparities exist between and within countries in terms of health systems development and access to health services. Health spending by many governments is relatively low. In many countries, health systems are still in a developing stage and do not cover large parts of the population. Antenatal coverage, an entry point for prevention of parents-to-child transmission (PPTCT) and congenital syphilis (CS) services, is also weak, with a minority of women accessing services at antenatal clinics. Linkages between HIV response systems and those working on maternal and child health (MCH) are tenuous. Stigma and discrimination remain strong and persistent barriers, even among health care workers. Marginalized groups, those most at risk for HIV, are still difficult to reach. Data are scarce, poorly analysed and often unused to inform programming or increase advocacy. Furthermore, global funding for the HIV response is diminishing.

Several regional initiatives have been made to address these issues, including a recent focus on eliminating new HIV infections in children and congenital syphilis. On 25 November 2010, UNICEF, WHO, UNAIDS and UNFPA, with support from over 150 delegates from 20 countries across Asia-Pacific, adopted the historic goal of eliminating all new paediatric HIV and CS infections in the region by 2015. The declaration of elimination as an aim by the Asia-Pacific UN PPTCT Task Force represents a paradigm shift in the response to HIV & AIDS and CS. Previously, agencies and health care providers had been working to prevent as many new infections as possible, with growing success but still with enormous gaps to be filled.

The elimination goal is ambitious. However, it has the potential to contribute to improved health care for all women and children and to achieving Millennium Development Goals MDGs 1 (eradicate extreme poverty and hunger), 4 (reduce child mortality), 5 (improve maternal health) and 6 (combat HIV and AIDS, malaria and other diseases). The chief question raised was whether or not elimination is achievable.

The challenges to the elimination agenda are formidable. Medically, it is possible to achieve it. New WHO guidelines on ART therapy for adults and adolescents, ARV prophylaxis for pregnant women, breastfeeding and paediatric treatment have reduced the rates of transmission and new infections in children to near zero for those who are tested and treated in time. Treatments for CS also have kept pace and the condition is preventable. Medical possibilities must be weighed, however, against the context of realities on the ground.

Based on WHO's new guidelines on treatment regimens, countries can choose between two varying options according to the complexity of the intervention and the ability of the health system to deliver either one. Many countries are phasing out single-dose nevirapine, one of the treatment options, and moving to more efficacious triple therapies. Breastfeeding policies are also left for countries to decide, depending upon local conditions. For instance, formula feeding could be a more risky option in settings where clean water and sanitation are not available.

Any push to achieve elimination would contribute to strengthening maternal and child health care, and sexual and reproductive health (SRH) services. Collaborations between these divisions of health care are taking place, and the goal of elimination could push these to a new and higher level. The view of the HIV community is that the HIV response should be an integral part of MCH services. Integration has the potential to mobilize more resources and increase overall investment in health.

Elimination would be difficult to achieve unless all four prongs of the PPTCT response are strengthened. The four prongs are:

Prong 1: Primary prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care, postpartum/natal care and other health and HIV service delivery points, including working with community structures

Prong 2: Providing appropriate counselling and support to women living with HIV to enable them make an informed decision about their future reproductive life, with special attention to preventing unintended pregnancies

Prong 3: For pregnant women living with HIV, ensuring HIV testing and access to the antiretroviral drugs that will help mothers' own health and prevent infection being passed on to their babies during pregnancy, delivery and breastfeeding

Prong 4: Better integration of HIV care, treatment and support for women found to be positive and their families

Community involvement is also a crucial component for success, as peer outreach is needed to reach marginalized groups who tend to shun interaction with government health services. Community involvement can also reduce the barriers of stigma and discrimination.

Because prevalence is lower than in sub-Saharan Africa, the Asia-Pacific region has an opportunity to be the first to achieve elimination. On the other hand, the sheer size of Asia-Pacific and its populations leads some to argue that scaling up to provide the near universal coverage needed to achieve elimination would be prohibitively expensive and logistically difficult. The better option, according to that argument, is to target groups engaged in high-risk behaviour.

At the 8th UN PPTCT Task Force meeting, however, evidence was presented to support scaling up to near universal coverage. Cost analyses conducted by the National Center for Global Health and Medicine (NCGM) in Japan concluded that taking programmes to scale by investing in providing near universal testing and treatment – even in low prevalence settings – is more cost effective in the long run than limited or targeted interventions. While elimination requires substantial upfront investment, the costs of paediatric treatment and care if elimination is not pursued are ultimately greater. This is a crucial point for advocacy with donors and with governments. Increasingly, governments will have to assume the role of funding the response.

Country experiences show that high levels of testing are possible. China achieved a rapid scale up of antenatal care HIV testing and syphilis screening in high-burden HIV provinces, and expanded its package of routine MCH services. Cambodia is bringing a linked response between HIV and SRH/MCH to national scale,

while Mongolia is pursuing a national scale up of syphilis screening and treatment through one-stop services. Cambodia and Mongolia are two of the most resource-constrained countries in the region. Malaysia and Thailand are investing to reduce PTCT to the lowest levels possible using a data-driven approach and high ANC coverage.

Costing analyses tools developed by UNICEF, such as the Marginal Budgeting for Bottlenecks tool, are useful in identifying health system bottlenecks that drain funds, and in increasing health system efficiencies. Operational research (OR) is also a growing component of the elimination response. Separate from traditional monitoring and evaluation (M & E), OR analyses barriers and inefficiencies in delivering services.

The meeting also provided an opportunity for participants to review and discuss the Terms of Reference (ToR) of the UN PPTCT Task Force, which is one of the longest functioning in UN history. Meeting participants decided that Task Force membership would remain open to all involved or interested in the response, while the secretariat would remain composed of the four convening UN agencies (UNICEF EAPRO and ROSA, WHO WPRO and SEARO, UNFPA and UNAIDS RSTAP). Clustering countries with similar epidemic profiles into working or information exchange groups was considered for the future.

The name of the Task Force was formally changed from Prevention of 'Mother-to-Child Transmission' to 'Parents-to-Child Transmission' to emphasize the responsibility of both parents in protecting their children from HIV infection.

The Task Force resolved to move the elimination agenda forward by advocating for high-level political support and appropriate allocation of resources within government frameworks, as well as rapidly finalizing the Conceptual Framework including feedback from the meeting. It is expected that countries will initiate a process of adapting the framework to their contexts.

Based on inputs from participants, the Task Force ToR was revised. The chief revision was to formulate one overarching goal with seven supporting objectives as follows:

Goal

The Task Force will serve as a regional technical forum in support of national actions to eliminate new HIV infections in children and CS, scale up HIV prevention among parents, enhance access to quality services for care, treatment and support of children and families living with HIV and contribute to the achievement of MDGs 4, 5 and 6 in Asia-Pacific.

Objectives

1. To advocate for and support mobilization of national leadership for the elimination of new infections in children and CS.
2. To provide technical guidance for the operationalization and adaptation of global policies and guidelines in low and concentrated epidemic settings that prevail in Asia-Pacific. The Task Force shall also serve as a platform that represents issues and situations specific to Asia-Pacific, including health systems strengthening and the elimination agenda, in the deliberation of global policy and guidelines.
3. To facilitate the development of a regional framework and country roadmaps and to monitor their implementation through UN co-sponsors and international partners' on-going country support. This includes development of targets and service models and the provision of technical assistance according to countries' epidemic status and needs.
4. To promote and support effective approaches to strengthen PPTCT, syphilis diagnostics and treatment and health systems strengthening, such as stronger operational linkages between MCH, paediatric, reproductive health and HIV/STI services.

5. To act as a knowledge resource by generating, documenting and disseminating knowledge on PPTCT, care and treatment of paediatric HIV, maternal HIV and syphilis. The mechanism of communication includes technical meetings and a knowledge management website that monitors elimination progress (in conjunction with the Asia-Pacific HIV & AIDS Data Hub – www.aidsdatahub.org).
5. To support operational research by fostering dialogues and networking with academic and research institutions.
6. To coordinate and liaise with regional UN agencies, national programmes, regional bodies and technical partners across countries in the Asia-Pacific region on major technical areas of interest and initiatives.

In conclusion, it was recognized that because of constraints on the ground in health systems development and other areas, elimination is to some degree an aspirational goal. Nonetheless, it was noted that other aspirational objectives of programmes such as the 3 x 5 campaign had been the basis for great progress and served to strengthen health systems. With advances already evident on the ground in many countries, and a paradigm shift in approach by those involved in the response, the meeting was capped by a spirit of optimism that pursuing the goal of elimination would have profoundly positive results.

Introduction

The 8th meeting of the Asia-Pacific UN Task Force for the Prevention of Parents-to-Child Transmission of HIV was held on 23-25 November 2010 in Vientiane, Lao PDR. It was followed by a meeting of Task Force secretariat members on 26 November 2010. The consultation was convened by United Nations Children's Fund East Asia and Pacific Regional Office (UNICEF EAPRO) and Regional Office for South Asia (ROSA), World Health Organization (WHO) Western Pacific Regional Office (WPRO) and South East Asia Regional Office (SEARO), the United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV and AIDS Regional Support Team for Asia and the Pacific (UNAIDS RSTAP).

A total of 150 delegates from 20 countries in Asia-Pacific, including those from international agencies, research institutes and civil society, were in attendance (see Annex C for the list of participants).

The meeting was historic in its adoption of the goal of eliminating PTCT and congenital syphilis (CS) in the region by 2015. Those involved in the response exchanged knowledge and experiences, and joined in group work to raise issues and propose solutions to potential barriers in achieving the goal of elimination.

Issues highlighted during the consultation included:

- Scaling up antenatal care, counselling and testing to near universal levels
- Implementing new treatment guidelines and regimens introduced by WHO
- Employing and improving data and operational research
- Costing tools for programme delivery and advocacy
- Increasing linkages with maternal and child health care divisions
- Determining the impact of the elimination agenda on the Millennium Development Goals
- Declining global funding for the HIV response

The meeting agreed on revising the ToR for the Task Force. The Task Force will remain an independent entity linked to the global UN Interagency Task Team with membership open to all involved or interested in the response. The Secretariat will remain composed of the core UN agency partners.

Adoption of the elimination agenda was met with enthusiasm tempered by recognition that the health system infrastructure in many countries was poorly developed and so a barrier to implementation. It was agreed, however, that pursuing the goal of elimination can have profoundly positive effects upon strengthening national health care systems, and members resolved to give their utmost to the effort.

Day One: 23 November, 2010

Welcome statement and opening remarks

“We must not forget that behind every statistic is a human face.” – Dr. Festo Kavishe

The 8th meeting of the Asia-Pacific UN Task Force for the Prevention of Parents-to-Child Transmission of HIV began with welcome statements and opening remarks from officials of the Lao People Democratic Republic (PDR)'s Ministry of Health and representatives of the UN agencies that comprise the core members of the Task Force: UNICEF EAPRO and ROSA, WHO WPRO and SEARO, UNFPA and UNAIDS RSTAP.

Master of Ceremonies **Dr. Bounpheng Philavong**, from the Lao PDR Ministry of Health expressed the gratitude of the Lao people to the UN for choosing Vientiane as the meeting venue, noting 2010 is Vientiane's 450th anniversary as capital of the country, and also the 50th anniversary of the founding of Lao PDR.

The significance of the 8th Task Force meeting was explained by **Dr. Hans Troedsson** of the WHO's Western Pacific Regional Office. This meeting stood apart from all preceding meetings because of the adoption of a new and historic goal: the elimination of parents-to-child transmission of HIV and CS by 2015. These goals represent a paradigm shift in strategy and approach. Previously, because many member countries have resource constraints, the aim was simply to share information in hopes of reducing rates of PTCT and CS. But advances in medical technologies and knowledge exchanges have now made the goal of elimination feasible. The campaign to eliminate PTCT and CS is also an opportunity to generate actions and investments to strengthen maternal, child and reproductive health systems, which have yet to receive the attention they deserve.

HIV is a communicable disease that puts couples and families at risk, said **Dr. Festo Kavishe**, the Deputy Regional Director of UNICEF East Asia and the Pacific Regional Office. The fact that infection rates have steadily risen among women who are not members of risk groups, indicates increased transmission from men with multiple sexual partners. This requires that attention also be focused on the father, not just the mother, and necessitates improved outreach to men. An equity-focused approach to HIV requires putting resources, energy and collective weight towards finding the children, women and men in the vulnerable populations who are currently lost to PPTCT, MCH and HIV services.

A public health perspective is necessary for effective HIV prevention, said **Mieko Yabuta** of the UNFPA. Many who are infected do not know their status. In many countries, basic antenatal services and skilled birth attendance are not at adequate levels. Providing services is a critical government role. But they must also ensure equity in access. The majority of infections are among men who have sex with men (MSM), injecting drug users (IDU), and sex workers and their clients. These groups are least likely to come for services. Many rural women have not received antenatal care and the number of skilled birth attendants is low. Partnerships between government, nongovernment organizations (NGOs) and civil society are critical to averting the epidemic.

In the face of declining budgets for HIV and AIDS, the HIV community must respond by adapting common mechanisms, such as the PPTCT Task Force, said **Dr. Bob Verbruggen**, the Regional Programme Advisor on Monitoring and Evaluation at UNAIDS-RSTAP. Evidence shows that elimination of PTCT is technically possible. Remarkable reductions have taken place in high-burden countries in Africa due to broader coverage. While coverage has increased in Asia-Pacific, the region is still lagging behind. The work is far from over. An estimated 25 million women in the region are pregnant and approximately 80,000 of them are HIV positive. Primary prevention will be the foundation for success. HIV has the power to rally governments and partners in the region to strengthen health systems and coverage. Pursuit of the goal of eliminating PTCT and CS is actually a 'Trojan Horse' for strengthening health care in the region.

Pursuing the goal of eliminating PTCT and CS will greatly contribute to Lao PDR's efforts to reduce maternal mortality and infant mortality, said **Dr. Bounphen Philavong** of the Ministry of Health. Although prevalence in Lao PDR is low, evidence is emerging of concentrated epidemics. Both parents must take responsibility for protecting their unborn children from HIV. There has been a lot of debate about how to increase male involvement in prevention, but few results. Too often the entire burden of HIV infection is borne solely by women. And too often, they face violence, stigma and discrimination. Action must not be delayed. Eventually resources will be depleted unless a greater and more effective effort is made on prevention.

Overview of meeting objectives and expected outcomes

Presented by Dr. Iyanthi Abeyewickreme, WHO Regional Advisor on HIV and AIDS for South-East Asia

Dr. Iyanthi presented the objectives and expected outcomes of the meeting and updated participants on progress in responding to PTCT and CS. The main objectives were:

- To advocate national leadership and commitment for the elimination of paediatric HIV and CS, and the improvement of maternal and child health and survival.
- To examine concepts of elimination including national baselines and targets.
- To discuss and identify processes and programmatic arrangement for the revised 2009 WHO guidelines: *Use of antiretroviral drugs for treating pregnant women and preventing HIV infection infants, antiretroviral therapy for HIV infection in adults and adolescents and in infants and children, and HIV and infant feeding.* This includes addressing effective linkages between HIV services and MCH, OI/ART, STI and SRH services, partners counselling and monitoring of PMTCT and CS outcomes and reporting.
- To examine opportunities and approaches for strengthening data management in MCH and health systems and, in coordination with communities, to improve PPTCT referral, outcomes monitoring and reporting, and the potential for innovative approaches through greater use of information technology.
- To review and endorse the PPTCT Task Force Terms of Reference.

Expected outcomes were:

- Consensus on advocacy and scale-up plan to eliminate parents-to-child transmission of HIV and CS, and enhanced awareness to access by women, including those most at risk and vulnerable, to PPTCT services.
- Enhanced clarity for the implementation of the new revised 2010 WHO technical recommendations (guidelines), programmatic implications and benefits to countries.
- Improved clarity on linkages, including data flow and data management, to enhance referral management and monitoring of PMTCT outcomes, as well as follow up and outcomes monitoring for congenital syphilis.
- Adoption of revised PPTCT Task Force Terms of Reference.

Dr. Iyanthi noted that countries will experience problems in implementing the new guidelines, and many are already having difficulties establishing baselines. Linkages are another area where countries, particularly in Southeast Asia, are grappling with turning the goal into reality.



Session 1

Progress towards elimination of paediatric HIV and plans for eliminating congenital syphilis

Presentation

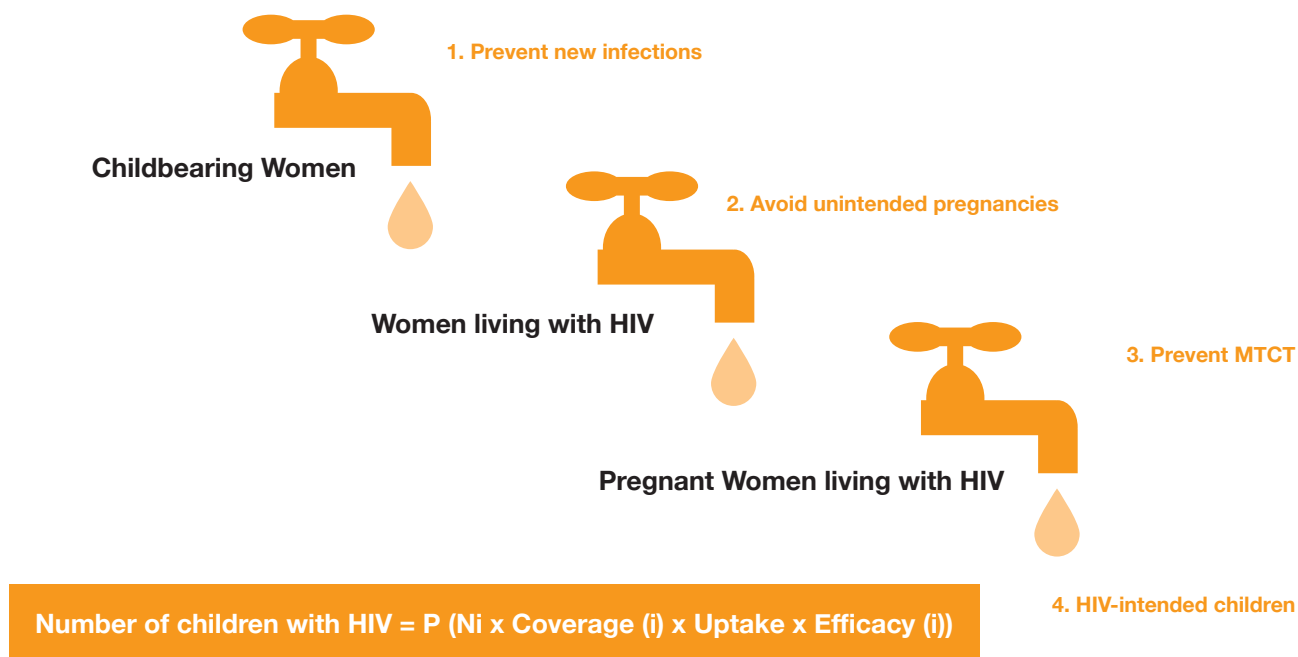
Elimination of parents-to-child transmission of HIV and syphilis: Global overview

Presented by Dr. Chewe Luo, Senior Advisor on HIV and AIDS, UNICEF Headquarters, New York

“You can see the synergies and the value added in approaching these two diseases together.” – Dr. Chewe Luo

Of an annual 125 million pregnant women in low and middle-income countries, 1.4 million are HIV positive. To make a case for PPTCT and CS as opposed to other competing priorities, one needs to analyse the effect on maternal and infant mortality. Understanding HIV in the context of the MDGs is crucial for rallying funding and support. About 27 per cent of all child deaths occur in Southeast Asia. Around 50 per cent of all child deaths are concentrated in just five countries: India, Nigeria, Democratic Republic of Congo, Pakistan and China. While estimates of the number of cases of syphilis during pregnancy are wildly divergent, globally 6 per cent of maternal deaths are related to HIV and AIDS. Similar analyses are needed in this region.

The four strategic elements of prevention of mother-to-child transmission of HIV

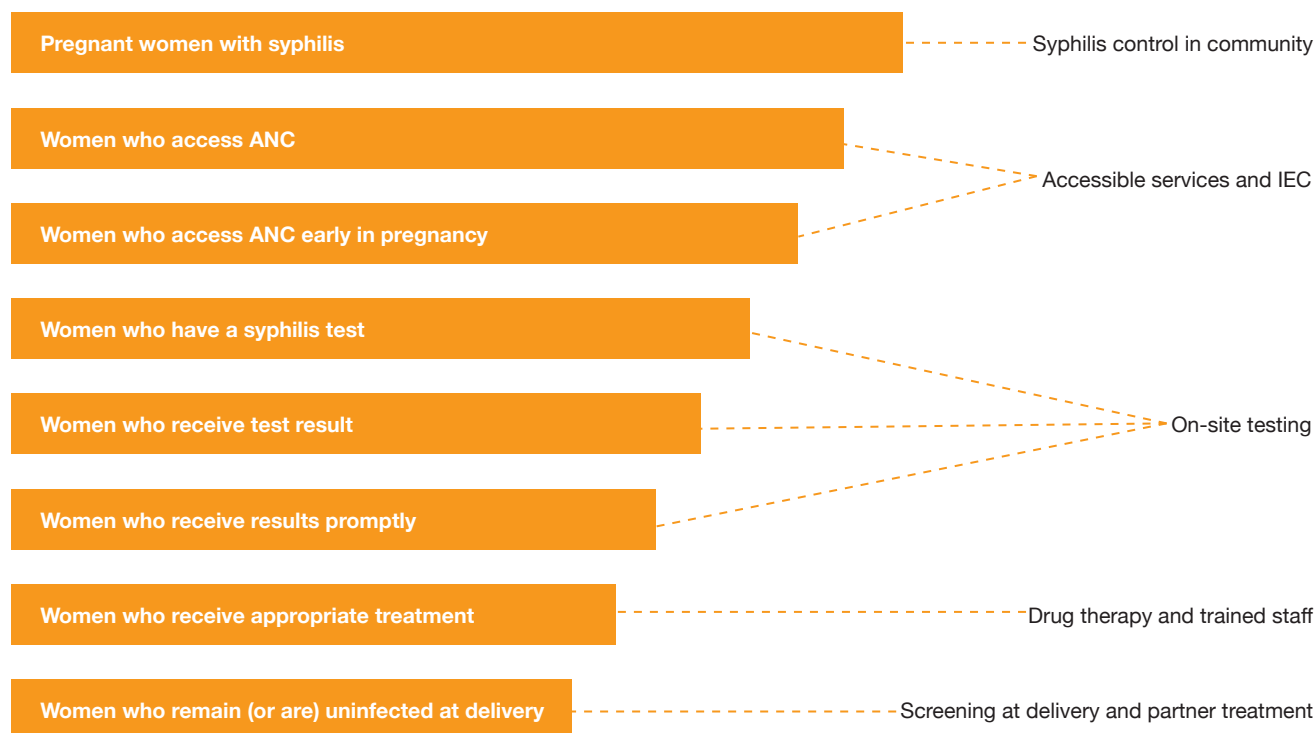


To eliminate PTCT, efforts need to be stepped up in all four prongs of the response. Unfortunately, most countries focus only on Prong 3. Deciding who takes ownership of the other prongs is a problem.

The MCH platform and overcoming barriers to prevent congenital syphilis HIV linkages

Prevention Barriers

Interventions



Looking at the cascade of women coming to test for syphilis, the steps are the same as those dealing with PPTCT. The synergies and value added with approaching these diseases together are clear. The goals are similar. As of 2009, only 2 per cent of mothers in this region were being tested. Resource-constrained countries argue for targeted testing, yet there are questions about whether they are testing the right populations. On the other hand, China has been able to implement widespread testing. Elimination will not be achieved unless the MCH platform is strengthened. The elimination agenda is gaining strength at the global level. The way forward is to build partnerships for results at the country level.

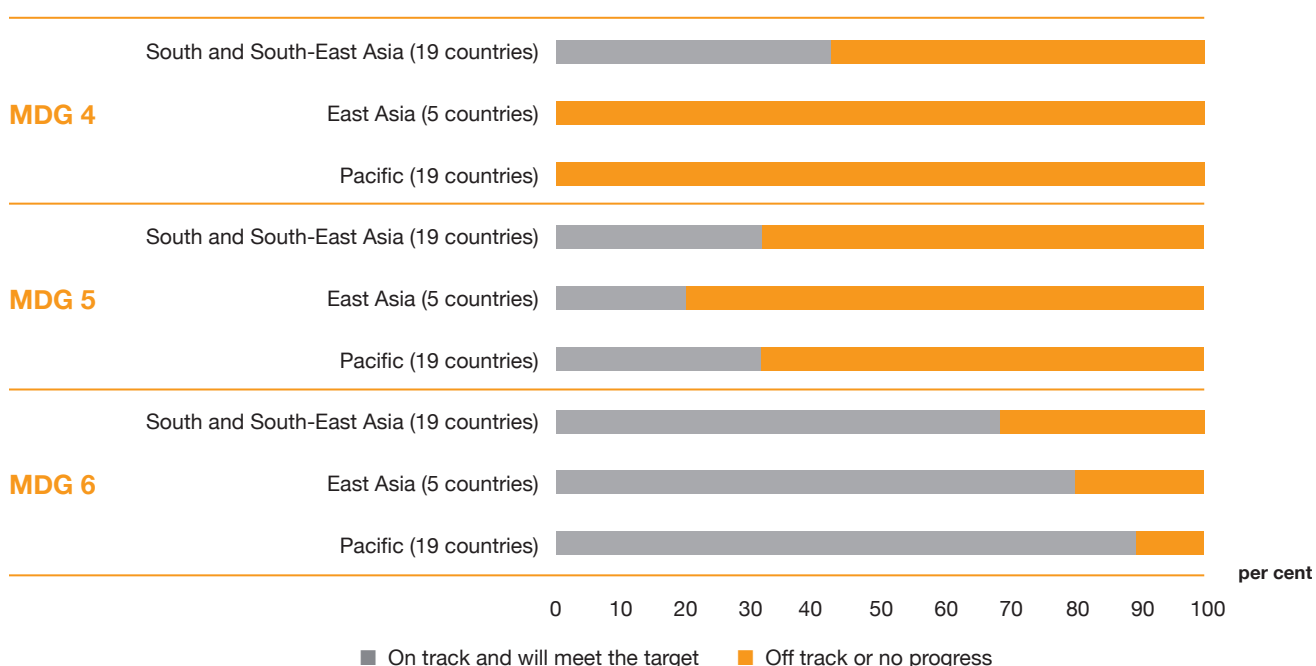
Presentation

Regional context for the elimination of paediatric HIV and congenital syphilis in Asia-Pacific

Presented by Dr. Massimo Ghidinelli, Team Leader for HIV and AIDS, WHO Western Pacific Regional Office

Asia and the Pacific is the second hardest hit region for HIV. Most countries have low prevalence but some also have concentrated epidemics. The mortality rates for children living with HIV are high – about 12,000 deaths each year. A limited number of women are being tested for HIV, because of a highly targeted and selective approach to testing. Nonetheless, the average is below the global average. PPTCT coverage is unevenly distributed, and the disparities are striking. When it comes to syphilis, there is a silent epidemic unfolding in the region. Implementation of measures to screen and treat maternal syphilis is lagging. In general, pregnant women should make four visits to an antenatal clinic (ANC), but we are fortunate in this region if they make one. There is a large unmet need in the region for family planning services. These are challenges to be faced in an elimination campaign.

Percentage distribution of countries progress by region in achieving MDG 4, 5 and 6 target



Source: UNESCAP, ADB and UNDP

There has been a marked increase in the provision of ARV to HIV-positive pregnant women to prevent transmission to their infants: 13 per cent in 2007 to 32 per cent in 2009. However, this is still far from achieving the 90 per cent target. ARV prophylaxis among exposed infants remains below 50 per cent in the majority of countries. ART coverage for women and children has substantially increased, and technology is also improving with single-dose nevirapine being phased out. The new WHO recommendations will impact the coverage. Wide variability of access and utilization of PMTCT and MCH services exists across countries. There has been progress towards MDGs 4, 5 and 6 and Universal Access, but full attainment by 2015 remains a challenge.

Discussion

It was noted that while great optimism prevails on the goal of elimination, pessimism permeates the future funding situation. Facing cuts in funding will make achieving progress more difficult. Acknowledging that resources are diminishing, presenters urged those involved in the response to make their cases for funding more evidence based. Efficiencies and economies of scale appeal to donors, and combining the response to PTCT with CS can achieve that. It is important to build a better business case for funding with donors. Linking various coverage levels of testing to broader MCH services can be cost effective.

Country progress reports

Lao PDR: Experiences on paediatric HIV and congenital syphilis care and treatment interventions

Presented by Dr. Chansy Phimphachanh, MD, Director for the Centre of HIV/AIDS and STI, Ministry of Public Health

Lao PDR, a country of 5.6 million, has approximately 10,000 People Living with HIV and AIDS (PLHA). It has an estimated prevalence of 0.2 per cent, and syphilis prevalence is believed to be very low. While the country has an integrated MCH package, only 28.5 per cent of pregnant women access ANC services, and only 11 per cent do so during their first trimester. In practice, there is little synergy between MCH and HIV services. There are no HIV services at the district level. ARV treatment is free, but only 14 per cent of the estimated 280 HIV-positive pregnant women were receiving it. Beginning in 2011, all pregnant women would receive a syphilis test. A linked response has been discussed and implementation would begin in 2011. Remaining challenges include technical support, human resources, competing priorities and funding.

India: Prevention of parents-to-child transmission programme

Presented by Dr. Suresh Mohammed, National Programme Officer, National AIDS Control Organization, Ministry of Health and Family Welfare

Half of India's 27 million births are home based, which presents a challenge for elimination by 2015. Of the 43,000 HIV-infected pregnancies, about 12,900 children are born infected for a transmission rate of 30 per cent. PLHA still face strong stigma and discrimination at the hands of health providers. The absolute number of infections, however, has been decreasing, indicating that primary prevention efforts are working. Efforts towards collaboration and integration of services are being made in six focus areas:

- Testing and counselling;
- PPTCT;

- STI treatment;
- Blood safety and availability;
- Condom promotion; and
- Information, education and communication.

The realities of the country must be kept in mind when considering elimination. Most practitioners are not trained on HIV, and few private sector health care providers offer PPTCT. Early infant diagnosis (EID) is being phased in, and a highly efficacious regimen for PPTCT is being introduced in 40 districts as of March 2011.

China: Experiences on paediatric HIV and congenital syphilis care and treatment interventions

Presented by Dr. Wang Linhong, National Centre for Women and Children's Health, China CDC

From one pilot project in 2001, China is now providing PPTCT services in 1,156 counties in all 31 provinces. From 2005 through 2008, there was a marked decrease in the rate of PTCT, dropping from 12.79 per cent to 5.97 per cent. The rate rose to 8.09 per cent in 2009 mainly because more HIV-positive pregnant mothers were detected in areas where service provision was still not good enough, despite a recent and rapid expansion of service areas. China is already providing integrated CS and PPTCT services. PPTCT received a big jump of US\$45 million in funding in 2010. China is aiming to reduce new first- and second-stage syphilis cases increasing to below 5 per cent, and reported CS cases to less than 30/100,000 live births by 2015. By 2020, the goal is to cut CS cases by another 50 per cent. China still faces challenges with stigma and discrimination, and finding HIV-positive women in remote areas and among ethnic minorities. The poor quality of services and human resources, and weak monitoring and evaluation are other hurdles to be overcome.

Papua New Guinea: Building synergies, creating the ripple effect – PPTCT, paediatric HIV and congenital syphilis programmes

Presented by Dr. Lahui Geita, Maternal Health Technical Advisor, National Department of Health

Papua New Guinea, where 800 languages are spoken and rural communities are isolated by poor infrastructure, is a challenging environment in which to strive for elimination. The country has a high maternal mortality rate (733/100,000); HIV prevalence is 0.9 per cent and syphilis prevalence among ANC attendees is 5.8 per cent. The HIV epidemic is shifting to rural areas, although syphilis prevalence is higher in cities. On a positive note, advances are being seen in male involvement in testing and counselling. MCH services, however, remain weak. Only 21 per cent of ANC women received HIV counselling and testing in 2010, 12 per cent of HIV-positive pregnant women received PPTCT services and only 10 per cent of HIV-positive children received ART. The targets are 80 per cent in all categories by 2015. An estimated \$12.5 million will be needed to achieve this through strengthened PPTCT and MCH programmes, but only \$3.9 million has been secured so far from the Global Fund.

Myanmar: Experiences on paediatric HIV and congenital syphilis care and treatment interventions

Presented by Dr. Theingi Aung, Assistant Director, National AIDS Programme, Ministry of Health

Although Myanmar is one of the four highest prevalence countries for HIV in the region, the trends of infection among groups with risk behaviours and the general population are both moving downward. Antenatal coverage has been steadily increasing, reaching 71.9 per cent in 2009. Of 3,679 pregnant women known in 2009 who needed PPTCT, 2,136 or 58 per cent received it. The rate of PTCT in 2009 was 6.7 per cent based on laboratory diagnostics, while 80.3 per cent of children who needed ART received it. All pregnant women who entered the health care system received a syphilis test, and were referred for treatment if found positive. Challenges for an elimination campaign include expanding ANC coverage, PPTCT and syphilis screening; establishing stronger linkages with RH and MCH programmes; improving reporting, data collection and follow up; and finding adequate resources.

Discussion

Questions were raised about how countries were getting men involved in ANC and family planning. Answers ranged from using NGOs for the task, to providing couples counselling and setting up a men's clinic in Papua New Guinea. Often, efforts were only made to counsel and test men known to be engaging in high risk behaviours, such as injecting drug use. Testing has been a source of system bottlenecks in some countries, and questions were raised about defining integrated testing and counselling, and where the funds would be found to support scaling up services. In India, integrated testing and counselling means anyone could be counselled and tested anywhere, whether at a VCT or PPTCT clinic; so far, 88 per cent of women coming to ANC had taken HIV tests. On funding, countries were urged to seek sources beyond the Global Fund.



Session 2

New WHO guidelines and implications towards virtual elimination of PTCT

Presentation

2010 WHO guidance: What is new in HIV testing, antiretroviral therapy and PMTCT?

Presented by Dr. Ying-Ru Lo, WHO Coordinator for Prevention in the Health Sector, Department of HIV and AIDS

The backbone of ART is access to quality testing and counselling. In this context, WHO just released its 2010 retesting guidance for adults. The key messages are to start testing earlier, use less toxic options, improve management of TB/HIV and HBV/HIV, and promote better use of laboratory monitoring. The review shows mortality can be reduced by 5 per cent if ART begins when the CD4 count is less than 350, irrespective of symptoms. Symptomatic patients should start ART immediately regardless of CD4 count. The problem is the majority of PLHA start treatment late. Furthermore, the majority of people have no access to testing and don't know their status. Increasing access to testing and care is critical. A new element in the guidelines is universal treatment for all children under two years of age who have been exposed, irrespective of CD4 counts or clinical criteria. Children are not just small adults. Health care workers have to be trained to apply the right treatment regimens. Several treatment regimens were outlined.

For HIV-positive women whose conditions have not progressed to the point where they are eligible for lifelong ART, the WHO is recommending two treatment options for ARV prophylaxis:

ARV Prophylaxis options	
Option A	Option B
Mother Antepartum AZT (from 14 weeks) sd-NVP at onset of labour* AZT + 3TC during labour & delivery* AZT +3TC for 7 days postpartum*	Mother Triple ARV (from 14 weeks until one week after all exposure to breast milk has ended) AZT + 3TC +LPV-r AZT + 3TC + ABC AZT + 3TC + EFV TDF + 3TC or FTC + EFV
Infant Breastfeeding population Daily NVP (from birth until one week after all exposure to breast milk) Non-breastfeeding population AZT or NVP for 4-6 weeks	Infant For all exposed infants AZT or NVP for 4-6 weeks
*sd-NVP and AZT + 3TC can be omitted if mother receives >4 wks AZT antepartum	

There are differences in cost and complexity between the two options. Local conditions could influence the choice of providers.

There is an exciting opportunity to eliminate paediatric HIV. WHO is promoting a comprehensive approach to elimination, including new guidelines on breastfeeding where transmission can be reduced to less than 5 per cent and, without breastfeeding, to less than 2 per cent. Effective interventions exist. The challenge is in implementation. An HIV-positive mother needs to be assessed as to whether or not she requires treatment and what kind. Lifelong ARV is recommended for HIV-positive pregnant women who are in need of treatment (CD4 less than 350 or clinical stage 3 or 4), and short-term ARV prophylaxis during pregnancy, and breastfeeding for one year for those not in need of treatment. For the first time, WHO is recommending mothers breastfeed up to 12 months if they are on ARV.

Pregnant women with CD4 less than 350:

- are about 40 per cent of HIV-positive pregnant women
- account for more than 75 per cent of MTCT risk
- account for more than 80 per cent of postpartum transmission
- account for 85 per cent of maternal deaths within two years of delivery

Strong benefits are clear from initiating ART for maternal health and PMTCT during pregnancy, labour, delivery and breastfeeding.

Adopting these guidelines can lead to significant progress towards the elimination of paediatric HIV.

Presentation

Adapting PPTCT Guidelines in Thailand

Presented by Dr. Nipunporn Voramongkol M.D., Department of Health, Ministry of Public Health

“Triple combination ART is actually more cost effective than single-dose nevirapine.” – Dr. Nipunporn Voramongkol

Thailand has made great strides in its PPTCT programme, developed from pilot projects in the mid-1990s to widespread coverage today. Of the nearly 800,000 pregnant women in 2009, 99.7 per cent received an HIV test. A few more than 5,000, or 0.64 per cent, tested positive, and 93.5 per cent of those who tested HIV positive received ARV, while 99.6 per cent of their children received ARV. The transmission rate for definitively diagnosed HIV-positive mothers has dropped to 3.4 per cent.

Thailand conducted two research studies during 2009 to test adaptation of the new WHO PPTCT guidelines. The results showed that triple combination ART is actually more cost effective than single-dose nevirapine or other therapies when all costs, including the cost of paediatric HIV treatment and care, were factored in. The national PPTCT committee decided in October 2010 to scale up the adoption of the guidelines nationwide. Next steps include:

- Training on couples counselling
- Supervision and monitoring by staff from 12 regional offices
- Situation analysis of early infants diagnosis
- Evaluation of programme implementation at 6 months and 12 months

Presentation

Cost estimation and financing of the new PMTCT policies

Presented by Dr. Sorakij Bhakeecheep, Fund Management of HIV and AIDS and TB, National Health Security Office, Thailand

Dr. Sorakij presented a deeper analysis of the cost of adopting the new WHO guidelines in Thailand. The country's PPTCT programme has a budget of about \$5 million and covers three target groups: mothers, husbands and children. The most important activities are counselling and systems strengthening. In examining the costs associated solely with PPTCT and the various medication regimens, therapy using single-dose nevirapine is the cheapest, while lopinavir-based (lpvr) combination therapy is the most expensive. However, when indirect and overall costs including the cost of care and treatment for mother and child were calculated, it was found that single-dose nevirapine actually yields very high cost. The transmission rate under the HAART regimen is lower, and the cost of care is also lower. By looking at the whole picture, the highest cost regimen is actually single-dose nevirapine. Lpvr adds \$2 million in costs to the budget, but in the longer run \$15,000 per child is saved because of lower transmission rates. Efirenz is cheaper but there have been reports of damage to the foetus and so it is not used. It is preferable to have one regimen for the whole country.

Discussion

Concerns were raised that when national treatment policies are adopted, women may not be told about other PPTCT and treatment options. Other options might be more appropriate for some women especially when it comes to formula feeding versus breastfeeding. Dr. Lo said the guidelines do not mean there cannot be individual decisions. However, providers should have a national policy to guide their decisions. Factors have to be considered, such as whether clean drinking water is available, and whether there is monitoring. Discussions revolved around which treatment option (A or B) is most appropriate. Countries with less developed health care systems advocated option B because it does not require testing CD4 levels, which cannot be done in a timely manner or at all in some settings, although CD4 testing is optimal. Targeted testing versus widespread testing in low-prevalence with concentrated epidemic settings also generated controversy, with many developing nations saying widespread testing was beyond their capacity.

Presentation

The business case for PPTCT: Joint action for results, the UNAIDS Outcome Framework

Presented by Dr. Chewe Luo, Senior Advisor on HIV and AIDS, UNICEF Headquarters, New York

"We can prevent mothers from dying and babies from becoming infected with HIV." – Dr. Chewe Luo

Elimination will not be achieved unless new infections can be stopped. The unmet need for family planning in many countries is critically important while partnerships, particularly with the wider health community, are needed for a comprehensive response. With increasing competition for decreasing donor funds, a business case for PPTCT must be made. PPTCT's contributions in achieving MDGs 3, 4, 5 and 6 provide a strong argument. Countries have the option of pursuing one of two goals: less than 5 per cent PTCT at the population level or 90 per cent reduction of HIV infections among young children by 2015, from 2009 baseline (430,000 down to 43,000). Both goals are bold and admittedly in some cases aspirational. Aspirations are needed to make progress.

Ten priority areas	
1. We can reduce sexual transmission of HIV	6. We can empower MSM, SWs and transgender people to protect themselves from HIV infection and to fully access ART
2. We can prevent mothers from dying and babies from becoming infected with HIV	7. We can remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS
3. We can ensure that people living with HIV receive treatment	8. We can stop violence against women and girls
4. We can prevent people living with HIV from dying of tuberculosis	9. We can empower young people to protect themselves from HIV
5. We can protect IDUs from becoming infected with HIV	10. We can enhance social protection for people affected by HIV

Of the first wave of 22 countries receiving maximum support for achieving these goals, only one, India, is in this region. These 22 countries account for 90 per cent of all PTCT and so they are being prioritized, but support is also available for countries in this region. The goals for 2015 for all 22 countries are 50 per cent reduction in HIV incidence in all women of reproductive age, 100 per cent of women in need of ARV receiving them, and full family planning coverage. Improved analysis, global commitment on funding, high-level advocacy, improved coordination and better linkages with MCH are needed to achieve these goals. Moving beyond targeted testing, as China has done, is a challenge but no country is starting from zero.

More than a few countries have poor health systems. Women are not coming for ANC or delivery. Strategic approaches, including lobbying and partnership, are needed to make PPTCT a reality for the majority of women who need it. The system is not supportive of these goals. Governments must be pushed to make it happen, and the focus must also be on quality services. NGO partnerships are vital to finding the right approaches and services within the local context. One size does not fit all in this region.

Discussion

Responding to questions about strategy, those working on PPTCT were urged to think beyond HIV and examine the wider health system and especially services addressing maternal mortality and immunization, which are often widespread and relatively strong in most countries. Linking with those services can be an entry point for expanding PPTCT coverage. The opportunity for vaccinations improves ANC attendance and HIV responders can take advantage of that. More focus needs to be put on how HIV can contribute to improving overall clinical care for mothers and children. Responders need to move away from focusing on one disease towards strengthening the health system.

Unless the HIV response can contribute to increasing skilled deliveries, it will not get attention from the MCH community. At the same time, eliminating PPTCT requires a strong commitment to Prong 1 (primary prevention) and that can only be handled by the HIV community. There is not a clear call within the region to prioritize PPTCT, and so it is essential to make a strong and pragmatic business case to raise the importance of, and support for, PPTCT.

Session 3

Draft Asia-Pacific framework for the elimination of paediatric HIV and congenital syphilis

Presentation

Global technical consultation on the elimination of mother-to-child transmission of HIV

Presented by Dr. Ying-Ru Lo, WHO Coordinator for Prevention in the Health Sector, Department of HIV and AIDS

“The future depends on what we do in the present.” – Mahatma Gandhi

The 2010-2015 WHO Strategic Vision – “Moving Towards the Elimination of Paediatric HIV” – contains guidelines that offer an opportunity to implement highly effective interventions in resource-limited settings, and promote the health of mothers and children. The framework, however, has not been finalized. It was drafted at The Global Technical Consultation on the Elimination of MTCT and HIV, which took place on 9-11 November 2010 in Geneva just two weeks before the 8th Meeting of the PPTCT Task Force. Feedback from the region is wanted. Elimination of PTCT in Asia-Pacific is possible. The definition of elimination, however, must be understood.

The principles of disease elimination and eradication

Control	Reduction of disease incidence, prevalence, morbidity or mortality to locally acceptable level, with deliberate efforts, e.g. diarrhoeal diseases
Elimination of disease	Reduction to zero incidence of specified disease, in defined area, continued interventions required, e.g. neonatal tetanus
Elimination of infections	Reduction to zero incidence of infection caused by specific agent, defined area, e.g. polio, measles
Eradication	Permanent reduction to zero of worldwide incidence, interventions no longer needed, e.g. smallpox

Sources: Walter R. Dowdle, MMWR – Supplements, 31 December 1999/48 (SU01); 23-7

Globally, there is increasing advocacy for PTCT elimination, but targets need to balance aspirations and feasibility even with an extended timeline. Although Universal Access calls for 80 per cent ARV coverage, PPTCT interventions need to reach 95 per cent coverage to achieve elimination. Elimination can only be achieved if there is success in primary prevention. Because the Asia-Pacific region is generally low in HIV prevalence it has a unique opportunity to be the first to eliminate PTCT. The challenges, however, are formidable. They include weak health systems, widely divergent settings and delivery of complex interventions. A baseline must be established for monitoring purposes; resources must be mobilized while competing with other health priorities. The WHO, UNICEF and partners will develop an elimination action framework for the region. The effort will require a new level of coordination between the UN, partners and donors to support country ownership, leadership, management and sustainability.

Presentation

Conceptual framework for the elimination of paediatric HIV and congenital syphilis in Asia-Pacific

Presented by Dr. Massimo Ghidinelli, Team Leader for HIV and AIDS, STI in the WHO Western Pacific Regional Office

There is an overall consensus on the possibility of achieving elimination. The latest state-of-the-art thinking on how to achieve this is applicable to the Asia-Pacific region. Most countries are not starting from scratch. There are experiences in the region that point to the possibility of elimination and lessons can be learned from them. Group discussion is the core of the consultation so that a consensus-based document on an elimination framework can be produced. Its purpose is to provide a reference and guidance to develop country-specific strategies and operational plans for a comprehensive national PPTCT and elimination of congenital syphilis (ECS) response, with the broader goal of improving maternal and child health.

The framework is different in that it is not limited to an HIV outcome, but is more inclusive and recognizes the broad goal of improving MCH. The HIV response can contribute in two ways: the first is by contributing in a small way to achieving MDGs 4 and 5; the second is by supporting greater ANC coverage, as it is the only logical means of testing high volumes of women. It is encouraging that China and India are pursuing universal testing as this broadens our goals beyond MDG 6. None of this would happen without an integrated approach pointing to health systems development. The only way to provide and sustain HIV services without functional health systems is if they contribute to health systems development.

A cheap and effective treatment to eradicate syphilis exists, so zero transmission is possible. Several countries in this region have signed a declaration committing themselves to ECS. For elimination of PTCT and ECS, six strategic objectives must be met:

1. To ensure commitment
2. To enhance provision of comprehensive linked services
3. To employ highly effective interventions
4. To advocate for equitable access including vulnerable populations
5. To promote health systems development in order to achieve MCH and HIV/STI outcomes (required not an option).
6. To improve measurement of performance and impact

Discussion

If 90 per cent coverage is achieved there are 10 per cent of women left uncovered, so how is elimination possible? The terminology of elimination is ambitious, but if the strategy is operationalized much can be achieved. Thailand is testing virtually all of its 800,000 pregnant and is aiming to reduce PTCT rates to 1.3 per cent, one of the lowest rates possible. With no interventions the rate would be 25 per cent, so there is a huge difference. Rather than debating terminology, what is required is buying into the goal, so that PTCT and ECS can be reduced to almost nil.

Presentation

Monitoring and evaluation (M&E) framework

Presented by Dr. Teodora Wi, Medical Officer, HIV and AIDS and STI, World Health Organization, Western Pacific Regional Office

Twenty-four indicators have been developed and proposed to track progress on elimination of PTCT and CS. They cover input, output, impact and process. Careful consideration needs to be given to this M&E framework. Is it feasible to have that many indicators to measure? Most are already being collected in existing frameworks, such as Universal Access and WHO, along with national-level monitoring frameworks for reproductive health. One challenge is how to measure unmet needs for family planning. What are the baselines?

Other important considerations include: specifying methods and requirements for measuring elimination goals, and the synergies that can be achieved with target indicators for PPTCT, ECS and MDGs; improving facility-level monitoring; using data to improve programme implementation; and developing monitoring tools that consider the varying scenarios for delivery.

Considerations for implementation include:

- Review of existing tools and indicators
- Agreement on proposed indicators and monitoring tools
- Reasonable pilot-testing – operational feasibility
- Revision based on assessment
- Decision on tools and strategy for dissemination, training and supervision – national roll-out

Discussion

Many barriers to elimination exist in the region, including slow uptake of serial rapid testing technologies, how counselling and testing are implemented and system bottlenecks. Scepticism was expressed on the ability to achieve testing 90 per cent of pregnant women considering the low levels of institutional delivery in many countries, resource constraints, and the lack of interest from those working in MCH. It was agreed that 90 per cent testing was a huge challenge, and it was suggested that examining barriers to ANC and reaching marginalized groups could be starting points for developing strategies to achieve the goal.

Countries may have to adopt a phased-in approach to testing, as experience in Thailand has shown. The goals are as highly ambitious and aspirational as those for Universal Access. What can be achieved, and how quickly, will depend on the country context. Outreach to MCH colleagues must continue; the goals of increased ANC utilization and skilled birth attendance support their objectives and MDGs 4 and 5. China moved from very little testing to 90 per cent in seven provinces in two years. Lessons can be learned from it. Improved operational research will also be an important aid to achieving elimination.

Presentation

Virtual paediatric HIV elimination and elimination of congenital syphilis in Cambodia: Achievements, challenges and next steps

Presented by Dr. Ngauv Bora, Deputy Head of AIDS Care Unit (Chief of Paediatric AIDS Care), National Centre for HIV/AIDS Dermatology and STD

Cambodia began implementing a linked response to PTCT and CS in 2008 with pilot projects in five operational health districts and, by the end of 2010, was expected to scale up to 61 out of the country's 77 operational districts. Implementation began with a Strategic Development Phase in which a technical working group developed standard operating procedures, which was later approved by the Ministry of Health. A Demonstration Phase followed. Standard monitoring tools (ANC registers, PMTCT report format, and early infant diagnosis or EID report format) are being developed and will be implemented in 2011. From 2006 until 2009, the numbers and percentages of pregnant women tested and given their results increased dramatically from 7 per cent to 42 per cent, as did the numbers and percentages of pregnant women who received ARV prophylaxis or HAART (7.5 per cent to 32 per cent).

To reduce PPTCT to less than 2 per cent nationally by 2020 and improve mortality among children living with HIV, Cambodia will pursue four strategies:

- Expand the existing Linked Response to reach 80 per cent ANC HIV testing and PMTCT coverage nationwide
- Boost Linked Response activities to expand ANC HIV testing coverage from 80 per cent to 98 per cent

- Boost Linked Response to address other key constraints (e.g. HIV exposed infant care)
- Decrease mortality and loss to follow-up among HIV-positive children

Presentation

Steps towards commitments to the elimination of paediatric HIV in Nepal

Presented by Dr. Krishna Kumar Rai, Director, National Centre for AIDS and STD Control

Mountainous Nepal has an HIV prevalence of 0.39 per cent, with concentrated epidemics among female sex workers and their clients, MSM, IDU and seasonal labour migrants. While 67 per cent of pregnant women over 20 years of age visit an ANC clinic at least once, only 14 per cent of pregnant women aged 20 years and under do the same. Only 19 per cent of births are handled by skilled attendants and PPTCT coverage is only 7 per cent. Syphilis tests have been included in National Medical Standard for reproductive health. HIV, STI testing and medications are free, as is institutional birth delivery. The PPTCT programme began in 2005 and now is available at 51 institutional and community-based sites. Further scale up will take place over the next five years.

Challenges include addressing stigma and discrimination, making syphilis tests more available at the community health centre level, and expanding coverage for ANC and PPTCT. The way forward is to work for more alignment between HIV and MCH programmes and conduct orientations on HIV and syphilis testing for all field workers at health sites.

Presentation

Towards elimination of paediatric HIV and syphilis, the Malaysian experience

Presented by Dr. Lokman Hakim Sulaiman, Director, Disease Control Division, Ministry of Health

Malaysia is lucky to have good commitment from its political leaders when it comes to HIV, STI and health issues. The country has more than 300 hospitals and over 3,000 health clinics, with some clinics as large as hospitals. PPTCT was piloted in 1997 and adopted as a national programme in 1998. Guidelines were revised in 2009 with rapid tests, HAART, PCR tests for babies and tracing of spouses and partners now part of the package of interventions. Infant feeding guidelines were also revised. VDRL coverage is at nearly 100 per cent, and HIV screening of pregnant women is at 98 per cent in public hospitals and 45 per cent in private hospitals. In 2008, 98.6 per cent of births were handled by a skilled birth attendant. In 2009, 98.1 per cent of ANC mothers were screened for syphilis; 0.08 per cent of them were found to have the disease. Malaysia is currently drafting its second National Strategic Plan on HIV and AIDS, which would run from 2011 through 2015.

Discussion

Questions were raised about which treatment options, A or B, countries were choosing and why. Most said cost effectiveness was a factor in their decision, as well as logistics and training of health workers. Practically, it will take time to train health workers in remote areas on how to administer more complex treatments. Resistance to certain drugs, such as nevirapine, was also a consideration. Most countries are phasing out single-dose nevirapine as a treatment option, but progress on this can be slow. How easily women can be traced so that they return for a full treatment course is another factor. All countries have taken account of the new treatment guidelines, but the speed with which they are being adopted varies. Bottlenecks in decision making, training and procurement affect how rapidly new treatments are used. These challenges must be overcome for a worthwhile investment in PPTCT.

Session 4

PPTCT in the context of MCH, health systems strengthening and community engagement

Presentation

MCH Perspectives in the provision of PPTCT services

Presented by Dr. Razia Pendse, Technical Officer, Partnership MPS/FCH, World Health Organization

“If we work hard enough we can virtually eliminate mother-to-child transmission.” – Secretary-General Ban Ki Moon, September 2009

HIV and maternal conditions are the two leading causes of death for women aged 20-59 in low-income countries around the world. This fact should provide a strong basis for linkages and cooperation between HIV and MCH programmes. In this region there are wide disparities in MCH and HIV coverage. Births attended by skilled personnel range from 20 per cent to 80 per cent, while ARV coverage ranges from 10 per cent to 80 per cent. A high unmet need for family planning exists in many countries.

Women and children are dipping in and out of the health care system, and not accessing the full range of interventions in an integrated way. Coverage for ANC is high, but then there is attrition. A way must be found to keep mothers accessing health services. Most men and women coming for ANC are healthy, and this is when they are most responsive to primary prevention.

More than 10 million people in the world tested positive for syphilis last year and more than half are women. There is a huge amount of under-reporting. Southeast Asia has a high syphilis prevalence. If syphilis is not addressed there will be a huge price to pay: 1.2 million pregnancy outcomes grossly affected. Despite regional strategies for CS in Southeast Asia and the Western Pacific, health financing is weak, especially at the health centre level. If community health centres are not strengthened, nothing will be achieved. Policy makers and donors want short-term results, but the solution requires long-term investments into health systems. MCH is an investment, not a cost.

Presentation

Data management: The foundation of measuring PPTCT

Presented by Wing-Sie Cheng, Regional Advisor on HIV and AIDS, UNICEF East Asia and the Pacific Regional Office

“How you manage information determines whether you win or lose” —Bill Gates

Reporting on PMTCT outcomes as a whole is not adequate. In most countries data are not well collated, summarized, recorded and reported. Even with the immense focus on Monitoring and Evaluation and PMTCT service delivery, data are scattered, which weakens the ability to monitor patients' in the PMTCT service chain, leading to “losses” throughout the health system. In essence, there is a limited capacity for monitoring, including data management, financial management, logistics, HR and supply management.

With the ubiquitous presence of internet, information and mobile services in Asia-Pacific, to link people, networks and systems together, UNICEF conducted an ICT assessment in 11 countries throughout the region. The assessment found unlimited potential in ICT as a mechanism for innovative and sustainable solutions to reach the unreached (women and children lost to follow up). ICT infrastructure and services can strengthen PMTCT, MCH and the entire health system.

Mobile Coverage Asia-Pacific



Importance of Data Management

Data management is the cornerstone of M & E. The key to moving beyond silos and vertical reporting towards effective:

- patient tracking,
- case management,
- health facility management and
- health situation and trend analysis

Ultimately, data management is the foundation for leveraging ICT to drive change, increase ownership, improve programme efficiency and foster the partnerships and collaboration necessary to move towards elimination of paediatric HIV by 2015 or beyond.



Presentation

Thailand's experiences in strengthening data and information management to monitor and improve PMTCT outcomes

Presented by Dr. Rangsim Lolekha, Chief, PMTCT and Paediatrics Section, CDC Southeast Asia Regional Office

PPTCT scale up under the Ministry of Public Health in Thailand began in 2000. PPTCT was available for all children of Thai nationality, free of charge. Thailand uses two main data collection programmes: PHIMS and PHOMS, but others also exist. Data collection and analysis followed by action has resulted in greater PPTCT uptake. As an example of how data management can drive the programme, studies showed that only 40 per cent of women not accessing ANC who needed ARV received them, while 85 per cent of ANC women in need received them. Action steps were taken – providing better training for health care workers and supplying rapid test kits – and the percentage of non-ANC women accessing treatment is now on the rise.

In recent years there have been rapid changes in treatment guidelines and standards. PPTCT uptake has fallen as a result. Monitoring the impact of those changes is informing decisions on how to adjust the programme so coverage and service uptake will increase. Nonetheless, Thailand is confronted with challenges such as the presence of several monitoring systems, changes in guidelines and the lack of continuous training. With a new national PPTCT policy, M & E is critical to define programme uptake, side effects, acceptability, and the PTCT rate of the new regimen.

Presentation

Engaging women living with HIV (WLHIV) to improve access to services for HIV-positive mothers and their children

Presented by Kirenjit Kaur, Women Programme Coordinator, APN+

“As an HIV-positive person I have been discriminated against for years in many ways. People like us can contribute to data. We face discrimination so we can work together and tell you how it can be done” – Kirenjit Kaur

APN+ is a regional network of PLHA that represents 29 countries across Asia and the Pacific. APN+ focuses on issues involving positive people – capacity building and network support, strategic information and advocacy. It has two specific working groups – women and MSM. The women’s working group focuses on advocating for women’s rights and gender equality; inclusion of HIV-positive women in decision and policy making, and strengthening of existing women’s national networks and groups.

Involving positive women networks can help increase service access, improve service quality and reduce loss to follow-up, and strengthen data collection and analysis. Positive networks can contribute to pre-service training to address issues of stigma and discrimination. The problem of stigma and discrimination, especially among healthcare workers, remains a strong and significant barrier to achieving the goals of elimination. Stigma and discrimination in health care must end, and involving positive women in the effort can help that happen. Furthermore, as a peer group, positive women can aid in collecting data, as they are more accepted by the marginalized and others who are difficult to reach.

Presentation

Pakistan PPTCT programming experience: Evidence and revised strategic approach

Presented by Dr. Naveeda Shabbir, Programme Officer, National AIDS Control Programme

Pakistan has a concentrated epidemic with prevalence in the general population still low at 0.1 per cent among 15-49 year-olds. Less than 10 per cent of those in need of treatment are receiving it. Pakistan’s PPTCT programme started in March 2007. There are six PPTCT centres currently operational across the country. All centres provide ARV or ART (through testing and counselling centres) and exclusive infant feeding counselling. Although 60 per cent of pregnant women in Pakistan have attended at least one ANC visit, only 34.3 per cent of deliveries were in a health facility, often because of cultural and gender barriers.

Evaluation of Pakistan’s PPTCT programme was conducted in consultation with partners in 2009. The three main recommendations from the evaluation were: focus available resources on identification and service delivery to most-at-risk individuals and populations; adopt an area-based programming approach to establish a continuum of care and coordination mechanisms based on clearly defined roles and responsibilities; and provide quality and comprehensive PPTCT services, as the numbers are small.

Conclusions and recommendations reached were as follows:

- Focusing PPTCT efforts at the tertiary ANC level is not cost-effective in a concentrated epidemic.
- Existing community health outreach cadres (lay health workers – LHWs) and NGOs working with most at risk populations and PLHIV should be utilized.
- Capacities of District Hospitals to identify and refer HIV cases need to be built up.
- A family-centred approach in culturally conservative countries should be implemented, creating a referral and service provision continuum through PPTCT, paediatric AIDS, and treatment care and support for families affected by HIV and AIDS.

Presentation

Born to live: Prevention of parents-to-child transmission programme in Papua New Guinea

Presented by Margarete Maria Hunhoff, Director, National Catholic AIDS Office, Port Moresby

Papua New Guinea is home to over 800 languages and cultures. It ranks among the poorest nations in social indicators and has the fastest growing rate of HIV in Asia and the Pacific. The PPTCT programme, however, is a success story and a small step forward. The programme started at St. Joseph's Rural Hospital, Mingende in 2003 with the training of midwives. Nevirapine was originally used, but triple ART began in July 2009. PPTCT has been integrated into MCH services, mostly in Catholic hospitals. Working closely with the community and community leaders has been the key to success. Exclusive breastfeeding is promoted because of poor water conditions, and Preventive Bactrim Therapy is provided from six weeks to reduce the risk of opportunistic diseases for both mother and the baby.

Poor road conditions make follow-up extremely difficult. Lack of human resources is a major challenge. But the programme has several achievements including 80 per cent of ANC mothers opting for testing, strong involvement of positive parents in outreach, and the high utilization of a men's clinic where men can get counselling and testing.

Discussion

Questions were raised on how Thailand captures reporting on women who do not deliver in hospitals or access ANC, and who are responsible for collecting and entering data, as it can be a burden on doctors and nurses. These issues are a challenge for Thailand and so far have not been answered. About 300 private hospitals do not take part in government data collection efforts and the system could not track ANC numbers. The way to move forward would be to have one national system for all health reporting in which the National AIDS Database would be integrated. WHO is supporting the country's monitoring and evaluation efforts. PNG was asked about the reported psychological benefits of its programme. Before the epidemic there was basically no counselling of any kind in PNG. With the introduction of HIV-related counselling, people, including men, are unburdening themselves about a host of problems, often related to domestic violence. This has brought about many benefits including behaviour change.



Session 5

Group Work

Participants formed six discussion groups to discuss steps and recommendations on areas needed to achieve elimination of PTCT and CS. Each group was assigned one major topic to discuss. The summarized results are as follows:

Group A

Ensuring commitment to achieve goals

Country level processes are needed to obtain formal endorsement/commitment to elimination:

- Advocate with key decision-makers based on evidence
- Commit to achieving full and quality PPTCT services
- Coordinate with decision-makers and between partners
- Anchor goals in existing local and international commitments

Processes of adapting elimination targets and timeline to the country level:

- Prioritize targets
- Build consensus and ownership
- Start with pilot activity

Processes and considerations in developing the national-level strategy in line with HIV and MCH plans:

- Review what exists – build on what you have
- Identify and use key entry points
- Use data to inform actions
- Build technical capacity and invite technical expertise
- Formulate Standard Operating Procedures (SOPs)
- Break out of silos and vertical programmes
- Leverage resources

Developing collaboration between countries towards regional elimination goals:

- Share country experiences
- Advocate and collaborate through regional structures
- Use community learning spaces
- Inform partnerships
- Clarify the division of labour between partners
- National and regional fora

Group B

Enhancing provision of comprehensive, linked HIV/STI and MCH services

Recommendations for national organizational and management structures:

- Consider cross-sectoral financing mechanisms
- Establish cross-sectoral committees
- Identifying “who leads” should be context-specific
- Senior MoH management may need to play a leading role in linkages.
- Build on decentralised structures
- Improve evidence-informed advocacy

Recommendations for overcoming barriers for syphilis screening in ANC:

- Point of care testing
- Combine several tests in routine ANC screening to maximize acceptance
- Harmonize reporting systems for government, donors, UN agencies, NGOs
- Provide data managers at lower levels and data hubs at district or provincial levels
- Unify health care codes to identify individuals and reduce double counting

Recommendations for increasing involvement of men in PPTCT:

- Engage male community and religious leaders as agents to promote men’s responsibilities and knowledge needs
- Couples counselling should allow brief one-to-one confidential risk assessment, linking to re-testing if there has been a significant risk.
- Identify and locate entry points for male MARPS (directory of services)
- Develop IEC materials addressing prevention of PMTCT and partner (partial) disclosure
- Include the private sector in all strategies
- Pre-marriage counselling and testing of both partners
- Give the results together (if appropriate)

Group C

Employing highly effective interventions

Recommendations for ANC and PNC:

- Review existing MCH system
- Allocate resources/infrastructure
- Target prioritized group through operational research
- Health insurance
- More male involvement

Recommendations for labour testing:

- Invest on ANC services
- Policy on testing for all pregnant women at delivery

Recommendations for CD4 testing:

- Allocate resources for cost, machine maintenance, staff training
- Develop a good mechanism for lab network and sample transportation

Recommendations for shifting ARV prophylaxis from single dose NVP to Options A and B:

- Expert consultation/advice
- Mobilize resources
- Government commitment

Recommendations for fast tracking access to ART and early treatment:

- Standard Operating Procedures
- Involvement of PLHIV network
- Community-based organizations

Recommendations for diagnosis of exposed infants:

- Standard Operating Procedures
- Foster link between VCT/ANC and paediatric Outpatient Centre (OPC)

Recommendations for infant feeding options:

- MCH and PPTCT should match on the feeding policy.

Group D

Supporting health systems development to achieve MCH and HIV/STI outcomes

Recommendations for eliminating bottlenecks in human resources:

- Task-shifting
- HIV testing and counselling as an integral part of essential package for ANC
- One-stop service provisioning - to make HIV testing as part of comprehensive package/routine care
- Ensure confidentiality
- Develop infrastructure
- Adolescent and MARP sensitive and friendly services
- Innovative strategies

Recommendations for eliminating bottlenecks in laboratory support:

- HIV and syphilis testing should be an integral part of essential ANC package
- Improve procurement and supply chain management
- Co-location of MCH and lab

Recommendations for mismatched services - ANC versus PPTCT:

- Information dissemination and community-level BCC activities
- Integrate/mainstream HIV into ANC
- Involve CSOs in referrals
- Continuum – post-partum
- Establish effective and efficient link between community and facilities, CSOs and institutions
- Give special attention to the needs of MARPs and adolescents

Recommendations for lost follow up in the PPTCT cascade:

- Quality counselling
- Collaboration with civil society, and between health facilities and home-based care teams
- Health information
- Delivery plan
- Incentive
- Health insurance, equity fund and community-based support
- Improve quality of post counselling for retaining negative status
- Social mobilization and BCC

Postnatal

- Integrate service delivery – immunization clinic – in paediatric clinic which includes immunization, EID and ARV (one-stop service)

Health information:

- SMS linked with HMIS
- Information can be provided by the staff during salary collection
- Promote appropriate use of data
- Provide feedback to the data collectors after analysing data and link it with performance monitoring

Group E

Ensuring equitable access to services

Recommendations for increasing access to, and strengthening, ANC/RH services:

- Offer financial incentive schemes (conditional cash transfer)
- Improve management of facilities at health care service points to maximize comfort of clients (addressing quality issues)
- Strengthen and extend the provision of health services: bring services closer to communities/villages
- Involve men

Recommendations for ANC HIV testing and counselling of women in low and concentrated epidemics:

- Target most-at-risk women (then phase in universal testing where appropriate and possible)

Recommendations for increasing access to PPTCT services for most-at-risk women, and minimizing stigma and discrimination:

- Address limited awareness and limited health-seeking behaviour of spouses of men at risk or women at risk (through BCC campaigns)
- Use the existing services (not parallel systems)
- Decriminalize risk behaviour (Pacific: decriminalization of same sex behaviour increases access to testing of MSMs)
- Include mobile populations and non-nationals
- Involve PLHIV and MARPs
- Foster trust between health workers and the population to be served
- Develop and implement anti-discrimination policies
- Partner with networks of PLHIV and media
- Make available PEP for health care settings
- Train service providers on stigma and discrimination interventions

Overall recommendations:

- Clarify the great diversity in the Asia-Pacific region (small vs. big countries, generalized epidemic vs. low epidemic, etc.) in the regional framework
- Operationalize the conceptual framework
- Develop country-specific actions/activities
- Include and ensure availability of budget in the strategic plans

Group F

Improving measurement of programme performance and impact

Recommendations for targets and programmatic objectives:

- Build M & E frameworks on existing global M & E frameworks and reporting cycles
- Identify selected indicators from MDGs 4,5 and 6 and Countdown (MDGs 4 and 5), UA to RH and UNGASS/UA to HIV
- Complement with carefully selected additional indicators
- Goal: add 'in the context of' or 'related to HIV' to focus better
- Targets need to be consistent with the Goal: replace target 2 (reduction of MTCT rate) with target(s) for child and maternal survival.
- For most countries targets are very ambitious – need to be adapted to country context.

Recommendations for proposed indicators:

- Indicator 17 is output and needs to be qualified (e.g. to measure consistency with national policy).
- Additional indicators:
 - Output: ARV toxicity and other ART indicators; male involvement (e.g. HIV testing)
 - Outcome: stigma & discrimination (e.g. # of tested HIV-positive women not delivering at facility)

Recommendations for operational research and evaluations:

- Targeting of more at risk women/couples: do we reach the actual women at risk? How many do we miss?
- Cost-effectiveness of two HIV tests during pregnancy in low/concentrated epidemic context
- How to measure equitable access to services?
- Outcomes of infant feeding practices

Recommendations for M & E systems issues:

- At the country level, HIV M&E framework needs to be integrated in/ linked to strengthened existing RH/MNCH M&E systems (not the other way round or parallel system)



Session 6

Cost estimates

Presentation

Cost implications for the elimination of new paediatric HIV infections in Asia-Pacific region

Presented by Dr. Naoko Ishikawa, Chief Advisor, SHIMA Project, National Centre for Global Health and Medicine, Japan

“PPTCT with universal testing for pregnant women is cost-effective and cost-saving even in low prevalence settings.” – Dr. Naoko Ishikawa

The Asia-Pacific region is home to 55 per cent of the world’s pregnant women. But HIV testing and PPTCT coverage remain low, presenting significant obstacles to achieving elimination of new paediatric HIV infections by 2015. While universal testing of pregnant women for HIV is fine for high-prevalence settings, doubts exist about whether it is feasible or too costly in low prevalence settings such as the countries in this region.

A costing tool was developed and applied to three prevalence scenarios typical of this region (1.0 per cent, 0.5 per cent and 0.1 per cent) to find out whether universal testing of pregnant women is appropriate and cost-effective. It included costs for PPTCT and paediatric treatment, with unit costs obtained from WHO sources including the Global Price Reporting Mechanism. The results showed that PPTCT with universal HIV testing for pregnant women is cost-effective and cost-saving even in a setting with HIV prevalence as low as 0.08 per cent for treatment option A, and 0.14 per cent for option B. By spending \$500 on prevention for one child, \$7,500 is saved in the long run. In fact, the savings are even greater because the burden of caring for the HIV-positive child into his/her adult years was not factored in. The impacts on cost savings and sharing with MCH and RH are also not accounted for and should mean even greater cost efficiencies. Lastly, aside from costs, ethics must be considered: health professionals have an obligation and responsibility not to limit access to services, but to provide them for everyone. People have a right to services.

Presentation

Result-based planning and costing

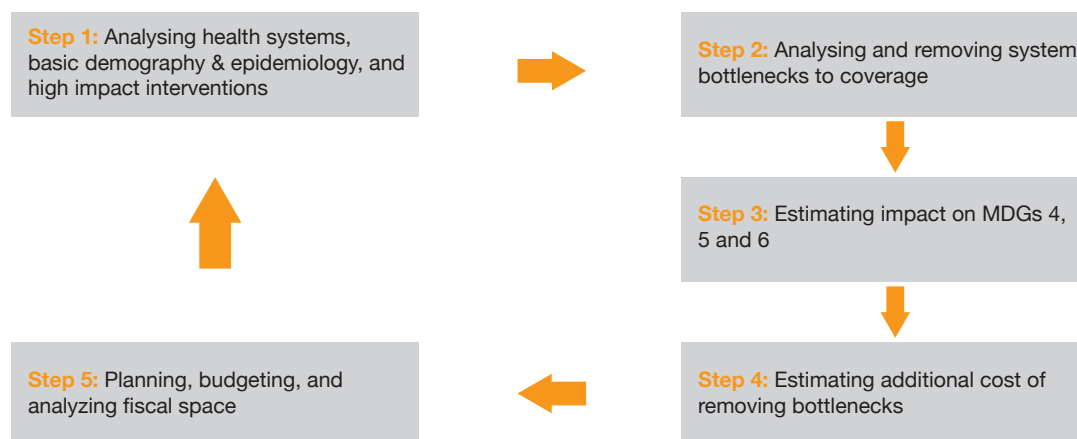
Presented by Dr. Kyaw Myint Aung, Consultant, United Nations Children’s Fund, East Asia-Pacific Regional Office

The Asia-Pacific region is marked by some of the lowest spending by governments on health care. In lower income countries people pay most health care expenditures out of pocket. When agencies and governments advocate for sustained and greater funding to achieve MDGs 1, 4, 5 and 6, donors want to know that the money is having the greatest impact possible.

UNICEF is using a tool called Marginal Budgeting for Bottlenecks (MBB) to aid in planning interventions. The MBB tool helps plan and forecast the potential cost and impact of scaling up investments to remove health system constraints towards increasing the intake, coverage and quality of high impact health, nutrition, malaria and HIV and AIDS interventions. It helps prepare results-oriented national health strategic plans,

expenditure programmes and health budgets, and simulates alternative policy scenarios and implementation strategies. It does not tell users what to do: its strength is in helping stimulate discussions to maximize the impact of funding.

Steps in Marginal Budgeting for Bottlenecks: application for results-based costing, planning and budgeting



The cost entered for each parameter reflects a country's strategy to overcome system bottlenecks. For example, human resource inputs are based on national salary and incentive policies. Some countries that have adopted this approach to costing have seen funding increases. In Mauritania, the Ministry of Finance increased the health budget by 40 per cent in 2002. It was influenced by Medium-Term Expenditure Framework (MTEF) analysis suggesting targeted increases would reduce infant mortality by 30 per cent and maternal mortality by 40 per cent in five years. In Rwanda, a similar process led to increased health budgets from six per cent of total government budget in 2004 to 10 per cent in 2006.

UNICEF aims to provide assistance to countries for results-based planning and costing. Service integration will be an important component of advocacy messages to governments and donor agencies for more efficient investments and outcomes.

Discussion

While the tools were viewed as potentially useful in advocating for increased funding, questions were raised as to whether the cost of care estimates were too low, and whether it should have included health care costs for mothers, and opportunity costs for health workers who could be performing other services. When actual country data are plugged into the models the cost of care may be higher. One of the models' limitations is that they do not factor in counselling and opportunity costs. That can be added to total costs when actual numbers are used.

During the discussion process, different numbers and scenarios can be employed, making the costing tools flexible and applicable. It was requested that a syphilis link be integrated into the models so they do not reflect a silo approach to PPTCT and HIV.

Session 7

Operational research

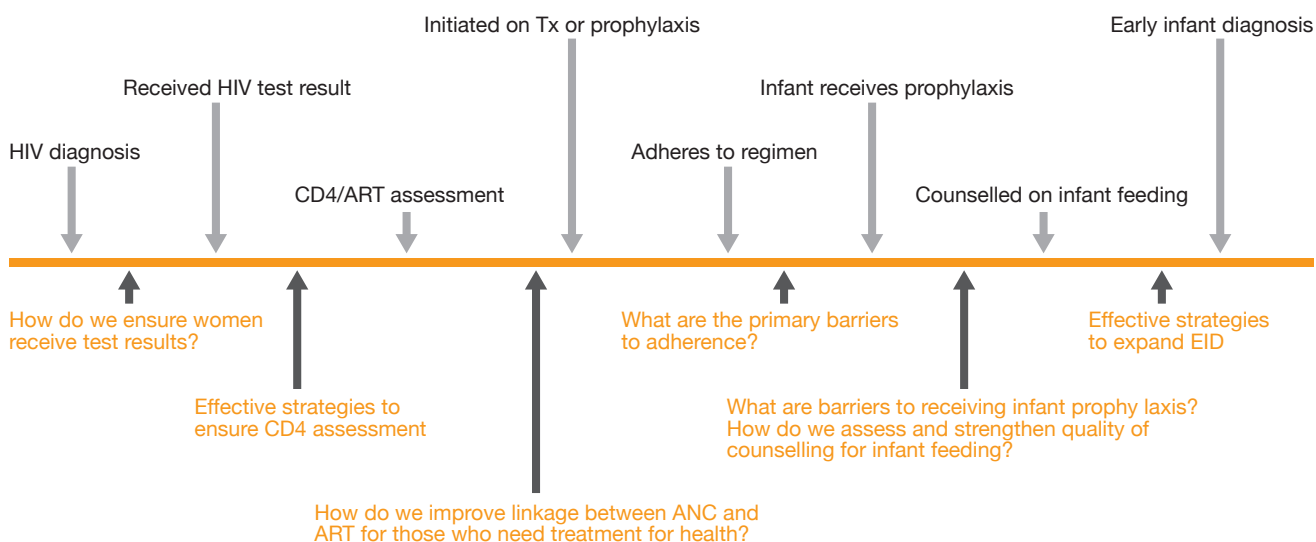
Presentation

Knowledge gaps in the elimination framework: Implementation research priorities

Presented by Dr. Padmini Srikantiah, HIV and AIDS Division, University of California, San Francisco

Gaps exist in our knowledge of how to make interventions work. Operations research/implementation science has a key role to play in guiding programme effectiveness. For example, sexual transmission of HIV can be reduced with condom use. Implementation research identifies barriers to proven interventions and facilitates the creation of local strategies to overcome them. Elimination lies somewhere between complicated and complex. What works in one country may not work in another. Current practices and baselines are variables that need to be established. Data must be used so that it informs policy and practice.

Interventions for HIV-positive pregnant women and their infants



A systematic evaluation of interventions is critical. Each mother-infant pair must navigate a complex series of steps for effective treatment and care. If they cannot, progress will not be made. Having efficacious interventions are useless if there is no coverage. A study in Africa showed that the higher the number of ANC visits, the more successful the PPTCT interventions. This shows the importance of linking PPTCT to MCH.

Key Issues for concentrated epidemic settings include obtaining evidence to guide strategies and scale-up for testing pregnant women, and identifying key pitfalls along cascade of services for HIV-positive mothers/babies and developing appropriate interventions. The importance of collecting and using routine programme data cannot be over-emphasized.

Presentation

Operational research priorities

Presented by Dr. Kazuhiro Kakimoto, National Centre for Global Health and Medicine (NCGM), Osaka Prefecture University, Japan

The new WHO guidelines contain 21 research priorities. Most are related to clinical studies and Prong 3. These are good research priorities for the needs of the WHO, but operational research comes from and addresses the needs of the people who are actually working in and implementing the programme. For instance, research conducted in Cambodia showed that 91 per cent of pregnant women wished to be tested for HIV. But, 88 per cent of them refused the test when offered. Operational research was conducted to determine why. Reasons for refusal included: the ANC facility was too far away; they were too busy or it was too difficult to come again; and 39 per cent said they needed to discuss it with their husband. Further research showed that only 18.7 per cent of women who came to ANC alone were willing to be tested, while 85 per cent who came with their husbands were willing. This indicates a significant need to promote male involvement. Despite having efficacious interventions, they were not as effective as possible without male involvement.

Conclusions



Research needs feedback. A three-day Asia HIV Research Network Workshop would be held in Tokyo in February 2011. Collaborating organizations are being invited to discuss collaboration research topics (with future technical and financial support by NCGM). Among the many keywords from this meeting that could provide the basis for research are male involvement, couples counselling, involvement of the private sector, early infant diagnosis, stigma, barriers to access and feasibility of the new WHO guidelines. Research should not be done for the sake of research, but for real needs.

Presentation

Consideration of other aspects of maternal, newborn and child health for PPTCT

Presented by Prof Jane Fisher, Centre for Women's Health, Gender and Society, WHO Collaborating Centre in Women's Health, University of Melbourne, Australia

Until recent years, many psychologists considered mental health problems of pregnant women and mothers to be a Western construct that did not exist in the developing world. There is a huge disparity between high-income and low-income countries in availability of evidence. However, the evidence that does exist indicates that prevalence of mental health problems in low- and middle-income countries is much higher than previously believed – as high as 42 per cent of pregnant women and 50 per cent of mothers of newborns.

Mental health problems make a substantial contribution to maternal morbidity and mortality. These include depression and anxiety, social suffering, disability, reduced participation and compromised functioning. Although there are many causes of common mental disorders among pregnant women, often it is a result of difficulties with a husband's behaviour - violence, verbal abuse, alcohol use, being illiterate and unemployed, receiving little assistance, and rejecting the pregnancy.

Maternal depression in resource-constrained settings is linked independently and directly to lower infant birth weight, higher rates of malnutrition and stunting in six-month old infants, higher rates of diarrheal disease, infectious illness and hospital admission, and reduced completion of recommended schedules of immunization. Mental health is integral to safe motherhood and needs to be integrated into all programmes and initiatives. Further research is needed on the mental health of HIV-positive pregnant women and mothers in the developing world.

Numerous mental health issues arise during PPTCT. For instance, learning of a positive status can be a life crisis, which could result in abandoning ANC, refusing treatment and other adverse outcomes. Women will be in distress for a range of reasons and this needs a response.

Presentation

Building national capacity in operations research: Experience from India

Presented by Dr. Suresh Mohammed, National Programme Officer, National AIDS Control Organization, Ministry of Health and Family Welfare

HIV is a relatively new programme area in India and there is a shortage of data and research to provide an evidence base. All three National AIDS Control Plans were formulated with limited evidence. Most evidence comes from Africa or Thailand. The latest plan includes a budget for operational and intervention research. Capacity building for research is needed. Operational research will be institutionalized in the Indian response through the formation of a technical resource group on research and development, prioritization and development of a research plan, capacity building workshops and the establishment of the Network of Indian Institutions for HIV and AIDS Research.

Challenges faced in research in India include:

- India is a large multi-ethnic country with varying demographic and social frameworks.
- Any exploratory research conducted in a limited setting does not reflect national scenario.
- Any intervention found effective in one setting may not work in another setting.
- It is important to conduct multi-centric studies in relevant areas to draw valid conclusions for policy formulation and programme management at national and/or state level.

Discussion

The importance of counselling was raised in the provision of mental health interventions, especially HIV and PPTCT, while community-based health care can also play an important role in identifying women with mental disorders and referring them to services and care. Linkages must be strengthened. While there is a great opportunity to invest more on operational research, more use of existing research was also urged. Interventions must be delivered in a timely manner, even if a lot of research is not yet available. It is also important to know what does not work. However, research journals are reluctant to publish studies of interventions that did not succeed. Finally, it was urged not to blur lines between M & E, which is routine, and operational research, which often is not. Countries should not wait for research results before implementing programmes. It is important to implement without delay; make adjustments based on research later.



Session 8

Panel discussion

Partnerships, technical assistance and resource mobilization: Countries' views on partnership with UN, bilateral organizations and INGOs

Panellists:

Dr. Wang Ailing of the China Centre for Disease Control and Prevention
Dr. Tith Khimuy of the Khmer HIV/AIDS NGO Alliance in Cambodia
Dr. Sujatha Samarakoon of the Ministry of Health in Sri Lanka
Dr. Luu Thi Hong of the Ministry of Health in Viet Nam
Prof Jane Fisher of the WHO Collaborating Centre for Women's Health
Dr. Kathleen Casey of Family Health International

Partnerships between countries, UN agencies and international NGOs are crucial for the success of the response to paediatric HIV, PPTCT and CS. In China, UN agencies, and in particular UNICEF, are the most important partners while others also play their roles. UNICEF supported the country's first pilot of PPTCT, including its scale up. The WHO's global guidelines were a basis for China to develop its own national guidelines. Cooperation with groups involved in the response has been good.

Cambodia depends upon partnerships for its successful response because the government can only supply 10 per cent of the funds. The rest comes from donors such as the Global Fund and USAID. The technical assistance provided by UNICEF and WHO has been key to developing national guidelines and mobilizing resources. Community groups are crucial partners, as they track and follow up with women for their continued access to treatment and other services. The community-based response has been a big factor in reducing PTCT. Linked response, however, is still weak.

Sri Lanka's national policy on PPTCT has not been completed, and the country is working in partnership with UNAIDS to achieve this. WHO SEARO is providing needed support for the elimination of CS. In addition, the International Labour Organization is helping with policies for dealing with HIV in the workplace. To reduce HIV by 50 per cent among women aged 15-49, however, more help is needed from UNFPA. The UN has been a partner in developing life-skills education, supplying rapid tests and kits and in a range of other programmes. Presently, there are few ANCs in Sri Lanka, and so the country lacks the depth for scale up.

With support from the international community, Viet Nam has made substantial progress in its response to HIV. This would not have been possible without good partnerships with UN agencies and international organizations. Partnerships have helped in the formulation of policies and HIV prevention as well as in setting up working groups and supporting activities. PEPFAR and the Global Fund were particularly helpful on prevention. UN agencies and the Clinton Foundation provided needed technical support.

The WHO has an international network of collaboration centres, mostly based in clinical or academic settings. A more systematic approach is now being taken to ensure they are all working together. The WHO Network for HIV and Health in the Western Pacific was formed in 2009. It draws together HIV-specific collaboration centres and others to meet gaps in knowledge and skills in a number of long-term WHO technical partners. The purpose is to provide member states with high quality, consistent and coherent technical assistance.

Family Health International (FHI) helps build capacities in communities to support health workers who feel overburdened. FHI works at the regional and country levels through partnerships and donor funds. At the country level it supports programme implementation with local NGOs and community-based organizations (CBOs) to build technical capacity. A recent initiative is working with countries on quality assurance. A barrier to uptake is the bad experiences people have at ANC. However, there is work being done on the site level with local partners. Strengthening lab capacity through its scientific research division and operational research into testing and counselling are other areas of work. FHI has worked with MSM, IDUs and female sex workers so they have knowledge and access to services such as family planning. Important partnerships are with UNICEF, UNAIDS, WHO and UNHCR.

Discussion

The importance of counselling was raised in the provision of mental health interventions, especially HIV and PPTCT, while community-based health care can also play an important role in identifying women with mental disorders and referring them to services and care. Linkages must be strengthened. While there is a great opportunity to invest more on operational research, more use of existing research was also urged. Interventions must be delivered in a timely manner, even if a lot of research is not yet available. It is also important to know what does not work. However, research journals are reluctant to publish studies of interventions that did not succeed. Finally, it was urged not to blur lines between M & E, which is routine, and operational research, which often is not. Countries should not wait for research results before implementing programmes. It is important to implement without delay; make adjustments based on research later.

Session 9

Feedback on the ToR of the PPTCT Task Force

Presentation

Task Force Terms of Reference: proposed revision

Presented by Wing-Sie Cheng, Regional Advisor HIV and AIDS, UNICEF EAPRO

The PPTCT Task Force was founded in 1999 by the Southeast Asia inter-country team at the request of UNICEF EAPRO. At the time, PPTCT was still a little known focus and intervention. The disease burden was high in Thailand, Myanmar and Cambodia. The idea was to establish technical information exchanges, raise awareness and build capacity. It started with five countries and now has grown to 25 across two regions.

In the intervening years knowledge and expertise have grown exponentially. It has moved from a Task Force to a regional interagency team with four co-sponsors and has fostered intense support across countries. Consequently, the terms of reference (ToR) was revised in 2004. A more formal collaboration with MCH is being proposed and so the ToR will need another revision. The first point is a name change from prevention of 'Mother-to-Child Transmission' to 'Parents-to-Child Transmission' to emphasize the role of both parents in preventing paediatric infection.

The 2004 ToR contained three objectives and seven roles. The proposed new ToR will contain one goal and seven objectives as follows:

Goal (3 elements)

- The Task Force as a regional extension of the Global Interagency Task Team (IATT) on PMTCT
- Serves as technical resource and forum for national actions to eliminate mother-to-child transmission of HIV (or eliminate paediatric HIV), scale up HIV prevention among parents, and enhance access to quality services for care, treatment and support of children living with HIV
- Contributes to the achievement of MDGs 4-5-6 in Asia-Pacific

Seven Objectives

1. To **advocate and support mobilization of national leadership** for the virtual elimination of mother-to-child transmission of HIV
2. To provide **technical guidance** for the operationalization of global policies and guidelines and their adaptation to low and concentrated epidemics. Serve as a **platform that represents issues and situations unique to Asia-Pacific** in the deliberation of global policy and guidelines
3. To **facilitate the identification of regional and country specific targets and monitor implementation of new recommendations and progress** (through UN co-sponsors and international partners' on-going country support)

4. To **promote and support effective approaches** to strengthen PPTCT, such as stronger operational linkages
5. To act as a **knowledge resource** by collecting/sharing and disseminating information on PPTCT and care and treatment of paediatric HIV, in collaboration with the AIDS Data Hub for Asia-Pacific (www.aidsdatahub.org)
6. To **coordinate** and liaise with regional UN agencies, national programmes, and technical partners across countries in the Asia-Pacific region on major technical areas of interest and initiatives
7. To **support resource mobilization**

Advocating policy changes is still relevant. But we see the ADB and World Bank taking on the role of analysing the socio-economic impact of HIV. The Task Force is taking on more of the technical side of operating guidelines and implementation. Membership will remain broad and inclusive of those involved in the response, while UNICEF and WHO will continue to serve as the secretariat and lead organizers of Task Force meetings.

Discussion

Discussions revolved around whether the Task Force should become part of the global UN Interagency Task Team (IATT) or stand alone, how to manage the growing membership of the Task Force, and mechanisms to follow up on recommendations from Task Force meetings. While some would like to see a regional or even country IATTs to foster closer linkages, the consensus was that the Task Force should remain an independent entity that links with IATTs but is not a direct extension of IATTs. The Task Force cannot replace technical working groups, but instead can serve as a knowledge-sharing forum. Although expanding participation in the Task Force had made it challenging to manage, restricting participation would run counter to the goals of the group. Alternatively, several suggestions were voiced to establish clusters of countries with similar epidemic scenarios or other characteristics, and smaller sub-groups focused on issues or aspects of the response. It was agreed that more follow up was needed to ensure recommendations from Task Force meetings were actually implemented, although no clear mechanism was agreed upon.

Session 10

Conclusions and recommendations

Three days of vigorous debate, sharing of knowledge and experiences, and the introduction of new goals, developments and aspirations produced a fruitful, interactive and dynamic meeting. Wide-ranging and open discussions, both in the general plenary and in a meeting of core agencies, produced a set of key messages, conclusions and recommendations. The major points are summarized below:

Key Messages

1. This consultation has been driven by an undeniable momentum towards the elimination of new paediatric HIV and CS by 2015/2020.
2. Listening to country experiences and in-depth discussions has bolstered the concept of 'Elimination' as an ambitious but appropriate goal for the Asia-Pacific region.
3. Elimination can contribute towards achieving Millennium Development Goals.
4. The new Conceptual Framework of elimination is a paradigm shift.
5. Strengthen the four prongs as well as the linkages between them to achieve and sustain the elimination of paediatric AIDS. Reducing HIV incidence among women (both female members of key affected populations (KAP) and intimate partners of male KAP) will be critical.
6. Collaboration between SRH, MCH and HIV in the Asia-Pacific region:
 - Until now, fruits of this collaboration are less than optimal in many settings.
 - Elimination agenda provides necessary impetus to push these collaborations to the next level.
7. The new WHO guidelines on ART for adults and adolescents, prevention of mother to child transmission and HIV feeding provide opportunities to reduce MTCT towards elimination.
8. HIV feeding options should be decided by national policies on nutrition and not left to individuals.
9. The new WHO guidelines provide a timely opportunity to significantly reduce the risk of HIV transmission through breastfeeding, while contributing to improved child survival.
10. Strengthening data management in MCH and health systems in coordination with the community, and the innovative use of mobile and information technology are essential to improving referrals, outcome monitoring, and reporting and reducing lost to follow up.
11. Communities, people living with HIV and community-based organizations play important roles in scaling up elimination initiatives and are critical in linking and sustaining HIV prevention, treatment and care, and SRH/MNCH services.

Lessons Learned from Country Experiences

1. Universal testing and counselling is feasible.
2. Leading experiences indicate that expansion of comprehensive services (MCH/ HIV) is feasible when active collaboration between SRH/MCH and HIV is maintained.
3. Use of data and quality data management are essential to monitor and guide an effective response and improve quality of services.

Bringing clarity to cost considerations:

1. Preliminary analysis suggests cost-effectiveness of necessary investments for comprehensive approach even in low prevalence settings. Doing nothing is more expensive in the long run.
2. Synergies between HIV and SRH/MCH are also cost saving.
3. Bottleneck analysis and identifying the additional marginal costs are essential.

Operational Research

Meeting participants acknowledge the role of operational research to improve the coverage and quality of services and address bottlenecks in strengthening synergies between HIV, SRH and MCH and filling gaps and strengthening health systems.

Asia-Pacific PPTCT Task Force

Task Force members have reviewed and endorsed the revised ToR (refer to Annex B).

Recommendations and Next Steps

1. Advocate for high-level political support and appropriate allocation of resources within government framework.
2. Task Force should rapidly finalize the Conceptual Framework taking into account feedback obtained during this consultation. Areas of improvement are as follows:
 - Promoting involvement of men, couples counselling, stigma and discrimination interventions, gender equity
 - Increasing focus on elimination of CS
 - M & E framework including data and information management, data quality, analysis, use and reporting; effective use of ICT to support M & E
 - Including costing tools, operational research
 - Clustering countries based on burden and infrastructure, country plans and performance in the context of commitment on elimination (with consideration to gross national income and national health expenditures)
 - Including paediatric HIV diagnosis and ARV care (early infant diagnosis and linking to paediatric ART services)
 - Including nutrition of positive mothers and infant feeding
 - Emphasizing the links of the four prongs of PMTCT as well as treatment for HIV-positive women
 - Specifying strategies needed to reach KAP and their partners under each prong
 - Detailed baseline data from selected countries, strengthening M & E
 - Role of mental health in increasing uptake of testing and counselling as well as treatment and adherence follow-up
 - Entry points to health systems strengthening and consideration to human resource management and family centred approach
 - Listing a logical sequence through the cascade of collaborative activities between HIV/MNCH/SRH (checklist)
 - Providing examples from countries with analysis of their effectiveness/ impact
3. Countries will initiate a process to adapt the framework to:
 - Re-energize existing mechanisms to link HIV and SRH/MCH programmes, conduct situational analysis, and develop appropriate targets and timelines.
 - Develop a country specific strategy and an operational plan, with focus on the following:
 - How to achieve universal antenatal HIV and Syphilis screening including KAP, point of care testing, and serial rapid testing

- Revising national guidelines, including selection of appropriate effective regimens
 - Defining the role of nutrition and/or MCH programmes in order to expand the availability of skilled counsellors, including support to promote appropriate maternal nutrition and infant feeding practices in the context of HIV
 - Identifying key opportunities (financial and advocacy) both internal and external
 - Linking with MDGs
 - Quick wins
- Phasing of implementation:
 - By geographic area, by year, by programmatic components
- Service delivery models
 - Investing and analysing service delivery models including their effectiveness and impact
- Generating, analysing and using the documentation of lessons learnt to foster optimal PMTCT services, including infant feeding practices and linkages between HIV and SRH in the context of low HIV epidemic settings and middle income countries
4. The Asia-Pacific PPTCT Task Force will:
- Reflect in the ToR the comprehensive and broader agenda of elimination of CS and its link to MDGs.
 - Support monitoring of progress of the eliminating of new paediatric AIDS initiative through a web-based platform.
 - Share information, provide updated guidance, and put in place a mechanism for countries to share new data.
 - Provide platforms to assess the efficacy and effectiveness of different service delivery models in Asia-Pacific countries.
 - Optimize existing platforms and networks, support development of new collaborations between HIV, MCH, STI, and a study of emerging and neglected issues.
 - Continue providing technical assistance through member UN Agencies of the Asia-Pacific Task Force (including IPPT, ICMGH, and FHI).
 - Support countries to mobilize resources for the elimination initiative (Global Fund Round 11).

There are many challenges – but each is an opportunity to improve the health of women and children, including those affected by HIV/STI.



Closing remarks

Delivered by Dr. Chansy Phimphachanh of the Lao PDR Ministry of Health, Dr. Shial Aya of Safe Motherhood in Nepal, Dr. Massimo Ghidinelli of WHO WPRO and Wing-Sie Cheng of UNICEF EAPRO

Dr. Chansy expressed gratitude to the government of Lao PDR for allowing the meeting to be organized in Vientiane and added that it had served to raise awareness in the Ministry of Health about linkages between MCH and HIV. Both programmes are young in Lao PDR and much was learned from participating in the meeting. Dr. Shial agreed that the meeting was a great opportunity for learning, especially as Nepal takes its early steps towards providing Universal Access. Dr. Ghidinelli noted that the PPTCT Task Force is one of the longest serving Task Force in the UN, and it remains relevant and continues to generate strategic thinking to keep HIV-positive mothers and their children alive. Wing-Sie Cheng added that the PPTCT Task Force meeting is one of the most well-attended, underscoring the significance of issues affecting women and children. Joint leadership will be the key to success. Sincere gratitude was expressed to Lao PDR for hosting the meeting, to participants and particularly to support staff from WHO, UNICEF and UNAIDS Lao country offices, WHO WPRO, UNICEF EAPRO, APSSC and ROSA whose logistical savvy and dedication made the meeting possible and a success.



Day Four: 26 November, 2010

Meeting of the UN PPTCT Task Force

Welcome, introductions and purpose of the meeting

Dr. Massimo Ghidinelli, WHO WPRO and Wing-Sie Cheng, UNICEF EAPRO

Subsequent to the 8th Meeting of the Asia-Pacific United Nations Task Force for PPTCT of HIV, representatives from the two core Secretariat Members – WHO and UNICEF – and other UN and international partners gathered to discuss the events and outcomes of the previous three days. Conducting a more extensive review of the Task Force ‘Terms of Reference’ and the meeting’s ‘Conclusions and Recommendations’ were main items on the agenda.

Dr. Ghidinelli sought feedback and opinions on whether the meeting had been inclusive and comprehensive, or whether important points had been overlooked. He asked participants to translate recommendations into action points and discuss next steps for the coming year, and to consider what structure would best suit the Task Force. Pursuing a dialogue with MCH colleagues is of primary importance as little can be achieved without active collaboration. Wing-Sie Cheng declared the meeting is historic for its adoption of the campaign to eliminate PTCT and CS. That effort will require all participants to give their best. As such, the follow-up meeting was organized to discuss joint actions that could be taken.

Discussion

The goal of elimination is ambitious. However, it was noted that previous campaigns, such as the 3 x 5 campaign, were also regarded as overly ambitious when they were initiated. Nonetheless, it moved people to work towards a common goal through an inspiring vision with a conceptual framework. A point was raised that the term elimination may be received negatively by those living with HIV, as they may associate it with feelings of society wanting to eliminate them, as evidenced by continuing stigma and discrimination. HIV is a sensitive issue in many societies and so sensitivities must be considered in any terminology adopted for the campaign.

Weak collaboration with the MCH sector was a common concern. The targets of country MCH programmes were unknown to most HIV responders. The push for integration and mainstreaming appears to be coming from HIV with little pull from MCH. PPTCT and CS coverage will depend on MCH coverage, but MCH coverage is inadequate in many countries to achieve elimination through that infrastructure. Expanding MCH coverage as a common goal could be one way to forge a closer alliance with MCH, but strategies on how to do that were not discussed at the meeting. MCH is very focused on reducing maternal mortality, but it was noted that PPTCT has a very small statistical impact on that and so it will be difficult to convince MCH to channel resources to PPTCT. To build stronger linkages, HIV in each country has to learn more about MCH and seek out common denominators based on the country context. Although China provides an excellent example of how this can be scaled up and achieved, there is not one single recipe.

The linkage with eliminating CS was also a topic of concern. Some HIV responders said there was not enough discussion on how to achieve ECS, not just from a medical perspective but also from a social perspective. In some countries, testing for and treating syphilis is officially part of ANC services, but is not being implemented for various reasons. The feeling was expressed that two vertical programmes were being built. One suggestion was to take a more diagonal approach: how a high volume of certain interventions could be used to strengthen health systems overall. In that way, the goals would appear more feasible and practical.

Other issues raised were the lack of data to support implementation, and logistical challenges in resource-constrained countries.

Moderators responded that the first priority should be to build communications and dialogues with MCH partners in countries. The push for elimination can take advantage of the increasing global focus on health issues and MDGs to build something stronger than what existed before. It won't be easy, but it is an opportunity. In setting forth the agenda and the conceptual framework, a level of success has already been achieved. Now it is time to work for success in implementation.

Review conclusions/recommendations of the 8th PPTCT Task Force meeting

Moderated by Dr. Bob Verbruggen, UNAIDS RSTAP

The draft of the conclusions and recommendations presented at the close of the Task Force meeting was put forth for discussion, debate and amendment. The conclusions and recommendations appearing in this report reflect the results of discussions on both occasions and afterwards by secretariat members.

Some points raised during the discussion on the fourth day were to: pursue programmes at scale; include SRS and SRH in linkages; strengthen all four prongs of the response, using quality data management (as opposed to merely data) to improve quality of services; urge the undertaking of systematic assessments to identify bottlenecks; and involve the community in operational research to ensure its relevance.

For recommendations and next steps participants made a number of amendments, among them include adding couples counselling and nutrition for HIV-positive mothers, and listing a logical sequence through the cascade of collaborative activities between HIV/MNCH/SRH; investing and analysing service delivery models including their effectiveness and impact; and supporting countries to mobilize resources and funding for elimination.

Dr. Ghidinelli said the final version of the Conclusions and Recommendations would be completed in a matter of days. The document would be circulated to participants to be used to shape country discussions about collaboration and what actions need to be taken.

Review and Agreement on UN PPTCT Task Force ToR

Moderated by Wing-Sie Cheng, UNICEF EAPRO

The key revision to the ToR for the Task Force was to narrow down several objectives into one overarching goal with seven supporting objectives. The final ToR appears in Annex B.

Another important issue was structure: should the Task Force become an extension of the global IATT, and whether country IATTs should be formed. The need for rapid response, including the formation of technical working groups to assist countries was cited as a rationale for remaining independent of the global IATT. The global IATT structure does not lend itself to understanding the region in-depth or rapidly establishing technical working groups. The consensus was that the Task Force would remain a Task Force, not a regional IATT. Countries said they had several channels through which to work with other divisions and so formally prescribing country IATTs was not necessary, although might be appropriate in some settings.

On membership, it was decided that all parties involved or interested in the response and the goals being pursued by the Task Force could be members. The secretariat, however, will remain populated by the four core members: UNICEF, WHO, UNAIDS and UNFPA. It was also decided that the Task Force would aim to meet twice during every three-year period.

Other points mentioned included adding the term 'health system strengthening' to objectives, whether to refer to elimination as an initiative rather than a campaign, developing a strong web platform to support data collection and dissemination, creating core groups in country to monitor progress and accountability, and developing a communications strategy.

Way forward and closing comments

Moderated by Dr. Massimo Ghidinelli of WHO WPRO, Wing-Sie Cheng of UNICEF EAPRO, Rachel Odede of UNICEF ROSA and Dr. Iyanthi Abeyewickreme of WHO SEARO

The discussion on elimination needs to continue, said Dr. Ghidinelli. Several fora exist through which that can happen, but there is no time to wait. Actions at country level should move forward. The ability to communicate with donors will make a difference. The success of the campaign will depend to some degree on how deeply the goal of elimination is embedded in national planning. Funding for the response is shifting away from donors and global sources to the countries themselves. The discussions were intense and fruitful, and all were thanked for investing their time and efforts into attending and making the meeting a success. Going forward, it will be critical to maintain a dialogue on elimination at the global level if the goals are to be achieved.

Annex A

Programme of activities

Day 1 – Tuesday, 23 November 2010		
08:00–08:30	Registration	
08:30–09:45	Opening session Master of ceremonies	Dr. Bounpheng Philavong
	Welcome statement and opening remarks <ul style="list-style-type: none"> World Health Organization 	Dr. Hans Anders Troedsson
	<ul style="list-style-type: none"> United Nations Children’s Fund 	Dr. Festo Kavishe
	<ul style="list-style-type: none"> United Nations Population Fund 	Mieko Yabuta
	<ul style="list-style-type: none"> Joint United Nations Programme on HIV/AIDS 	Dr. Bob Verbruggen
	<ul style="list-style-type: none"> Ministry of Health, Lao PDR 	Dr. Ponmek Dalalay
	Overview of meeting objectives and expected outcomes (10 mins)	Dr. Iyanthi Abeyewickreme
	Introduction of participants by countries / institutions (10 mins)	Master of ceremonies
	Group Photo (10 mins)	
9:45-10:15	<i>Coffee break: Administrative announcements</i>	Editha Venus-Maslang
Session 1. Progress towards elimination of paediatric HIV and plan for eliminating congenital syphilis Chairperson: Dr. Lokman Hakim Sulaiman		
10:15-10:35	1.1 Global overview (20 mins)	Dr. Chewe Luo
10:35-10:55	1.2 Asia-Pacific overview (20 mins)	Dr. Massimo Ghidinelli
10:55-11:10	Discussion - Questions/clarifications	
11:10-12:25	Country progress (15 mins each) <ul style="list-style-type: none"> Lao People’s Democratic Republic India China Papua New Guinea Myanmar 	Dr. Chansy Phimpachanh Dr. Suresh Mohammed Dr. Wang Linhong Dr. Lahui Geita Dr. Theingi Aung
	Discussion – Questions / clarifications	
12:20-12:45	Discussion – Questions / clarifications	
12:45-14:00	<i>Lunch break</i>	
Session 2. New WHO guidelines and implications towards virtual elimination of MTCT (2 hrs 15 min) Chairperson: Dr. Suresh Mohammed		
14:00-16:00	<ul style="list-style-type: none"> New WHO guidelines on PMTCT and ART Adapting PMTCT guidelines in Thailand Cost estimates for the national PMTCT programme in Thailand and financing the new PMTCT policies (triple combination ARV and couples testing and counselling) 	Dr. Ying-Ru Lo Dr. Nipunporn Voramongkol Dr. Sorakij Bhakeecheep
16:00-16:30	<i>Coffee break</i>	
16:30-17:00	Session 2 (continuation)	
17:00-17:30	<ul style="list-style-type: none"> Joint action for results: UNAIDS outcome framework – PMTCT business case 	Dr. Chewe Luo
18:00	<i>Welcome reception</i>	

Day 2 – Wednesday, 24 November 2010

Session 3. Draft Asia-Pacific framework for the elimination of paediatric HIV and congenital syphilis (2 hrs)

Chairperson: Dr. Fonny Sylfanus

8:30-8:45	<ul style="list-style-type: none"> Global technical consultation on the Elimination of Mother-to-Child Transmission of HIV 	Dr. Ying-Ru Lo
8:45-10:00	<p>Regional framework to eliminate new paediatric infections:</p> <ul style="list-style-type: none"> Draft conceptual framework: Vision, goals, targets and objectives Strategic directions: <ul style="list-style-type: none"> Priority actions towards elimination Monitoring and evaluation framework 	Dr. Massimo Ghidinelli Dr. Teodora Wi
10:00-10:30	<i>Coffee break</i>	
10:30-11:15	Q/A and discussion on conceptual framework and M&E framework	Dr. Massimo Ghidinelli Dr. Teodora Wi Dr. Padmini Srikanthiah Nina Hakamies
11:15-12:00	<p>Countries commit towards elimination of paediatric infections</p> <ul style="list-style-type: none"> Scaling up PMTCT through the Linked Response in Cambodia 	Dr. Ngauv Bora
	<ul style="list-style-type: none"> Steps towards commitment to the elimination of paediatric HIV infections in Nepal 	Dr. Krishna Kumar Rai
	<ul style="list-style-type: none"> Towards elimination of paediatric HIV by 2015: The Malaysian experience 	Dr. Lokman Hakim Sulaiman
12:00-12:30	Discussion	
12:30-13:30	<i>Lunch break</i>	

Session 4. PMTCT in the context of MCH, health systems strengthening and community engagement (2 hrs)

Chairperson: Dr. Endang Budi Hastuti

13:30-14:00	<ul style="list-style-type: none"> MCH perspectives in the provision of PMTCT services 	Dr. Razia Pendse
	<ul style="list-style-type: none"> Measuring progress towards the elimination of MTCT – leveraging ICT effectively for PMTCT data management 	Wing-Sie Cheng
14:00-15:30	<ul style="list-style-type: none"> Thailand's experiences in strengthening data and information management to monitor PMTCT outcomes 	Dr. Rangsima Lolekha
	<ul style="list-style-type: none"> Engaging women living with HIV to improve access to services for HIV-positive mothers and their children 	Kirenjit Kaur
	<ul style="list-style-type: none"> Pakistan PPTCT Programme Experience: Evidence and Revised Strategic Approach 	Dr. Naveeda Shabbir
	<ul style="list-style-type: none"> Freeing newborns of HIV – the Mingindie experience, Papua New Guinea 	Margarete Maria Hunhoff

Session 5. Group work (2 hrs)

15:30-17:30	<p>Introduction to group work</p> <ol style="list-style-type: none"> Ensuring commitment to achieve goals 	Dr. Padmini Srikanthiah Facilitators: Dr. Naoko Ishikawa
	<ol style="list-style-type: none"> Employing highly effective interventions 	Dr. Padmini Srikanthiah
	<ol style="list-style-type: none"> Enhancing provision of comprehensive, linked HIV/STI and MCH services 	Prof Jane Fisher
	<ol style="list-style-type: none"> Ensuring equitable access to services 	Dr. Paula Bulancea
	<ol style="list-style-type: none"> Supporting health systems development to achieve MCH and HIV/STI outcomes 	Dr. Teodora Wi
	<ol style="list-style-type: none"> Improving measurement of programme performance and impact 	Dr. Bob Verbruggen
	<i>Coffee break during group work</i>	

Day 3 – Thursday, 25 November 2010

Session 5. (continuation)

Chairperson: Dr. Iqbal Ahmed Lehri

8:30-10:00	Plenary session – presentation of group work – 15 min per group (1½ hrs)	
10:00-10:30	<i>Coffee break</i>	

Session 6. Cost estimates (30 mins)

Chairperson: Dr. Vong Sathianary

10:30-11:00	<ul style="list-style-type: none"> • Cost implications of elimination of mother-to-child transmission of HIV in low and concentrated epidemics • Introducing marginal budgeting for bottlenecks (MBB), a tool for prioritizing strategies and options for maternal and child health, including PMTCT 	Dr. Naoko Ishikawa Dr. Kyaw Myint Aung
11:00 –11:15	Discussion (15 mins)	

Session 7. Operational research (1 hr)

Chairperson: Rachel Odede

11:15 -12:15	<ul style="list-style-type: none"> • Knowledge gaps in the framework: implementation research priorities • Operational research priorities • Addressing issues in PMTCT • Experience in operational research in India 	Dr. Padmini Srikantiah Dr. Kazuhiro Kakimoto Prof Jane Fisher Dr. Suresh Mohammed
12:15 -13:30	<i>Lunch break</i>	

Session 8. Panel discussion (1 hr)

Chairperson: Dr. Somehit Akkhavong

13:30-14:30	Partnerships, technical assistance and resource mobilization: Countries' views on partnership with UN, bilateral organizations and INGOs <ul style="list-style-type: none"> • China • Cambodia • Sri Lanka • Viet Nam • WHO Collaborating Centre – Melbourne University • Family Health International (FHI) 	Dr. Wang Ailing Dr. Tith Khimuy Dr. Sujatha Samarakoon Dr. Luu Thi Hong Prof Jane Fisher Dr. Kathleen Casey
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Session 9. Feedback on the Terms of Reference of the PPTCT Task Force (30 mins)

Chairperson: Sonan Wangdi

14:30-15:00	Terms of Reference of the PPTCT Task Force	Wing-Sie Cheng
15:00-16:00	<i>Coffee break</i>	

Session 10. Conclusions and recommendations

Chairperson: Dr. Honorata L. Catibog

16:00-16:30	Conclusions and recommendations including adoption of the revised Terms of Reference of the PPTCT Task Force	WHO, UNICEF, UNAIDS, UNFPA
16:30	Closing session	

Annex B

Revised Terms of Reference

Asia-Pacific Task Force on the Prevention of Parents-to-Child Transmission of HIV and Care Support and Treatment for Paediatric HIV

Goal

The Task Force will serve as a regional technical forum in support of national actions to eliminate new HIV infections in children and congenital syphilis, scale up HIV prevention among parents, enhance access to quality services for care, treatment and support of children and families living with HIV, and contribute to the achievement of MDG 4, 5, and 6 in Asia-Pacific.

Objectives

1. To advocate for and support mobilization of national leadership for the elimination of new infections in children and congenital syphilis.
2. To provide technical guidance for the operationalization and adaptation of global policies and guidelines in low and concentrated epidemic settings that prevail in Asia-Pacific. The Task Force shall also serve as a platform that represents issues and situations specific to Asia-Pacific, including health system strengthening and the elimination agenda, in the deliberation of global policy and guidelines.
3. To facilitate the development of a regional framework and country roadmaps and to monitor their implementation through UN co-sponsors and international partners' on-going country support. This includes development of targets and service models and the provision of technical assistance according to countries' epidemic status and needs.
4. To promote and support effective approaches to strengthen PPTCT, syphilis diagnostics and treatment and health system strengthening, such as stronger operational linkages between MCH, paediatric, reproductive health and HIV/STI services.
5. To act as a knowledge resource by generating, documenting and disseminating knowledge on PPTCT, care and treatment of paediatric HIV, maternal HIV and syphilis. The mechanism of communication includes technical meetings and a knowledge management website that monitors elimination progress (in conjunction with the Asia-Pacific AIDS Data Hub).
6. To support operational research by fostering dialogues and networking with academic and research institutions.
7. To coordinate and liaise with regional UN agencies, national programmes, regional bodies and technical partners across countries in the Asia-Pacific region on major technical areas of interest and initiatives.

Organization

1. Membership

- a. Regional representatives of the Inter-Agency Task Team (IATT), including four UN agencies (UNICEF, WHO, UNFPA, UNAIDS) and US CDC, and other International Organizations and Foundations e.g. National Centre for Global Health and Medicine, Japan; Family Health International; International Planned Parenthood Federation; and bilateral organizations

- b. Policymakers and programme managers of national governments, including HIV and MCH, Sexual Reproductive Health and nutrition programmes
- c. Technical experts/partner organizations in the field of PPTCT and treatment, care, and support for paediatric HIV
- d. Regional networks and organizations such as the Asia-Pacific Positive Network (APN+), the Association of Southeast Asian Nations (ASEAN), the South Asian Association for Regional Cooperation (SAARC) and the Secretariat of the Pacific Community (SPC)

2. Secretariat

UNICEF and WHO will jointly serve as Secretariat of the Task Force, and organize bi-regional or joint Asia-Pacific regional meetings twice in three years, on a geographic, rotational basis, with the support of Task Force members, in particular, the Core Group of regional members.

The Core Group members comprising both MCH and HIV/STI sectors of the four UN agencies (UNICEF, WHO, UNAIDS and UNFPA) and international partners (IPPF, NCGM, FHI) should meet annually to monitor and review progress. On-going dialogues through e-Forum and emails will also be utilized.

Background

The Task Force on the Prevention of Mother-to-Child HIV Transmission (PMTCT) was set up in 1998 by the UNAIDS Southeast Asia-Pacific Inter-Country Team (SEAPICT) at the request of one of its co-sponsors, UNICEF East Asia-Pacific Regional Office (EAPRO). The intent was to establish a technical and information exchange forum to raise awareness, know-how and capacity for implementing global guidelines to prevent HIV in newborns among countries in Southeast Asia. At the time, PMTCT interventions were piloted on a small scale in Southeast Asia. Many countries were at the stage of examining global guidelines for national adaptation and training to prepare healthcare providers for ARV prophylactic treatment to reduce transmission risks in newborn.

The first Task Force meeting took place in Northern Thailand (Region 10) in 1998, hosted by the Ministry of Public Health, which had made a head start with clinical trials on efficacious ARV regimen, and scaled up PMTCT services in the mid-1990s. By 2004, at its 5th meeting, participants expressed interests to expand the Task Force's membership beyond Southeast Asia to share PMTCT knowledge and experiences with a larger number of countries in Asia-Pacific.

The Task Force Secretariat, UNICEF EAPRO, agreed in 2004 to jointly organize the regular forum alternately with the UNICEF Regional Office for South Asia at least twice a year, or thrice in two years. The venue of the Task Force meeting would be opened to other countries besides Bangkok, Thailand, alternating between East Asia-Pacific and South Asia. The national government of the venue selected would host and preside over as Chair of the Task Force meeting, supported by the Secretariat and the national office.

The regional members, comprising UNICEF, WHO, UNFPA and UNAIDS, would work closely with the Secretariat to jointly identify issues, set agendas and invite members to the Task Force forums.

The ToR of the Task Force was revised to reflect a progressive change of PMTCT foci from initial pilots to scaling up as more was known about the AIDS epidemics, as more efficacious antiretroviral drugs became available and cheaper, which also coalesced with WHO's global 3 x 5 initiative to ensure 3 million people were on ART by 2005.

Paediatric HIV care, support and treatment – for exposed children born undetected and testing HIV positive – also became an integral part of the PMTCT agenda. Since then, the Task Force had fostered greater exchanges of knowledge and experience, and through its regional members and their country offices, supported governments with strengthening PMTCT and paediatric HIV treatment services.

Common issues identified over the years included the need to adopt more efficacious ARV regimens to

reduce transmission risks, evidence-informed scale up given that not all provinces and states had similar HIV prevalence, and to address a high rate of loss to follow-up owing to weak referral management, inadequate data management and inter-departmental operational linkages.

Over the years, national actions to scale up PMTCT had raised coverage from 19 per cent in East Asia-Pacific and 5 per cent in South Asia in 2004 to 37 per cent and 21 per cent in 2008, respectively. For Asia-Pacific region as a whole, testing coverage for pregnant women was still low. Only 17 per cent of pregnant women (with annual pregnancies of 69 million in Asia-Pacific) had been tested and 33 per cent received antiretrovirals for PMTCT in 2009 (Universal Access 2010). The huge population denominator with a regional HIV prevalence below 0.5 per cent necessitated the adaptation of strategies to test pregnant woman in accordance with national situation.

Scale-up of services based on surveillance data and close monitoring of sub-regional prevalence thus become important considerations. Strengthening operational linkages between departments – MCH, OI/ART services and paediatric care – will ensure that pregnant women test HIV-positive will access CD4 test, given appropriate ARV prescription, deliver at PMTCT sites, return with their HIV-exposed newborns for early infant diagnosis, and eventually enroll in life-long ARV treatment. Further linkages with Sexual Reproductive Health and STI services will ensure that couples are counselled and partners of those at-risk of HIV are tested as well and referred for PMTCT.

Recent major Task Force actions

The Task Force came together on its 6th meeting in 2006 to address issues of operational linkages by fostering dialogues between the MCH, SRH, paediatric care, ART services and the national AIDS programme through a Joint Forum. Seven regional offices: UNICEF EAPRO, ROSA, WHO WPRO, SEARO, UNFPA CST EAP and South Asia as well as UNAIDS RSTAP jointly convened a bi-regional consultation in Kuala Lumpur, Malaysia, attended by delegates from over 20 countries, to consult the MCH sector on integration or operationally linking comprehensive PMTCT through the continuum of HIV prevention, treatment and care services. It was held back to back with the 6th Task Force meeting to ensure participation from all of the concerned departments in one forum.

The following joint UN actions were taken:

1. Development of a Regional Conceptual Framework linking sexual, reproductive, maternal and newborn health for comprehensive prevention of mother-to-child transmission, as basis for the Joint Forum consultation in November 2006.
2. A further consultation with 10 governments, convened by WHO WPRO in May 2007 and hosted by the People's Republic of China in Guilin, Guangxi Province, to operationalize the framework.
3. Finalization of the Joint WHO-UNICEF-UNFPA-UNAIDS Asia-Pacific Operational Framework for Linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services in July 2007, also known as "The Guilin Framework".
4. Piloting "operational linkages" in four priority countries: Cambodia, China, Papua New Guinea and Viet Nam, through a joint UNICEF-WHO proposal in 2007– 2008 that led to a small grant of \$100,000 from UNAIDS' Programme Acceleration Fund.
5. An Inter-Country consultation on "Expanding Linkages between HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services" in Phnom Penh, Cambodia, July 2009, to review progress of the pilots and discuss lessons learned.

The meeting, jointly organized by WHO WPRO and UNICEF EAPRO, and hosted by the Government of

Cambodia, also saw the early results of operational linkages in the form of a “Linked Response” model that not only reached more pregnant women needing PMTCT services and HIV-exposed newborns, but also ensured PMTCT outcomes were accounted for and followed through.

6. A cost-effectiveness analysis of Cambodia’s “Linked Response” to PMTCT through operational linkages of SRH, MNCH and HIV/STI services conducted by the Economist Intelligence Unit, Asia Division, jointly commissioned by UNICEF and WHO for policy advocacy, August 2009 (on-going until April 2010).

The regional Inter-agency task team (IATT) members, namely UNICEF, WHO, UNFPA and UNAIDS, also collaborated with the Global IATT and national governments to conduct national PMTCT programme reviews in five countries since 2004:

- India (2005)
- Myanmar (2006)
- Cambodia (2007)
- China (2008)
- Papua New Guinea (2009)

The IATT recommendations were subsequently adopted by governments to fine-tune and improve the management, operational linkages, the quality and monitoring and evaluation of PMTCT services.

Recent recommendations

The 7th Task Force meeting, organized jointly by UNICEF ROSA and WHO SEARO and hosted by the Government of India in Chennai, Tamil Nadu, September 2009, further emphasized the importance of strengthening operational linkages in support of comprehensive PMTCT.

Some of the Task Force’s roles such as situation assessment, collaborating with countries to identify needs and priorities for assistance, are deemed less relevant now compared to 2004. National capacity has enhanced over the years along with increased technical resources from UN co-sponsors’ to support PMTCT implementation together with governments.

At the same time, new HIV transmission trends among intimate partners, the growing proportion of women newly infected in Asia-Pacific, and the need for intensified actions to free children of HIV, also call for the re-examination of the Task Force’s role and focus. As a result, several recommendations were made among regional members and participants at the meeting in relation to the Task Force:

- Update and revise the 2004 Terms of Reference to reflect new priorities for PPTCT in the region.
- Rename the Task Force to emphasize the Prevention of PARENTS TO CHILD HIV TRANSMISSION. The rationale is to draw attention to comprehensive PMTCT, which includes prevention among pregnant women, who in Asia-Pacific are largely infected by their husband or male partner, and the prevention of HIV among men with high-risk behaviours, as ultimate means of freeing children of HIV.
- Emphasize Task Force’s role in promoting monitoring of PPTCT outcomes, accountability of results and reporting through enhanced operational linkages and evidence-informed scale-up.
- Provide technical guidance on rollout of new WHO guidelines on PMTCT regimens, HAART for mothers, infant feeding and early infant diagnosis.
- Advocate bold goals for the region: towards the elimination of mother-to-child transmission and congenital syphilis.
- Greater knowledge generation and dissemination through creative means – besides meetings – and foster a community of practices on PPTCT, early infant diagnosis and paediatric HIV treatment.
- Diffusion of good practices – referral management, decentralized actions, including greater support for exclusive breastfeeding for six months.
- Bi-regional: more active engagement of all major co-sponsors and UNAIDS Secretariat from both regions.
- A suggestion for WHO to cooperate with UNICEF as Joint Secretariat of the Task Force, which is favourably considered given WHO’s major role in technical guidelines development and its on-going partnership with UNICEF in the region.

Annex C

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