Meeting of HIV/AIDS Programme Managers in the Western Pacific Region

8–10 September 2008
Vientiane, Lao People’s Democratic Republic

World Health Organization
Western Pacific Region
REPORT

Meeting of HIV/AIDS Programme Managers in the Western Pacific Region

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Vientiane, Lao People's Democratic Republic

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WORLD HEALTH ORGANIZATION
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Acronyms

AIDS  acquired immunodeficiency syndrome
APN+  Asia Pacific Network of People Living with HIV/AIDS
APNSW  Asia Pacific Network of Sex Workers
AHRN  Asian Harm Reduction Network
ART  antiretroviral therapy
CDC  Centres for Disease Control and Prevention
GAVI  Global Alliance for Vaccines and Immunization
Global Fund  Global Fund to Fight AIDS, TB and Malaria
GTZ  Gessellschaft für Technische Zusammenarbeit
HIV  human immunodeficiency virus
IDU  injecting drug user
IHP  International Health Partnership
MARP  most-at-risk population
MDG  Millennium Development Goal
MCH  maternal and child health
MSM  men who have sex with men
PHC  primary health care
PLHIV  people living with HIV
PMTCT  prevention of mother-to-child transmission
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 AIDS
UNFPA  United Nations Population Fund
WHO  World Health Organization
Executive Summary

Since the last HIV/AIDS programme managers meeting in Manila in December 2005, response to the epidemic has evolved quite substantially along with a marked increase of available resources. Progress has been remarkable in several areas of work, particularly: scaling up targeted interventions for injecting drug users; expanding condom promotion measures; increasing coverage of antiretroviral therapy (ART) services; and addressing strategic information. However, not all elements of a comprehensive response are equally well established; for example, interventions targeting men who have sex with men and the prevention of mother-to-child transmission are still insufficiently developed. Major challenges remain in expanding coverage of comprehensive services towards the commitments of universal access, as well as in maintaining effectiveness of interventions over time.

A three-day meeting was organized from 8 to 10 September 2008 for HIV/AIDS programme managers in the Region to share the latest findings, report on progress since the last meeting, and identify challenges and opportunities for scaling up prevention and control of HIV and other sexually transmitted infections (STI).

Programme managers from 13 countries and key partners attended the meeting hosted by the Lao Ministry of Health and acknowledged the usefulness of the meeting. A range of technical updates and country experiences focusing on HIV/AIDS prevention, treatment, care and support were shared. Progress made by countries since the last meeting in 2005 were also reported, including sharing and identification of challenges and proposed solutions. The participants also expressed specific technical support needs required from WHO and other partners.

Updates were provided on recent regional consultations such as the Low Prevalence Country Meeting held in Manila, Sixth Stop TB Technical Advisory Group Meeting for the Western Pacific Region in Tokyo, and HIV Testing Consultation in Ha Noi, Viet Nam. Brief presentations on health systems strengthening, control of congenital syphilis, and linkages of services using the Western Pacific Regional Office's latest framework completed the general updates.

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

Health information systems:

- Progress has been made in HIV information systems and reporting.
- Key challenges identified were: tensions between international and national reporting, harmonization of indicators, and quality assurance.
- Technical assistance needs identified were: capacity-building in strategic information including quality assurance.

Targeted interventions:

- While considerable progress has been made, countries have often overlooked one or more most-at-risk populations (MARPs), e.g. men who have sex with men (MSM).
• Countries recognized the need to prioritize and scale up interventions targeted to MARPs.

• They also identified a lack of strategic Information on MARPs as a key gap.

• Technical assistance needs identified were: conducting population size estimates and second generation surveillance among MARPs; monitoring and evaluation of programmes; and in building capacity for programme implementation and expansion.

**Treatment, care and support:**

• Participants were updated on the WHO framework for reviewing evidence and developing recommendations.

• Existing WHO recommendations and potential updates vis-à-vis emerging evidence were presented.

• The status of country guidelines and revisions were presented and programmatic implications identified.

• Technical assistance needs identified were: costing models, refining estimates particularly for ART needs, and supporting programme managers in critical decision-making.

**Health systems strengthening:**

• Participants acknowledged the need to strengthen health systems and the role to be played by HIV programmes.

• Decentralization of health services and commitment to primary health care approach are well established, but with high out-of-pocket payments.

• Countries shared progress and experiences made since inception of the WHO framework on linkages of services (HIV, sexual and reproductive health, maternal and child health, tuberculosis).

• Need to focus on implementation of activities at the level of service delivery.

• Technical assistance needs identified were: supporting countries on health systems strengthening and advocating among decision-makers.

Further, countries agreed on the following to move the agenda forward:

1. Organize a technical consultation on HIV care and treatment in 2009, providing a forum for programme managers, technical experts, and beneficiaries to discuss and plan together.

2. WHO to provide technical and programmatic support and to clarify roles of partners in order to intensify PMTCT, including through the existing PMTCT regional task force.

3. WHO to strengthen its presence in country and to provide more technical support, particularly on strategic information, PMTCT, targeted interventions, HIV prevention, treatment and care.
(4) WHO and other United Nations agencies to continue to support implementation of the linkages framework.

(5) HIV programme managers acknowledged the opportunities currently available to support health systems strengthening, e.g. Global Alliance for Vaccines and Immunization (GAVI), Global Fund to Fight AIDS, TB and Malaria, International Health Partnership, and requested the WHO Regional Office to capitalize on them.
1. INTRODUCTION

1.1 Background

A Meeting of HIV/AIDS Programme Managers in the Western Pacific Region was held in Vientiane, Lao People's Democratic Republic from 8 to 10 September 2008. The three-day meeting was organized for HIV/AIDS programme managers in the Region to share the latest findings, report on progress since the last meeting, and identify challenges and opportunities for scaling up prevention and control of HIV and other sexually transmitted infections (STI).

Since the last HIV/AIDS programme managers meeting in Manila in December 2005, response to the epidemic has evolved quite substantially, along with a marked increase of available resources. Progress has been remarkable in several areas of work, particularly: scaling up targeted interventions for injecting drug users; expanding condom promotion measures; increasing coverage of antiretroviral therapy (ART) services; and addressing strategic information. However, not all elements of a comprehensive response are equally well established; for example, interventions targeting men who have sex with men (MSM) and the prevention of mother-to-child transmission (PMTCT) are still insufficiently developed. Major challenges remain in further expanding coverage of comprehensive services towards the commitments of universal access, as well as in maintaining effectiveness of interventions over time.

1.2 Objectives

(1) To update information on the HIV and STI situation and response in the Western Pacific Region, and note progress made since the last programme managers meeting.

(2) To identify key and emerging challenges and opportunities for scaling up HIV and STI prevention, care, treatment and support in the health sector, and monitoring and reporting on the health sector's response towards universal access.

(3) To identify future steps and country support needed to strengthen HIV/AIDS and STI prevention, care, treatment and support in the Region.

1.3 Meeting participants

Meeting participants were programme managers and senior staff of the National AIDS Prevention and Control Programmes from 13 Western Pacific Regional countries, as well as representatives and observers from other development partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Asia Pacific Council of AIDS Service Organizations (APCASO), United States Centres for Disease Control and Prevention and President’s Emergency Plan for AIDS Relief (CDC/PEPFAR) in Viet Nam, and Family Health International (FHI) in the Lao People’s Democratic Republic. The HIV Netherlands Australia Thailand Research Collaboration (HIV-NAT) was invited as temporary adviser.
1.4 Opening remarks

Opening remarks were made by Dr Dong Il Anh, WHO Representative in the Lao People’s Democratic Republic, and by a representative of the Ministry of Health. Dr Massimo Ghidinelli, WHO Regional Adviser in HIV/AIDS and STI, oversaw the introduction of participants, selection of a chairperson, and presentation of objectives and expected outcomes of the meeting.

2. PROCEEDINGS

Panel discussions and presentations focused on prevention; treatment, care and support; other-relevant strategies and areas such as health systems strengthening, linkages of services, control of congenital syphilis and support from WHO and other partners. The meeting ended with an agreement on the next steps on how to move forward.

2.1 Prevention

2.1.1 Presentations: Managing data on the health sector response

2.1.1.1 Regional overview

Surveillance systems have improved in countries that have second generation surveillance including HIV prevalence surveys, behavioural surveillance and STI surveillance. However, reports of the health sector’s response have shown limited progress. WHO designed a framework to monitor progress made by the health sector in assuring Universal Access to HIV/AIDS treatment. The Universal Access Framework, comprising 39 indicators on availability, coverage and impact of high priority HIV interventions delivered by the health sector, was discussed at a meeting in Manila in July 2007. In addition, the United Nations Children’s Fund (UNICEF) and WHO designed a Report Card on Prevention of Mother-to-Child Transmission (PMTCT) and Paediatric HIV Care and Treatment in Low and Middle-income Countries to monitor progress of national programmes to prevent HIV infection among infants and young children.

The results from the Universal Access reporting highlight a low coverage of HIV testing, except in Cambodia and Papua New Guinea and a low coverage of PMTCT services. Although ART has been scaled up significantly, many countries of the Region are unlikely to meet the goal of Universal Access by 2010 because a high proportion of individuals are still unaware of their HIV status. Patient retention rates on ART are often poor. The Universal Access reporting also revealed a lack of comprehensive quality data in prevention, HIV testing and counselling, and access to services for most-at-risk populations.

Therefore, WHO calls for more investment in HIV/AIDS information systems to be used for programme planning in country and for international reporting.
2.1.1.2 Country experiences

Cambodia

Since 2005, Cambodia has had a well-established, decentralized HIV/AIDS information system for monitoring the health sector's response in 11 provinces. The system uses standardized paper-based and electronic tools. Comprehensive HIV/AIDS reports are compiled by the central unit on a quarterly basis and measure performance against national core indicators. Cambodia's system is strong because of the central coordination of all HIV/AIDS data by the National Programme under one National Monitoring and Evaluation Framework (37 indicators) harmonized with the Universal Access framework. Current challenges include: (1) requests by partners to increase the number of indicators despite standardized national core indicators; (2) limited capacity for passive surveillance; (3) limited data sharing between health programmes; (4) limited use of strategic information for assessing quality of services and for programme planning; and (5) lack of motivation of health staff for data collection and reporting at facility level.

Lao People's Democratic Republic

The Lao People's Democratic Republic is in the process of establishing its HIV/AIDS information system with funding support from the Global Fund. A national monitoring and evaluation unit has been created and a national consensus on monitoring and evaluation plan established. However, training for data collection at district level has not yet been conducted. Current challenges include: (1) implementing one monitoring and evaluation plan at all levels; (2) poor coordination of reporting to WHO, UNICEF and UNGASS - leading to variations in data for the same indicators; and (3) lack of information sharing by various partners - leading to difficulties in compiling data from different sources. The information system is still limited to project-based indicators collected and reported directly to the Global Fund and other donors, without centralization by the National Programme.

Papua New Guinea

Papua New Guinea has improved its HIV/AIDS information system over the last three years, with the harmonization of monitoring and evaluation indicators frameworks, standardization of data monitoring tools, and decentralization of surveillance and data management to provincial level under the National Monitoring Unit. Current challenges include limited human resources, data quality, funding and sustainability.

Viet Nam

Viet Nam has a national monitoring and evaluation framework for HIV/AIDS (54 indicators), which is harmonized with international frameworks, and an established decentralized HIV/AIDS data management system under the National Unit. Viet Nam also has an HIV/AIDS case and death reporting system. Current challenges include: (1) the recent expansion of monitoring and evaluation indicators to 900 indicators; (2) the absence of a standardized data management system for harm reduction programmes; (3) limited data quality; (4) lack of human resources at district and provincial levels; (5) different reporting formats for various donors; and (6) lack of analytical capacity and data utilization for programme planning.
Key discussion points:

- HIV/AIDS information systems have progressed in the Region but are still in their early stage of development.

- Reporting requirements for different organizations including United Nations organizations create confusion despite reporting harmonization efforts by United Nations agencies.

- The National Programmes have to lead the process of establishing the national monitoring and evaluation indicators.

- More technical assistance is needed for the development of HIV/AIDS information systems (paper-based versus electronic systems) and for establishing quality assurance systems for data.

- Countries expressed frustration in the differences between country estimates of "number of people in need of ART" and estimates of the UNAIDS/WHO working group on global HIV/AIDS and STI surveillance, particularly when country estimates were reached by consensus that included UNAIDS and WHO in country.

In conclusion, this session highlighted that most countries in the Region have made some progress in setting up a system for HIV/AIDS data collection and reporting. However, there are still difficulties in establishing a harmonized monitoring and evaluation indicators framework to be used by and for the various partners and donors under the coordination of the National Programme.

2.1.2 Group work on targeted interventions

In an afternoon session on Day 1, country participants were divided into three groups to share experiences and challenges faced in implementing targeted interventions. WHO secretariat members were assigned as facilitators. Each group chose a chairperson to coordinate the discussion according to specific guiding questions, and a rapporteur to share in plenary the individual group discussions outputs.

To put the group work session into context, the Report of the Commission on AIDS in Asia (Redefining AIDS in Asia – Crafting an Effective Response) was presented. This report highlighted that prevention is not prioritized in the Region, although it is both feasible and affordable. Current programmes are not adequate to reverse the epidemic. Addressing social exclusion and involving communities are critical to an effective response. Asia has the resources for an effective HIV response but needs to invest them sensibly to yield substantial returns. Impact mitigation in Asia is needed primarily at the household level.

The Commission recommended focusing interventions and resources in order to achieve maximum impact. Investing 40 cents per capita per year could allow reaching 80% of most-at-risk populations in geographic hot-spots to avert 60% of new HIV infections. It is important to combat stigma and remove discrimination, to adopt a human-centred approach, to speak out on controversial issues and to stimulate community participation.

Focusing on three high-risk groups (female sex workers and their clients, injecting drug users, men who have sex with men) could avert 93% of the new infections in the Region. Adding counselling and testing and PMTCT could avert 98% of the epidemic.
Group work was organized to discuss the following: (1) the contribution of sex workers, MSM and injecting drug users to the HIV epidemic in the countries of the Western Pacific Region; (2) the existing interventions among these three groups; (3) the challenges and barriers to implementing these interventions; (4) the approaches for scaling up towards Universal Access; and (5) the support needed by countries from WHO.

Highlights of the group work include the following:

Most countries have size estimates of their most-at-risk populations (MARP). However, specific MARPs may be defined differently by countries and may contribute to the epidemic in varying degrees in each country. Participants identified challenges in standardizing the methodology for estimating population sizes and in conducting second generation surveillance among different types of MARPs. It was also mentioned that in countries with an epidemic driven by a specific MARP, the other MARPs lack surveillance data. Since it is difficult to identify MSM, estimating population size of MSM is a challenge. Nongovernmental organizations (NGOs) usually collect data among MSM.

Most countries are implementing proven prevention strategies such as behaviour change communication through community outreach and peer education work; 100% Condom Use Programme (CUP); harm reduction for IDUs (including methadone maintenance therapy), closed-setting programmes with provision of ART, counselling and testing; and provision of STI services.

The groups identified stigma and discrimination and religious and cultural beliefs as challenges to programme implementation and barriers to access of services by MARPs, particularly by IDUs and MSM. These were further aggravated by brothel crackdowns and drug raids, lack of political commitment in some countries to address MARPs, and lack of capacity within NGOs to do mapping and size estimation. The challenge of defining MSM has also affected the design of an appropriate programme for them.

The groups requested continuous technical assistance from WHO in all aspects of the health sector response, particularly conducting population size estimates and second generation surveillance, supporting for monitoring and evaluation of MARPs programmes, and building capacity for programme implementation and expansion.

Common key issues raised by the three groups:

- lack of national policies;
- difficult to scale up programmes for MARPs as most of them are implemented by a small number of NGOs;
- limited access of MARPs to existing health services because of stigma and discrimination (particularly for IDUs and MSM), criminalization of their activities, and lack of skills among health staff to provide the necessary services; and
- lack of expertise in methodology for population size estimation and for HIV prevalence and behavioural surveillance surveys among hidden populations such as MSM and IDUs.
2.2 Treatment, care and support

2.2.1 WHO evidence framework for making recommendations

Use of evidence-based information is essential for making recommendations for guidelines. Therefore, WHO established a guidelines working group in 2008 to harmonize all existing guidelines and to guarantee that they were:

- based on evidence from trials or observational studies;
- tested for quality of the evidence;
- checked for cost implications and feasibility; and
- assessed for their value to end users.

2.2.1.1 Update on new evidence and recommendations for ART management in adults, adolescents and pregnant women

Guidelines can have a public health or a clinical approach (WHO guidelines versus United States Department of Health and Human Services guidelines). The WHO guidelines working group follows a process, as best practice, when providing recommendations for guidelines.

The steps in the process are as follows:

(1) declaration of interest in the evidence;
(2) simplification of the evidence;
(3) standardization of the evidence;
(4) targeting of the evidence at policy-makers; and
(5) identification of first, second and alternative lines of drugs or regimes.

The following key issues were presented:

(1) Issues on WHEN to start treatment

- If started late, consider demand, increase of disease burden, and reduced ART in PMTCT.
- If started early, CD4 <350 – the only data on benefit are from industrialized countries using cohort data than random clinical trial. This has been seen to be costly, decreasing feasibility by increasing demand by 30%, and the ability to use Nevirapine in women is not feasible, though the impact on transmission is minimized.

(2) Issues on changing single-dose PMTCT to triple-dose

Consideration of treating all pregnant women with combination ART (cART), including those breastfeeding, and then deciding when to stop in post partum, should be taken into account as issues of resistance are evident, as seen in the Strategies for Management of Antiretroviral (SMART) data.
Feasibility of facilities to handle increase in demand, as well as the contraindication of Nevirapine in women with high CD4 (>250) and use of protease inhibitors, should be taken into account if cART is used. There will be a need to harmonize and use uniform recommendations and assure equity issues in ART access.

(3) Issues on first-line treatment

There is lack of data on durability, potency and toxicity of some combination ARVs. Before starting first-line antiretrovirals, consideration needs to be given to the lack of data on use of Tenofovir in children and pregnant or breastfeeding women and the costs associated with laboratory tests, drugs, strengthening the health system infrastructure as well as of training human resources.

Monitoring and evaluation are needed for all changes recommended in programmes for treatment such as timelines and targets. They are also needed to evaluate the impact of such changes in cost, feasibility (pilot then roll-out) to improve effectiveness. It would also help to reverse policies, e.g. changes/results that are unfavourable.

(4) Issues on switching

The benefits of using immunological and clinical criteria to determine whether to switch to second-line antiretrovirals are limited. There is a need to use viral load as an indicator of failure. WHO’s HIV ResNet is needed to support HIV drug resistance prevention and surveillance. Good laboratory support is necessary for quality ART programmes.

2.2.1.2 Update on treatment of infants and children

Recent results from the Children with HIV Early Antiretroviral Therapy (CHER) study have shown that treatment outcomes are better when HIV-positive infants and children start ART early. Treatment should include early diagnosis of exposure, prevention of infection (use of Cotrimoxazole) and early diagnosis of HIV infection. All HIV-positive infants and children should be started on ART irrespective of CD4 count. Where protease inhibitors are not available, ART can be any Nevirapine-based regimen.

2.2.1.3 Country perspectives on implementing new evidence: programmatic implications, experiences and sustainability

Cambodia

Cambodia has had HIV treatment programmes since 2003, with 50 sites offering ART to more than 29,000 people and 2,800 children. With its dynamic surveillance and reporting systems, it is able to enrol and start people on antiretrovirals using WHO staging and CD4 (<350 except in pregnant women) from four decentralized sites. Cambodia uses WHO criteria for switching treatment from clinical, immunological, and virological perspectives. Cambodia has been collecting early warning indicators from eight of its sites as surrogate markers for programme monitoring and evaluation.

China

China started ART in 2003 and has more than 32,000 people on treatment. Of these, 800 children are on first-line antiretrovirals and more than 300 are on second-line regimens in pilot sites. China uses WHO staging as criteria to initiate treatment as well as the CD4 threshold of <350 as an immunological marker for initiating ART.
Papua New Guinea

Papua New Guinea follows WHO guidelines and uses WHO clinical and immunological criteria to switch from first- to second-line regimens. Without the capacity to detect HIV by RNA polymerase chain reaction, it cannot switch base on virological determinants. Treatment is initiated at a CD4 threshold of <350; social criteria, such as the availability of an adherence support system, are also used to determine initiation of ART. There are some programmatic issues peculiar to Papua New Guinea such as terrain, distance from treatment sites, and ability of the health system to support such programmes. Currently, Papua New Guinea has 49 sites and more than 4500 people on treatment.

Malaysia

Malaysia has been keeping HIV surveillance data since 1986 and has more than 80,000 reported cases of HIV. More males (83.7%) are infected with HIV than females (16.3%), mainly IDUs and prisoners. Malaysia has harm reduction programmes such as needle and syringe exchange programmes. Malaysia uses WHO-recommended regimens and has strong government commitment to scale up programmes, e.g. offering free first-line antiretrovirals and certain second-line regimens to special groups such as children.

Viet Nam

Viet Nam has the biggest number of donor-supported HIV treatment programmes and its epidemic is IDU driven. It has a peer outreach programme for harm reduction. Viet Nam has treatment guidelines and standardized recording and reporting procedures. It uses WHO staging and a CD4 threshold of <350 to initiate antiretroviral treatment. More than 22,000 people on ART including more than 1200 children. Viet Nam's treatment protocol contains 30 different first- and second-line regimens and 20 regimens for children. The programme has challenges in surveillance, reporting and monitoring of programmatic issues.

2.2.2 Panel discussion: Programmatic implementations of implementing scientific advances in ART knowledge in Asia

Starting ART early reduces AIDS deaths as well as serious illnesses and malignancies. Implementing scientific advances in ART in Asia is dependant on the availability of antiretrovirals and funding. Countries will use drugs available if they are cost-effective and feasible, even if the regime is not the best, e.g. the use of Stavudine. Substitutions due to frequent toxicities of Stavudine to Zidovudine have caused an increase in anaemia cases within one year of switching. Costs associated with rolling out new drugs are increasing for programmes (revising drug forecasts, laboratory tests and others) as well as for the clients (transport costs, absenteeism). Changes in regimens, such as the introduction of Tenofovir in Zambia, dramatically increase the need for resources, e.g. training human resources, building laboratory capacity to monitor renal functions. Countries need to carefully select safe, cheap and easy-to-adhere first-line regimens before arbitrarily changing them, and they need to consider the impact of a second-line choice. For example, Abacavir has high failure rates, increased risk of cardiomyopathies as well as hypersensitivity; Tenofovir is a better choice in first-line regimens; and Zidovudine should be used in optimum dose for different populations and monitoring of haemoglobin.

Second-line drugs are limited in all Western Pacific Region countries. Countries are encouraged to use viral load as an indicator of treatment failure and to avoid inappropriate switching in order to preserve the few second-line drugs that are available. In the Western Pacific Region, very few sites use the HIV RNA test for infant diagnosis.
2.3 Health systems strengthening

Dr Dean Shuey, WHO Regional Adviser in Health Services Development, presented an overview of health systems strengthening and primary health care (PHC). The definition of health systems from the World Health Report 2000 was stated. It was mentioned that health systems strengthening is all about disease control. It was noted that Declaration of Alma-Ata (1978) was the renewal of primary health care within WHO and PHC remains one of the main fields of WHO work. The historical development of PHC was highlighted.

It was emphasized that donations to the health sector increased greatly from 2000 to 2005. Donations were provided not only by bilateral agencies, World Bank and development banks, but also by the United Nations. A large proportion of aid for the health sector goes to HIV/AIDS programmes and activities. However, increased funding creates challenges, such as: (1) focusing on access to services, especially for the poor; (2) defining appropriate and inclusive packages of services; (3) scaling up to achieve "health for all" or "universal access, which requires increasing health system capacity aid and national funding architecture, making it more complicated; and (4) having new global health partnerships (e.g. Global Fund and Global Alliance for Vaccines and Immunization [GAVI]) can lead to increased risk of fragmentation. However, development assistance for health is being delivered for specific diseases in a fragmented way with serious implications for health systems and other health problems. There are various vertical health programmes such as maternal and child health programme, TB programme, malaria programme. In many settings, there is lack of human resources. Fragmented approach results in duplications, distortion, disruptions and distractions.

WHO is trying to address these issues by developing the WHO Framework for Action. It concentrates on how the WHO secretariat can provide more effective support to Member States in strengthening their health systems to achieve better health outcomes. It consists of four pillars: (1) a single 'health systems' framework with six clearly defined building blocks; (2) systems and programmes: getting results; (3) a more effective role for WHO at country level; and (4) the role of WHO in the international health systems agenda. In addition, WHO developed a regional strategy for strengthening health systems in the Western Pacific Region with vision of universal access to quality of services for improved health outcomes for all. PHC serves as guiding principle for the strategic plan. It was highlighted that there are huge variations in the outcomes of the health system even among countries that are spending the same amount of funding.

The following major issues in terms of health systems were mentioned:

- The misdistribution of human resources between and within countries is a major concern. Training is not enough to remedy the problem. It is important to have skill-mix generalists, mid-level professionals, volunteers, etc. In addition, a long-term vision for development of human resources is crucial.

- The next issue that was discussed was health care financing. Currently, countries have different types of financing sources such as taxes, social health insurance, private health insurance and out-of-pocket payments. The predominant source of health care financing in Asian countries, especially China and India, is out-of-pocket spending. As such, 150 million people suffer financial catastrophe and 100 million people are pushed into poverty annually due to health spending. It was noted that rational management of health services is unlikely if financial incentives for both providers and patients are irrational.
- Information systems are often lacking, of low quality, not used, and uncoordinated among programmes. Each donor uses its own forms.

- There is a need to do better in provision of medical products and technologies.

- In terms of service delivery, issues related to package definition, quality versus quantity of services, continuum of care, and public-private mix should be addressed.

- Leadership and governance should be strengthened.

In order to improve health systems performance and scaling up for better health, the international community should give more emphasis on the following: integration of services; "diagonal approach" addressing health systems bottlenecks; support of national plans and strategies; and improved coordination between country needs, the key global health actors and bilateral commitments.

Furthermore, cross-cutting issues such as gender, human rights, trade and health, poverty and access/health for all require a systems approach.

Key discussion points:

- Possible health systems strengthening areas for action were proposed to participants. The new global initiative like International Health Partnership (IHP) involves six bilateral agencies. IHP supports seven pilot countries. Cambodia is the only country from WPR supported by this partnership.

- Due to increase of donors' support, a concern was expressed by participants that government commitment is reducing.

- There were discussions about primary health care, the reasons why PHC failed in countries, and the involvement of private providers in PHC. The participants agreed that private providers should be involved in PHC, but that their involvement should be better controlled. Many countries are successful in PHC.

- The Brazilian experience showed that it is possible to provide HIV services—drugs and testing—free of charge. Brazil also succeeded in involving the community in the provision of HIV services.

- Some countries lack data on the allocation of government funds to HIV/AIDS.

- It was noted that the National Programmes contribute to health systems strengthening. They work through existing health systems and support community participation. However, determining how to bring all these programmes together is still a challenge.

- Participants urged WHO to provide support to countries for health systems strengthening and to advocate for health systems strengthening among decision-makers.

2.4 Linkages of services: HIV/AIDS services with reproductive, adolescent, maternal, newborn and child Health

Dr Liu Yunguo, WHO Regional Adviser in Gender, Women and Reproductive Health, made a presentation on the Asia-Pacific Operational Framework for Linking
HIV/AIDS Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services, developed jointly by WHO, UNICEF, UNAIDS and United Nations Population Fund (UNFPA). The Framework was developed to provide guidance to countries for the strengthening of links between reproductive, adolescent, maternal, newborn and child health, and the prevention and management of HIV and other STI. It was mentioned that the establishment of linkages should be based on existing services. Linkages make clients happy because they can be provided by multiple services in a single visit. However, linking strategies should be country specific and determined by: epidemiology, such as HIV and STI prevalence; current skill sets and capacity of providers; organization of health care system; resources available for training and supervision; and usage pattern for particular health system services. Representatives from China, Cambodia and Papua New Guinea made presentations on linking HIV/AIDS services with reproductive, adolescent, maternal, newborn and child health.

Key discussion points:

- A concern was raised that only UNICEF supports PMTCT. It was stressed that WHO should provide more support to countries in this area because PMTCT is related to maternal mortality. Therefore, linking maternal health services and PMTCT is important to reduce maternal mortality.

- It was also noted by participants that WHO should advocate and disseminate the Asia-Pacific Operational Framework for Linking HIV/AIDS Services with Reproductive, Adolescent, Maternal, Newborn and Child Health to health providers and stakeholders working in maternal and child health. It is important to know key players in maternal and child health within national structure and availability of resources to support PMTCT. PMTCT support should be based on the epidemiological situation of the country.

- In the Philippines, prongs 1 and 2 of the PMTCT programme will be under the responsibility of the Maternal and Child Health Programme, while prongs 3 and 4 will be covered by the National AIDS STI Prevention and Control Programme.

2.5 Update on congenital syphilis

2.5.1 Global update

Dr Antonio Gerbase presented on one of the global health priorities—elimination of congenital syphilis. Because of HIV/AIDS, funding, prestige and visibility have increased for STI programmes. The public health approach to controlling an HIV epidemic—prioritizing primary prevention, behaviour change interventions, focusing on groups with high-risk behaviour, the human rights approach and community involvement—have replaced the old ways of dealing with STI.

Programmatic opportunities include:

- integration of national and local programmes,
- joint training,
- joint monitoring and evaluation,
- joint education campaign,
• integration of clinical services,
• counselling for prevention in clinic settings,
• routine offer of HIV testing to STI patients, and
• syphilis testing among antenatal clinic attendees.

Every year, at least half a million infants are born with congenital syphilis. Maternal syphilis causes another half million stillbirths and miscarriages annually. There are new reliable, simple tests and easy treatment (single dose of penicillin early in pregnancy). Also, there is global interest by WHO, CDC and partners.

The main funding opportunity is when linking with PMTCT. The case should be constructed pointing out that:

• congenital syphilis elimination contributes to better HIV PMTCT outcomes and to the Millennium Development Goals;

• operational issues are the same; and

• countries are moving: e.g. Mongolia, Brazil.

Collaboration is needed among health programmes (HIV/AIDS, STI, sexual and reproductive health, maternal and newborn health); among prevention, care and surveillance teams; and among national, regional and local levels. One plan with clear defined roles and responsibilities is needed with everyone working with the same objective.

Proposals to the Global Fund for elimination of congenital syphilis should link with PMTCT and should be short, accurate and evidence based. Early dialogue and involvement of the maternal and newborn health programme is fundamental. Interventions proposed should include concrete activities to address STI control and elimination of congenital syphilis. Strategies must be focused, simple, practical, measurable and consider implementation issues.

Update on Capacity Building Workshop for Global Fund Proposal Writing in Maternal and Neonatal Health, WHO Regional Office for South-East Asia, New Delhi, 19-22 August 2008

WHO Headquarters (Department of Reproductive Health and Research, Department of Making Pregnancy Safer and ATM) organized a technical workshop with the WHO Regional Offices for South-East Asia and the Western Pacific with the overarching aim to enhance countries' capacity to develop Global Fund proposals on: (1) prevention of mother-to-child transmission (PMTCT), (2) elimination of congenital syphilis, and (3) malaria in pregnancy using maternal and newborn health service delivery framework through health systems strengthening.

Specific objectives included:

• to provide guidance on key principles and procedures for application to the Global Fund;

• to review, discuss, and assess country experiences with maternal and newborn health activities and interventions supported through the Global Fund;
to develop skills in effective proposal writing with the inclusion of key maternal and newborn health interventions, through health systems strengthening, that address major challenges in PMTCT, ECS and MIP.

Invited to the workshop were government representatives from five countries in the South-East Asian Region (Bangladesh, India, Indonesia, Myanmar, Sri Lanka) and five countries in the Western Pacific Region (Cambodia, China, Mongolia, Papua New Guinea, Viet Nam) as well as representatives from the WHO country offices. Almost all countries were represented by experts in the fields of STI, HIV, sexual and reproductive health, and maternal and newborn health. Myanmar was represented only by the country office. The Global Fund, UNAIDS, UNFPA and UNICEF as well as Engender Health were invited to the meeting. The WHO Regional Office for the Western Pacific and WHO Headquarters (HTM/HIV/OTS) served as technical resources to impart knowledge on establishing links between HIV, STI and congenital syphilis and developing Global Fund proposals.

HTM/HIV/OTS made a presentation on possible links between congenital syphilis elimination and STI control with HIV prevention. They also participated in the discussions.

Countries improved their knowledge of the Global Fund, in general, and of possible links between maternal and newborn health with HIV/AIDS when developing proposals. Current evidence of STI treatment as an intervention of preventing HIV transmission is very weak. Linking congenital syphilis with prevention of mother-to-child transmission of HIV seems the most appropriate way to go when developing proposals for the Global Fund. The argument of strengthening STI services in Global Fund proposals should be built on the fact that STI patients have a high incidence of HIV infection and should be used as a target group for HIV prevention.

2.5.2 Case study from Mongolia

A case study on the elimination of congenital syphilis in Mongolia was presented. Three pilot projects were introduced: (1) “one-stop shop” in two selected provinces supported by WHO; (2) comparison study of one-stop services with conventional services supported by WHO; and (3) integration of ANC and STI services supported by UNFPA and GTZ. During discussions it was stated that mass treatment can be done if the prevalence of syphilis is very high.

2.6 Updates from technical meetings

2.6.1 Report from the Technical Consultation on HIV Testing in Ha Noi, Viet Nam

Following the HIV Testing and Counselling Regional Consultation held in Phnom Penh in 2007, a technical consultation was held in Ha Noi in July 2008 to: (1) review the implementation of HIV testing, including identification of the most appropriate testing algorithms in the context of the Western Pacific Region; (2) review and finalize the draft document “Guidance for HIV Testing in Low and Concentrated Epidemic Settings”; and (3) identify steps for implementing the guidelines as part of strengthening HIV prevention, care, treatment and support towards Universal Access.

The meeting recognized that scaling up HIV/AIDS programmes presents an unprecedented opportunity to address integration of quality laboratory services as a whole into health systems. The meeting recognized the value of a regional technical forum to provide specific expertise in medical laboratory technology and quality management for
HIV testing. The meeting endorsed the draft "WHO/CDC Guide for scaling up quality HIV testing in the Western Pacific Region".

The meeting issued the following 14 recommendations:

1. A technical working group should be established in each country to assist the national HIV/AIDS programme in identifying, validating and reviewing testing strategies and algorithms.

2. The technical working group should be guided by sound scientific and methodological principles, as exemplified by international practices in securing efficacious testing.

3. Appropriately evaluated HIV rapid tests that offer reliable, high quality performance should be used to minimize HIV testing result turn-around time.

4. While recognizing the varied epidemiological settings in countries of the Western Pacific Region, current testing strategies should be simplified to minimize complexities and reduce technical and financial burden.

5. Given the available scientific evidence, it is recognised that appropriately validated two-test algorithms can yield highly accurate anti HIV-1 test results.

6. The role of a third test as a confirmatory test and in resolving problematic results at a referral laboratory should be addressed through validation and operations research.

7. HIV testing services should comply with the national standard for quality management systems.

8. The technical working group should guide a continuing training programme for national quality management system.

9. The introduction of HIV testing kits into the market must be regulated because the accuracy of a test outcome depends both on the quality of the kits and on their correct usage.

10. To enable consistent application of standardized testing algorithms, procurement agencies should work closely with national programmes to ensure that only the prescribed test kits enter the system.

11. WHO and partners should strengthen their regional collaboration to better assist member nations to enhance quality in HIV testing and HIV-related laboratory systems.

12. WHO and US CDC should continue to work together to help address outstanding HIV-related laboratory issues.

13. WHO, through its collaborating centres and other partners, should provide technical assistance to Member States in conducting validation studies. This could include the establishment of a regionally representative specimen bank for assay evaluation and algorithm validation.

14. Links between national and regional reference laboratories should be strengthened to increase the availability and application of appropriate quality assurance programmes.
The immediate next steps of the technical consultation in countries of the Region include:

- Viet Nam (situation analysis conducted);
- Philippines (revising strategy for quicker turn-around times);
- South Pacific (validation rapid strategy in progress);
- Papua New Guinea (Phase II validation completed); and
- Cambodia (strengthening laboratory network and integration).

2.6.2 Report from the 2nd Asia-Pacific Regional Meeting on Universal Access to HIV Prevention and AIDS Treatment, Care and Support in Low Prevalence Countries

The 2nd Regional Consultative Meeting on Universal Access to HIV Prevention and AIDS Treatment, Care and Support in Low Prevalence Countries was held from 26 to 28 August 2008 in Manila, Philippines. Participants represented governments, civil society organizations and international partners from 12 countries, namely Bangladesh, Bhutan, Fiji, the Lao People's Democratic Republic, Indonesia, Malaysia, Maldives, Mongolia, the Philippines, Singapore, Sri Lanka and Timor Leste.

The objectives of the second Regional consultation meeting were: (1) to review progress of countries and identify steps to address gaps in the operationalization of the Ulaanbaatar 2006 Call for Action; (2) to identify emerging issues in scaling up comprehensive national AIDS responses towards universal access; and (3) to reaffirm political commitment among governments, civil society organizations, and international agencies by adopting concrete ways forward towards universal access to prevention, treatment, care and support.

Discussion on the first day covered: HIV epidemiology in low prevalence countries and factors that account for the current situation; progress made in low prevalence countries in achieving universal access to prevention, treatment, care and support; highlights of the Commission on AIDS in Asia report; and scaling up prevention, treatment, care and support programmes with maximum effectiveness.

Discussion on the following day focused on obstacles to universal access, as identified at the Asia Pacific regional consultation in Pattaya in 2006, including: access to commodities and low-cost technology; human rights; stigma and discrimination; human resource and system constraints; sustainable financing; civil society participation; and delivering quality interventions and reaching coverage. The last day identified concrete actions that could be taken by low prevalence countries towards achieving UA.

The meeting concluded that the following actions should be undertaken to reach universal access to prevention and care in the Region: (1) estimate or update MARP size and accelerate targeted interventions with adequate coverage; (2) prioritize resources to high impact interventions; (3) increase involvement of civil society organizations; (4) implement programmes to reduce stigma and discrimination; (5) promote and protect human rights; (6) develop guidelines for improved access and availability of low-cost quality commodities; (7) train health care and social workers to provide better services for HIV-positive persons and for MARPs; (8) train people living with HIV for positive prevention; (9) invest in health systems to ensure sustainability; (10) ensure that communities are involved in designing, implementing and monitoring programmes;
strengthen multisectoral involvement in National AIDS Coordination mechanism; build capacity of the local government officials who manage national, provincial and local level programmes; and explore other models for integrating and/or linking the HIV programme.

The meeting participants decided to hold a third meeting, which will be hosted by Sri Lanka in 2010.

2.6.3 Report from the Sixth Stop TB Technical Advisory Group Meeting for the Western Pacific in Tokyo, Japan

One of the objective's of the meeting was to review and provide recommendations on the implementation of national TB control plans of the seven countries with a high burden of TB and Malaysia, with special focus on MDR-TB, TB-HIV co-infection and TB laboratory services.

Although 3% of new TB cases in the Western Pacific Region are estimated to be MDR-TB, and even though cases of extremely drug-resistant (XDR) tuberculosis have been reported by some countries of the Region, treatment of MDR-TB is still lacking. With regards to TB laboratory services, good progress has been made in quality assurance of microscopy, but access to quality-assured culture is limited in the Region. As for TB-HIV activities, the Region still has a low rate of HIV testing among new TB cases. New evidence from the Region has shown that patients with both TB and HIV are very immuno-suppressed at initial presentation with high early mortality rate without ART.

Finally, the regional framework to address TB-HIV co-infection in the Western Pacific Region was endorsed during the Technical Advisory Group (TAG) meeting. The regional framework promotes scaling up RN testing for TB patients and the application of the "three I's" concept: (1) intensified TB case finding among people with or at high risk of RN, (2) isoniazid preventive therapy (IPT) for people living with RN based on a symptoms algorithm, and (3) infection control.

3. ROLES OF WHO AND ITS PARTNERS

3.1 Support in the Region

WHO and other development partners supporting HIV work discussed in a panel the type of assistance and initiatives they provide to countries.

WHO

WHO, as the directing and coordinating authority on international public health, takes the lead within the United Nations system in the global health sector's response to HIV. WHO is organized at three levels: country office, regional office and Headquarters. The WHO country office, which is considered the most important level, reports to the regional office. The regional office mobilizes resources for technical assistance. WHO Headquarters assists the regional office. Technical assistance is provided in different areas of HIV: testing and counselling, treatment and care, strategic information, maximizing health sector's response, health system strengthening.
Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund is a funding agency that bases its funding primarily on a round-based approach. It was mentioned that future funding will also be based on national strategy application. The Global Fund does not provide technical assistance for implementation. Technical support is provided through other partners such as WHO. The Global Fund tries to simplify and increase efficiency to shorten grant negotiations. It is aiming for most grants to be signed within three to four months. Consolidation of multiple grants is also encouraged by the Global Fund.

APCASO

APCASO is a key regional network of NGOs and CBOs that provide HIV/AIDS services across Asia Pacific region. Its main strategies are to increase the capacity of NGOs and CBOs to respond to HIV/AIDS, and to facilitate regional responses through capacity-building, advocacy and networking. It works with and through focal points/partners in most countries in the region. It is also the founding member of the Coalition of Asia Pacific Regional Networks on HIV/AIDS, also known as the Seven Sisters. These comprise APN+ (dealing with PLHIV), APNSW (dealing with sex workers), AHRN (harm reduction), Caram Asia (migrant workers) and Asia Pacific Rainbow (dealing with lesbian, gay, bisexual and transgender communities). Its primary objectives are to raise awareness, collectively mobilize resources and elicit and sustain the participation of key stakeholders for an integrated and comprehensive response to HIV/AIDS in Asia and the Pacific. In terms of support in the region, civil society organizations can contribute to strategic information, resource mobilization and allocation; they should also be involved in monitoring and evaluation. Participants requested WHO to provide technical support to CSOs and involve CSOs in technical support.

Key discussion points:

- WHO has good relationships with NGOs especially in the implementation of the 3 by 5 Initiative.
- During an international conference in Mexico, WHO participated in a session involving civil society. WHO's Director-General stated that the Organization would continue and intensify collaboration with civil society.
- It was stressed that there is a need to have a more consultative process between WHO and NGOs at the local level. Although WHO primarily works with the governments, there is a need to intensify collaboration with civil society.

3.2 Cross-cutting roles

Understanding people with specific roles and tasks can strengthen partnerships and working relationships. Participants of the meeting were given the opportunity to explore and experience how it feels to be in the position of their counterparts. Participants were divided into four groups, each given a hypothetical country scenario to interpret and act on; WHO focal persons took the role of their national counterparts and vice versa.

Through a role play, the activity provided a different methodology to understand the pressures that national counterparts are facing and the challenges that WHO is experiencing as it tries to assist and guide the country in responding to specific public health situations. It also depicted the real situation that—despite best efforts and intentions—both parties still face certain limitations beyond their control. The activity
also provided participants the opportunity to take a short break from technical sessions and understand each other’s role in a light and enjoyable manner.

4. SUMMARY OF CONCLUSIONS AND NEXT STEPS

The programme managers from 13 countries and key partners who attended the meeting hosted by the Lao Ministry of Health acknowledged the usefulness of the meeting. A range of technical updates and country experiences were shared. Progress made by countries since the last meeting in 2005 were reported, including sharing and identification of challenges and proposed solutions. The participants also expressed specific technical support needs required from WHO and partners. This meeting also provided updates on recent regional consultations such as the Low Prevalence Country Meeting in Manila, Sixth Stop TB Technical Advisory Group Meeting for the Western Pacific Region in Tokyo, and HIV Testing Consultation in Ha Noi, Viet Nam.

The following conclusions were made:

Health information systems:
- Progress has been made in HIV information systems and reporting.
- Key challenges identified were: tensions between international and national reporting, harmonization of indicators, and quality assurance.
- Technical assistance needs identified were: capacity-building in strategic information including quality assurance.

Targeted interventions:
- While considerable progress has been made, countries have often overlooked one or more most-at-risk populations (MARPs), e.g. men who have sex with men.
- Countries recognized the need to prioritize and scale up interventions targeted to MARPs.
- They also identified the lack of strategic information on MARPs as a key gap.
- Technical assistance needs identified were: conducting population size estimates and second generation surveillance among MARPs; monitoring and evaluation of programmes; and building capacity for programme implementation and expansion.

Treatment, care and support:
- Participants were updated on the WHO framework for reviewing evidence and developing recommendations.
- Existing WHO recommendations and potential update vis-à-vis emerging evidence were presented.
- The status of country guidelines and revisions was presented and programmatic implications identified.
• Technical assistance needs identified were: costing models; refining estimates particularly for ART needs; and supporting programme managers in critical decision-making.

Health systems strengthening:

• Participants acknowledged the need to strengthen health systems and the role to be played by HIV programmes.

• Decentralization of health services and commitment to primary health care approach are well established, but with high out-of-pocket payments.

• Countries shared progress and experiences made since the inception of the WHO framework on linkages of services (HIV, sexual and reproductive health, maternal and child health, tuberculosis).

• Need to focus on implementation of activities at the level of service delivery.

• Technical assistance needs identified were: support countries on health system strengthening and advocate among decision-makers.

Further, countries agreed on the following to move the agenda forward:

(1) Organize a technical consultation on HIV care and treatment in 2009, providing a forum for programme managers, technical experts, and beneficiaries to discuss and plan together.

(2) WHO to provide technical and programmatic support and to clarify roles of partners in order to intensify PMTCT, including through the existing PMTCT regional task force.

(3) WHO to strengthen its presence in country and to provide more technical support particularly on strategic information, PMTCT, targeted interventions, HIV prevention, treatment and care.

(4) WHO and other United Nations agencies to continue to support implementation of the linkages framework.

(5) HIV programme managers acknowledged the opportunities currently available to support health systems strengthening, e.g. GAVI, Global Fund to Fight AIDS TB and Malaria, International Health Partnership, and requested the WHO Regional Office to capitalize on them.
# PROGRAMME OF ACTIVITIES

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<td>09:00-09:30 Coffee/Tea Break</td>
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<td>10:00-12:00 Panel discussion: Managing data on the health sector response—development of a national HIV Data Management System</td>
<td>Dr M. Ghidinelli / Dr Z. Patel</td>
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<td>• Cambodia</td>
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<td>12:00-13:30 Lunch Break</td>
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<td>13:30-14:00 Report from the Technical Consultation on HIV Testing in Ha Noi, Viet Nam</td>
<td>Dr M. Ghidinelli</td>
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<td>14:00-16:00 Targeted interventions</td>
<td>Dr F. Mesquita</td>
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<td>• Group A</td>
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<td>16:20-16:35 Report from the 2nd Asia-Pacific Regional Meeting on Universal Access to HIV Prevention, Care and Support in low prevalence countries</td>
<td>Dr G. Belimac</td>
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### Annex 1

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<td>Report from the Sixth Stop TB Technical Advisory Group Meeting in Tokyo, Japan</td>
<td>Dr. G. Mezzabotta</td>
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<td>Update on treatment of infants and children</td>
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<td>14:00-16:00</td>
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<td>Summary of conclusions and recommendations</td>
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**Presenters**

- Dr. G. Mezzabotta
- Dr. S. Crowley
- Professor C. Gilks
- Dr. C. Duncombe
- Dr. D. Shuey
- Dr. L. Yunguo
- Dr. A. Gerbase
- Dr. M. Ghidinelli
- Dr. M. Fujita
- Professor C. Gilks
- Dr. M. Vun / Dr. E. Daoni
- Dr. M. Ghidinelli / Dr. M. Fujita
- WHO / Partners
- Dr. F. Mesquita

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Meeting of HIV/AIDS Programme Managers in the Western Pacific Region
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