Meeting on Strengthening Monitoring the Health Sector Responses to HIV/AIDS in the Western Pacific Region

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Meeting on Strengthening Monitoring the Health Sector Responses to HIV/AIDS in the Western Pacific Region

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NOTE

The views expressed in this report are those of the participants in the Meeting on Strengthening Monitoring the Health Sector Responses to HIV/AIDS in the Western Pacific Region and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Meeting on Strengthening Monitoring the Health Sector Responses to HIV/AIDS in the Western Pacific Region, which was held in Manila, Philippines from 2 to 4 December 2010.

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Keywords: Acquired immunodeficiency syndrome/ HIV infections/ Health care sector

Acronyms

ADB	Asia Development Bank
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CDC	Centers for Disease Control and Prevention
CTX	cotrimoxazole
CQI	continuous quality improvement
EWI	early warning indicators
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
IDU	injecting drug user
MARPs	most-at-risk populations
MDG	Millennium Development Goal
MCH	maternal and child health
M&E	monitoring and evaluation
MSM	men who have sex with men
OI	opportunistic infections
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
SGS	second generation surveillance
STI	sexually transmitted infection
SRH	sexual and reproductive health
TB	tuberculosis
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization

SUMMARY

A Meeting on Strengthening Monitoring the Health Sector Responses to HIV/AIDS in the Western Pacific Region was held from 2 to 4 December 2009 for HIV/AIDS programme managers and strategic information focal persons in the Region to share the latest findings, report on progress since the last meeting on strategic information in July 2007, and identify challenges and opportunities for strengthening the monitoring and evaluation of health sector responses to HIV/AIDS.

Forty-nine participants from 10 countries and areas (Cambodia, China, Fiji, Hong Kong [China], the Lao People's Democratic Republic, Malaysia, Mongolia, Papua New Guinea, the Philippines and Viet Nam) and five partners (Asian Development Bank, Joint United Nations Programme on HIV/AIDS [UNAIDS], United Nations Children's Fund [UNICEF], United States Centers for Disease Control and Prevention [CDC] and the HIV/AIDS Data Hub) attended the meeting, collaborating in the domain of HIV strategic information.

The objectives of the meeting were:

(1) to review progress and share experiences and lessons learnt on implementing WHO's framework for monitoring health sector responses to HIV/AIDS;

(2) to identify gaps and key challenges and agree on key steps to strengthen the monitoring and evaluation (M&E) system and to implement the WHO framework in the Region, with particular focus on monitoring and evaluation of antiretroviral therapy (ART) and prevention programmes for most-at-risk populations (MARPs); and

(3) to formulate action points for enhancing reporting of health sector responses to HIV/AIDS in Western Pacific Region countries.

During the meeting, a range of technical updates and country experiences were shared, focusing on strengthening strategic information on prevention, treatment, care and support in the Region. A variety of formats were used throughout the proceedings, including plenary presentations, group work, as well as panel discussions. It was concluded that significant progress had been made in implementing the WHO monitoring framework for health sector response to HIV/AIDS in the Region. It was reported that the data and information collected through the process are a powerful tool for high-level advocacy, policy-making, planning of interventions and resource mobilization. However, there are still important gaps in the capacity, guidance and information for monitoring and evaluation of intervention for MARPs in countries. There is also a need for standardization and capacity-building for ART patient monitoring. Participants suggested ways to improve the Universal Access reporting tools and indicators.

1. INTRODUCTION

1.1 Background

Strengthening strategic information has been one of the five strategic directions of the WHO HIV/AIDS programme to guide more effective health sector responses to HIV/AIDS. Key components of strategic information for the health sector include: (1) second generation HIV surveillance (SGS); (2) HIV/AIDS estimation and projection; (3) monitoring of priority interventions of the health sector's response; (4) surveillance and monitoring of HIV drug resistance; and (5) specific surveys and operational research.

Since the launch of the "3 by 5" initiative in 2003, WHO has intensified its efforts in monitoring the health sector's responses to HIV/AIDS in countries, together with partners such as UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and The US President's Emergency Plan for AIDS Relief (PEPFAR). For example, WHO's framework on monitoring and reporting the health sector's response to HIV/AIDS, which was published in 2005, has been revised and reprinted since. Progress reports on the health sector's response to HIV/AIDS towards universal access were published in 2007, 2008 and 2009. These reports have been widely distributed and cited as authoritative sources of information. Meanwhile, WHO has intensified its technical support to countries for monitoring and evaluating HIV/AIDS programmes. A number of technical guidelines, including patient monitoring for HIV care and antiretroviral therapy (ART), M&E on prevention of mother-to-child transmission (PMTCT) and testing and counselling, have been developed and published. Strategies and guidelines have been developed and implemented for prevention and assessment of HIV drug resistance in the context of rapidly scaling up ART globally. All these activities and efforts have greatly promoted WHO's profile as the leading technical agency for health sector responses to HIV/AIDS.

In July 2007, the WHO Regional Office for the Western Pacific Region, for the first time, convened a technical meeting on strengthening strategic information for HIV/AIDS in the Region. In this meeting, participants reviewed and discussed the WHO framework on monitoring health sector responses to HIV/AIDS, and proposed ways and measures to strengthen the monitoring of health sector responses to HIV/AIDS among countries. Since then, much progress has been made and many lessons have been learnt in implementing the framework in countries. Now, more countries are reporting higher-quality data on the epidemic and the responses, owing to their strengthened M&E capacity. However, it is also realized that there are still gaps for the collection, analysis and utilization of strategic information in countries. It is now a relevant time to review the progresses in M&E of the HIV/AIDS programmes in countries, and propose ways for improvement.

This meeting is the second since 2007, which called together national programme managers and strategic information focal points of the ministries of health of countries in the Region, together with key regional partners. It is intended to provide an opportunity for countries to review and follow up the progresses and activities in implementing the WHO framework, discuss gaps and challenges, and agree on the next steps for sustained implementation. It also gives special attention and focus to areas relevant to the monitoring and evaluation of health sector responses to HIV in countries of the Region, in particular the monitoring and evaluation of prevention programmes for most-at-risk-populations (MARPs).

1.2 Objectives

(1) To review progress and share experiences and lessons learnt on implementing WHO's framework for monitoring health sector responses to HIV/AIDS.

(2) To identify gaps and key challenges and agree on steps to strengthen the monitoring and evaluation system and to implement the WHO framework in the Region, with particular focus on the monitoring and evaluation of antiretroviral therapy and prevention programmes for most-at-risk populations.

(3) To formulate action points for enhancing reporting of health sector responses to HIV/AIDS in Western Pacific Region countries.

1.3 Meeting participants

The meeting was participated by programme managers and strategic information focal persons from 10 Western Pacific Regional countries and areas, as well as representatives from regional development partners, including Asian Development Bank, UNICEF East Asia and the Pacific Regional Office, UNAIDS Regional Support Team and Philippine Country Office, United States Centers for Disease Control and Prevention (CDC) Global AIDS Programme, and HIV/AIDS Data Hub for the Asia Pacific Region.

1.4 Opening remarks

The opening remarks of Dr Shin Young-soo, WHO Regional Director for the Western Pacific, were delivered by Dr Tee Ah Sian, Director, Combating Communicable Diseases. She welcomed the representatives and partners to the meeting. She stated that countries in the Western Pacific Region have made significant progress in a number of areas of HIV prevention, treatment and care, including enhanced country capacity in strategic information. She highlighted the challenges in monitoring and reporting health sector responses, especially targeted interventions for most-at-risk populations, such as sex workers, injecting drug users (IDUs), and men who have sex with men (MSM). She emphasized the importance of strengthening strategic information for maximizing the health sector's contribution towards the goal of universal access to HIV/AIDS services.

1.5 Appointment of chairpersons and rapporteurs

Dr Esorom Daoni of Papua New Guinea and Dr Ma Ye of China were appointed as Chairpersons on Day 1. Dr Chansy Phimphachanh of the Lao People's Democratic Republic and Dr Genesis May J. Samonte of the Philippines were appointed on Day 2. Dr Sha'ari Ngadiman of Malaysia and Dr Ly Penh Sun of Cambodia were appointed on Day 3.

Dr Madeline Salva of the WHO Representative Office in the Philippines and Dr Harpal Singh of the WHO Representative Office in Malaysia were appointed as the rapporteurs.

2. PROCEEDINGS

2.1 Session 1 - Overview on strengthening strategic information for the HIV/AIDS programme

The first session provided an overview of the global and regional progress in M&E reporting, , particularly through: the WHO Framework for Monitoring and Evaluating the Health Sector Response to HIV/AIDS, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), and reporting on prevention of mother-to-child transmission (PMTCT) of HIV.

2.1.1 Global progress in monitoring and reporting the health sector responses to HIV/AIDS

There has been continued progress in the expansion of health sector interventions for HIV prevention, treatment and care in low- and middle-income countries. In 2009, the volume and scope of data to measure progress improved substantially as compared with previous years. Globally, more than 4 million people were receiving antiretroviral therapy at the end of 2008, reaching 42% of those in need. Around 45% of HIV-positive pregnant women received antiretrovirals to prevent HIV transmission to their children. Progress has been made in all priority interventions in all WHO regions. Most notably, the availability and uptake of HIV testing and counselling has increased. Nearly 90% of reporting countries had HIV testing and counselling policies in 2008, compared with 70% in 2007. While the number of HIV tests performed more than doubled between 2007 and 2008 (39 low- and middle-income countries), the knowledge of HIV status remains low—a median of 39% of people living with HIV knew their HIV status (population surveys in seven countries, 2007–2008). This remains a concern.

Despite the encouraging progress, some critical areas, such as coverage of interventions for populations at risk, remain uneven, indicating the need for non-complacency in responding to the HIV epidemic and the need to further invest in strategic information.

Since UNGASS indicators are expected to be reported in 2010, the reporting on health sector responses towards universal access will be notably "light" in 2010: no double collection of UNGASS indicators, limited list of others (18 indicators), and coordinated process with the UNGASS reporting.

2.1.2 Regional progress on the United Nations General Assembly Special Session (UNGASS) reporting

While the global response rate of UNGASS reporting increased in 2008 compared to 2006, the response rate of the Asia Pacific region fell to 70% because fewer Pacific island countries were reporting. As a result, the region's response rate was the second lowest after Middle East and North Africa. In spite of this, improvements were observed in the number of indicators reported and in the quality of the data reported. The Asia Pacific region appears to have more data on most-at-risk populations than the global average. However, as with universal access reporting, the availability and quality of data on key affected populations remain insufficient overall. Participants were also reminded to use caution when using survey-based data since surveys from different sites cannot simply be aggregated to reflect national averages. The region also scored low on funding and expenditure tracking, with only seven of 25 reporting countries presenting detailed data.

2.1.3 Regional progress on HIV/AIDS strategic information for women and children, including prevention of mother-to-child transmission

An estimated 21 000 children in the Western Pacific Region are living with HIV. There are reasons to be optimistic for the possibility of an elimination of paediatric HIV in the Asia Pacific region: (1) increased coverage of PMTCT services including ARV use in HIV-positive pregnant women, (2) relatively high ART coverage for children, and (3) constantly improved health and information infrastructure. The region has demonstrated many public health successes, with strong commitment to child health and public health.

The need for health systems strengthening is an essential step towards universal access. The integration of health systems and operational linkages are vital, which includes improved referral and reduced loss to follow-up, improved prevention, treatment and care for both scale and quality aspects. Cost-effectiveness analysis needs to be developed to assist health ministries and related international and domestic nongovernmental organizations (NGOs) to understand the impact of linked response to PMTCT services.

2.1.4 Progress on strategic information for HIV/AIDS in the Western Pacific Region

Major areas of strengthening strategic information in the Western Pacific Region include: (1) surveillance of HIV/AIDS, sexually transmitted infections (STI) and risk behaviours within the SGS approach; (2) HIV/AIDS estimation and projection; (3) monitoring health sector responses; (4) HIV drug resistance surveillance, monitoring and prevention for key countries; and (5) operational research and specific studies. The common goal is to provide information for improving programmes and responses.

The HIV/AIDS strategic information system is comprehensive, as each component does not stand alone. The strategic information elements mentioned above are linked to each other. For example, SGS data are crucial sources of information for monitoring health sector responses among various data inputs. The sub-areas comprising strategic information have shown progress in the Western Pacific Region and this would have not been possible without the political commitment, the collaboration of multiple partners and improved coordination to strengthen the HIV/AIDS information system, including data collection and reporting. Nonetheless, more effort is needed in tracking information on MARPs, e.g. population size estimates; more attention needs to be paid to the quality of HIV/AIDS information, e.g. ART patient monitoring data; more guidance is needed on using strategic information for policy and programme improvements; and further investments are needed in preparing impact measurements to generate reliable evidence in achieving the goals of MDG 6 by 2015.

2.1.5 Discussions

Overall, the usefulness of data being collected through the regular M&E reporting must not be under-estimated as it is prudent that Member States use the information for national benefits and political advocacy to influence resource commitment. More guidance is needed to generate information in a useful manner. The role of global, regional and national data use for resource mobilization is important. The process is not only an indication that Member States already have functioning M&E systems, but also a reflection of the ability of the United Nations system to deliver timely coordination for effective country support.

Certain indicators, such as the denominator for coverage indicators, pose major challenges for resource-constrained countries. An understanding of links between different coverage indicators is crucial in identifying and addressing gaps in priority interventions for MARPs. The revisions of treatment guidelines by WHO will further affect ARV coverage indicators. These data need to be interpreted with caution as the coverage can represent a mismatch of country's efforts. This change in policy should be viewed as an opportunity and every effort should be made by countries to justify gaps in provision of ART to people living with HIV (PLHIV).

Triangulation of data remains a subset of strategic information and the primary goal should be invested in strengthening strategic information. The evolving direction into data collection and the implementation of operational research and inevitable need to strengthen national health systems will be crucial to guide the national decision making process. The collaborative effort between sectors and/or units, and the evaluation through impact assessments will be crucial in the process.

2.2 Session 2 - Implementation of the WHO Framework for Monitoring and Reporting the Health Sector Responses to HIV/AIDS and strengthening national monitoring and evaluation (M&E) systems

Session 2 focused on the gaps and challenges identified in monitoring and reporting on health sector responses to HIV/AIDS and on the key steps taken by countries to strengthen their monitoring and evaluation systems while implementing the WHO framework. The lessons learnt by one country will form a very solid platform for another to exploit.

2.2.1 Regional summary on 2009 reporting of health sector responses to HIV/AIDS

The response rate for universal access reporting in 2009 was encouraging, as 95% of low- and middle-income countries in the Western Pacific Region responded (including all focus countries). The high response rate has been attributed to support from partners, in-country technical assistance and country missions, as well as global and regional guidance and improved coordination in the process, which increased country responses in addition to data of better quality. The better-reported indicators related to adult and paediatric ART, testing and counselling, and sex workers. Indicators with poorer responses dealt with IDUs and MSM, infant feeding practices, and TB-HIV collaborative activities. These findings clearly show that countries must continue to strengthen strategic information in some areas.

2.2.2 Country experiences

2.2.2.1 China: Data harmonization and integration for efficient monitoring and reporting of the national HIV programme

The process of integration and harmonization of data in China has been successful because of the Government's strong commitment and receptiveness to having a sound M&E system to monitor the progress and challenges of the national HIV programme. The most critical step has been "effective communication", through which the demands of stakeholders were met.

The operational links between case-reporting, sentinel and behaviour surveillance (integrated in 2009), testing and counselling, health education and behaviour intervention for high-risk groups, methadone maintenance treatment (MMT) databases and national free ART programme were harmonized efficiently. This harmonization has resulted in a unified web-based HIV/AIDS Comprehensive Information System, launched on 1 January 2008, which has significantly improved the efficiency of data collection, reporting, analysis and utilization, as well as data security. Coverage has been expanded to all

levels (national, province, prefecture, county and local clinics) and standardized monthly/quarterly/annual reports on the progress of the national HIV programme are published.

Despite challenges, such as ensuring data quality, building capacity and proficiency in data analysis at the grassroots level, and improving horizontal integration of databases (HIV-TB; PMTCT), the major goal of establishing a unified M&E database has been impressively attained in China. This is a very progressive step towards an efficient and effective information system.

2.2.2.2 Papua New Guinea: Monitoring testing and counselling services

The Voluntary Confidential Testing and Counselling (VCCT) programme is notably one of the best-performing programmes under the National Strategic Plan (NSP) for Papua New Guinea. Types of VCCT in Papua New Guinea include standalone, integrated (STI, TB and ANC), outreach and mobile, such as those in a church's mission. The success of the VCCT programme has been attributed to an array of interrelated factors: 208 VCCT sites (standalone, integrated); 23 new sites accredited (July–September 2009); increasing uptake of VCCT; Patient-Initiated Testing and Counselling in STI, TB and antenatal care; and VCCT as a routine component of in-patient care. In addition, national-level policies have clearly indicated VCCT as an entry point for treatment and care. Papua New Guinea is currently in the expansion phase of the VCCT programme and is rapidly scaling up VCCT sites and well-staffed at national level. A system of accreditation has been installed to make VCCT a routine service.

Collaboration between all levels in Papua New Guinea (national and subnational, provincial and district level) has resulted in a training programme for staff at facilities, standardization of reporting and the development of aggregated monthly reports. Challenges such as decentralizing VCCT services, improving infrastructure and building up human resources are being addressed.

2.2.2.3 Philippines: Monitoring health sector responses in low prevalence country

The HIV epidemic in the Philippines is considered to be one of low prevalence. By 2006, however, there was notably an increase in the number of new HIV cases, an increase in the number of asymptomatic cases, a shift from more females being infected to more males being infected, a shift from heterosexual transmission to homosexual/bisexual transmission, and a decrease in the mean age of infected people. Together, these factors warranted the setting of priorities to address this expanding epidemic. Although low prevalence is still observed, the evolving trends point to a larger epidemic in the future. Remarkable achievements have been made in strengthening strategic information, notably: institutionalizing Integrated Biological and Behaviour Surveillance (IBBS) and securing an annual government budget to ensure the programme's sustainability, and mapping data gaps to strengthen national strategic information. The Philippine Government has responded by re-strategizing targeted interventions, such as scaling up VCT, devising innovative strategies for MSM and achieving 85% ART coverage for PLHIV by September 2009. In order to ensure sustainability and financing of these efforts, HIV plans were integrated into city development plans.

The key to the Philippines' success has not been data collection and analysis alone, but a concerted effort at every level (national, regional and local) to translate the information into programmes, and identify needs to advocate for resource mobilization and policy development. The response of the health sector, while extremely crucial, should not be limited to the Department of Health. Multisectoral collaboration and cooperation are vital to achieve coverage vis-à-vis universal access.

2.2.3 Discussions

Countries such as the Philippines are using unconventional sources of information and/or data, such as medical records and data from the social sector for universal access reporting, to address the gaps in strategic information. Including HIV-related questions in surveys conducted by other sectors (working on HIV or not) has been another important method to fill data gaps.

Cross-border surveys, which require strong shared political commitment, are important for generating evidence that depicts sexual-transmission and IDU risk near border towns. Comprehending and addressing the "migrating" epidemic is crucial.

Timely reaction and operational response mechanisms are crucial in ensuring that preventive and control efforts are met. This is seen through the provision of PMTCT with lack of ART coverage and inefficient referral systems. While PMTCT remains a 'procedural' component, notification using regular case-based reporting of HIV-positive pregnant women including efficient and prompt referrals to ARV services is important. As such, the extent of integration of information systems is pivotal in ensuring that service delivery for treatment and care, including follow-up, are met. The working relationships and interactions between units and information systems have proven to be very significant steps that need to be strengthened.

The scaling up of VCT services must be efficiently translated into operational reporting with crucial data collected to ensure that strategies are placed in the right direction. The Papua New Guinea experience was helpful in showing practical ways to improve data quality. Multiple factors need to be addressed; while scaling up VCT services is important for increasing the uptake of testing and counselling, it remains to be only a part of the equation. Operational referral systems for the provision of treatment and care (including ART) to health care facilities need to be in place. This stresses the importance of multisectoral health sector responses, with the Ministry of Health taking the lead. Challenges such as repeat testers and testing, loss to follow-up and data quality assurance, should be addressed. The action would be a step towards health system strengthening.

2.2.4 Group Work: Improving the monitoring and reporting of health sector responses to HIV/AIDS

The participants were divided into three groups. Group 1 focused on the process of data collection, either through regular service (routine health information systems) or through surveys, the translation of data collected into advocacy documents and the identification of needs for capacity-building and/or technical support. Groups 2 and 3 focused on selected indicators from the universal access framework as depicted in the tabulation in Annex 4.

While many countries recognized the need to have efficient M&E systems in place, they also suggested ways to make the reporting more practical. Participants emphasized the need to provide feedback once a report has been submitted. Two-way communication is very important. While countries want to know how they faired in compliance with the report submission, they also want an analysis of the report that they submitted. The key highlights are enumerated as follows:

Reporting process:

- Reporting processes of countries vary but overall coordination is handled through United Nations agencies; government sectors and civil sectors are crucial in ensuring the consistency of data collection and mapping of available data sources.

- Consensus meetings with the participation of civil societies are notably important in providing estimates, validating data and reaching consensus.

- Identification of focal points at all levels (national, provincial and local levels) is crucial in ensuring data quality.

- Most countries concluded that the process will continue to be taxing unless the integration of information systems is addressed.

Data utilization:

- Some countries organized high-level advocacy workshops to disseminate the findings, while others used web-based approaches and conventional publishing for dissemination.

- Disseminating and/or sharing information has led to greater commitment from governments to strengthen existing M&E systems; in addition, the information has been basis for strategic planning (such mid-term planning).

- In addition to providing evidence on effectiveness of interventions, data sharing has enabled countries to compare their performances with those of other countries in the Region with similar epidemics. More importantly, the data give HIV programmes a very valuable advocacy tool to garner additional financial support from international donors and commitment from national governments.

Capacity-building and technical assistance needs:

- Among areas identified were size estimations of MARPs and training in data collection.

- Technical assistance is needed for the integration of information systems, development of guidelines for private sector providers and data collection, and preparation of narrative reports, especially for policy-makers.

Separately, the discussions on specific indicators from the universal access framework provided an understanding of the difficulties at the country level. Overall, the groups concluded that in addition to indicator-specific recommendations, the joint reporting forms should have built-in links to definitions and guidelines. The presence of a separate guideline document is inevitably overlooked and severely underused. While suggestions were also made that indicators should be kept simple, feasible and easily available at the country level, more sophisticated analysis and/or interpolation of information can be done at the global and/or regional level. Complicated and incomprehensible indicators often pose the risk of not getting a response at all. Specific comments, suggestions and relevance of indicators are depicted in the table in Annex 4.

2.3 Session 3: Monitoring targeted interventions for most at risk populations (MARPs)

This session focused on monitoring targeted interventions for MARPs, one of the areas with important information gaps in the Region. During this session, size estimation of MARPs, current status of M&E of interventions for MARPs in the Region, as well as tools and guidelines for monitoring and evaluating interventions were reviewed and updated. Experiences from the field were shared. Through group work, participants discussed the indicators specific to MARPs, as well the gaps and challenges for M&E of interventions at country and sub-country levels.

2.3.1 Review and update on size estimation of MARPs

In carrying out population size estimates, countries must decide why they are necessary, and how they can be generated. It was emphasized that the backbone of having good population size estimates is having country-agreed definitions of each MARP based on available evidence and current country context, as well as recommendations and guidance from United Nations agencies.

Population size estimates are used to assess intervention coverage, accessibility and utilization gaps; to advocate for policy and implementation changes; to serve as a basis for programme and resource planning and programme implementation; to assess trends in risk behaviours; and to decide on requirements from development partners. Eight methods for population size estimation were presented. Each method has advantages and disadvantages. Once a country has decided why it needs population size estimates, it needs to ensure that the method complies with the ethical standards, has clear definitions of the MARPs, and identifies the geographic coverage. No one method is perfect for all countries. It is recommended to use at least three methodologies, compare the results, and then agree on which of these estimates will be used by the country. Special caution in using estimates was flagged: "may backfire leading to a law enforcement response rather than a prevention response".

An update on MARPs size estimation in the Asia Pacific region was also shared. Six countries from the Western Pacific Region participated in a training workshop hosted by UNAIDS and the WHO South-East Asia Region in Bangkok in July 2009. Some of the problems with size estimation in the Asia Pacific region include: estimates usually not based on mapping or survey data but on ‘rules of thumb’; estimates based on only one method; estimates based on extrapolation from a few cities; estimates that don't separate establishment and non-establishment-based female sex workers; few estimates of clients of female sex workers.

2.3.2 Review and update on M&E of interventions for MARPs

Findings from the 2008 universal access report showed that a wide range of services was available to MARPs across the Region. However, coverage of interventions varied from country to country. Specifically, for sex workers, “condom use” was impressive and consistent with decreasing HIV prevalence in some countries, but data were mostly from venue-based surveys. For MSM, there was no indicator or data for availability of service; coverage was increasing but insufficient; condom use and HIV prevalence were not consistent in some countries. For IDUs, progress was made but insufficient in terms of availability of service, coverage and impact in most of the countries.

Progress has been made in M&E of interventions for MARPs. However, countries still face pressing challenges that need to be continuously addressed: M&E culture and political will; methodologies such as sampling and laboratory testing; social, cultural and legal barriers for accessing hidden, hard-to-reach populations; and capacity for data collection, analysis and utilization at national and subnational levels. There has been insufficient involvement of community based organizations (CBOs) as resource persons in tool development and data collection and validation.

It was suggested that the development of regional and global guidelines and tools for M&E of interventions for MSM should be accelerated. Countries are encouraged to adapt available tools and guidelines on M&E of interventions for MARPs according to international standards and country context. Partners should coordinate and harmonize their efforts through consensus-building. Countries should seek support for the adaptation and development of national guidelines based on global and regional ones, and on the synthesis or triangulation of multiple data sources.

2.3.3 Updates on guidelines and tools for M&E of interventions for MARPs

Key guidelines, toolkits and other reference documents recently developed for programming and M&E of targeted interventions for sex workers, MSM and IDUs were presented are as follows:

- WHO Toolkit for Monitoring and Evaluation of Interventions for Sex Workers;
- WHO, UNODC & UNAIDS Technical Guide for Countries to Set Targets for Universal Access to Prevention, Treatment and Care for IDUs;
- Priority HIV and Sexual Health Interventions in the Health Sector for Men who Have Sex with Men and Transgender People in the Asia Pacific Region;
- WHO, UNODC & UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Men who Have Sex with Men (draft, available in mid-2010);
- Monitoring and Evaluation Guidelines for HIV Prevention for Men who Have Sex with Men (Monitoring and Evaluation Reference Group, draft, available in mid-2010).

Enormous effort was poured into the development of these documents. The intention was not to flood countries with too much information, but rather, to guide countries in scaling up pilot or "boutique" projects to national-level programmes. The aim was to assist countries in getting the right strategies to deliver their programmes, agree on targeted MARPs at the country level, involve as many at-risk populations and partners as possible, and ensure that countries not only set up M&E systems, but also commit to making them functional. A good M&E system relies on an effective implementation of programmes.

2.3.4 Discussions

Countries have expressed a strong need for technical support from development partners on size estimation of MARPs. To meet this need, WHO, UNAIDS and other partners have been developing guidance on the recommended methodologies, organizing training workshops, and providing technical support to countries for size estimation. Support may be expanded if specific requests emerge through coordinated efforts of different organizations. Efforts should be made to assist countries in implementing challenging size estimation methods and survey sampling methods, such as respondent-driven sampling (RDS). There have also been requests for technical support and guides on definitions, size estimation and M&E of interventions for people with multiple risks, such as sex workers who are injecting drug users.

Capacity-building for M&E is a long-term and continuing process, and should not be focused on the national level and government sector only. This is especially true for M&E of interventions for MARPs, where civil society organizations play an important role in implementing activities. Capacity-building and technical support should also be targeted to grassroots nongovernmental organizations involved in data collection, analysis and utilization for programme improvements.

Meanwhile, countries need to regularly update strategic information on MARPs: identifying behaviour patterns, emerging sub-groups and locations of the groups with high risk-behaviours. Early warning systems should be established to identify new sources of infection in a timely and effective manner.

2.3.4 Country (region) experiences

2.3.4.1 Malaysia: Harm reduction services in Malaysia

The goal of Malaysia's harm reduction programme is clearly articulated in their Strategic Plan 2006–2010, that is, to reduce HIV vulnerability among injecting drug users (IDUs) and their partners. The programme, which started on 12 April 2006, offers services ranging from primary to tertiary prevention interventions. It aims to target 40 000 IDUs by 2010, with 25 000 receiving methadone maintenance therapy and 15 000 participating in the needles and syringes programme (NSP). The Government is investing a total budget of US$ 56 million from 2006 to 2010.

Methadone maintenance therapy is offered at government hospitals and clinics, private clinics, Anti Narcotic Agency service centres and the prisons. The Government works in partnership with nongovernmental organizations to run the NSP, including its programme on condoms. Successes could be attributed to strong government commitment; partnership, clear targets to anchor planning and measurement of impact, results-based management and fast scale-up of programmes.

2.3.4.2 Cambodia: Monitoring and evaluation of the continuum of prevention to care and treatment of HIV and sexual reproductive health among entertainment workers

One of the goals of the HIV programme is to reduce HIV prevalence and impact among entertainment workers. The outcome centres on the development and implementation of a new HIV and sexual health approach for entertainment workers. The strategies include: strengthened policy, coordination, outreach and service linkages; improved service provision for entertainment workers; implementation of a sexual and reproductive health approach in transactional sex environments; strengthened human, network and institutional capacity; and coordinated data collection, analysis and utilization. This strives to respond to Cambodia's changing epidemic which is currently experiencing shift of patterns from brothel-based to non-brothel-based entertainment workers.

In order to provide the needed services following the principles of continuum of prevention to treatment and care for HIV, a functional referral system was put in place. This current mechanism is captured in the current M&E work, including the lines of responsibility from programme beneficiaries to the National Center for HIV/AIDS, Dermatology and STDs, data collection points, reporting structure and flow, and use of standardized reporting forms.

2.3.4.3 Hong Kong (China): Strategic information for monitoring interventions for MSM

The HIV epidemic in Hong Kong (China) is considered to be one of low prevalence among female sex workers and people who inject drugs. One of the reasons is because clients of sex workers consistently use condoms (80%). However, the opposite situation is happening among MSM. The prevalence of HIV among MSM is rapidly growing, as captured in the testing services and reporting system.

There are four channels for collecting strategic information on MSM: (1) voluntary HIV/AIDS case-based reporting; (2) seroprevalence studies (HIV prevalence and risk behavioural survey of MSM; voluntary counselling and testing on MSM); (3) behavioural studies; and (4) molecular identification of subtype and cluster and statistics on STI.

One of the lessons highlighted is that campaigns can cover a substantial population, if messages are relevant, informative and creative. Current Internet-type interventions can be strengthened by having a greater understanding of the segmentation of behaviour from Internet-based versus venue-based. Other

efforts are important such as resource mobilization, collaboration and partnership with a wide range of agencies and organizations, and creation of a technical working group of MSM.

2.3.4.4 Discussion

Countries and regions explore innovative approaches to deliver the services needed by MARPs according to the context and changing epidemic patterns. Internet-based interventions in Hong Kong (China) are one such example. Countries could consider sexual and reproductive health as a broader platform for MSM interventions.

Another important aspect is to get the information needed to track the epidemic and responses for more efficient and effective delivery of services. The M&E system of Cambodia looks complex but it's functional. The system involves NGO implementers, who report to the Ministry of Health, thus avoiding duplication of efforts. However, the NGOs face the challenge of inadequate human resources and expertise.

2.3.5 Group work

Three groups, different than the ones formed on Day 1, were organized to discuss strengthening the monitoring of interventions for MARPs. Group 1 reviewed the packages of services, tools and indicators to monitor the services provided to MARPs in countries. Group 2 reviewed the strengths and weakness of the current indicators for universal access and UNGASS. Group 3 discussed the barriers for effective M&E of interventions for MARPs, as well as the needs for capacity-building and technical assistance in countries.

There is no consensus-based definition for MARPs. Definitions used by most countries differ from the global ones. For example, the time period involved in risk behaviour can be different for defining IDUs and female sex workers. Consensus for surveillance purpose has been reached on MSM definition in the Philippines; however, this does not mean the surveillance definition will apply to programmes.

All countries attempt to provide a package of services for female sex workers based on their definitions, which is replicated for MSM. While most countries do not have a defined package of services for IDUs, Malaysia provides a comprehensive package of services recommended by WHO, excluding hepatitis treatment. The challenge now is to provide an integrated package of services to populations with multiple risks, such as female sex workers who are also IDUs.

Major barriers for effective M&E of interventions for MARPs include: (1) dichotomy of the M&E systems – standard indicators of international reporting may not be what is really needed in local programme level; (2) lack of service level indicators – what should be collected and why; (3) lack of capacity among NGOs, civil society organizations and MARPs themselves to implement M&E, though they are important stakeholders; and (4) lack in ‘culture’ for data quality, evidence and M&E; and (5) stigma and discrimination towards MARPs.

Participants expressed strongly the needs for high-quality technical guidance in definition of MARPs; a comprehensive package of services; and an integrated package for persons with multiple risks.

See Annex 4 for comments and suggestions for MARPs indicators.

2.4 Session 4: Antiretroviral therapy (ART) patient monitoring

Session 4 focused on M&E systems of antiretroviral treatment (ART), which highlights the need to ensure that systems are in place to report on outputs and outcomes in a timely manner. Such data are vital to ART programmes, as they not only help track progress but also produce evidence of implementation of treatment programmes. The absence of monitoring systems pose very significant risk in preventing premature death among PLHIV, HIV drug resistance, and tracking eligibility of PLHIV to initiate treatment. With the revision of WHO treatment guidelines and earlier initiation of treatment, the opportunity for countries to advocate for patient monitoring systems has never been stronger.

2.4.1 Review and update on ART patient monitoring system

Following the development of a standardized patient monitoring system by WHO in 2006, revisions were made to produce three interlinked patient monitoring systems to cover HIV care and ART, maternal and child health and PMTCT, and TB-HIV co-infection. The patient monitoring system has been implemented by countries in the Region to varying degrees, either as paper-based or electronic systems. The system is useful for appointment-keeping; co-management of TB-HIV; cross-sectional analysis of patients (new on ART, lost, dead, transferred out, currently on ART); cohort analysis of short- and long-term outcomes (survival and/or retention on ART); and HIV drug resistance. However, there are still challenges to be addressed.

Quality and comprehensiveness of data remain to be addressed, including lack of disaggregation of MARPs and pregnant women among PLHIV on ART, and HIV-TB collaborative activities. Information on cohort survival and ART retention are essential for ensuring the success of ART programmes, which runs parallel to the objective of increasing survival and quality of life of PLHIV. However, there is limited use of ART data and limited cohort analysis of longer-term survival and ART retentions at 24, 36 and 48 months. A simplified approach for cohort analysis is currently being developed.

Analysis of data from the patient monitoring system is an important measure for continuous quality improvement (CQI), which could identify reasons and risks for poor outcomes. Key CQI indicators can be monitored using information from the patient monitoring system. Examples of CQI indicators are depicted in the tabulation below.

PMS Information	CQI Indicators
To monitor pre-ART care:	
% patients with CD4<250 at initial visit % patients with CD4 <200 on CPT % OI patients screened for TB and treated	Causes of first months mortality on ART
To monitor care of patients on ART:	
% patients with CD4<250 or WHO stage 4 who start ART within 30 days after eligible	Causes of first months mortality on ART
% patients who had late visit beyond ARV buffer	HIV drug resistance and early warning indicators
% patients on ART identified with treatment failure and switched to second line ART	Cause of long-term mortality on ART

2.4.2 Country experiences

2.4.2.1 Viet Nam: ART patient monitoring programme

The ART programme was initiated in Viet Nam in 2000. Following a rapid donor-supported scale-up in 2005, Viet Nam now has 288 care and treatment sites nationwide, with an estimated coverage of 49% for adult ART. Data gathered from patients' records at the ART sites linked to pre-ART and ART registers. This information is aggregated at the national level together with drug records to produce cross-sectional, cohort and ARV drug reports. This is essential in monitoring and improving quality of care. Several complementary data collection channels have also been developed.

2.4.2.2 Lao People's Democratic Republic: Database development for ART monitoring

Progressive effort from the Government was crucial in building capacity at central level for ARV quantification, forecasting for procurement, as well as for staff at ARV sites. Repeated consultations and discussions among international agencies and national and subnational counterparts were important to develop a functional M&E system, which in turn supports ARV treatment and detects treatment failure. At present, the national HIV clinical management software has been developed and piloted in addition to the national M&E reporting system training package, software and plan.

2.4.2.3 Papua New Guinea: ART patient monitoring

The ART programme in Papua New Guinea was initiated in 2004 at two sites. By 2009, there were a total of 55 sites with over 550 health care workers trained, achieving ART coverage of 62%. Three WHO standardized forms were utilized, namely: HIV patients admission form, HIV follow-up form and ART monthly data collection form. Information gathered at ART sites are fed into a national-level database, which produces timely reports to guide programme implementation. In addition, five early warning indicators (EWIs) were piloted in two sites in 2009 and data analysis is being conducted.

The challenges in Papua New Guinea, including limited human resources, data quality issues, manual data entry, delayed roll out of database and limited capacity and/or computer knowledge at rural sites, have been addressed to ensure the patient monitoring system remains a valuable tool in Papua New Guinea. It is evident that operating a patient monitoring system is possible even in resource-constrained countries with standard harmonization of ART, PMTCT and paediatric data management.

2.4.3 Panel discussion

The panel was composed of Dr Esorom Daoni, Dr Massimo Ghidinelli, Dr Bruce Baird Struminger, Dr Patrick Nadol, Dr Masami Fujita, and Dr Ma Ye, and moderated by Dr Massimo Ghidinelli. Topics of discussions included: summary of challenges for ART patient monitoring; country experiences and ongoing activities on improving ART site performance in China and Papua New Guinea; initiatives for ART site quality improvement; as well as ART scaling up versus health system strengthening.

The past several years have seen rapid scaling up of the ART programme globally and in the Region, and significant progress has been made in terms of number of people receiving ARV treatment and ART coverage. It is a daunting task to accomplish, and presenting formidable challenges: management of individual patients; the life-long treatment requiring high adherence in a context of mobility of patients; the uninterrupted supply of ARVs and diagnostics, among many others. Efforts are being made on monitoring the ART programme in countries through quality assurance initiatives, collection of early warning indicators for HIV drug resistance, as well as management of HIV-TB co-

infection. Nonetheless, ART patient monitoring would be further complicated by the revised recommendations of changing CD4 threshold and phasing out of d4T.

Many countries have experienced a rapid scaling up of ART coverage, but the information on the quality of services and interaction with health systems has always been patchy and incomplete. It is now time to expand ART while also improving the quality of services. In this regard, coordinated efforts should be made for CQI, within the overall framework of strengthening health systems in countries. HIV/AIDS care is a good entry point for medical care and quality improvement, i.e. to spin the benefits of the programme for overall health system strengthening.

In China, several ART quality improvement indicators have been developed and implemented in order to improve the ART outcome, such as the percentage of patients receiving CD4 test and percentage of patients who have four visits in a year. The new web-based ART monitoring system incorporated the TB-HIV co-infection and EWI components. Given that the doctors in the ART clinics and sites are busy, the computer-based system helps the clinical staff to track the patient status for improving appointment-keeping and adherence. In Papua New Guinea, a strong national technical team has been set up, with 12 staff dedicated to surveillance and M&E. The HIVQAL project, which was implemented in collaboration with partners, is intended to improve the quality of ART service. The CDC Viet Nam has initiated the development of an ART site assessment tool, which would be used for routine and standardized site visits. It is specific to the country situation of Viet Nam, but would be beneficial to the Region as a regional quality improvement tool.

2.5 Session 5: The way forward in strengthening the strategic information for HIV

Before the conclusion of the meeting, there were a number of presentations for information sharing, including introduction of resources and tools (HIV/AIDS Data Hub and generic tool for operations research), UNGASS beyond 2010, and the meeting on the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) versus health systems strengthening.

2.5.1 HIV/AIDS Data Hub for the Asia Pacific Region

The HIV/AIDS Data Hub for the Asia Pacific Region is a joint effort of the Asian Development Bank (ADB), UNAIDS, UNICEF and WHO. The website offers access to strategic information for 24 countries in Asia and the Pacific and Hong Kong (China) in HIV epidemiological status, vulnerability and HIV knowledge, risk behaviours, socioeconomic impact of the epidemic, and national responses. The information can help monitor HIV prevalence and trends; knowledge, programmes and resource gaps; national and regional responses including service coverage information.

2.5.2 UNGASS beyond 2010

Based on the analysis of the 2008 reports, the following are regional priorities for UNGASS 2010 country progress reports: (1) pro-active planning by a country task team, including for technical assistance and funding needs; (2) inclusive processes from data collection to validation and reporting; (3) focus on main data gaps in availability and quality (financial data, key affected populations, and modelling-based denominators); (4) comprehensive narrative report including alternative data; and (5) adequate report dissemination and use.

As the UN Joint Team on AIDS joins efforts to support and harmonize country reporting processes, it was suggested that UNAIDS, WHO, UNICEF and the HIV/AIDS Data Hub collaborate at the regional level in providing regional analysis and summaries. In 2010–2011, UNAIDS is expected to support the

development of regional AIDS reports. This would need to take place through a broadly inclusive process of country and regional partners.

It is expected that UNGASS reporting will merge into the broader MDG monitoring mechanism after 2010. There will not be a separate AIDS High Level Meeting in May 2010 but a joint MDG Summit in September 2010. UNAIDS is preparing a thorough review of the UNGASS process involving country consultations in late 2010 until 2011 to prepare for this transition process.

2.5.3 Operations research

WHO has developed a generic tool for operations research on HIV/AIDS entitled "HIV Testing, Treatment and Prevention: Generic Tools for Operations Research". It covers testing and counselling; disclosure, stigma and support to ART; and prevention among those HIV-positive. It is intended to document evidence on policy-relevant topics, proposed questions for operational research, data collection tools both for the client and the provider, and simple research design that can be done in a facility.

2.5.4 HIV and health systems strengthening

The highlights of the recent regional meeting on global health initiatives and health systems strengthening were shared with the audience.

3. CONCLUSIONS

After the three-day meeting, the following conclusions were made:

On implementation of universal access monitoring and reporting framework and strengthening national M&E capacity:

(1) Significant progress has been made in implementing the WHO Framework for Monitoring and Evaluating the Health Sector Response to HIV/AIDS in the Western Pacific Region. Levels of comprehension and appreciation of the framework and indicators have greatly increased. Universal access progress data and information are powerful tools for high-level advocacy, policy-making, planning of interventions and resource mobilization. However, more guidance is needed for maximizing benefits from increased availability of data and information through triangulation of data and improved presentation of information.

(2) There is need to review and refine the universal access monitoring indicators and further harmonize the reporting process. There was a call for reporting on UNGASS and universal access to be further harmonized and aligned among the partner agencies. Since 2010 is an UNGASS reporting year, there will be lighter version of the universal access report, with the reporting tool being integrated with the web-based UNGASS reporting process.

On M&E of targeted interventions for MARPs:

(3) Tools and guidelines are increasingly available for monitoring and evaluation of the targeted interventions for MARPs at the global level, but there are important gaps on tools, guidelines and information at the country and sub-country levels, particularly for MSM. The regional initiative for developing a package of comprehensive services for MSM has been gaining momentum. Countries

are encouraged to adapt these available tools and guides according to the country context. Attention must be paid to coordinating efforts for developing regional guidelines and technical support.

(4) There is a need for quality technical guides on population size estimations and populations with multiple risk behaviours (e.g. sex workers or MS who inject drugs).

On ART patient monitoring:

(5) There is increased availability of ART patient monitoring data, along with significant investments in both human and financial resources. Cross-sectional analysis has sufficiently been established with degrees of data disaggregation, but longitudinal cohort analysis remains a challenge for some countries. Options are being explored to simplify the process for cohort analysis (targeted or based on a sample of sites).

(6) There is great potential for quality improvement schemes, such as the site assessment tools being developed by CDC Viet Nam, CQI in Cambodia, and HIVQAL in Papua New Guinea. It is recommended to develop a regional ART monitoring task force or platform, aiming to coordinate and harmonize the definitions, quality improvement variables, site assessment and programme review and tools for ART data quality improvement in the Region.

ANNEX 1

PROGRAMME OF ACTIVITIES

Activity/Agenda item /Subject of presentation		Facilitator/Presenter
Day 1 – Wednesday, 2 December 2009		
08:00–08:30	Registration	
08:30–09:45	Opening Session – Welcome and opening remarks by the Regional Director – Introduction of participants – Objectives	Dr Massimo Ghidinelli
	– Administrative Announcements Group photo	Dr Yu Dongbao
09:45–10:15	*Coffee Break*	
Session 1:	**Overview on strengthening strategic information for the HIV/AIDS programme**	
10:15–10:35	Global progress in monitoring and reporting the health sector responses to HIV/AIDS	Dr Yves Souteyrand
10:35–10:50	Regional progress on the United Nations General Assembly Special Session (UNGASS) Reporting	Dr Bob Verbruggen
10:50–11:20	Regional progress on HIV/AIDS strategic information for women and children including PMTCT	Dr Wing Sie Cheng
11:20–11:40	Progress on strategic information for HIV/AIDS in Western Pacific Region	Dr Nguyen Thi Thanh Thuy
11:40–12:00	Discussions	
12:00-13:00	*Lunch Break*	
Session 2:	**Implementation of the WHO framework for monitoring and reporting the health sector responses to HIV/AIDS and strengthening national monitoring and evaluation (M&E) systems**	
13:00–13:15	Regional summary on 2009 reporting of health sector responses to HIV/AIDS	Dr Yu Dongbao
13:15–14:00	Country experiences in monitoring and reporting health sector responses (15' each) 1. China: Data harmonization and integration for efficient monitoring and reporting of the national HIV programme	Dr Ye Ma

	2. Papua New Guinea: Monitoring testing and counselling services	MOH PNG

	3. Philippines: Monitoring health sector responses in low prevalence country	MOH Philippines
14:00–14:30	Discussions	
14:30–15:00	*Coffee Break*	
15:00–16:30	Group work: Improving the monitoring and reporting of health sector responses to HIV/AIDS	Dr Yu Dongbao
16:30–17:00	Plenary presentation	
18:00	*Welcome Reception*	

Day 2 – Thursday, 3 December 2009

Session 3: Monitoring targeted interventions for most at-risk populations (MARPs)

08:30–08:40	Summary of Day 1	Dr Harpal Singh
08:40–09:20	Review and update on size estimation of MARPs	Dr Keith Sabin
09:20-10:00	Discussion	
10:00-10:30	*Coffee break*	
10:30-11:00	Review and update on monitoring and evaluation of interventions for MARPs	Dr Yu Dongbao
11:00–11:30	Guidelines and tools on M&E of interventions for MARPs (10' each)	
	– WHO SEARO/WPRO toolkit for M&E of sex workers (SW) interventions	Dr Teodora Wi
	– Target setting guidelines for interventions for injecting drug users (IDUs)	Dr Teodora Wi
	– M&E of interventions for men having sex with other men (MSM)	Dr Nguyen Thi Thanh Thuy
11:30–12:00	Discussions	
12:00–13:00	*Lunch Break*	

Session 3: Continued

13:00–13:45	Country (region) experiences in monitoring interventions for MARPs (15' each)	
	1. Cambodia: M&E of sex work interventions	MOH Cambodia
	2. Malaysia: Monitoring needle and syringe exchange programme for IDU	MOH Malaysia
	3. Hong Kong: MSM interventions and monitoring in HK Special Administrative Region	Dr Kenneth Chan

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Day 3 – Friday, 4 December 2009

Time	Item	Speaker
13:45–14:15	Discussions	
14:15–14:45	*Coffee Break*	
14:45-16:30	Group Work: Strengthening monitoring interventions for MARPs	Dr Yu Dongbao
16:30–17:00	Plenary presentation	
Session 4:	**Antiretroviral therapy (ART) patient monitoring**	
08:30-08:35	Summary of Day 2	Dr Madeline Salva
08:35-09:05	Review and update on ART patient monitoring systems	Dr Nicole Seguy
09:05-09:15	Discussions	
09:15-10:00	Country experiences on ART patient monitoring (15' each)	
	1. Viet Nam: ART patient monitoring programme	MOH Viet Nam
	2. Lao PDR: Database development for ART monitoring	MOH Laos
	3. Papua NewGuinea: ART patient monitoring	MOH PNG
10:00-10:15	Discussions	
10:15–10:30	*Coffee Break*	
10:30-12:00	Panel discussion	Dr Massimo Ghidinelli
12:00-13:00	*Lunch Break*	
Session 5:	**The way forward in strengthening strategic information for HIV/AIDS**	
13:00-13:30	Introduction of HIV/AIDS Data Hub for the Asia Pacific Region	Dr Michel Carael
13:30-13:45	UNGASS beyond 2010	Dr Bob Verbruggen
13:45-14:00	Operations research	Dr Yves Souteyrand
14:00-14:15	HIV and health systems strengthening	Dr Masami Fujita

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14:15-14:30	Discussions	
14:30–15:00	*Coffee Break*	
15:00	Conclusions and recommendations	Dr Massimo Ghidinelli
	Closing of the meeting	

ANNEX 2

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ANNEX 3

Opening speech by Dr Shin Young-Soo
WHO Regional Director for the Western Pacific

(Delivered by Dato Dr Tee Ah Sian, Director, Division of Combating Communicable Diseases)
Manila, Philippines, 2-4 December 2009

Distinguished national HIV/AIDS managers; Official of the Ministries of Health; representatives of partner agencies; organizations and communities; colleagues, ladies and gentlemen:

It is a pleasure to welcome you to Manila for the Meeting on Strengthening and Monitoring the Health Sector Response to HIV/AIDS in the Western Pacific Region. This week, we will review progress and share experiences on implementing the WHO Framework for Monitoring and Evaluating the Health Sector Response to HIV/AIDS since our last meeting in October 2007. More importantly, we will look for ways to strengthen monitoring and evaluation of the health sector response in our Region.

Political leaders made a commitment to universal access to comprehensive prevention programmes, treatment, care and support by 2010 at the United Nations General Assembly High-Level Meeting on HIV/AIDS in 2006. The Fifty-Ninth World Health Assembly in May 2006 directed WHO to monitor countries' health-sector responses in scaling up efforts towards universal access, and the progress to be reported annually.

WHO, in collaboration with other UN agencies including UNAIDS and UNICEF, has been working closely with Member States in monitoring and reporting health sector responses towards universal access to prevention, treatment and care for HIV/AIDS. In addition, country capacity on strategic information collection and utilization has been strengthened.

In our Region, the Western Pacific Regional Office has been working closely with Member States to implement the WHO monitoring framework. In July 2007, the Regional Office for the Western Pacific convened the first regional consultation on implementation of the framework. A joint working mechanism was established and was further enhanced to improve 2009 reporting. We are working with UNAIDS and UNICEF at the country and regional levels to support government partners in data collection, validation and analysis.

In the 2009 universal access progress report, major progress has been attained in the health sector response to HIV/AIDS. At the end of 2008, some 4 million people globally were receiving antiretroviral therapy, or ART, accounting for 42% of the total number of people estimated to be in need. In 2008, about 45% of HIV-infected pregnant women globally have received antiretroviral drug for the prevention of HIV transmission from mother to child.

In our Region, we have made significant progress in some areas of HIV prevention, treatment and care. For example, about 6600 HIV-positive children received antiretroviral therapy, up from 4822 in 2007, representing an ART coverage rate of about 74%. However, we are lagging behind in some other important indicators. For example, approximately 122 000 people received ART in low- and middle-income countries in our Region, with 31% ART coverage. Some 3600 HIV-positive pregnant women in our Region had access to antiretroviral drugs to prevent mother-to-child transmission in 2008, which is around 23% coverage.

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We are facing even greater challenges in monitoring and reporting the targeted interventions to most-at-risk populations, such as sex workers, injecting drug users, and men who have sex with men. Among the major obstacles, there is lack of consensus-based methodologies and tools for measuring the outcome and impact of the interventions.

Strengthening strategic information is one of the five pillars of the WHO's strategic framework for maximizing the health sector's contribution towards universal access. WHO is committed to strengthening the capacity of countries in strategic information on HIV/AIDS.

I welcome our partners from UNAIDS, UNICEF, United States Centers for Disease Control and Prevention and the Secretariat of the Pacific Community. 2010 is an important year for the reporting on the Declaration of Commitment by the United Nations General Assembly Special Session. We will make every effort to contribute to an efficient and effective process.

Welcome our colleagues from HQ, Drs Yves Souteyrand and Keith Sabin, and thank them for their technical assistance in areas related to the monitoring and evaluation of the health sector response to HIV/AIDS.

I also would like to thank the country office staff for their efforts in implementing the framework and for arranging time to attend this meeting.

Welcome again to Manila, and I wish you a successful meeting.

Thank you.

ANNEX 4

Comments and suggestions for selected UA indicators

Indicator No.	Indicator Text	Comments and Suggestions
#A1	Percentage of health facilities that provide HIV testing and counseling services	Generally acceptable to most countries; however reservations were made by countries with low-prevalence as HIV T&C services in health care facilities may not encompass all T&C services. As such the dilution of VCT coverage is a possible misinterpretation.
#A2	Number of individuals aged 15 and over who received HIV testing and counseling and know their results	There are three variables in the indicator: testing, counseling and know results. In addition in many countries, those who test negative are not made aware of their results as such counseling is not conducted. In some countries, there are laws that prohibit the testing of those below 18 years old without parental and/or guardian consent. As such for data for those age 15, 16 and 17 may not be available. Many VCT clients do not indicate age and/or gender. As such most of the time notification of positive cases and follow-up is not possible.
#C1	No. of needle & syringe programme sites per 1000 IDUs	Easy to count the sites but difficult to get denominator. Comparison by country is difficult because of organizational differences. Need to have a standardised definition of site.
#C2	No. of opioid substitution sites per 1000 IDU	Definition of site would be different by countries. Need to have standardized definition of site. Suggest disaggregation by type of product.
#C3	No. of needles/syringes distributed per IDU per year by NSP	Not applicable to countries where needles are with the social marketing programme.
#F1	No. of targeted service delivery points for sex workers where STI services are provided	No standard definition of STI service. Difficult to get number of sex workers. Need to define minimum package of services for STI. Some countries have no policies for targeting services. Needs to include private sectors and NGOs.
#F3	Prevalence of syphilis amongst sex workers	Data on sex workers visiting private clinics excluded.
#F4	Prevalence of syphilis among men who have sex men	Data on MSM visiting private clinics excluded. Guide needed for categorizing transgender, and disaggregation of the two groups.
#G1	Percentage of health facilities that offer antiretroviral therapy	Most country experiences deemed this indicator as useful and the information was readily available

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#G3b #G3c #G3d	Percentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy; Percentage of adults and children with HIV known to be on treatment 36 months after initiation of antiretroviral therapy; Percentage of adults and children with HIV known to be on treatment 48 months after initiation of antiretroviral therapy	Generally, issues pertaining to patients who transfer out or loss to follow-up were raised. Despite numerous reservation by countries on this indicator, most member states agree that the indicator provides very significant information. Clearer guidance is needed on identifying cohorts for each category. In addition, recommendations on sampling methods need to be provided to countries as not all ART sites monitor these indicators and if most or all ART sites do monitor, the burden for data collection is extensive.
#H1	Percentage of health facilities dispensing antiretrovirals that have experienced a stock-out of at least one required antiretroviral	In addition to also being an EWI, this indicator was notably important and useful but needs to be addressed on the platform of health systems strengthening specifically at strengthening procurement and supply management of HIV drugs. Some countries, for example Malaysia, shared their experience of having a system that 'flags' a warning when ARV stocks go below a 3 month availability. As such Malaysia does not experience a stock-out of ARVs.
#I8	Percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labour and delivery and during the postpartum period (<72 hours), including those with previously known HIV status	This indicator was notably not very relevant to national programmes in this region. The relevance of this indicator in countries with high prevalence and/or generalized epidemics was notably more important. Overall, it was suggested that this indicator be disaggregated into 3 phases (during pregnancy, during labour and delivery and during the postpartum period). The need to disaggregate the indicator into programme and non-programme areas was also suggested in addition to developing another indicator using the number of ANC sites as a denominator
#I11	Percentage of HIV-infected pregnant women assessed for antiretroviral therapy eligibility through either clinical staging or CD4 testing	Overall, the relevance of this indicator was to monitor referral practice from MCH to HIV programmes. In addition, this indicator was deemed irrelevant for countries using viral load to assess eligibility for ARTs. The data required for this indicator is available solely in programmatic areas. Suggestions were made to disaggregate the indicator between pregnant women arriving before labor and those arriving during labour.

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#I13	Percentage of infants born to HIV-infected women receiving any antiretroviral prophylaxis for prevention of mother-to-child transmission	The deliberation of this indicator was not possible as most countries found this indicator (numerator) to be confusing and difficult to comprehend. Suggestions were made to provide clearer guidance.
#I14	Percentage of infants born to HIV-infected women started on co-trimoxazole prophylaxis within two months of birth	Although it was noted to be available and relevant in most countries, reservations were made for countries that do not have a CTX prophylaxis policy in place. The deliberation on this indicator led to a request for WHO to facilitate adoption of global guidelines on CTX prophylaxis.
#I15	Percentage of infants born to HIV-infected women who received an HIV test within 12 months	This indicator was noted to be very relevant and readily available but there is limitation in the systems to track HIV-infected mother who move to other areas. In addition the issue of multiple counts due to multiple tests before 12 months was also raised. In addition; some countries recommended that the indicator be made clearer. As such suggestions were made to add the punctuation mark ' ; ' before the word 'who' (Percentage of infants born to HIV-infected women; who received an HIV test within 12 months) was made. Suggestions on modification of the indicator to 'who have confirmed HIV status within 12 months' was also made.
#I16	Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV infected women at 3 months	This indicator was deemed relevant but reservations were made as information was not available in countries without guidance for post-natal visit at 3 months. The group, however, did not make suggestions on modifying the indicator but instead made a recommendation that WHO should facilitate and recommend to countries to develop guidance on post-natal visit at 3 months and harmonize it with child health services

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