WORLD HEALTH ORGANIZATION
Regional Office for the Western Pacific Region

REPORT

MEETING OF PUBLIC HEALTH OFFICIALS RESPONSIBLE FOR THE PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED INFECTIONS AND HIV/AIDS IN PACIFIC ISLAND COUNTRIES AND TERRITORIES

Nadi, Fiji

4–7 June 2001

Manila, Philippines
August 2001

(WP)HSI/ICP/HSI/003

Report series number: RS/2001/GE/16(FIJ) English only

REPORT

MEETING OF PUBLIC HEALTH OFFICIALS RESPONSIBLE FOR THE PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED INFECTIONS AND HIV/AIDS IN PACIFIC ISLAND COUNTRIES AND TERRITORIES

Convened by:

WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR THE WESTERN PACIFIC REGION

Nadi, Fiji

4-7 June 2001

Not for sale

Printed and distributed by:

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

August 2001

NOTE

The views expressed in this report are those of the participants in the Meeting of Public Health Officials Responsible for the Prevention and Control of Sexually Transmitted Infections and HIV/AIDS in Pacific Island Countries and Territories 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 of Public Health Officials Responsible for the Prevention and Control of Sexually Transmitted Infections and HIV/AIDS in Pacific Island Countries and Territories.

CONTENTS

Page

SUMMARY 1

1. INTRODUCTION 3

   1.1 Objectives 3
   1.2 Organization 3
   1.3 Opening ceremony 3

2. PROCEEDINGS 4

   2.1 STI, HIV and AIDS Global and Asia 4
   2.2 STI/HIV/AIDS situation in Pacific island countries 5
   2.3. Programme Management 7
   2.4 Introduction to surveillance methods 7
   2.5 STI prevalence survey 8
   2.6 Behavioural surveillance 8
   2.7 Round table discussion on surveillance and data collection 8
   2.8 Group work on surveillance 9
   2.9 UN agency overview 9
   2.10 Nongovernmental organizations and country presentations 10
   2.11 Round table discussion 11
   2.12 Access to STI clinical services 12
   2.13 STI syndromic case management 13
   2.14 HIV/AIDS care 13
   2.15 Counselling and confidentiality 14
   2.16 One year action plans 14
   2.17 Statements by partner agencies 15
   2.18 Closing remarks 15

3. CONCLUSIONS AND POINTS OF ACTION 15

ANNEXES:

ANNEX 1 - DETAILS OF THE COUNTRY PRESENTATIONS AND PRIORITIES 17

ANNEX 2 - LIST OF PARTICIPANTS 21

ANNEX 3 - AGENDA 31

Keywords: Sexually transmitted diseases – prevention and control / HIV infections / Acquired Immunodefiency syndrome / Pacific islands

SUMMARY

Since the days of the Global Programme on AIDS sponsored by the World Health Organization in the mid 1980, there has been little focus on programme management training for sexually transmitted infections (STI) and HIV/AIDS for Pacific island countries (PICs) and territories. Following the "Time to Act" study supported by UNAIDS and the development of the STI and HIV/AIDS Regional Strategy facilitated by the Secretariat of the Pacific Community (SPC), there has been little attention paid to building regional capacity in comprehensive programme management in STI and HIV/AIDS. A project facilitated by the MacFarlane Burnet Centre for Medical Research (MBC) focused on the development of national strategic plans by involving selected individuals from Pacific island countries. Recently, the World Health Organization developed the 2000 – 2002 plan of action for the prevention and control of STI in the Pacific to focus on six areas:

1. awareness in the general population;
2. special outreach and services programmes for people with high risk behaviour;
3. primary health care services;
4. surveillance;
5. laboratory support; and
6. policy and programme management.

This meeting, while addressing the major issues of concern for the countries and territories in the Pacific, focused on developing priority areas for action in the next year to enable support by the World Health Organization.

Some of the participants are not programme managers in their respective countries and territories. However, for all participants the meeting provided an opportunity to highlight the development and implementation of comprehensive action plans for the prevention, treatment, care and support of people with STI and HIV/AIDS.

The objectives of the meeting were to:

1. exchange and review updated information about STI and HIV/AIDS situation and programmes in the Region;
2. increase collaboration and networking in the area of STI and HIV/AIDS prevention and control in the Region; and
3. update strategies for prevention and control of STI and HIV/AIDS, and identify priorities for action in the Pacific island countries and territories.

The programme of the four-day meeting focused on six areas:

1. STI, HIV/AIDS programme management issues,
2. STI, HIV/AIDS surveillance,

3. nongovernmental organization (NGO) and community-based action (prevention of HIV/STI infection at the community level),

4. STI/AIDS treatment and care,

5. counselling and confidentiality, and

6. development of priority plans of action.

1. INTRODUCTION

1.1 Objectives

The objectives of the meeting were to:

(a) exchange and review updated information about STI and HIV/AIDS situation and programmes in the Region;

(b) increase collaboration and networking in the area of STI and HIV/AIDS prevention and control in the region; and

(c) update strategies for prevention and control of STI and HIV/AIDS, and identify priorities for action in the Pacific Island countries and territories.

1.2 Organization

The WHO Meeting of Public Health Officials Responsible for the Prevention and Control of Sexually Transmitted Infections and HIV/AIDS in the Pacific Island Countries and Territories was held in Nadi, Fiji, from 4 to 7 June 2001. A total of 15 countries and territories were represented in the meeting. Representatives frm AusAID and Ministry of Health, New Zealand were official observers, as were representatives from other UN agencies (UNICEF, UNFPA and UNDP), the Secretariat of the Pacific Community (SPC), and two nongovernmental organizations (NGOs): AIDS Task Force of Fiji, and the Reproductive and Family Health Association of Fiji. A number of other NGOs were invited to take part on day two of the workshop on community-based interventions.

1.3 Opening ceremony

Following his nomination as meeting chairman for the opening day, Dr Malakai ‘Ake of Tonga introduced the speakers for the opening ceremony. Participants were welcomed to Fiji and to the meeting by Mr Luke Rokovada, the Permanent Secretary for Health, Fiji Ministry of Health. Mr Rokovada drew attention to the significant problem of STI in Fiji, and the potential for acceleration of the HIV epidemic, referring also to issues of stigmatization, and the need for good policies and for education and other initiatives to promote positive behaviour change.

Dr Shichuo Li, the WHO Representative in the South Pacific, delivered opening remarks on behalf of WHO, reviewing the magnitude of the problem of STI and HIV/AIDS in the Pacific and the world, and emphasizing the need to move strongly ahead in addressing the critical issues of HIV, AIDS, and STI prevention and control, and to do so in a collaborative manner.

2. PROCEEDINGS

2.1 STI, HIV and AIDS Global and Asia

It is estimated that more than 35 million individuals in the world are HIV infected. The largest number of infected is in Africa - 25 million – where HIV infects up to one third of the adult population in some countries. In the Americas and Europe, the epidemic is stabilising or even regressing in some countries. The future of the epidemic in Africa and Asia is difficult to predict - it might stabilise or continue to expand.

Factors of HIV transmission are now better understood:

(i) HIV transmission is essentially linked to human behaviours: sharing injecting equipment and having sexual intercourse with multiple sexual partners.

(ii) HIV transmission by sex is inefficient – transmitting on average in one per 1000 episodes of vaginal sexual intercourse with an infected person. These two factors explain that extensive HIV transmission in the general population occurs when there is a high prevalence of overlapping and concurrent sexual partners combined with a high level of sexual partner exchange. In Asia, this is essentially observed among sex workers and their clients.

(iii) Two facilitating factors of transmission have been identified: genital ulcerative lesions and high proportion of recent HIV infections (who have a higher viremia).

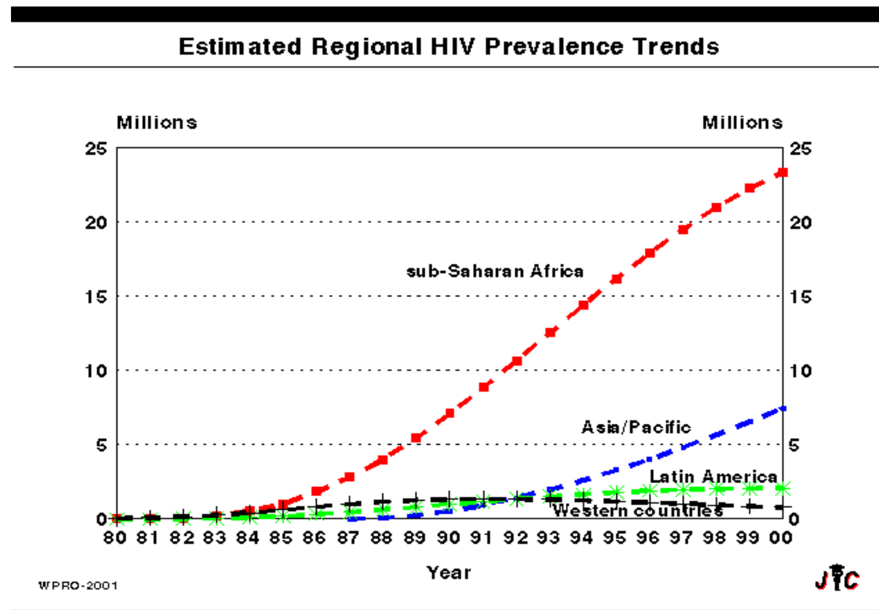
In Asia, the estimated rate of infection is the highest, between 2% and 3% of the adult population, in three countries: Cambodia, Thailand and Myanmar. HIV transmission is related to injecting drug use and sex work. However, because on average most women will not have multiple sexual partners, HIV infection does not spread extensively to the general population. AIDS cases are expected to increase from 400 000 in the year 2000 to 600 000 in the year 2005.

The most common STI observed are chlamydial and trichomonas infections, which are common among young women below 25 years of age.

Successful HIV prevention control programmes in Asia and the Pacific (Australia, Thailand, Cambodia, New Zealand) have been a result of high-level commitment, raising awareness of the general population and intervention targeting high-risk populations (injecting drug users, sex workers).

The future of HIV transmission in Asia will depend on how extensive the heterosexual transmission of HIV will be and on the extent of infection in countries with the largest populations, China and India. Figure 1 provides an estimate of prevalence in the different regions of the world.

Fig 1:



2.2 STI/HIV/AIDS situation in Pacific island countries

Through December 2000, almost all of the 725 cumulative reported cases of HIV and AIDS in the Pacific had occurred in 10 of the 20 Pacific island countries (excluding Papua New Guinea). More than 75% of these were reported from only three countries: Guam, New Caledonia and French Polynesia. The rate of reporting has not accelerated in recent years, although many reasons for under-reporting are recognized: lack or avoidance of testing, concerns over confidentiality, alternative diagnoses recorded on medical records or death certificates, and in the case of HIV, the large percentage of asymptomatic infected persons.

While HIV and AIDS remain at low levels in the Pacific, recent surveys have confirmed that other STI are common, particularly chlamydia trachomatis and richomonas vaginalis. Because HIV is almost entirely a sexually transmitted infection in the Pacific, these high STI rates imply behavioural risks, which could facilitate greater HIV transmission in the future. Reducing this risk includes meeting the challenge of reducing sexual risk-taking behaviour, and preventing, or successfully treating curable infections.

Figure 2 illustrates the number of cases of HIV and AIDS reported for twenty countries in the Pacific islands and, Figure 3 shows the large prevalence of STI in the Region.

Fig 2: Number of Reported HIV/AIDS cases, 20 Pacific countries – 1985 to 1999

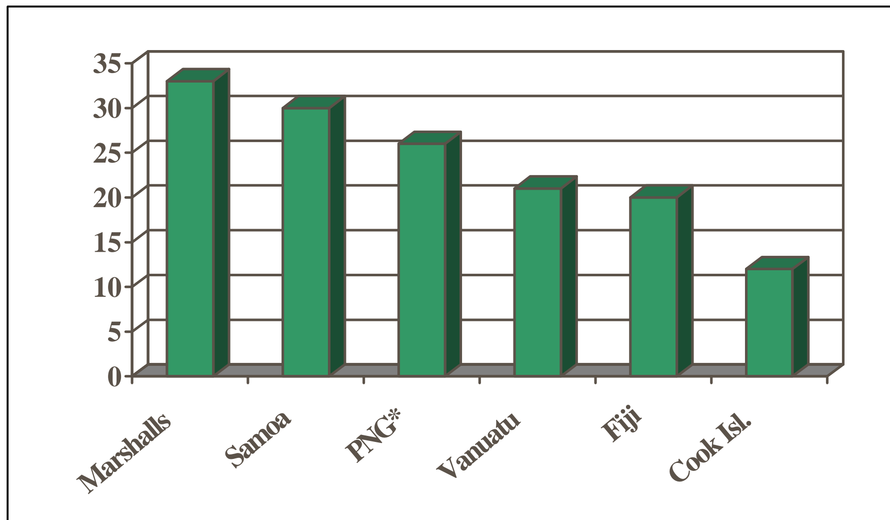
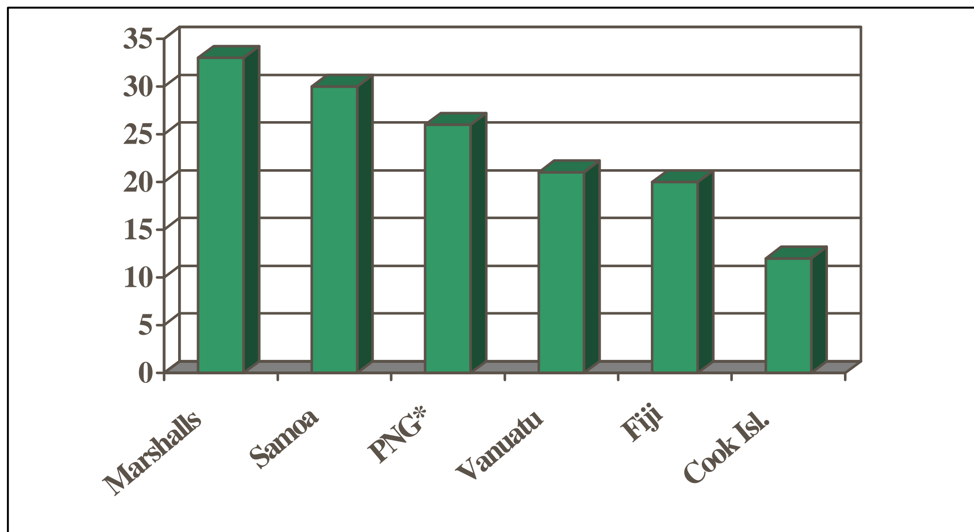


Fig 3: Prevalence of chlamydial infection amongAntenatal women
in selected Pacific countries



2.3 Programme management

The management of comprehensive multi-sectoral response programmes in small island settings is a major challenge and requires innovative approaches.

Policies should be developed at the national level to ensure that there is an appropriate and sustained response to the HIV/AIDS epidemic. Policies should take into consideration global standards of best practice and be able to fit them into the local geo-political and socio-cultural setting. Taking stock of existing government policies and understanding regional structures and systems of support should be kept in mind in developing appropriate policies.

The use of surveillance information for decision-making should be emphasized at all levels of response. Information should be utilized actively in policy development, advocacy and measurement of impact of interventions.

Management capacity was noted to be lacking and there was a need to improve management capacity at all levels of the response, both at the government and nongovernmental organization level.

Given the small size of many of the countries and territories, it is important that appropriate structures of a comprehensive multi-sectoral response be developed and put in place based on the appropriateness and the capacity to sustain the STI and HIV/AIDS response.

As a significant amount of resources are made available to the national response by partner agencies, it is important that the public health official responsible for STI and HIV/AIDS be familiar with the different donor requirements and philosophies. The focal point should ensure there is coordinated support in the national response to STI and HIV/AIDS.

Programme managers and public health focal points for STI and HIV/AIDS should be open minded and should create an environment that allows everyone to take part in the response. Appropriate networks should be created with NGOs, community-based organizations (CBOs), church groups and other key stakeholders.

Managers and public health focal points should also be in tune with changes in the overall health system and in the socio-political environment of the country. Major regional issues of concern such as regional security and socio-economic development initiatives should be considered in managing STI and HIV/AIDS programmes in the Region.

2.4 Introduction to surveillance methods

Good information on the magnitude and distribution of HIV, STI, and behavioural risk factors provides the basis for effective action. Surveillance is the source of this information. HIV surveillance has recently been refined to focus on issues of greatest significance, and to link infection data with behavioural risk data. This "second-generation HIV surveillance" provides guidelines which vary by epidemic state. In a "low-level" epidemic, as is the case in the Pacific, the focus is on monitoring of infection rates in vulnerable subpopulations (e.g. commercial sex workers, or men who have sex with men (MSM) to detect early expansion of the epidemic, and to describe the behavioural patterns and risks which facilitate HIV transmission within and between communities.

Surveillance for information purposes or epidemic monitoring should be distinguished from testing for diagnosis or case finding. National programmes should carefully consider the benefit of each existing surveillance strategy, weighing the yield against the cost and effort involved. Continuous HIV screening of very low prevalence populations, for example, may not be a cost-effective use of resources. Similar information might be obtained by periodic or

sentinel screening of samples of the population. HIV surveillance should thus be carefully conducted in a low-level epidemic setting. Substantial information may additionally be obtained from surveillance for curable STI, which are much more common, and for behavioural risk factors and patterns of sexual networking.

2.5 STI prevalence survey

The antenatal clinic STI survey took place from October 1999 to February 2000 at Vila Central Hospital (VCH), Port Vila, Vanuatu. It was a laboratory-confirmed STI prevalence survey whose aim was to determine the prevalence rates of gonorrhoea, chlamydiosis, trichomoniasis, treponemal seroreactivity and HIV among women on the first visit to antenatal clinic at VCH. Five hundred forty (547) seven pregnant women aged 15-46 years were recruited and tested.

The most prevalent laboratory confirmed STIs were trichomoniasis (27.4%), chlamydiosis (21.4%) and gonorrhoea (5.9%). Two point four percent (2.4%) had positive treponemal antibodies.

Facing the unexpectedly high burden of disease among a traditionally low-risk population of antenatal women, the Ministry of Health adopted a very innovative policy: to treat all the women aged 15-25 years attending the antenatal clinic in the two main hospitals (in Port Vila and Luganville) with erythromycin and flagyl (if evidence of trichomonas). The partners are treated with the same regimen. Three hundred forty seven (347) women and 315 partners have been prescribed with this presumptive treatment from 29/01/2001 to 25/05/2001. An assessment of the presumptive treatment will be made within two years.

2.6 Behavioural surveillance

In the absence of a cure or vaccine for HIV, reduction in HIV transmission depends largely on reducing the burden of curable STI, and especially on reducing sexual risk-taking behaviours. For the latter a good baseline understanding is required, as is the capacity to monitor the effectiveness of efforts to reduce sexual risk. Behavioural surveillance now has well-defined and standardized methods globally, which may be adapted to national and local situations to provide key information on sexual risks, and on barriers and facilitating factors in reducing such risks.

In 1999, an independent SBR Task Force (the Social and Behavioural Research Task Force on Sex and Sexuality) was established in Suva, open to all with an interest in sexual behavioural research and in reducing sexual risks of HIV and STI transmission. The task force has developed a permanent collection of sexual behavioural research in the Pacific (the collection is housed at the Fiji School of Medicine library, and partially available electronically), and is promoting and supporting new priority research efforts.

2.7 Round table discussion on surveillance and data collection

The need to get standardized and timely data is an important aspect of information collection. Such information is vital in attaining comparable statistics in different countries and territories in the region. Unreliability of the data may be a result of several different factors.

The difference in figures between AIDS and deaths due to AIDS may be the result of mis-classification in the cause of death by the statistical clerk or due to the fact that AIDS cases reported in other countries may be returning home to die. The need to get most recent updates to WHO was noted to be a major factor in mapping out the situation in each country in a timely and comparable manner.

Major concerns noted included:

- the lack of training in ICD and clarity in the classification of cause of deaths due to AIDS;
- delay in the reporting time to WHO;
- the question of reliability of tests and the need for a central reference laboratory to provide timely results;
- the issue of reporting of HIV and AIDS cases when there are mobile cases involving several countries; and
- the issue of logistics and the capacity of countries to have the infrastructure to diagnose and report reliably and on time.

2.8 Group work on surveillance

In the first group work session, participants reviewed existing national surveillance strategies and data sources for HIV and AIDS, STIs, and behavioural risks. They were charged with considering both the effort and the yield of these current strategies, and to determine which should be modified or eliminated; and which new surveillance methods or strategies should be added to improve knowledge and to develop appropriate interventions.

Many countries are conducting routine screening among low prevalence populations such as antenatal clinic clients, pre-employment screening, or travellers. The reasons for these may range from legal requirements to the possibility of effective interventions such as counselling, or preventive therapy for newborns. However, the low yield of these efforts is recognized. Blood bank screening provides a special case in this regard, given the ease of prevention of transmission when routine screening is in place, and the significant risk when not.

Many other "surveillance" methods for HIV may more properly be considered case finding, or patient-oriented diagnostic services. While some HIV positive patients may be identified in this way, and perhaps some activities implemented to prevent further transmission, the resulting information can seldom be generalized beyond the very specific test situation.

Only a very few countries had engaged in any regular or even *ad hoc* behavioural surveillance. Some collect items of behavioural information at patient encounters but without conducting subsequent analysis. Most countries agreed that an increased focus on understanding sexual behaviour risk-taking and on sexual networking would provide useful information for programme planning.

2.9 UN agency overview

UN agencies continue to play a supportive and facilitating role in national and community responses to STI and HIV/AIDS. The UN responsibility was originally concentrated in WHO's Global Programme on AIDS from the mid-1980s. With the advent of UNAIDS in 1995, several UN agencies began to collaborate directly on the use of their resources and technical support staff, through the mechanism of UN Theme Groups on AIDS. There are two of these in the Pacific, based in Suva and in Apia (with a third in Port Moresby). The Theme Groups provide a mechanism for UN collaboration in responding to STI and AIDS, but neither they nor UNAIDS replace the work of WHO or any other UN agency, and in fact UNAIDS represents the sum of the work of each of these agencies. In the Pacific, the individual UN agencies each maintains an array of activities at the country and the regional level, as described by representatives of each agency during this session. The task at hand is to support the implementation of key activities as

defined in national and regional strategic plans, according to priorities defined by countries. This would be further addressed over the next two days of the meeting.

2.10 Nongovernmental organizations and country presentations

Below is a brief summary of eight presentations by NGOs and participants from member countries.

2.10.1 University of the South Pacific (USP)

The main presentation was on formulation of HIV/AIDS policy in tertiary institutions. Definition, components and contents of policy were briefly discussed. Issues brought up from the floor include the existing sexual network in the university setting, the taboo of talking about sex, and problems with confidentiality.

2.10.2 Kiribati Ministry of Health

A brief description of the STI situation in Kiribati with current surveillance tools and strategies was presented. The main focus was on condom promotion with 90 outlets located in bars, shops and clubs. Issues of seafarers, stigmatisation and the need to advocate to the community were discussed. It was made known to the participants that WHO no longer recommends the routine use of Western blot as a confirmation test for HIV, as it is too costly and causes delays in obtaining the results. Instead a combination of ELISA and other tests is recommended.

2.10.3 Secretariat of the Pacific community (SPC)

Although SPC is not an NGO, the STI and HIV/AIDS project of SPC has been involved in a seafarer's project and other community-based activities. The presentation focused on the seafarer's project, with activities including training of seafarers, peer education training and also making services available at ports. Future activities will focus on human-rights issues, problems with alcohol, and family support. This could link HIV to a development issue, as the economic impact of the country would be affected if seafarers were infected with HIV.

2.10.4 Fiji Council of Churches/CAPE

Real life stories were presented. Issues raised include stigmatisation; problem with policies and legislation, the need for cooperation with Ministry of Health, the lack of funding of NGOs and the need to look at the critical role that NGOs are playing. An interesting metaphor for networking is that of an orchestra, requiring the coordinated participation of many different players, who must work together to provide a proper tune. Nongovernmental organizations may be seen as powerless, often with no resources to act. The question is how to create an orchestra where all the players can work together in the Pacific.

2.10.5 Seventh Day Adventist Church

Approaches include camp meetings, young people’s meetings, ladies' group targeting ladies in the community and using puppets as a medium of communication when dealing with sensitive issues in the area of STI and HIV/AIDS. Challenges include cultural taboos, sensitivity of issues, questions of the involvement of the church, treating of STI/HIV/AIDS as a moral issue, parents not assuming responsibility, young people and church not being given the correct information to make informed decisions and choices and parents not having the right information package. Participants were encouraged to use the church network to create awareness among the people and also to build on existing expertise in the region, e.g. drama group in Vanuatu and peer education with the AIDS Task Force. The SDA Church has made particular use of puppets in

this regard, as a non-confrontational means of addressing sensitive subjects with both children and adults.

2.10.6 AIDS Task Force in Fiji

The task force's presentation included experiences in working with NGOs and National AIDS Program Managers in eight different countries. Success and sustainability of programmes depended on the selection criteria and the commitment of staff. Of the 32 peer educators trained, 30 are still functioning in their respective countries. ATFF has been significantly involved in regional capacity building for NGOs. Problems for many NGOs include donor preference for funding only regional strategies rather than offering direct country support. However, there is a need for clear direction from the Ministry of Health as a coordinating body for STI and HIV/AIDS responses with regards to identifying specific roles and responsibilities for nongovernmental organizations.

2.10.7 Reproductive and family health

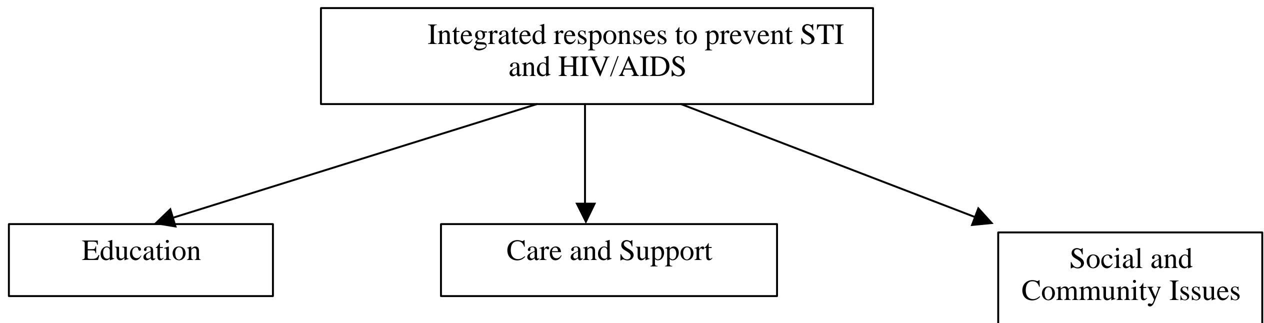
Main issue from this presentation is to start sex education at primary level before the onset of sexual activity. Health workers need to question themselves and to ensure that they are not the ones creating the barrier for young people to get access to services such as condoms. Important questions were raised (Do we really care?, Are we committed?, Is there collaboration and coordination between the nongovernmental organizations, government, community and church?, Is culture a barrier? How do we approach the church and chiefs?, and What kind of changes are needed, such as bringing the clinic to the community?) Comments from the participants highlighted the need to look at how sex could be discussed in the community, the role of research and the need to target men in prevention activities.

2.10.8 Young people's representatives

The presenters described the importance of young people working with young people and using the language of young people. Training should be ongoing and consistent and peer educators should be properly trained. There should be availability of resources for implementation or else young people may lose interest and confidence in the programme. The formation of a virginity club was raised, including suggestions for further need to look at other ways of sexual expression, the need to talk about masturbation, and the types of relationship being promoted. Some participants supported the concept but there is a need to clarify issues and to look more broadly than just the simple meaning of virginity and to apply the virginity club concept to those for whom this appeals the most, while also continuing all other interventions.

2.11 Round table discussion

A brief description of the responses undertaken in the past years to prevent the spread of HIV infection was presented to give an overall view of what has been the impact of the interventions implemented. Experiences and lessons learnt indicated that some of the strategies adopted were not as effective as anticipated. This, of course, provided some input in relation to redirection and development of new strategies in relating HIV/AIDS as a development issue rather than a health problem. A conceptual framework of this new approach involving a multi-sectoral approach that facilitates a integrated response was illustrated with emphasis on behaviour change in relation to changing the course of HIV/AIDS epidemic. Below is an integrated responses diagram mapping out the three specific areas of responses (education, care and support, and social and community issues).



In relation to the above conceptual frame, the Pacific situation was mapped out to determine what is the current position with regards to implementing STI and HIV/AIDS responses/activities. For most of the Pacific island countries, most of the activities are related to provision of STI and HIV/AIDS education to community and vulnerable groups. There are fewer activities in the other two main components. In spite of this, a few countries, for example Papua New Guinea, had already implemented activities under the other two main components, although the progress is slow. There are also examples in the other smaller islands states in relation to developing policies on Human Rights supported by UNDP for a few countries. These included Fiji, Kiribati and Tonga.

In relation to behaviour change, lack of understanding and the need to involve many partners were highlighted as the two main issues to sexual issues and STI and HIV/AIDS education. The emphasis at the moment for most Pacific island countries is focused on information dissemination. The sequential steps in achieving behaviour change were mapped out, starting with ignorance, to awareness raising, wanting to change, making behaviour changes and sustaining behaviour change. Many examples of vital issues to address were raised in relation to behavioural change, which is often a difficult process. A diagram illustrating this process is shown below.

Ignorance → Awareness → Want to change → Behaviour change → Sustaining behavioural change

Education	*HIV is real*	*Access to services*	*Reinforcement*
Sexual issues	*Attitudes*	*Counseling*	*Consistent support*
STI/HIV/AIDS info	*Individual plan*	*Support group*	*Creative*
	Safe alternatives	*Access to condoms*	
		Negotiation skills	

2.12 <u>Access to STI clinical services</u>

Access of STI patients to appropriate clinical services is one of the cornerstones of prevention and control of STI/HIV/AIDS. Early and effective treatment of STI conditions reduces the risk of HIV infection.

Basic requirements to access to clinical services include adopting the ‘user-friendly’ concept or non-stigmatising setting for the clinic with a conducive and convenient set-up for providing at one location most of the services needed, including consultation, counselling, diagnostic procedures, giving of medication including condoms, and any referrals indicated. The commitment of the staffs in terms of attitude, behaviour, confidentiality and gender sensitivity

are important in creating a friendly environment for patients to utilize the services. Services should be provided at an affordable price. A continuous supply of appropriate medication and condoms should be maintained to ensure the provision of comprehensive care to those seeking treatment at STI clinics.

Identified potential barriers can be addressed through good and timely information, by increasing integration of services at the local level, and through collaboration with donors and continuous dialogue with the various partners, stakeholders and organizations that are involved in the provision of care.

2.13 STI syndromic case management

STI syndromic case management responds to the needs of STI case management at the primary level and has the following advantages:

(i) avoiding follow-up;

(ii) providing rapid cure with effective drugs;

(iii) standardization of treatment;

(iv) simplicity;

(v) appropriate for integration in all primary level clinics (including family planning and maternal and child health); and

(vi) no need for sophisticated laboratory services.

The approach is comprehensive, including not only treatment but also education, condom promotion and partner notification. It targets symptomatic STI which are at higher risk of complication (including HIV transmission).

STI syndromic case management was introduced in the Pacific in 1994. Since then most Pacific island countries and territories have adopted it and trained their personnel, although some countries still need to adopt supporting policies. More work is needed in the region to guarantee antibiotic and condom availability. There are a number of areas in which action is required, including a need to update flowcharts with the latest developments, adopt supporting policies (in selected countries), integrate the approach in medical officers and nurses curricula and provide refresher courses to health professionals.

2.14 HIV/AIDS care

The number of AIDS patients is expected to increase rapidly in the next few years in the Western Pacific Region. However, the number of AIDS patients in the Pacific countries and territories is not expected to overburden the health services. AIDS care needs are in (i) identification of HIV infected individuals (ii) reinforcing confidentiality and reducing discrimination (iii) improving access to treatment and psycho social support, and (iv) developing palliative care.

The Pacific has a wide variety of AIDS care services with some countries providing access to the most advanced care (e.g. Guam and French Polynesia), while others still do not have access to the essential AIDS care components. In the latter, there are needs to progress on policy development (e.g. for issues such as access to treatment, confidentiality, psycho social support,

etc.), technical guidelines development (e.g. for voluntary and testing services, for treatment of opportunistic infections, for antiretroviral drugs treatment including prevention of mother-to-child HIV transmission, etc.) and training health professionals. Guidelines developed at the regional level (e.g. Cambodia) could serve as a reference for the Pacific. Training of health professionals using developed guidelines needs to be reinforced. The rapidly decreasing cost of antiretroviral drugs and development of standardized treatment may lead to increase accessibility to these drugs and will justify special consideration. Training of health professionals is expected to reduce substantially discrimination in health institutions. Efforts are also needed to develop awareness of the general population through social networks such as churches.

2.15 Counselling and confidentiality

Effective counselling must be client-centered and individually-focused. Counselling involves considerably more than education or awareness; at a personal level, it involves providing support in decision-making for positive behaviour change. Counselling must be further supported with services, to allow decisions to result in action. Several countries, including Guam, Northern Mariana Islands and Fiji, have established policies and procedures for confidential counselling, but their implementation is often constrained by the pressures on health worker's time, limited resources, and a need to train and support health workers in effective counselling techniques.

Confidentiality is an important element of STI and HIV/AIDS treatment and care, due to the persistent stigma associated with these diseases, and to the trust necessary in the relationship between health worker and patient. Health care worker attitudes are important to this relationship and to setting an example for the community. Instilling positive attitudes and promoting an appreciation for the importance of confidentiality require training of health workers and regular reinforcement.

As long as fear and ignorance, and stigma, remain common where HIV/AIDS is concerned, counselling and confidentiality will continue to occupy a place of particular importance.

2.16 One year action plans

A number of countries have already developed strategic plans through the MacFarlane Burnet Centre for Medical Research (MBC) regional project facilitated by SPC and UNAIDS. In reviewing the strategic plans several areas needed review. There was a need to do the proper costing of plans so that future regional projects can focus on implementation rather then planning processes. Other social and economic development concerns may not have been properly addressed by the plans and needed some attention if the national responses were to have been perceived as comprehensive multi-sectoral responses. It was also noted that the plans needed to have a mechanism for monitoring and implementation built into the documentation so there was clear guidance on how each of the plans can be monitored and evaluated.

Participants were urged to focus on three to five priority activities in the next one year in developing their plan of action.

Participants were reminded of the need to consider, in planning, the major principles of management, including information for action, ensuring an appropriate policy setting, knowledge of global, regional and local standards of best practice, acknowledging appropriate networks, and remaining realistic in the planning process.

Annex 1 provides details of the country presentations and priorities.

It was acknowledged that the priority listing was done by individuals attending the meeting and that the relevant authorities in the respective countries and territories would be consulted before final activity plans were submitted to WHO for support.

2.17 Statements by partner agencies

AusAID has had a sustained partnership with both government and NGOs throughout the region. There was a need for a policy environment where many of the initiatives can be sustained by recipient governments and institutions. For obvious reasons, it was important that AIDS be given priority and that it be elevated on the agenda of the governments of the region. In order that there is a collective response to the epidemic, it was important that there be an updated regional strategic plan.

The representative from the Ministry of Health, New Zealand, informed that they are keen to be involved wherever possible as they share many problems with Pacific islands due to the large Pacific islander population in New Zealand. NGO responses in New Zealand were a major factor in the successes of the programme. New Zealand stands ready to work together in sharing the problems and assisting in solving the problems together.

2.18 Closing remarks

Words of appreciation were given to the workshop participants and staff of WHO at both the Manila and Suva offices for the excellent job in organizing the meeting. Participants were thanked for their hard work during the week.

3. CONCLUSIONS AND POINTS OF ACTION

While HIV and AIDS remain at low levels in the Pacific, recent surveys have confirmed that other STI are common in most Pacific island countries and territories. Because HIV is almost entirely a sexually transmitted infection in the Pacific, these high STI rates imply behavioural risks which could facilitate greater HIV transmission in the future. Reducing this risk includes meeting the challenge of reducing sexual risk-taking behaviour, and preventing, or successfully treating curable infections.

Key points from the meeting included:

(1) Sexually transmitted infections(STI) are recognized as a serious problem in the Pacific, needing renewed attention. Renewed commitment from political, cultural, community and traditional leadership is called for if there is to be a concerted effort to contain the HIV/AIDS epidemic in the Pacific islands.

(2) Sustained, well-coordinated and progressive support is required by all partner agencies in the region if there is to be a well-resourced comprehensive response to the STI and HIV/AIDS epidemic in the Region.

(3) Programme managers should recognize the importance of, and be aware of, both internal and external mechanisms for resourcing the implementation plans to enable a sustained response to the epidemic.

(4) Although the Pacific as a whole is currently at a low-level HIV epidemic state, the problem seems to be clearly increasing in some countries. There is definite concern for the future, given the magnitude of the STI problem in general in the Pacific.

(5) Better information is still needed on the magnitude and distribution of the STI and HIV problem in most countries, and the economic burden to society including the loss of productivity. In addition, HIV testing, STI surveys, and much better behavioural surveillance data are needed to monitor and evaluate interventions.

(6) Nongovernmental organizations play an activist and committed role in many countries, with limited resources, and there are many opportunities for collaboration between government and NGOs.

(7) Programme managers need to maintain a "big-picture" in the planning, implementation and monitoring of STI and HIV/AIDS initiatives. Managers should be able to determine priorities and to ensure financial support and trained committed staff. Management capacity should be strengthened where needed, to ensure that this is achieved.

(8) Prevention of HIV transmission is still the primary intervention mode for controlling the AIDS epidemic in the Pacific. At this early epidemic stage, the most productive activities may be focused on identifying and working with populations at higher risk, and drawing on the experience of successful programmes and best practices in other areas and be able to share these experiences.

(9) Prevention of STI and of HIV transmission requires a good understanding of sexual behaviour patterns and networking, and on promoting and sustaining behaviour change.

(10) Control of curable STI requires an educated population that depends on accessible and acceptable clinic settings including regular supplies of drugs and laboratory equipment. Provision of well-trained staff at all levels of the health system with the ability to provide effective treatment at a single visit to all those who seek care is an important part of comprehensive care. The syndromic approach addresses these and related needs.

(11) AIDS care and support is an increasingly important issue in many countries, and includes addressing important issues of discrimination and stigmatization. The training of staff to provide high quality evidence based treatment and care to all HIV positive individuals in the community should be enhanced.

(12) In parts of the Pacific, population mobility has led to the need to improve collaboration between countries and territories to ensure appropriate follow up to enhance appropriate, comprehensive care and support is provided to people affected by STI and HIV/AIDS.

(13) The need to mount a comprehensive multi-sectoral response is noted to be valuable in the small island setting, and sectors apart from health should be encouraged to take an active part in the response to the epidemic.

ANNEX 1

COUNTRY PRESENTATIONS AND PRIORITIES

COUNTRY	AREAS OF PRIORITY
American Samoa	1. Clinical Care of STI and focusing on training in syndromic approach 2. Use of drugs over the counter assessment of resistance and development of appropriate guidelines and protocols 3. Community activity - Training of peer educators Churches, youth village, public and private schools and NGOs
Cook Islands	1. Training in counselling and Care among Youth Sports & NGOs (Nov. 2001) 2. Seminar to increase awareness for parliamentarians (March 2002) 3. Health Promoting activities through the media (October 2001) 4. Baseline Surveillance for STI and identify vulnerable groups (June 2002) 5. Continue community activities including condom promotion (Sept. 2001) 6. School Health Promotion activities (HIV/AIDS Curriculum etc.) (Oct 2001) 7. Training of peer educators (June 2002)
Fiji	1. Review of NACA its structure and roles and responsibilities. Advertise the Fiji plan and get others involved in the plan of action 2. Review of Family Life education Curriculum Proposal writing 3. Standardize peer education training its management and support 4. Co-ordinate NGO involvement to be facilitated by NACA 5. Developing network on care and support to be coordinated by red cross etc.. 6. IEC Targeted interventions 7. Capacity building of NGOs 8. Evaluation and monitoring

Annex 1

Federated States of Micronesia (State of Pohnpei)	1. Prepare for a comprehensive response – available 5-year plan in draft form 2. Promote 100% Condom Use in bars and seaports 3. Peer education in schools and local NGOs (by August and implement by Dec) 4. Set up system on communication and network counselling 5. HIV/AIDS laboratory support and identification of lab support 6. Develop policies and protocols on counselling and pre and post test counselling
Guam	1. Counselling 2. Clinical Care 3. Create appropriate structures for a national AIDS focal point i.e update on comprehensive plans 4. Treatment care guidelines (syndromic approach and laboratory confirmation approach as determined by the attending physicians). 5. Behaviour Surveillance studies
Kiribati	1. Programme Planning and improving management skills 2. STI Prevalence study on seafarers, adolescence, ANC attendees (Oct 2001 – June 2002) 3. Improve quality care. Improve and create good standards of practice for health workers (2001 –2002) 4. HIV Prevalence study in selected groups of about 5,000 people (July 2001 – Jan 2002)
Marshall Islands	1. STI/HIV/AIDS School Health Education in 8 schools (Sept 2001 - March 2002) 2. STI/HIV/AIDS education in specific groups (Sea farers) (Nov 2001) 3. Promotion of community health education in six zones (2002) 4. Clinical Treatment and Care Syndromic approach (Feb – March 2002) *** Including other NGOs
Nauru	1. Political Leadership and Commitment (Political Leaders in addressing the Yanuca Island Declaration) 2. Religious Leaders focus 3. Counselling Training 4. Condom availability 5. Focus on Sporting groups and Schools

Annex 1

New Caledonia	1. Access to condom (1) 2. Sexuality Education (3) 3. Access to screening 4. Care and support to PLHA (5) 5. Coordinating the multi sectoral response (2) 6. Information. Motivation. Communication (4) Creating a website
Commonwealth of the Northern Mariana Islands (CNMI)	1. Behaviour Surveillance 2. Community Activities - Establish Communication with the Catholic Church 3. Develop Health Information Packet 4. Develop better dialogue with politicians 5. Clinical Treatment and Care - Provide access to treatment for all HIV positive individuals - Find better sources and systems for supplies - Lab support systems sample management by airline agencies etc.. 6. Capacity building of other relevant people involved in the response 7. Counselling issues and training of nurse counsellors
Palau	1. Condom Promotion - to achieve 100% condom use in all sexual encounters outside committed monogamous relationship between two individuals 2. Health Promotion in special Populations - Map out groups of particular risk and develop specific interventions to address their risks 3. School Health Promotion activities - Develop specific school health interventions to address STI and HIV/AIDS risks
Tonga	1. Training of Syndromic management for two groups: main island and outer islands 2. Development of IEC materials weekly programmes 3. Training of counsellors same two groups 4. STI, HIV & AIDS Surveillance Protocol (improve existing recording and reporting system) 5. Laboratory request for reagents 6. Attachment of clinician/nurse attachment to overseas institutions

Annex 1

Solomon Islands	1. Sexual health counselling in service training on syndromic approach 2. Health worker reorientation and training focusing on attitudes etc… 3. Health Promotion 4. Focus on youths and other settings of priority 5. Laboratory Services, i.e. test kits 6. Treatment requirements
Samoa	1. Increase awareness among politicians 2. Surveillance and epidemiology 3. STI and do literature search (already has a surveillance data) 4. HIV care and support for health care providers 5. Workshop for seafarers 6. Additional Discussion on political commitment: 7. Political leadership, i.e. Global, Regional and country commitment (reporting to parliament)
Vanuatu	Programme Management 1. Policy Development - STI Policy - NGO Networks - Parliamentary Act 2. Prevention and Control 3. Condom Promotion targeted interventions 4. Surveillance - Ongoing and looking at other groups - Behaviour Surveillance 5. Treatment and Care - On job training and refresher courses – 12 nurses on syndromic approach - NGO training for those NGOs providing care

ANNEX 2

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

MEETING OF PUBLIC HEALTH OFFICIALS RESPONSIBLE FOR THE PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED INFECTIONS AND HIV/AIDS IN PACIFIC ISLAND COUNTRIES AND TERRITORIES

WPR/HSI(2)/2001/IB/2
06 June 2001

Nadi, Fiji
4-7 June 2001

ENGLISH ONLY

LIST OF PARTICIPANTS, CONSULTANT,
TEMPORARY ADVISERS, OBSERVERS/REPRESENTATIVES,
AND SECRETARIAT

1. PARTICIPANTS

AMERICAN SAMOA

Ms Tai Ripley
Nurse in-charge
STD Clinic
LBJ Medical Center
Pago-pago
Tutuila
American Samoa
Tel.: (684) 633 4606
Fax: (684) 633 5379

COOK ISLANDS

Ms Edwina Tangaroa
Health Educator
Ministry of Health
Cook Islands
Tel.: (682)29110
Fax: (682) 29100
E-mail: aremaki@oyster.net.ck

Annex 2

FIJI	Dr Salanieta Taka Saketa Epidemiologist Ministry of Health Dinem House, Amy St. Suva Fiji Tel.: (679) 306 177 Fax: (679) 306 163
GUAM	Ms Bernadette Schumann Communicable Disease Control Coordinator III Program Supervisor STD/HIV Prevention Program Department of Public Health and Social Services 123 Chalan Kareta, RT 10 Mangilao Guam 96932 Tel.: (671) 735 7311 Fax: (671) 734 2437
KIRIBATI	Dr Kabwea Tiban Acting Public Health Consultant Public Health Division Ministry of Health Tarawa Kiribati Tel.: (686) 28871 Email: kabweatiban@yahoo.co.nz
MARSHALL ISLANDS	Ms Florina Bellu Nathan Public Health Nurse Supervisor Ministry of Health and Environment P.O. Box 16 Majuro Marshall Islands 96960 Tel.: (692) 625 5817 Fax: (692) 625 3431 E-mail: oihemohe@ntamar.com
MICRONESIA, FEDERATED STATES OF	Ms Mary Lou Hawley, MPH Chief of Administration and Health Planning Acting Chief of Primary Health Care Department of Health, Education and Social Affairs Division of Primary Health Care Kolonia, Pohnpei Federated States of Micronesia 96941 Tel.: (691) 320 2217 or 3652 Fax.: (691) 320 8382 E-mail: healthcare@mail.fm

Annex 2

NORTHERN MARIANA ISLANDS	Dr James U. Hofschneider STD & HIV/AIDS Physician Department of Public Health Commonwealth of the Northern Mariana Islands P.O. Box 500409 CK Saipan MP 96950 Tel.: 1 670 234 8950 Fax: 1 670 234 8930 Email: jhofschneider@saipan.com
NAURU	Mrs Ruby Thoma Coordinator, Health Promotion Centre Nauru General Hospital Nauru Tel.: (674) 444 3883 Fax: (674) 444 3106
NEW CALEDONIA	Dr Yves Perroy DPASS-ILES, BP 1014 Noumea 98845 New Caledonia Tel: (687) 242 740 Fax: (687) 242 744
PALAU	Dr Helen Ngirmekur Sokau Physician In-charge Division of Communicable Diseases Ministry of Health Box 6027 Koror 96940 Palau Tel.: (680) 488 2552 Fax: (680) 488 1211
SAMOA	Mr Alapati Anoia Nurse Department of Health Office of the Director-General Apia Samoa Fax: (685) 26 553

Annex 2

SOLOMON ISLANDS	Mr Amos Lapo STI National Coordinator Ministry of Health and Medical Services P.O. Box 349 Honiara Solomon Islands Tel.: (677) 25154 Fax: (677) 21250
TONGA	Dr Malakai 'Ake Chief Medical Officer, Public Health Ministry of Health P.O. Box 59 Nuku'alofa Tonga Tel.: (676) 23200 Fax: (676) 24291 Email: mohtonga@kalianet.to
VANUATU	Mr Katimal Kaun Acting AIDS/STI Programme Manager Public Health Department Ministry of Health Private Mail Bag 009 Port Vila, Vanuatu Tel.: (678) 22512 Fax: (678) 26204 Email: ttamata@vanuatu.gov.vu

2. CONSULTANT

Dr Clement Malau
Director, National AIDS Secretariat
P. O. Box 1743
Boroko,
Papua New Guinea
Tel: (675) 323 6161; 325 9424
Fax: (675) 323 1629
E-mail: clementm@datec.com.pg

Annex 2

3. TEMPORARY ADVISERS

Dr Seini Tupou Veihola Kupu
Senior Medical Officer i/c Communicable Disease Section
Public Health Division
Ministry of Health
P.O. Box 1748
Nuku'alofa,
Tonga
Tel: (676) 23 200 ext. 30
Fax: (676) 24 291
E-mail: mau@kalianet.to; mogtonga@kalianet.to

Mr Kenneth Fox Konare
Director, Disease Prevention and Control Division
and National AIDS Programme Manager
Ministry of Health and Medical Service
Honiara
Solomon Islands
Tel.: (677) 21043
Fax: (677) 20085

4. OBSERVERS/REPRESENTATIVES

AUSTRALIAN AGENCY FOR INTERNATIONAL DEVELOPMENT (AusAID)

Ms Iris Domeier
Program Officer Health & Social Services
Pacific Regional Section
Australian Agency for International Development
Canberra
Australia
Tel: (02) 6206 4411
Fax: (02) 6206 4720
e-mail: iris_domeier@ausaid.gov.au

Ms Kathleen Kay
Project Design Consultant (AusAID)
HIV/AIDS Regional Pacific Program
Secretariat of the Pacific Community
B.P. D.5
98848 Noumea Cedex
New Caledonia
Tel: (687) 26 01 89
Fax: (687) 26 38 18

Annex 2

MINISTRY OF HEALTH, NEW ZEALAND

Dr Douglas Lush
Senior Advisor (Communicable Diseases)
Public Health Programmes
Public Health Directorate
Ministry of Health
Wellington
New Zealand
Tel: 04 496 2336

SECRETARIAT OF THE PACIFIC COMMUNITY

Mr Andrew Peteru
HIV/AIDS and STD Project Coordinator
Secretariat of the Pacific Community
BPD5
98848 Noumea cedex
New Caledonia
Tel.: (687) 262 000
Fax: (687) 263 818
Email: spc@spc.int

Dr Rufina Latu
Population Advocacy and Reproductive Health
IEC Adviser
Secretariat of the Pacific Community
BPD5
98848 Noumea cedex
New Caledonia
Tel.: (687) 262 000
Fax: (687) 263 818
Email: spc@spc.int

Annex 2

AIDS TASK FORCE OF FIJI	Ms Jane Keith-Reid Executive Director Aids Task Force of Fiji GPO Box 12718 Suva Fiji Tel.: (679) 313 844 Fax.: (679) 314 199 Email: aidstaskfiji@is.com.fj
	Mr Robert Verebasaga AIDS Task Force of Fiji GPO Box 12718 Suva Fiji Tel.: (679) 313 844 Fax.: (679) 314 199 Email: aidstaskfiji@is.com.fj
	Ms Sala Tupo AIDS Task Force of Fiji GPO Box 12718 Suva Fiji Tel.: (679) 313 844 Fax.: (679) 314 199 Email: aidstaskfiji@is.com.fj
UNICEF	Dr Sarita Neupane Health & Nutrition Officer UNICEF 3rd Floor, FDB Building 360 Victoria Parade Suva, Fiji Tel.: (679) 300 439 Fax : (679) 301 667 email: sneupane@unicef.org
UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)	Mrs Virisila Raitamata Programme Analyst Human Development Division UNDP Private Mail Bag Suva Fiji Tel.: (679) 312 500 Fax: (679) 301 718 Email: virisila.raitamata@undp.org

Annex 2

UNITED NATIONS POPULATION FUND (UNFPA)

Mrs Jiko Luveni
Programme Management Officer
Sub-Regional Office
UNFPA
Private Mail Bag
Suva
Fiji
Tel.: (679) 308 022
Fax: (679) 312 785
Email: jluveni@unfpa.org.fj

UNITED NATIONS POPULATION FUND COUNTRY TECHNICAL SERVICES TEAM FOR THE PACIFIC (UNFPA/CST)

Ms Susan Aradeon
Specialist on Population Advocacy and Information, Education and Communication
UNFPA/CST
5th Floor
FDB Building
PO Box 441
Suva
Fiji
Tel.: (679) 312 865
Fax: (679) 304 877
Email: saradeon@unfpacst.org.fj

5. SECRETARIAT

Dr Corinne Capuano
Epidemiologist
World Health Organization
P.O. Box 177
Port Vila,
Vanuatu
South Pacific
Tel.: (678) 27 683
Fax: (678) 22 691
Email: capuanoc@van.wpro.who.int

Annex 2

Dr Michael O'Leary
Epidemiologist
World Health Organization
P. O. Box 113
Suva,
Fiji
Tel.: (679) 304 600
Fax: (679) 300 462
E-mail: olearym@fij.wpro.who.int

Ms Gaik Gui Ong
Short-term Professional/Technical Officer
World Health Organization
Regional Office for the Western Pacific
P.O. Box 2932
United Nations Avenue
1000 Manila
Philippines
Tel.: (632) 528 9718
Fax.: (632) 521 1036
E-mail: ongg@wpro.who.int

Dr Gilles Poumerol
Regional Adviser, Sexually Transmitted Infections,
including HIV/AIDS
World Health Organization
Regional Office for the Western Pacific
P.O. Box 2932
United Nations Avenue
1000 Manila
Philippines
Tel.: (632) 528 9714
Fax: (632) 521 1036
Email: poumerolg@wpro.who.int

Annex 2

NGO participants – Tuesday special session
5 June 2001

Agency	Name of attendee
USP	Mr Lai Wainikesa
	Mr Mitimiti Siamomua
Safety Net Fiji	Matia Dari
Fiji Council of Churches, Ecumenical Youth Group	Divulasi Vodo
Fiji Red Cross	Semi Mawi
AIDS Task Force Fiji	Jane Keith-Reid
	Robert Verebasaga
	Sala Tupou
Ministry of Information	Sylvia Low
Prison Fellowship (Mr Aporosa Rageci)	Mr Aporosa Rageci
Reproductive and Family Health Association of Fiji (Dr S. I. Varea)	Sr Vika Tikinatabua
Seventh Day Adventist Church	Tom Osborne
Fiji Community Education Association (Joe Veramu)	Filipe Merekula
Fiji Nursing Association (Ms Sereana Bulicokocoko)	Bulou Robanakadavu
International Federation of Red Cross	Hannelle Virtanen

ANNEX 3

AGENDA

1. Opening ceremony

2. STI and HIV/AIDS situation in the Pacific Island Countries
(including HSS, BSS and STI prevalence survey)

3. STI and HIV/AIDS prevention and control
(sharing of experience from member countries, other agencies etc.)

4. Priority strategies and future action
(problem identification followed by identifying priority strategies and actions)

5. Conclusions/Closing ceremony