WHO releases four new treatment guidelines

During the XVIII International AIDS Conference held in Vienna, Austria, from 18 to 23 July 2010, WHO released four new treatment guidelines:

- Antiretroviral Therapy for HIV Infection in Infants and Children (2010 revision)
- Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infections in Infants (2010 version)
- Antiretroviral Therapy for HIV Infection in Adults and Adolescents (2010 revision)
- Guidelines on HIV and infant feeding

These guidelines are intended primarily for use by treatment advisory boards, national AIDS programme managers and other senior policy-makers who are involved in the planning of national and international HIV care strategies. The new guidelines are part of WHO’s commitment to achieve universal access to antiretroviral therapy (ART) by 2010.

Overarching principles

1. Do no harm. Preserve access for the most ill and most in need when introducing changes.
2. Ensure access and equity. All clinically-eligible people should be able to enter treatment services including ART with fair and equitable distribution of treatment services.
3. Promote quality and efficiency. Ensure delivery of the highest standards of care within a public health approach so as to achieve the greatest health impact with the optimal use of available human and financial resources.
4. Be sustainable. Understand the long-term consequences of change with the vision of providing continued, lifelong access to ART for those in need.

From evidence to recommendation

The process of formulating each set of guidelines began with a comprehensive and coordinated review and synthesis of available evidence focused on the three critical patient outcomes of mortality, HIV disease progression and severe adverse events. However, in creating these guidelines, consideration was given by WHO not only to the evidence and its quality but also to the risks and benefits, acceptability, feasibility and financial implications of the recommendations

(continued on Page 2)
within the framework of a public health approach that seeks to maximize enrolment into quality HIV care and treatment programmes. A risk and benefit analysis was performed for each recommendation, resulting in it being rated either as strong or conditional. The quality of evidence was rated as high, moderate, low or very low based on the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) system for interpreting results from systematic reviews and making recommendations, which now is used by WHO for all guidelines’ formulation. Details of the GRADE process are available in the WHO Handbook for Guideline Development. Geneva, WHO, 2010 (http://intranet.who.int/homes/rpc/documents/grc_handbook_mar2010-1.pdf)

WHO normative guidelines are meant for a global audience and it is expected that each country will adapt these guidelines to meet their own circumstances.

A major challenge in the implementation of these new recommendations in the context of limited human and financial resources will be the sustainability and maintenance of equity for ART access. The cost-effectiveness of ART is well established. However, providing ART to HIV-infected patients with higher CD4 counts, the use of more user-friendly, but currently more expensive, ART regimens and additional monitoring will increase initial financial demands in countries that already are struggling to provide ART to people in immediate need. Therefore, choices will need to be made and priorities set. Immediate and full adoption of these recommendations may not be practical, feasible or affordable in every setting. However, ART country planning should be directed towards the goal of their eventual implementation.

**The difference between recommendations and guiding principles**

While specific recommendations are provided wherever possible, some guidance is not amenable to the GRADE system of review because it reflects a set of values and practical considerations that should be applied to providing care within a particular programmatic setting. For the sections on laboratory monitoring and the package of care interventions, recommendations are replaced by guiding principles. Additionally, in the infant feeding *Rapid Advice*, recommendations are complemented by an extensive list of key principles (HIV and infant feeding: Revised Principles and Recommendations. *Rapid Advice*, November 2009 http://www.who.int/hiv/pub/ paediatric/advice/en/).

**Key messages**

**For adults and adolescents**, the key messages are to start ART earlier (CD4 count ≤350 cells/mm$^3$), use less toxic and more patient-friendly ARV, including gradually phasing out stavudine (d4T) in first-line regimens. In addition, ART should be initiated in all individuals with TB/HIV coinfection and those with HBV/HIV coinfection who need treatment for their HBV and promote better use of laboratory monitoring.

**For pregnant women** who need ART for their own health, start ART at any gestational age following the same criteria
as for the general population and continue throughout pregnancy, delivery and thereafter. For pregnant women who are not in need of ART for their own health, antiretroviral (ARV) prophylaxis to reduce transmission to the infant should be started from as early as 14 weeks gestation (second trimester) or as soon as possible when women present late in pregnancy, in labour or at delivery.

There are two recommended options – A and B.

**Option A** consists of antepartum daily zidovudine (AZT), single dose nevirapine (sd-NVP) at the onset of labour, AZT + lamivudine (3TC) during labour and delivery and for seven days postpartum. Sd-NVP and AZT+3TC intra- and postpartum can be omitted if the mother receives more than four weeks of AZT during pregnancy. In breastfeeding infants, maternal ARV prophylaxis should be coupled with daily administration of NVP to the infant from birth until one week after all exposure to breast milk has ended. In nonbreastfeeding infants, maternal ARV prophylaxis should be coupled with the daily administration of NVP or AZT to the infant from birth until four weeks old to six weeks old.

**Option B** consists of triple ARV prophylaxis starting from as early as 14 weeks of gestation until one week after all exposure to breast milk has ended. Although triple ARVs do not offer any greater protection against *in utero* and intrapartum transmission compared to AZT alone, HIV-infected mothers who breastfeed need to start the three drugs at least three to four weeks in advance of delivery in order to protect their infants against HIV transmission through breastfeeding in the first few weeks of life.

Neither of these options is preferred over the other. All infants born to mothers on option B should receive NVP or AZT from birth until four to six weeks.

**Recommendations on HIV and infant feeding include:**

National health authorities should decide whether health services principally will counsel and support mothers known to be HIV-infected to either breastfeed and receive ARV interventions or to avoid all breastfeeding as the strategy that most likely will give infants the best chance of HIV-free survival. This decision¹ should be based on international recommendations and consideration of the socioeconomic and cultural contexts of the populations served by maternal, newborn and child health services, availability and quality of health services, local epidemiology, including HIV prevalence among pregnant women, the main causes of maternal and child under-nutrition and the main causes of infant and child mortality.

In settings where breastfeeding and ARVs are promoted, mothers known to be HIV-infected (and whose infants are HIV-uninfected or of unknown HIV status) should exclusively breastfeed their infants for the first six months, introducing appropriate complementary foods thereafter and continue breastfeeding for the first year. Breastfeeding should then only stop once a nutritionally-adequate and safe diet without breast milk can be provided.

While ARV interventions are being scaled up, national authorities should not

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¹ WHO is developing guidance to assist countries in this decision-making process, including guidance on steps to reach these standards of care.
be deterred from recommending that HIV-infected mothers breastfeed as the most appropriate infant feeding practise in their setting. ARV interventions to prevent postnatal transmission of HIV make breastfeeding even more advantageous for child development and survival. However, the absence of ARVs should not be a contraindication for HIV-infected mothers to breastfeed where environmental and social circumstances are not safe or supportive of replacement feeding. It is important to prevent the misconception that HIV-infected mothers only should breastfeed if they have ARVs.

Commercial infant formula milk only should be considered as an alternative to breastfeeding if home and social conditions are such that it is safe and carries a low risk of diarrhoea and malnutrition, it is adequate to support normal growth and development of the infant and is feasible and acceptable in the community. For infants more than six months old, animal milk (boiled for infants under 12 months), is another alternative. All children need complementary foods from six months old. Heat-treated, expressed breast milk may be used as an interim feeding strategy, for example in the case of mastitis. When the infant is known to be HIV-infected, exclusively breastfeed for the first six months of life and continue breastfeeding as per the recommendations for the general population, which is up to two years or beyond.

The recommendations are summarized in Tables 1, 2 and 3.

**Table 1: Antiretroviral treatment for HIV infection in adults and adolescents**

| When to start | 1. Start antiretroviral treatment in all patients with HIV who have CD4 count ≤350 cells/mm³ regardless of clinical symptoms.  
2. CD4 testing is required to identify if patients with WHO clinical stage 1 or 2 disease and need to start ART.  
3. Start antiretroviral treatment in all patients at WHO clinical stage 3 or 4 regardless of CD4 count. |
| What to start | First-line therapy should consist of a nonnucleoside reverse transcriptase inhibitor (NNRTI) + two NRTIs, one of which should be AZT or tenofovir (TDF). Start one of the following regimens in ART-naïve individuals eligible for treatment:  
• AZT +3TC + efavirenz (EFV)  
• AZT + 3TC + NVP  
• TDF + 3TC or emtricitabine (FTC) + EFV  
• TDF + 3TC or FTC + NVP  
Do not start EFV during the first trimester of pregnancy. |
| ART for HIV/tuberculosis coinfection | 1. Start ART in all HIV-infected individuals with active tuberculosis (TB) regardless of CD4 cell count.  
2. Start TB treatment first followed by ART as soon as possible after starting TB treatment.  
3. Use efavirenz EFV as the preferred NNRTI in patients starting ART while on TB treatment. |
ART for HIV/HBV co-infection
1. Start ART in all HIV/HBV coinfected individuals who require treatment for their HBV infection, regardless of CD4 cell count or WHO clinical stage.
2. Start TDF and 3TC- or FTC-containing antiretroviral regimens.

When to Switch ART
1. Where available, use viral load (VL) to confirm treatment failure.
2. Where routinely available, use VL every six months to detect viral replication.
3. A persistent viral load above 5000 copies/ml confirms treatment failure.
4. Where VL is not available, use immunological criteria to confirm clinical failure.

Second-line ART
1. Use a boosted protease inhibitor (PI/r) plus two nucleoside analogues (NRTIs).
2. ATV/r and LPV/r are the preferred boosted PIs for second-line ART.
3. Simplification of second NRTI options is recommended
   - If d4T or AZT has been used in first-line use TDF+3TC or FTC as the NRTI backbone in second line
   - If TDF has been used in first-line use AZT+3TC as the NRTI backbone in second line

Third-line regimens
1. National programmes should formulate policies for third-line therapy that consider funding, sustainability and providing equitable access to ART.
2. Third-line regimens should include new drugs likely to have anti-HIV activity.
3. Patients failing a second-line regimen with no new ARV options should continue with a tolerated regimen.

Table 2: Use of ARVs for treating women and preventing HIV infection in infants

| Start ART in all pregnant women with HIV and CD4 count <350 cells/mm³, regardless of clinical symptoms. |
| Start ART in all pregnant women with HIV and WHO clinical stage 3 or 4, regardless of CD4 count. |
| HIV-infected pregnant women in need of ART for their own health should start ART regardless of gestational age and continue throughout pregnancy, delivery and thereafter. |
| Start one the following regimens in ART-naïve pregnant women eligible for treatment: AZT + 3TC + EFV, AZT + 3TC + NVP, TDF + 3TC or FTC+ EFV, TDF + 3TC or FTC + NVP (Do not use EFV in the first trimester) |
| Infants born to HIV-infected women receiving ART for their own health should receive: |
| a. for breastfeeding infants: daily NVP from birth until six weeks old |
| b. for nonbreastfeeding infants: daily AZT or NVP from birth until six weeks old |
| All HIV-infected pregnant women who are not in need of ART for their own health require an effective ARV prophylaxis strategy to prevent HIV transmission to the infant. ARV prophylaxis should be started from as early as 14 weeks gestation (second trimester) or as soon as possible when women present late in pregnancy, in labour or at delivery. |
| Depending on the prophylactic option chosen, either the mother or the exposed infant should receive ARVs from birth until a week after all exposure to breast milk has ended. |
## Table 3: Infant feeding

<table>
<thead>
<tr>
<th>Ensuring mothers receive the care they need</th>
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<tr>
<td>Provide lifelong antiretroviral therapy or antiretroviral prophylaxis interventions to reduce HIV transmission through breastfeeding.</td>
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<th>Which breastfeeding practices and for how long</th>
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<tr>
<td>Mothers known to be HIV-infected (and whose infants are HIV uninfected or of unknown HIV status) should exclusively breastfeed their infants for the first six months, introducing appropriate complementary foods thereafter, and continue breastfeeding for the first year. Breastfeeding should then only stop once a nutritionally adequate and safe diet without breast milk can be provided.</td>
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<thead>
<tr>
<th>When mothers decide to stop breastfeeding</th>
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<tr>
<td>Stop gradually within a month. Mothers or infants who have been receiving ARV prophylaxis should continue prophylaxis for a week after breastfeeding is fully stopped. Stopping breastfeeding abruptly is not advisable.</td>
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<tr>
<th>What to feed infants when mothers stop breastfeeding</th>
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<tr>
<td>Infants should be provided with safe and adequate replacement feeds to enable normal growth and development. Alternatives to breastfeeding include:</td>
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<tr>
<td>For infants less than six months old:</td>
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<tr>
<td>• Commercial infant formula milk so long as home conditions are fulfilled,</td>
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<tr>
<td>• Expressed, heat-treated breast milk</td>
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<tr>
<td>For children over six months old:</td>
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<tr>
<td>• Commercial infant formula milk so long as home conditions are fulfilled,</td>
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<tr>
<td>• Animal milk (boiled for infants under 12 months) as part of a diet providing adequate micronutrient intake. Meals, including milk-only feeds, other foods and combination of milk feeds and other foods, should be provided four or five times per day. All children need complementary foods from six months old.</td>
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<tr>
<th>Conditions needed to safely formula feed</th>
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<tr>
<td>Only give commercial infant formula milk as a replacement feed to their HIV-uninfected infants or infants who are of unknown HIV status, when specific conditions are met: (referred to as AFASS – affordable, feasible, acceptable, sustainable and safe)</td>
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<tr>
<td>a. safe water and sanitation are assured at the household level and in the community, and,</td>
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<tr>
<td>b. the mother, or other caregiver reliably can provide sufficient infant formula milk to support normal growth and development of the infant, and,</td>
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<tr>
<td>c. the mother or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition, and,</td>
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<tr>
<td>d. the mother or caregiver can, in the first six months, exclusively give infant formula milk, and,</td>
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<tr>
<td>e. the family is supportive of this practise, and,</td>
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<tr>
<td>f. the mother or caregiver can access health care that offers comprehensive child health services.</td>
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</table>
Heat-treated, expressed breast milk
Consider expressing and heat-treating breast milk as an interim feeding strategy:
• In special circumstances such as when the infant is born with low birth weight or is otherwise ill in the neonatal period and unable to breastfeed; or
• When the mother is unwell and temporarily unable to breastfeed or has a temporary breast health problem such as mastitis; or
• To assist mothers to stop breastfeeding; or
• If antiretroviral drugs are temporarily not available.

When the infant is HIV-infected
Mothers strongly are encouraged to exclusively breastfeed for the first six months of life and continue breastfeeding as per the recommendations for the general population, which is up to two years or beyond.

Update on nevirapine (NVP)

The efficacy and safety of nevirapine in adults and pregnant women was the subject of much discussion during the preparation and peer review of these guidelines.

On the question of efficacy, six randomized clinical trials (RCTs) which have compared NVP to EFV found no differences in virological outcomes. One RCT reported that EFV was less likely than NVP to be associated with development of antiretroviral resistance.

On NVP safety, while WHO continues to recommend caution in the use of NVP in women with CD4 counts >250 cells/mm³ or in those with unknown CD4 cell counts, the review conducted during the formulation of the guidelines did not confirm an increased risk of serious adverse events in this group. This became an important issue since NVP is recommended for initial ART and the new CD4 cell threshold for initiation is ≤350 cells/mm³. The United States of America Food and Drug Administration (FDA) has cautioned against the use of NVP in women with CD4 cell counts 250-350 cells/mm³ and men with CD4 count >400 cells/mm³. In addition, the manufacturer includes a black boxed warning in the product information.

Data are conflicting, with increased rates of hepatotoxicity and hypersensitivity reported in some studies and not in others. Some studies reported no difference in adverse events between those with low and high CD4 cell counts in virologically suppressed patients switching to NVP. These studies support the concept that a suppressed viral load is a protective factor for NVP-related hypersensitivity when patients need to switch from an EFV- (or PI) based regimen to NVP. Only one study reported an increased risk of hypersensitivity and hepatotoxicity in men with a CD4 count >400 cells/mm³.

On NVP safety in pregnant women, data from two prospective cohorts report no association between NVP and liver enzyme elevation. However, pregnancy itself was associated with an increased risk of any liver enzyme elevation.

On whether NVP can be used once or twice daily, WHO continues to recommend...
that NVP be dosed at 200 mg twice daily. Currently, only the guidelines of the European AIDS Clinical Society (www.europeanaidsclinicalsociety.org/guidelines.asp) recommend that NVP can be dosed at 400 mg once daily. However, this recommendation applies to patients who begin a standard regimen of 200 mg BID (with a two-week lead-in dosing), achieve subsequent virological suppression and then switch to 400 mg OD. The evidence is mixed. Three studies have reported failure to suppress viral replication in patients receiving NVP once daily.\textsuperscript{25–27} However, the ARTEN study reported noninferiority among patients taking either NVP once or twice daily or ATZ/r arm, both in combination with two NRTIs.\textsuperscript{28} Data from cohort studies (AIDS Therapy Evaluation in the Netherlands [ATHENA] and Swiss HIV Cohort) support that NVP once daily is at least as effective in suppressing VL as NVP twice daily.\textsuperscript{29} It should be noted that, in the landmark 2NN study, higher rates of hepatotoxicity were reported NVP in the 400 mg OD arm of the study.\textsuperscript{6} For now, NVP 200 mg BID remains the recommendation in resource-limited settings, especially when VL and liver enzyme monitoring is not available.

**Update on generic antiretroviral drugs**

As of 25 February 2010, the FDA had issued approval or tentative approval of 107 generic ARV drugs, either as single products or dual and triple fixed-dose combinations.\textsuperscript{30} Tentative approval means that the product has met all safety, efficacy and manufacturing quality standards for marketing in the United States of America but the product still has marketing protection there. This FDA approval scheme was started in 2004 to support the roll-out of ART under the United States President’s Emergency Plan for AIDS Relief (PEPFAR), which can purchase any product that has either a “full” or “tentative” FDA approval.\textsuperscript{30} The largest manufacturer of generic ARVs is India, with all WHO-recommended first- and second-line ARVs available from one of the many Indian companies.

The WHO-prequalified list of generic ARVs does not include atazanavir. India’s Patent Office (IPO) recently rejected a patent application for darunavir, paving the way for generic versions of this second generation protease inhibitor, which is now recommended by WHO as one of the components of third-line regimens. \textsuperscript{31}
The World Health Organization Network for HIV and Health in the Western Pacific Region: An Innovative Approach to Technical Support
By: Ms Charmaine Turton of the Albion Street Centre, Sydney, Australia

Introduction
A comprehensive response to HIV and AIDS requires mobilization and collaboration across many sectors and partners. The health sector plays a central leadership and coordination role in response to the epidemic and provides many critical opportunities for scaling up HIV-related services.

WHO, within the Joint United Nations Programme on HIV/AIDS (UNAIDS), is responsible for providing technical support for the health sector response to HIV/AIDS. With increased availability of funds and resources, there has been unprecedented demand from Member States for assistance in responding to the complexities of global health issues and the interpretation of the technical contents of WHO’s programme on HIV/AIDS.

To address this demand, the Western Pacific Regional Office recognized the potential to build a network of WHO Collaborating Centres and other key Technical Partners that are well positioned to provide technical cooperation to Member States. Following a review of the technical expertise of existing WHO Collaborating Centres and partner institutions to contribute towards effective HIV/AIDS interventions, a consultation was held in December 2008 that, among other things, endorsed the establishment of the WHO Network for HIV and Health in the Western Pacific Region.

Since then, work has progressed steadily to establish the Network. In November 2009, a second consultation was held to consolidate achievements to date and identify future steps and strategies for the advancement of the Network.

The Innovative Concept and Establishment of the WHO Network for HIV and Health in the Western Pacific Region

The concept of the WHO Network for HIV and Health in the Western Pacific Region is to implement a multidisciplinary approach to HIV as a public health issue. In contrast to other networks, the aim is to link centres beyond a single topic area, recognizing both HIV-specific centres and those with the potential to work alongside these centres, to provide valuable input to HIV approaches and activities and support the HIV response.

In accordance with the concept of a multidisciplinary network, preliminary research was completed in 2008 to map the capacity and potential of existing collaborating centres and technical partners in the Western Pacific Region to contribute to a regional HIV network. Through a two-stage process of database analysis and survey methodology from almost 200 institutions, 25 were selected for invitation to the initial consultation in December 2008. Seventeen of these conducted work with a direct or strong
relationship to the field of HIV and eight had possible potential to contribute to an HIV network. Some had related overlapping interests (communicable disease, harm reduction, nursing, paediatrics, reproductive health, women) and others had broader fields of expertise (health promotion, health systems planning, research).

**Overview of the WHO Network for HIV and Health in the Western Pacific Region**

**Mission**
To collaborate in supporting Member States to implement effective multidisciplinary public health approaches to HIV according to WHO strategic directions.

**Objectives**
1. Provide Member States with sustainable technical assistance through a multidisciplinary Network.
2. Ensure quality of technical assistance through consistent and coherent approaches provided by a Network of experts in the field.
3. Support Member States to build health system capacity in HIV and health.
4. Contribute to critical review, update of evidence, scientific debate and operational research related to HIV and health.

**Functions**
- Advocacy
- Capacity-building
- Information dissemination
- Networking
- Operational research
- Technical support
- Tools and guidelines

**Membership**
Membership has been based on the concept of establishing a network of multidisciplinary organizations which together have the capacity to support the HIV response within a public health approach focused on the strengthening of health systems as a whole.

The Network is composed of 18 core and founding member institutions that attended the first and second consultations and each of which have completed a Declaration of Commitment to the Network. Fifteen of these are WHO Collaborating Centres and three are Technical Partners of WHO*. Overall, they represent nine countries from the Western Pacific Region across a range of disciplines and fields of expertise.
Table 4: Members of the WHO Network for HIV and Health in the Western Pacific Region

<table>
<thead>
<tr>
<th>INSTITUTION</th>
<th>COLLABORATING CENTRE (CC)</th>
<th>COUNTRY</th>
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<tbody>
<tr>
<td>The Albion Street Centre</td>
<td>WHO Collaborating Centre for Capacity Building and Health Care Worker Training in HIV/AIDS Care, Treatment and Support</td>
<td>Australia</td>
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<tr>
<td>National Serology Reference Laboratory</td>
<td>WHO Collaborating Centre for Diagnostics and Laboratory Support for HIV/AIDS and Other Blood-Borne Infections</td>
<td>Australia</td>
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<tr>
<td>Key Centre for Women’s Health in Society, Melbourne School of Population Health</td>
<td>WHO Collaborating Centre for Women’s Health</td>
<td>Australia</td>
</tr>
<tr>
<td>Programme of International Research and Training, National Drug and Alcohol Research Centre</td>
<td>WHO Collaborating Centre for the Prevention and Control of Alcohol and Drug Abuse</td>
<td>Australia</td>
</tr>
<tr>
<td>Department of Microbiology, The Prince of Wales Hospital</td>
<td>WHO Collaborating Centre for Sexually Transmitted Diseases</td>
<td>Australia</td>
</tr>
<tr>
<td>Royal Children’s Hospital, Melbourne</td>
<td>WHO CC for Research and Training in Child and Neonatal Health</td>
<td>Australia</td>
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<tr>
<td>Burnet Institute (Macfarlane Burnet Institute for Medical Research and Public Health)*</td>
<td>WHO Collaborating Centre for Blood Transfusion Services</td>
<td>Australia</td>
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<tr>
<td>Centre for International Health</td>
<td>WHO Collaborating Centre for Prevention and Control of Sexually Transmitted Infections</td>
<td>China</td>
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<tr>
<td>Centre for Virology</td>
<td>WHO Collaborating Centre for Comprehensive Management of HIV Treatment and Care</td>
<td>China</td>
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<tr>
<td>The Hong Kong Polytechnic University</td>
<td>WHO Collaborating Centre for Community Health Services</td>
<td>Hong Kong, (China)</td>
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<td>INSTITUTION</td>
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<tr>
<td>Research Institute of Tuberculosis</td>
<td>WHO Collaborating Centre for Reference, Research and Training on Tuberculosis</td>
<td>Japan</td>
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<tr>
<td>University of Malaya*</td>
<td>WHO Collaborating Centre for Research in AIDS (CERIA)</td>
<td>Malaysia</td>
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<tr>
<td>Pacific Paramedical Training Centre</td>
<td>WHO Collaborating Centre for External Quality Assessment in Health Laboratory Services</td>
<td>New Zealand</td>
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<tr>
<td>College of Nursing, University of the Philippines</td>
<td>WHO Collaborating Centre for Leadership in Nursing Development</td>
<td>The Philippines</td>
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<tr>
<td>Communicable Disease Education Department, Adult Health Division, Singapore Health Promotion Board</td>
<td>WHO Collaborating Centre for Health Promotion and Disease Prevention</td>
<td>Singapore</td>
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<tr>
<td>Occupational Disease Department, National Institute of Occupational &amp; Environmental Health</td>
<td>WHO Collaborating Centre for Occupational Health</td>
<td>Viet Nam</td>
</tr>
<tr>
<td>National Centre in HIV Epidemiology and Clinical Research*</td>
<td>WHO Collaborating Centre for Capacity Building and Health Care Worker Training in HIV/AIDS Care, Treatment and Support (Sydney, Australia), has supported the Western Pacific Regional Office HSI team by acting as key facilitator to follow up the agreed next steps from consultation meetings.</td>
<td>Australia</td>
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*Technical Partner

**Management**

Management of the Network is the responsibility of the Western Pacific Regional Office, mainly through its HIV/AIDS/STI (HSI) team within the Division of Combating Communicable Diseases (DCC). The Albion Street Centre, WHO Collaborating Centre for Capacity Building and Health Care Worker Training in HIV/AIDS Care, Treatment and Support (Sydney, Australia), has supported the Western Pacific Regional Office HSI team by acting as key facilitator to follow up the agreed next steps from consultation meetings.

**Next steps in the Western Pacific Region**

The WHO Network for HIV and Health in the Western Pacific Region has achieved significant progress since the endorsement of its establishment in December 2008. Members have committed to progression of the Network guided by the agreed mission, objectives and principles of operation. These include quality, synergy, coherence, timeliness, predictability, country ownership, approaches for sustainability and long-term national capacity.
The Network possesses a diverse range of multidisciplinary expertise to support Member States in the continued scale-up of interventions for the health sector response to HIV, health systems strengthening and progress towards universal access and the Millennium Development Goals. In addition to responding to requests for technical assistance from Member States, the Network proactively will pursue initiatives for regional health systems strengthening. Approaches of the Network will be directed by knowledge of the epidemic and national health systems and will ensure monitoring and evaluation measures that can document results and demonstrate success.

Dr Shin Young-soo, WHO Regional Director for the Western Pacific, has stated that his expectations from the Network are for significant increases in the volume and quality of technical support provided to national programmes in the Region. In addition, he hopes that the Network will engage in other functions to make use of its technical competencies, such as promoting and engaging in technical dialogue and exchanges on critical scientific matters and developments and offering a regional audience for analysis and interpretation of emerging issues.

Key goals of the Network in the next phase of its evolution are establishing a viable business plan and building self-sustainability in order to attract donor funds. Promotion of the Network -- through engagement of WHO Country Offices, the establishment of a website and an official launch, including a white paper for public distribution -- will play a major role in this phase.

**Initiatives in other regions**

The innovation of the WHO Network for HIV and Health in the Western Pacific Region has guided the exploration of a new paradigm of response at a broader level within Headquarters. Mirroring the Western Pacific Region’s experience, this response involves multidisciplinary collaboration among WHO Collaborating Centres, Knowledge Hubs and other key Technical Partners and Institutions with established expertise in various aspects of the health sector response to HIV/AIDS.

In September 2009, Headquarters convened a consultation which endorsed the establishment and development of WHO HIV/AIDS Regional Technical Support Networks. The consultation built extensively on the initial experiences of establishing this Network in the Western Pacific Region and expanded the lessons learnt to all other WHO regions. An operational framework was generated as a foundation for a common and shared approach across regions, and the Western Pacific Region Network progress is in line with the agreements and overarching framework of the September 2009 global consultation. The Western Pacific Region Network is leading the way with this innovation and future work undertaken will indeed be looked upon by other regions with interest.

**For more information**

Please contact Dr Massimo Ghidinelli, Regional Adviser, HIV/AIDS and STI, WHO WPRO at ghidinellim@wpro.who.int or Charmaine Turton, Albion Street Centre at charmaine.turton@sesiachs.health.nsw.gov.au
References


30. FDA. International Programs President’s Emergency Plan for AIDS Relief Approved and Tentatively Approved Antiretrovirals in Association with the President’s Emergency Plan. 2010
This was formerly known as the Antiretroviral Newsletter. The aim of this biannual newsletter is to provide health workers in the Region with a brief, up-to-date summary of the latest developments in HIV prevention and in the management of HIV infection, including antiretroviral therapies and co-morbidities (or associated conditions).

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35. WHO Regional Office for the Western Pacific Database http://www.wpro.who.int/information_sources/collaborating_centres/collaborating_centres.htm
