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

14–16 June 2010
Phnom Penh, Cambodia
REPORT OF THE MEETING OF HIV/AIDS PROGRAMME MANAGERS
OF ASIAN COUNTRIES IN THE WESTERN PACIFIC REGION

14–16 June 2010
Phnom Penh, Cambodia

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NOTE

The views expressed in this report are those of the participants who attended the Meeting of HIV/AIDS Programme Managers of Asian Countries in the Western Pacific Region and do not necessarily reflect the policies of WHO.

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 HIV/AIDS Programme Managers of Asian Countries in the Western Pacific Region from 14 to 16 June 2010 in Phnom Penh, Cambodia.

"Support for this meeting was provided by the Australian Agency for International Development, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Japan Voluntary Contribution."
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Keywords:

HIV infections – prevention and control / Sexually transmitted disease – prevention and control / Antiretroviral therapy, Highly active / Adults / Adolescent / Infant / Pregnant women
ABBREVIATIONS

3TC lamivudine
ABC abacavir
AFH Action for Health
AIDS acquired immunodeficiency syndrome
ALT alanine aminotransferase
AMR antimicrobial resistance
ANC antenatal clinic
APCOM Asia Pacific Coalition on Male Sexual Health
APN+ Asia–Pacific Network of People living with HIV
APCASO Asia Pacific Council for AIDS Service Organizations
APNSW Asia Pacific Network of Sex workers
ASEAN Association of Southeast Asian Nations
ASRH adolescent sexual and reproductive health
ART antiretroviral therapy
ARV antiretroviral
ATS amphetamine-type stimulant
ATV atazanavir
AusAID Australian Agency for International Development
AZT zidovudine
BCC behaviour change communication
BMI body mass index
bPI boosted protease inhibitor
CBO community-based organization
CD4 cell T-lymphocyte bearing CD4 receptor
CDC-GAP Centers for Disease Control Global AIDS Programme
CENAT National Center for Tuberculosis and Leprosy Control
CHAI Clinton Health Access Initiative
CHAS Centre for HIV/AIDS/STI
CoPC continuum of prevention and care
CoPCT continuum of prevention, care and treatment
CPT co-trimoxazole preventive therapy
CUP condom use programme
d4T stavudine
D&A drug and alcohol
DBS dried blood spot
DOTS directly observed treatment, short course
ECS elimination of congenital syphilis
EFV efavirenz
EQAS external quality assurance scheme
ESC extended-spectrum cephalosporin
ETV etravirine
FBO faith-based organization
FDC fixed-dose combination
FSW female sex worker
FTC emtricitabine
GASP Gonococcal Antimicrobial Sensitivity Programme
GC gonococci
Global Fund Global Fund to fight AIDS, Tuberculosis and Malaria
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>GRADE</td>
<td>Grading of Recommendations Assessment, Development and Evaluation</td>
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<tr>
<td>GTZ</td>
<td>Deutsche Gesellschaft für Technische Zusammenarbeit</td>
</tr>
<tr>
<td>HAART</td>
<td>highly active antiretroviral therapy</td>
</tr>
<tr>
<td>Hb</td>
<td>haemoglobin</td>
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<tr>
<td>HBsAg</td>
<td>hepatitis B surface antigen</td>
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<tr>
<td>HBV</td>
<td>hepatitis b virus</td>
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<tr>
<td>HCV</td>
<td>hepatitis c virus</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>HIVDR</td>
<td>HIV drug resistance</td>
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<td>HR</td>
<td>harm reduction</td>
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<td>HSP</td>
<td>health systems programme</td>
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<td>HSS</td>
<td>health systems strengthening</td>
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<td>IDU</td>
<td>injecting drug user</td>
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<tr>
<td>IHBSS</td>
<td>integrated HIV behavioural and serological surveillance system</td>
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<tr>
<td>INH</td>
<td>isoniazid</td>
</tr>
<tr>
<td>IPT</td>
<td>isoniazid prophylaxis treatment</td>
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<tr>
<td>IRARE</td>
<td>international rapid assessment and response evaluation</td>
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<tr>
<td>IUATLD</td>
<td>International Union Against Tuberculosis and Lung Disease</td>
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<tr>
<td>JICA</td>
<td>Japan International Cooperation Agency</td>
</tr>
<tr>
<td>KAP</td>
<td>knowledge, attitude and practices</td>
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<tr>
<td>LPV</td>
<td>lopinavir</td>
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<tr>
<td>LPV/r</td>
<td>lopinavir/ritonavir</td>
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<tr>
<td>MARP</td>
<td>most-at-risk population</td>
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<tr>
<td>MEDICAM</td>
<td>Medical in Cambodia</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MCH</td>
<td>maternal and child health</td>
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<tr>
<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<tr>
<td>MIC</td>
<td>minimum inhibitory concentration</td>
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<tr>
<td>MMT</td>
<td>methadone maintenance therapy</td>
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<tr>
<td>MNCH</td>
<td>maternal, neonatal and child health</td>
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<td>MPS</td>
<td>Making Pregnancy Safer (programme)</td>
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<tr>
<td>MSM</td>
<td>men who have sex with men</td>
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<tr>
<td>MTCT</td>
<td>mother-to-child transmission</td>
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<tr>
<td>NAAT</td>
<td>nucleic acid amplification test</td>
</tr>
<tr>
<td>NCHADS</td>
<td>National Center for HIV/AIDS, Dermatology and STD</td>
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<tr>
<td>NCGM</td>
<td>National Center for Global Health And Medicine</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>NNRTI</td>
<td>non-nucleoside reverse transcriptase inhibitor</td>
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<tr>
<td>NRTI</td>
<td>nucleoside reverse transcriptase inhibitor</td>
</tr>
<tr>
<td>NVP</td>
<td>nevirapine</td>
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<tr>
<td>OI</td>
<td>opportunistic infection</td>
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<tr>
<td>PCR</td>
<td>polymerase chain reaction</td>
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<tr>
<td>PEPFAR</td>
<td>US President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PITC</td>
<td>provider-initiated testing and counselling</td>
</tr>
<tr>
<td>PLHIV</td>
<td>people living with HIV</td>
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<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>PNAC</td>
<td>Philippine National AIDS Council</td>
</tr>
<tr>
<td>PPTCT</td>
<td>prevention of parent-to-child transmission</td>
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<tr>
<td>PSM</td>
<td>procurement and supply management</td>
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<tr>
<td>PWID</td>
<td>people who inject drugs</td>
</tr>
<tr>
<td>/r</td>
<td>low-dose ritonavir</td>
</tr>
<tr>
<td>RCT</td>
<td>randomized control trial</td>
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The 2009 Epidemic update by Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) clearly indicates that the epidemic is stabilizing in the Western Pacific Region (WPR) and that interventions for HIV prevention are showing results. Despite the progress achieved, the 80% coverage target of universal access needed to reverse the epidemic remains unattained in the majority of Member States.

A three-day meeting was organized from 14 to 16 June 2010 in Phnom Penh, Cambodia with the aim of updating information on the progress of the response to HIV in Asian countries of WPR. It also aimed to update knowledge on the latest WHO recommendations and guidelines, especially on antiretroviral therapy (ART) in adults and adolescents; identify and commit to steps for a phased implementation of the new recommendations; and identify technical support needs and a sustainable mechanism for providing such support to Member States through the newly established WHO Network for HIV and Health.

The meeting focused on health sector responses that have not achieved a good coverage and face major challenges, including accelerating HIV prevention among men who have sex with men (MSM), people who inject drugs (PWID), prevention of parent-to-child transmission (PPTCT), expanding access to ART beyond the current 31% coverage, and enhancing HIV/tuberculosis (TB) collaborative activities, including programme implications.

Participants included programme managers from twelve countries in WPR, as well as representatives of other development partners from the Asia-Pacific Network of People living with HIV (APN+), Asia Pacific Council for AIDS Service Organizations (APCASO), Clinton Health Access Initiative (CHAI), National Center for Global Health and Medicine (NCGM), Centers for Disease Control Global AIDS Programme (CDC-GAP), United States President’s Emergency Plan for AIDS Relief (PEPFAR), Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) and Albion Street Centre. Staff from the WHO Regional and Country Offices, UNAIDS Country Office and United Nations Children’s Fund (UNICEF) East Asia and the Pacific Regional Office also attended the meeting.

The meeting was structured to provide technical updates and share country experiences through plenary sessions and panel discussions, and participatory discussions through group work. Countries shared the progress made since the last meeting, challenges faced and windows of opportunity in scaling up the health sector response towards universal access to prevention, treatment, care and support for HIV and other sexually transmitted infections (STIs). Moreover, through the group work, countries devised plans on how to operationalize the adaptation of the new WHO guidelines on ART for adults/adolescents, PPTCT, and HIV/TB collaborative activities and their programmatic implications. Health systems strengthening and the principles of continuum of prevention and care (CoPC) were also shared.

Conclusions and recommendations

(1) The Programme Managers’ meeting served as useful forum for exchange of experiences and dialogue on technical and programmatic issues across programmes and with technical partners.

(2) It generated constructive contribution from people living with HIV (PLHIV) and civil society.
(3) It noted that significant progress had been made in generating strategic information from different countries in WPR.

(4) It encouraged sharing of experiences in collaborating with public health programmes such as TB and Maternal and Child Health (MCH) despite persisting difficulties and challenges.

(5) WHO’s approach to developing evidence-based technical recommendations were better appreciated and understood.

(6) There were no major concerns vis-à-vis the new set of new WHO ART guidelines. These were generally well received and, in some countries, the new recommendations are being implemented.

(7) The meeting committed to convening technical working groups at the country level to unpack the recommendations and begin reviews, projections, estimates, planning and corrections/validation of current information.

(8) Development of standard operating procedures (SOPs) is the key to overcoming challenges in collaboration among programmes; good examples in implementing linkages at the district level are available from Cambodia.

(9) Countries confronted with a fast-changing scenario promised to progress and “rethink” in the area of targeted interventions.

(10) Continued advocacy will be needed to support and encourage interprogrammatic collaboration and promotion of specific recommended interventions.

(11) Comprehensive guidance must be developed on HIV management, including prophylaxis, care, treatment, ART and co-morbidities.

(12) Technical and programmatic matters related to prevention of mother-to-child transmission (PMTCT)/PPTCT and HIV/TB collaborative activities must be addressed jointly with the MCH and TB Programmes at both the Regional (UN Task Force PPTCT) and national levels.

(13) Deeper discussions must be pursued at the country level on the implications of the new ART and PMTCT guidelines, particularly on:

- estimated increase in PLHIV eligible for ART (higher CD4 threshold and fast-track access for HIV-positive mothers)
- revision of existing national guidelines and orientation of service providers
- costing, monitoring and logistics
- phasing out of stavudine (d4T)-containing regimens.

(14) Deeper discussions must be held at the country level on the new TB/HIV recommendations for intensified TB case finding (ICF) and isoniazid prophylaxis treatment (IPT), with a focus on:

- monitoring and collecting/reporting data
- joint work planning.

(15) Further communication with national programmes and implementing partners is needed to promote the Technical Network for HIV and Health.

(16) The regional forum for HIV Programme Managers must be maintained and continuously improved.
1. INTRODUCTION

1.1 Background

The 2009 Epidemic update by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO) clearly indicates that the epidemic is stabilizing in the Western Pacific Region (WPR) and that interventions for HIV prevention are showing results. Despite the progress achieved, the 80% coverage target of universal access needed to reverse the epidemic remains unattained in the majority of Member States. The meeting aimed to focus on health sector responses that have not achieved a good coverage and face major challenges. These include accelerating HIV prevention among men who have sex with men (MSM) and people who inject drugs (PWID), prevention of parent-to-child transmission (PPTCT), expanding access to antiretroviral therapy (ART) beyond the current 31% coverage, and enhancing HIV/tuberculosis (TB) collaborative activities.

The meeting provided a forum to share country experiences and update progress on the HIV response among HIV Programme Managers from Asian countries of WPR.

1.2 Objectives

(1) to update information on the progress of the response to HIV in Asian countries of the Western Pacific Region;

(2) to update knowledge on the latest WHO recommendations and guidelines, especially on ART in adults and adolescents, and on HIV/TB collaborative activities, including programme implications;

(3) to identify and commit to steps for a phased implementation of the new WHO ART guidelines; and

(4) to identify technical support needs of and a sustainable mechanism for provision of such support to Member States through the newly established WHO Network for HIV and Health.

1.3 Meeting participants

The meeting was attended by programme managers from twelve countries in WPR, as well as representatives from other development partners such as the Asia-Pacific Network of People living with HIV (APN+), Asia Pacific Council for AIDS Service Organizations (APCASO), Clinton Health Access Initiative (CHAI), National Center for Global Health and Medicine (NCGM), Centers for Disease Control Global AIDS Programme (CDC-GAP), United States President's Emergency Plan for AIDS Relief (PEPFAR), Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and Albion Street Centre. Staff also attended from the WHO Regional and Country Offices, UNAIDS Country Office, and the East Asia and the Pacific Regional Office of the United Nations Children’s Fund (UNICEF). The list of participants is attached as Annex 1.
2. PROCEEDINGS

After the Opening Ceremony, the participants introduced themselves and selected a chairperson. The objectives and expected outcomes of the meeting were presented. These were followed by thematic presentations and group work.

The meeting was structured to provide technical updates and country experiences through plenary sessions, panel discussions and participatory discussions by countries through group work.

2.1 Regional updates

2.1.1 Progress of the health sector response towards universal access (UA) in WPR

Findings from the 2009 UA progress report showed that epidemic is stabilizing in the Region. Available data for sex workers and people who inject drugs (PWID) show that interventions are working. However, there is still a need to invest in intense efforts to reach men who have sex with men (MSM).

A wide range of services is available across the Region. However, not all countries provide these. Coverage varies from country to country depending on the prevalence of HIV and other sexually transmitted infections (STIs) but is insufficient in terms of availability and impact of services. Although capacity for data collection, analysis and utilization at the national and subnational levels remains poor, significant progress has been made in scaling up and reporting the health sector response to HIV in WPR.

Most of the information presented in this report is taken from the latest UA country progress reports, which are currently being validated. The validated country/regional data will soon be released and will be publicly available by the third quarter of 2010.

2.1.2 Response to eliminate paediatric HIV and congenital syphilis

Current available data for East and South-East Asia show that the estimated number of pregnant women living with HIV needing services for prevention of mother-to-child transmission (PMTCT) in the Asia-Pacific region is 85 000; the estimated number of newborns of HIV infected mothers in the Asia-Pacific region and WPR ranges from 12 000 to 16 000. Another estimated 12 000 to 16 000 infants are infected through breastfeeding from an HIV-positive mother (depending on a range of factors such as viral load, and many more die of...
diarrhoeal dehydration and other infections. In the Asia-Pacific region, 65 million births take place annually (including about 29 million in Asia-Pacific). The big question to be answered is: is elimination of paediatric HIV in Asia-Pacific possible?

As of December 2008, PMTCT coverage in low- and middle-income countries was 25%. Current implementation of PMTCT/PPTCT interventions straddles different departments and programmes. Thus, for PPTCT programmes to be successful, dedicated, well-managed efforts (management, referral and follow up with different health facilities/services) are required.

While a larger number of pregnant women who test HIV-positive are accessing PMTCT services, the status of HIV-exposed newborns is still not systematically monitored and reported. Drop-out or loss to follow up occurs at every step of the PMTCT cascade from testing and counselling of pregnant women and their male partners; enrolment to PMTCT services; regular provision of antiretroviral (ARV) prophylaxis to the mother and infant; testing of HIV-exposed newborns at six weeks, seven-and-a-half months, 12 and 18 months; CD4 testing and ART for mothers; and infant-feeding counselling and options. To address this concern, there is a need to strengthen the health system through creation of operational linkages and increased community engagement.

The goal is to improve reproductive health (RH), adolescent reproductive health (ARH), PMTCT and STI/HIV services through maximizing the linkages and synergies between sexual and reproductive health (SRH)/maternal, neonatal and child health (MNCH) and HIV and other STI services. To assist countries in achieving this goal, WHO, in collaboration with UNICEF, United Nations Population Fund (UNFPA), UNAIDS, and seven countries (Cambodia, China, India, Indonesia, Thailand and Viet Nam), has developed the regional framework to operationalize these linkages (Guilin Framework).

Given the high level of resources for and technical capacity of HIV programmes, linking SRH with HIV/STI services provides an opportunity to increase access to vulnerable groups, generate greater efficiencies for health systems and allow underfunded SRH services to benefit from a well-resourced HIV programme.

The application of operational linkages holds greater potential for linking the three health-related Millennium Development Goals (MDGs) – reducing child mortality (MDG 4), improving maternal health (MDG 5) and combating HIV/AIDS (MDG 6) – in low-resource settings.

**Cambodia's linked response: linked response is effective in improving PMTCT service uptake**

- Operational linkages can be used to good effect to improve outcomes related to the coverage of HIV testing for women and their partners, and to improve service utilization and retention of HIV-positive pregnant women and HIV-exposed infants in PMTCT services.
- Cost savings and efficiency benefits accrued to patients in sites where the linked response was operational.
- Operational linkages can be deployed to achieve good results in improving coverage and patient retention in a short time frame. There is potential for such actions to contribute towards specific MDG outcomes.
- The linked response approach has emerged as an effective mechanism for rapidly improving coverage rates of HIV testing. There have also been considerable gains in detecting and enrolling HIV-positive pregnant women into PMTCT care.
• Since the commencement of linked response activities in the Prey Veng cluster over 21 months until December 2009, 27 new cases were detected across the cluster as compared with three cases in the standard cluster.

• In the Takeo linked response site, between the start of activities in July 2008 and December 2009, 12 new cases were detected compared with three in the standard site.

**Papua New Guinea: operational linkages**

• ART coverage has reached 61%.
• PPTCT coverage increased from 5% in 2008 to 12% in 2010.
• Outcome monitoring of PPTCT has improved as observed in POM-Gen, Minginde (all 22 cases tested at the twelfth month are all HIV negative) and Mount Hagen.
• Introduction of dried blood spot (DBS) technology for early infant diagnosis has substantially improved testing of newborns.
• The Department of Health concentrates on strengthening health systems for ART, PPTCT and paediatric HIV treatment.

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**Current status of congenital syphilis**

• In the Asia-Pacific region, there are more than 580 000 cases of congenital syphilis each year.
• It is a major cause of stillbirth.
• It is an important cause of perinatal death, serious neonatal infection and low birth weight.
• A reliable and simple test is available.
• Treatment is available and affordable.
• It has similar operational requirements as with PPTCT of HIV. Over two million pregnancies are affected.
• 750,000–150,000 cases of congenital syphilis occur each year; 69% of infected pregnant women will have an adverse outcome of pregnancy (congenital syphilis); there will be 450,000 stillbirths, 200,000 neonatal deaths, 250,000 preterm or low birth-weight infants and 350,000 infants with clinical infection. Up to 25% of stillbirths in some developing countries are associated with syphilis.

While better information on congenital syphilis is now available, the response is still inadequate.

• Responses vary from country to country and provinces within the same country (in India and China).
• There are excellent prevention efforts, but these are not to scale.
• Babies are still getting infected – PMTCT coverage in the region is very low (25%).
• If reducing the new infections by half by 2015 is the goal, many countries need to act fast!

**In-country focus**

<table>
<thead>
<tr>
<th>Cambodia</th>
<th>China</th>
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<tr>
<td>• Syphilis screening is integrated</td>
<td>• Rapidly increasing syphilis; increasing government commitment to PMTCT</td>
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<td></td>
<td>• Free services for pregnant women, HIV-infected pregnant women and children</td>
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</table>

### 2.1.3 Targeted interventions: way forward

The 2008 *AIDS Commission Report* highlighted that targeted interventions among most-at-risk populations (MARP) are the most cost-effective.

In order to assist countries in prioritizing interventions for MARPs, below is a summary of the global and Regional response to the unfolding HIV epidemic among MSM and transgender persons (TG).

**Response to the HIV epidemic among men who have sex with men (MSM) and transgender persons (TG)**

| September 2008 | WHO, United Nations Development Programme (UNDP) and UNAIDS convened a global consultation on “Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender populations” in Geneva. |
| February 2009 | WHO Regional Office for the Western Pacific (WPRO), in collaboration with UNDP, UNAIDS, the Asia Pacific Coalition on Male Sexual Health (APCOM) and the Department of Health, Hong Kong SAR (China), organized the first “Consultation on health sector response to HIV/AIDS among men who have sex with men in Asia and the Pacific” in Hong Kong (China). |
June 2009 | These efforts paved the way for the “Regional Consensus Meeting on developing a comprehensive package of services to reduce HIV among men who have sex with men and transgender populations in Asia and the Pacific” held in Bangkok, Thailand, convened by UNDP, WHO, United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNAIDS, in partnership with the Association of Southeast Asian Nations (ASEAN), United States Agency for International Development (USAID) and APCOM.

November 2009 | “Asia Regional Consultation on MSM HIV/AIDS care and support” convened by USAID, US Centers for Disease Control and Prevention (CDC) and the UNDP Asia Pacific Regional Centre in partnership with WHO, UNAIDS, Asia Pacific Network of Positive People (APN+), and APCOM, Bangkok, Thailand

April 2010 | *Priority HIV and sexual health interventions in the health sector for men who have sex with men and transgender people in the Asia Pacific Region* was jointly published by WHO, UNDP, UNAIDS, APCOM and the Hong Kong Health Department.

May 2010 | The Global Fund has created a new funding stream for HIV proposals focusing only on MARPs including MSM – Round 10 only (United States President’s Emergency Plan for AIDS Relief [PEPFAR] Five-Year Strategy 2010–2014 also emphasizes targeting interventions at MARPs).

“People who inject drugs (PWID) – a strategy to halt and reverse HIV epidemic among people who inject drugs in Asia and the Pacific, 2010–2015” was developed by the United Nations Regional Task Force on Injecting Drugs and HIV/AIDS for Asia and the Pacific.

Despite progress made in designing, implementing, monitoring and evaluating interventions, the following key issues on MARPs remain and need to be addressed:

<table>
<thead>
<tr>
<th>MSM</th>
<th>PWID</th>
<th>Sex workers</th>
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<tbody>
<tr>
<td>- HIV among MSM is an emerging epidemic</td>
<td>- Insufficient coverage of harm reduction services (needle–syringe programmes [NSP], methadone maintenance therapy [MMT])</td>
<td>- Varied impact of interventions adopted at the country level</td>
</tr>
<tr>
<td>- National response is at an early stage; scope and coverage of interventions are far from adequate</td>
<td>- Inadequate emphasis on sexual transmission of HIV in harm reduction interventions</td>
<td>- Insufficient involvement of sex workers in programme planning and implementation, and inadequate consideration of gender and human rights issues</td>
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<td></td>
<td>- Limited attention to coinfection with HIV and viral hepatitis</td>
<td>- Challenge to sustain the momentum of 100% condom use programme (CUP)</td>
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<td></td>
<td>- Challenges in complying with human rights</td>
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principles during programme implementation
- Increase in use of amphetamine-type stimulants (ATS) and lack of evidence-based drug dependence treatment

The way forward

<table>
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<th>MSM/TG</th>
<th>PWID</th>
<th>Sex workers</th>
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<tr>
<td>- Continue to collect evidence to support comprehensive interventions, particularly management of STI among MSM/TG; psychological factors affecting behavioural change</td>
<td>- Advocate for and support implementation of the new regional strategy in countries</td>
<td>- Systematic review of current HIV response among sex workers (Regional Consultation on HIV and sex workers, October 2010, UNFPA–Asia Pacific Network of Sex Workers [APNSW])</td>
</tr>
<tr>
<td>- Develop case studies to document evidence-based, innovative and effective best practices</td>
<td>- Prepare a Regional Policy Brief on issues faced by PWID regarding HCV/HIV coinfection</td>
<td>- Re-define or re-package the 100% CUP to address the changing pattern of sex work and ensure compliance to human rights principles</td>
</tr>
<tr>
<td>- Maintain regional partnerships to coordinate programmes, support operational research and generate new ideas</td>
<td>- Develop a comprehensive approach to address coinfections with HIV and hepatitis C virus (HCV) among PWID (in response to the 63rd WHA Resolution)</td>
<td>- Deal with gender issues and increase interventions targeting male and TG sex workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Target male clients of sex workers through STI clinics (public, private), pharmacies, behaviour change communication (BCC) and/or condom social marketing programmes targeting special groups or locations</td>
</tr>
</tbody>
</table>
2.1.4 Guidelines for antiretroviral therapy in adults and adolescents (2010)

WHO has a mandate to define global health norms and standards, and to help countries adopt and adapt these recommendations to their national circumstances. Based on the Grading of Recommendations Assessment, Development and Evaluation (GRADE) process, the WHO guidelines have been revised. WHO’s ART guidelines for adults and adolescents are intended to optimize patient care and survival. They recommend the delivery of simple, standard, quality interventions on a large scale, including in resource-limited settings.

Considerable evidence and experience on when to initiate ART and what drug regimens to use have accumulated since the 2006 revision of the guidelines. Most high-income countries have revised their national ART guidelines to recommend an earlier start of treatment and to avoid the use of stavudine (d4T), which is still widely used in first-line therapy in low-income countries. Stavudine use has well-recognized long-term toxicity problems that are not reversible.

WHO recommends that all governments adopt national policy guidelines that promote an earlier start of treatment and transition to less toxic first-line drugs. Implementation of the recommendations will depend on national circumstances, resources and priorities.

The following revisions were made.

**When to start:**

Based on the Cochrane systematic review and two randomized controlled trials (RCTs), the CIPRA HT001 in Haiti and the SMART study, the following are being recommended:

- Treat all patients with a CD4 count \( \leq 350 \) cells/mm\(^3\) irrespective of WHO clinical stage (strong recommendation, moderate quality of evidence).
- Patients in WHO clinical stages 1 and 2 should have access to CD4 testing to decide when to initiate treatment (strong recommendation, low quality of evidence).
- Treat all patients in WHO clinical stages 3 and 4 irrespective of CD4 count (strong recommendation, low quality of evidence).

The table below compares the new (2010) and the old (2006) guidelines:

<table>
<thead>
<tr>
<th>2010 ART guidelines</th>
<th>2006 ART guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4 count ( \leq 350 ) cells/mm(^3)</td>
<td>CD4 count ( \leq 200 ) cells/mm(^3)</td>
</tr>
<tr>
<td>WHO clinical stage 3 or 4 irrespective of CD4 cell count</td>
<td>WHO clinical stage 2 or 3 and CD4 ( \leq 200 ) cells/mm(^3), or</td>
</tr>
<tr>
<td></td>
<td>WHO clinical stage 3 if CD4 measurement not available, or</td>
</tr>
<tr>
<td></td>
<td>WHO clinical stage 4 irrespective of CD4 cell count, or</td>
</tr>
<tr>
<td></td>
<td><em>Consider treatment</em> between 200 and 350 cells/mm(^3) (initiate treatment before CD4 count drops below 200 cells/mm(^3))</td>
</tr>
</tbody>
</table>
What to start:

The following regimens should be started in ART-naive individuals (strong recommendation and moderate quality of evidence).

- AZT + 3TC + EFV
- AZT + 3TC + NVP
- TDF + 3TC (or FTC) + EFV
- TDF + 3TC (or FTC) + NVP

There is no evidence to indicate the superiority of regimens based on zidovudine (AZT), d4T or tenofovir disoproxil fumarate (TDF), or of either efavirenz (EFV) or nevirapine (NVP). While AZT and d4T regimens have equivalent efficacy, data from three RCTs and 24 observational studies have shown that d4T has significant toxicity. TDF-containing regimens have a higher proportion of non-detectable viraemia, lower rate change due to toxicity and an overall greater durability.

Data are conflicting on the increased risk of hepatic toxicity with NVP in women with CD4 counts between 250 and 350 cells/mm³. The panel found that there was limited evidence to cause concern but it has recommended close clinical monitoring and laboratory monitoring, if feasible, especially during the first 12 weeks of therapy.

It has also been recommended that EFV should not be initiated in the first trimester but can be initiated in the second and third trimesters. Evidence for the risk of EFV causing neural tube defects is of low quality and conflicting.

Special populations: Pregnancy

The current recommendation is to initiate ART with AZT + 3TC + EFV or NVP when the CD4 count is ≤350 cells/mm³. It is also essential to note the following:

- Do not initiate EFV during the first trimester.
- TDF is an acceptable option.
- There are special considerations for women exposed to PMTCT interventions.

Special populations: HIV/HBV coinfection

- Start ART in all HIV/hepatitis B virus (HBV) coinfected individuals who require treatment for their HBV infection (chronic active hepatitis), irrespective of CD4 cell count or WHO clinical stage (strong recommendation, low quality of evidence).
- Start TDF and lamivudine (3TC) or emtricitabine (FTC) (strong recommendation, moderate quality of evidence).
- Definition of chronic active hepatitis in resource-limited settings
  - hepatitis B surface antigen (HBsAg) and HBV DNA >2000 IU/ml and alanine aminotransferase (ALT) > upper limit of normal (ULN)
  - HBsAg positive and cirrhosis diagnosed on liver biopsy or clinical criteria.
Special populations: HIV/TB coinfection

Several studies have shown that there is a decrease in mortality when ART is started early among tuberculosis (TB) patients and there is a 54–92% reduction in TB risk among patients on ART. The following are recommended:

- Start ART in all individuals with active TB irrespective of CD4 cell count (strong recommendation, low quality of evidence).
- Start TB treatment first followed by ART as soon as possible and within the first eight weeks of starting TB treatment (strong recommendation, moderate quality of evidence).
- Use EFV as the preferred non-nucleoside reverse transcriptase inhibitor (NNRTI) (strong recommendation, high quality of evidence).
- If the patient is taking a boosted PI and needs TB treatment: use rifabutin (150 mg 3 times/week) + standard dose boosted protease inhibitor (bPI) or use rifampicin + super-boosted bPI.
  - Lopinavir/ritonavir – LPV/r (400 mg/400 mg)
  - Saquinavir/ritonavir – SQV/r (400 mg/400 mg)
  - Double-dose LPV/r (800 mg/200 mgBID)

When to switch:

- Where available, use viral load (VL) to confirm treatment failure (strong recommendation, low quality of evidence).
- Where routinely available, use VL every six months to detect viral replication (conditional recommendation, low quality of evidence).
- A persistent VL above 5000 copies/ml confirms treatment failure (conditional recommendation, low quality of evidence).
- When VL is not available, use immunological criteria to confirm clinical failure (strong recommendation, moderate quality of evidence).

Because of the limitations of clinical/immunological monitoring for diagnosing failure, there is a need to optimize the use of virological monitoring.

A comparison of targeted versus routine strategy:

<table>
<thead>
<tr>
<th>Targeted</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective – confirm suspected clinical and immunological failure</td>
<td>Objective – detect virological failure early</td>
</tr>
<tr>
<td>Reduce unnecessary switching</td>
<td>Apply interventions to increase adherence</td>
</tr>
<tr>
<td></td>
<td>Change therapy earlier</td>
</tr>
<tr>
<td></td>
<td>Limit the accumulation of resistance mutations</td>
</tr>
<tr>
<td></td>
<td>Protect second-line therapy</td>
</tr>
</tbody>
</table>
Second-line regimens:

- A bPI plus two nucleoside reverse transcriptase inhibitor (NRTIs) are recommended for second-line ART regimens (strong recommendation, moderate quality of evidence).
- Atazanavir/ritonovair (ATV/r) and LPV/r are the preferred bPIs (strong recommendation, moderate quality of evidence).
- Simplification of second NRTI options is recommended (strong recommendation, moderate quality of evidence).

<table>
<thead>
<tr>
<th>Target population</th>
<th>Second-line regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-positive adults and adolescents</td>
<td>If d4T or AZT used in first-line → TDF + 3TC (or FTC) + ATV/r or LPV/r</td>
</tr>
<tr>
<td>If TDF used in first-line → AZT + 3TC + ATV/r or LPV/r</td>
<td></td>
</tr>
<tr>
<td>HIV/HBV coinfection</td>
<td>AZT + 3TC (or FTC) + ATV/r or LPV/r + keep TDF for anti-HBV activity</td>
</tr>
</tbody>
</table>

Third-line regimens:

- National programmes should develop policies for third-line therapy (conditional recommendation, low quality of evidence).
- Third-line regimens should include integrase inhibitors, second-generation NNRTIs (etravirine [ETV]) and PIs (darunavir) (conditional recommendation, low quality of evidence).
- Patients on a failing second-line regimen with no new ARV options should continue with a tolerated regimen (conditional recommendation, very low quality of evidence).

Countries may have financial constraints that might limit the adoption of third-line regimens.

Guiding principles for laboratory monitoring

- Currently, there is no evidence on which to base recommendations for laboratory monitoring.
- Laboratory monitoring is not a pre-requisite for the initiation of ART.
- CD4 and VL testing are not essential for monitoring patients on ART.
- Symptom-directed laboratory monitoring for safety and toxicity is recommended for those on ART.
- If resources permit, use a targeted or routine approach to VL.
Currently, there are no trials that demonstrate a survival benefit of using regular VL monitoring. No consensus has also been reached on ART monitoring and diagnosis of treatment failure. However, the panel supported the following:

- reduced reliance on definitions of clinical failure
- expanded use CD4 criteria
- use of VL testing for confirmation when deciding to switch to second-line regimens.

**Package of care interventions – pre-ART**

- Countries should establish a package of care interventions, in addition to ART, to reduce HIV transmission, prevent illness and improve the quality of life.
- Key components should include the following:
  - Promote early diagnosis of HIV.
  - Promote testing and knowledge of HIV status of partner (and children).
  - Enrol people into care before they get sick.
  - Prepare patients for lifelong treatment (treatment/prescription understanding, adherence).
  - Minimize late initiation of ART
  - Maximize HIV prevention

2.1.5 Adaptation and implementation of the new ART guidelines: revised principles and recommendations

The major challenges in implementing these new recommendations in the context of limited financial resources will be the sustainability and maintenance of equitable access to ART. The cost-effectiveness of ART is well established. However, providing ART to HIV-infected patients with higher CD4 counts, the use of more expensive ART regimens and additional monitoring will increase the financial burden in Member States that are already struggling to provide ART to people in immediate need. Choices will therefore have to be made and priorities set. Immediate and full adoption of these recommendations may not be practicable, feasible or affordable. Countries planning to provide ART and care should be directed to implement all the recommendations within a realistic time frame.

The WHO ART Guideline Review Committee recognized that the new recommendations contained in the 2010 guidelines will provide significant benefits to HIV-infected individuals but they have the potential to substantially increase the number of people in need of ART and thus the cost of delivering it. Depending on how the recommendations in the new guidelines are implemented, there may be unintended consequences, such as reduced access to ART for people most in need or undermining of existing ART coverage. An adaptation guide has been developed to provide a basis for difficult choices and decisions in Member States, and to assist programme managers to choose and prioritize recommendations, especially where resources are limited. In addition, the guide is intended to serve as an advocacy tool for policy-makers.
Situational assessment

A situational assessment comprises the internal and external factors that may affect programme implementation. It requires a serious scrutiny of all the factors affecting the future success of the programme as they relate to the overall strategy of programme implementation. Once these factors are identified, select those that are most critical and develop long-term objectives to address them.

<table>
<thead>
<tr>
<th>Elements</th>
<th>Some considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART coverage</td>
<td>What is your success in reaching those in need at current CD4 thresholds?</td>
</tr>
<tr>
<td>New CD4 eligibility criteria</td>
<td>How many additional individuals will be eligible?</td>
</tr>
<tr>
<td>ARV procurement</td>
<td>What are the increased costs?</td>
</tr>
<tr>
<td>Specific populations</td>
<td>Could prioritizing specific populations (pregnant women, those with HIV/TB) help phase-in changes?</td>
</tr>
<tr>
<td>Laboratory capacity</td>
<td>How to implement “new” technologies (VL)?</td>
</tr>
</tbody>
</table>

CD4 count and when to start:

- Raising the threshold for initiation of ART will have little impact on the number of people on ART if CD4 testing is not routinely available.
- If universal access to CD4 testing is not feasible:
  - Prioritize CD4 testing for pregnant women with the objective of improving maternal and infant outcomes.
  - Prioritize CD4 testing for asymptomatic individuals to identify those who need to start ART before they become ill.

Adaptation steps

- First, ensure ART access:
  - for those most in need
  - for pregnant women with CD4 counts ≤ 350 cells/mm³
  - for those with HIV/TB coinfection.
- Waiting lists in clinics
  - should be addressed first before changing to a higher CD4 threshold
  - the new thresholds may create waiting lists
  - task-shifting may be needed
  - spacing of visits for stable patients can be increased.
- Capacity and waiting lists vary within programmes and within countries. It is essential to pilot initiation of new CD4 count eligibility in sites which are ready.
What to start:

- Programmes select the preferred regimen(s) that is applicable to the majority of PLHIV and preferably in a fixed-dose combination.
- These should be implemented in a phased manner.
- Decisions need to be made between AZT and TDF, and between EFV and NVP.

The following should be considered when choosing between AZT and TDF:

<table>
<thead>
<tr>
<th>Efficacy</th>
<th>Comparable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>• Safety profiles differ without being in favour of either drug</td>
</tr>
<tr>
<td></td>
<td>• Limited experience with TDF in pregnancy</td>
</tr>
<tr>
<td></td>
<td>• In March 2010, the FDA extended approval of TDF for use in those &gt;12 years of age</td>
</tr>
<tr>
<td>Cost</td>
<td>• Cost of AZT and TDF will be comparable based on current and projected costs</td>
</tr>
<tr>
<td></td>
<td>• Consider costs of monitoring (haemoglobin [Hb] for AZT, creatinine clearance for TDF, liver function tests for NVP)</td>
</tr>
<tr>
<td>Feasibility and acceptability</td>
<td>• Will clinicians use AZT without Hb monitoring or TDF without creatinine clearance monitoring?</td>
</tr>
<tr>
<td></td>
<td>• Is there capacity to detect anaemia if AZT is chosen?</td>
</tr>
<tr>
<td></td>
<td>• Is there capacity to detect renal insufficiency if TDF is chosen?</td>
</tr>
<tr>
<td>Availability</td>
<td>• How secure is the supply of these medications, now and in the future?</td>
</tr>
<tr>
<td></td>
<td>• Are fixed-dose formulations or co-packs available?</td>
</tr>
</tbody>
</table>

Reduction in the use of d4T

There is a clear recommendation from WHO to reduce the use of d4T. This should be done immediately, phased in or even deferred, so that access to existing treatment is not jeopardized. However, if AZT or TDF is not available, a d4T-based regimen is strongly preferred to no ART. In addition, d4T can still be used as a back-up drug in case of toxicity to AZT or TDF. Irrespective of the reason for its use, intensified monitoring for d4T toxicity is recommended.

Strategies for immediate reduction in the use of d4T:

- Assess the cost and feasibility of reducing d4T use.
- Assess present inventories.
- Decide on alternative regimens and make them available in clinics.
- Assess the supply chain management, including the capacity to cope with change, and ensure that stock-outs do not occur.
- Train health-care workers in the use of the newer drugs.
- Agree on a phase-out plan and timeline.
Strategies for phased or deferred d4T reduction:

- Update the guidelines to move progressively towards AZT or TDF-based regimens.
- Review programmes and protocols to improve detection, prevention and management of d4T-related toxicity.
- Secure more funding if possible including renegotiation with existing funders and development of new funding proposals.
- Build political commitment for change.
- Engage support from PLHIV to advocate for change.

Clinical perspectives in d4T reduction:

It is essential to provide alternative drugs for those with established toxicity to d4T. It is also important to avoid initiation of d4T in individuals at higher risk for adverse events. These conditions could include lipoatrophy in patients less than 35 years of age, lactic acidosis especially in women with a high body mass index or those who are pregnant; and peripheral neuropathy among those using isoniazid (INH). The use of d4T should be limited to a period of six to 12 months and then substituted; d4T can be used when AZT is contraindicated because of anaemia or when TDF is contraindicated because of renal impairment.

Prioritizing when to start versus what to start:

Earlier initiation of ART will have an impact on mortality and morbidity, and on rates of HIV and TB transmission. This will also mean that patients will need to be on ART for an additional year or two. On the other hand, phasing in newer drugs will reduce toxicity, improve the quality of care and probably improve adherence. Thus, while the initial cost will certainly increase, this will be offset by longer-term cost savings in toxicity management and fewer new TB cases.

CD4 and viral load testing for the diagnosis of failure:

It is important to note that any decision on implementing CD4, VL or any other laboratory testing should not undermine improved access to better ART. In expanding access to CD4 measurement, it is important to prioritize testing among pregnant women and well patients. Targeted VL testing should be used to confirm failure.

Adaptation steps would include assessment of the following:

- collection and transport requirements;
- purchase and running costs; how to fund CD4 and VL testing;
- turnaround time and its impact on clinical care;
- new technologies such as point-of-care tests; and
- rationalizing procurement to avoid stock-outs.

Monitoring and evaluation:

A plan for monitoring progress in implementing the recommendations should be developed. Periodic surveys and audits should be done on the adaptation, dissemination and acceptance of the new guidelines. A periodic ascertainment of the unit cost per patient would
also be essential. Access, utilization, availability and coverage should be assessed. Moreover, the availability of CD4 testing in antenatal settings should be assessed.

2.1.6 Use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants towards elimination of vertical transmission

Globally, significant progress has been made in scaling up PMTCT, including in high-burden and resource-limited settings. The elimination of mother-to-child transmission (MTCT) is now considered a realistic public health goal and an important factor for achieving the MDGs. It is critical to provide the best evidence-based interventions to reduce the risk of transmission from an HIV-infected mother to her newborn child.

There is evidence that providing ART to eligible pregnant women with CD4 counts <350 cells/mm³ initiating ART for their own health, and PMTCT during pregnancy, labour and delivery, and breastfeeding have strong benefits. This is because around 40% of all HIV-positive persons are pregnant women who account for >75% of cases at risk for MTCT and >80% of postpartum transmission. About 85% of maternal deaths due to HIV occur within two years of delivery.

Guiding principle:

- HIV-infected women, including pregnant women who are in need of ART for their own health, should receive lifelong ART.
- Antenatal CD4 measurement is critical for offering optimal interventions.
- Optimal interventions should include maximizing reduction of MTCT, effectively stopping HIV transmission due to breastfeeding and preserving future HIV treatment options.

The 2010 revised PMTCT recommendations are based on two key approaches:

- Lifelong ART: Women who need treatment for their own health (CD4 count ≤350 cells/mm³ or in WHO stage 3 or 4). ART in such women will also be effective in reducing MTCT.
- ARV prophylaxis to prevent MTCT during pregnancy, delivery and breastfeeding should be offered to HIV-infected women not in need of treatment.

**Lifelong ART for mother and prophylaxis for HIV-exposed infants:**

<table>
<thead>
<tr>
<th>Mother</th>
<th>Infant</th>
</tr>
</thead>
<tbody>
<tr>
<td>• AZT + 3TC + NVP or</td>
<td>For all exposed infants (regardless of type of infant-feeding)</td>
</tr>
<tr>
<td>• AZT + 3TC + EFV or</td>
<td>• AZT for 4–6 weeks OR</td>
</tr>
<tr>
<td>• TDF + 3TC/FTC + NVP or</td>
<td>• NVP for 4–6 weeks</td>
</tr>
<tr>
<td>• TDF + 3TC/FTC + EFV</td>
<td>Lifelong treatment, beginning as soon as possible during pregnancy</td>
</tr>
</tbody>
</table>

Lifelong ART for mother and prophylaxis for HIV-exposed infants:
ARV prophylaxis to prevent MTCT

This is provided as early as 14 weeks of gestation (second trimester) or as soon as possible thereafter. There are two options:

- Maternal **AZT** prophylaxis, or
- Maternal **triple ARV** prophylaxis.

For the breastfeeding mother, ARV is provided to the child or the mother during the period when the infant is breastfeeding.

**Options for ARV prophylaxis:**

<table>
<thead>
<tr>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother</strong></td>
<td><strong>Mother</strong></td>
</tr>
<tr>
<td>Antepartum AZT (from 14 weeks)</td>
<td>Triple ARV (from 14 weeks until one week after stoppage of breastfeeding)</td>
</tr>
<tr>
<td>Single-dose (sd)-NVP at onset of labour*</td>
<td>AZT + 3TC + LPV/r</td>
</tr>
<tr>
<td>AZT + 3TC during labour and delivery*</td>
<td>AZT + 3TC + ABC</td>
</tr>
<tr>
<td>AZT + 3TC for 7 days’ postpartum</td>
<td>AZT + 3TC + EFV</td>
</tr>
<tr>
<td></td>
<td>TDF + 3TC or FTC + EFV</td>
</tr>
<tr>
<td><strong>Infant</strong></td>
<td><strong>Infant</strong></td>
</tr>
<tr>
<td>Breastfeeding population</td>
<td>For all HIV-exposed infants</td>
</tr>
<tr>
<td>Daily NVP (from birth until one week after stoppage of all exposure to breast milk)</td>
<td>AZT or NVP for 4–6 weeks</td>
</tr>
<tr>
<td>Non-breastfeeding population</td>
<td></td>
</tr>
<tr>
<td>AZT or NVP for 4–6 weeks</td>
<td></td>
</tr>
</tbody>
</table>

*sd-NVP and AZT+3TC can be omitted if the mother receives >4 weeks AZT antepartum.

- Both options A and B provide a significant reduction in the risk of MTCT.
- One option is not better than the other.
- Both have advantages and disadvantages in terms of feasibility, acceptability, safety and cost.
- The choice of option should be made at a country level, after considering the advantages and disadvantages.
### Advantages:

<table>
<thead>
<tr>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Significant reduction in the risk of MTCT</td>
<td>• Significant reduction in the risk of MTCT</td>
</tr>
<tr>
<td>• Low rates of maternal NVP resistance with use of AZT+3TC tail</td>
<td>• Low rates of adverse events in infants</td>
</tr>
<tr>
<td>• Low rates of adverse events in infants</td>
<td>• No change in maternal regimen between ante- and postpartum period</td>
</tr>
<tr>
<td>• Long life of NVP allows for a potential miss in the daily dose (breastfeeding population)</td>
<td>• May improve maternal health during the prophylactic period</td>
</tr>
</tbody>
</table>

### Disadvantages:

<table>
<thead>
<tr>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Intrapartum AZT+3TC tail (with sd-NVP) is complex</td>
<td>• Risk to maternal health is not known if prolonged triple ARV prophylaxis is stopped</td>
</tr>
<tr>
<td>• Likelihood of NNRTI resistance in infected infants</td>
<td>• Risk of multiple drug resistance if adherence is poor</td>
</tr>
<tr>
<td>• Safety, effectiveness and feasibility of NVP beyond 6 months in infants is not known</td>
<td>• Likelihood of NRTI and NNRTI resistance in infected infants</td>
</tr>
<tr>
<td>• Acceptability of prolonged use of NVP is not known</td>
<td>• More frequent follow-up visits required</td>
</tr>
</tbody>
</table>

### Cost:

<table>
<thead>
<tr>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother + infant = US$ 55</td>
<td>US$ 300–800</td>
</tr>
</tbody>
</table>

### Infant-feeding in the context of HIV

All stakeholders should decide whether health services should counsel and support mothers known to be HIV-positive to breastfeed and receive ARV interventions, or avoid breastfeeding altogether as the strategy that will most likely give infants the greatest chance of HIV-free survival.

The infant-feeding method chosen should balance HIV prevention, nutritional requirements and protection from other causes of non-HIV child morbidity and mortality.
It is important to consider ARV prophylaxis for HIV-positive mothers or those of unknown status. Exclusive breastfeeding for the first six months of life is essential followed by introduction of complementary foods. Breastfeeding can be continued up to 12 months. Breastfeeding can be stopped if a nutritionally adequate and safe diet without breast milk can be provided. It is essential to provide ARV prophylaxis to the mother or infant during the entire period of breastfeeding.

**Adaptation and implementation:**

- Successful implementation depends on planning and thinking carefully about options A and B.
- Option B is not necessarily better. The SMART study provides guidance on starting and stopping ART, and also the need to consider more than one pregnancy.
- Universal HIV testing and counselling for pregnant women is important.
- There is a need to consider the availability of CD4 testing and ARVs in the following:
  - primary care-level and antenatal facilities;
  - settings where most maternal–child health care is provided; and
  - not just in specialized clinics.
- Improve antenatal and postnatal follow up.
- Prophylaxis should be provided to the mother or baby throughout breastfeeding, along with infant-feeding counselling and support.
- Staff should be appropriately trained.

**Operational issues that need to be considered:**

- Systems for CD4 screening of pregnant women
  - Need to move towards point-of-care tests if the intervention is based on CD4 results
- Coordination of PMTCT, ART and infant-feeding programmes
- Availability and initiation of ART in MCH clinics
- Tracking of women and infants
  - in the context of extended breastfeeding prophylaxis (12 months)
- Programme monitoring and reporting

**2.1.7 New guidelines on intensified case finding and INH prophylaxis therapy (IPT) for TB/HIV collaborative activities**

The new guideline on IPT was released in 2010. This guideline defines the WHO 12-point policy package and the evolution of the global IPT policy and implementation, which is structured under three main components: establish the mechanism for collaboration; decrease the burden of TB among PLHIV; and decrease the burden of HIV among those with TB. Under each component are the following sets of activities:
a. Establish the mechanism for collaboration
   - TB/HIV coordinating bodies
   - HIV surveillance among TB patients
   - TB/HIV planning
   - TB/HIV monitoring and evaluation

b. Decrease the burden of TB among PLHIV
   - Intensified TB case finding
   - IPT
   - Infection control for TB

c. Decrease the burden of HIV among those with TB
   - HIV testing and counselling
   - HIV preventive methods
   - Co-trimoxazole preventive therapy (CPT)
   - HIV/AIDS care and support
   - ART for TB patients

Evolution of the International IPT Policy:


1998: Policy Statement on Preventive Therapy against Tuberculosis in PLHIV

2004 onwards: Interim Policy in TB/HIV Collaborative Activities; Framework to address TB/HIV coinfection in the Western Pacific Region; A Revised Framework to address TB/HIV coinfection in the Western Pacific Region

In brief, the WHO policy and guidelines development process is as follows:

(1) Composition of the external guidelines panel and declaration of conflicts of interest
(2) Formulation of the questions and the choice of relevant outcomes
(3) Evidence retrieval, evaluation and synthesis, benefit, equity and cost
(4) Recommendations
(5) Evaluation of the impact of recommendations
(6) Areas for further research
(7) Finalization and expiry date
Strength of recommendations:

- Strong: the desirable effects of a recommendation outweigh the undesirable effects.
- Conditional: the desirable effects probably outweigh the undesirable effects. However,
  - data are scant or
  - only applicable to a specific group/population or setting or
  - new evidence may change the risk-to-benefit balance or
  - benefits may not warrant the cost or resources required.

Key recommendations with their evidence base:

**Recommendation 1: TB screening**

Adults and adolescents living with HIV should be screened with a clinical algorithm and those who do not report any one of: current cough, fever, weight loss or night sweats are unlikely to have active TB and should be offered IPT. *(Strong recommendation, moderate quality of evidence)*

**Recommendation 2: TB screening**

Adults and adolescents living with HIV screened with a clinical algorithm and reporting one of the following: current cough, fever, weight loss or night sweats may have active TB and should be evaluated for TB and other diseases. *(Strong recommendation, moderate quality of evidence)*

---

**Table 2: GRADE quality assessment criteria**

<table>
<thead>
<tr>
<th>Quality of evidence</th>
<th>Study design</th>
<th>Lower if *</th>
<th>Higher if *</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Randomized trial</td>
<td>Study quality:</td>
<td>Strong association:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-1 Serious limitations</td>
<td>+1 Strong, no plausible confounders, consistent and direct evidence**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-2 Very serious limitations</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td>-1 Important Inconsistency</td>
<td>+2 Very strong, no major threats to validity and direct evidence***</td>
</tr>
<tr>
<td>Low</td>
<td>Observational study</td>
<td>Directness:</td>
<td>+1 Evidence of a Dose response gradient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-1 Some uncertainty</td>
<td>+1 All plausible confounders would have reduced the effect</td>
</tr>
<tr>
<td>Very low</td>
<td>Any other evidence</td>
<td>-2 Major uncertainty</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-1 Sparse data</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-1 High probability of Reporting bias</td>
<td></td>
</tr>
</tbody>
</table>
Evidence for TB screening recommendations (1 and 2)

Individual patient data meta-analysis: What is the most sensitive clinical algorithm to screen for culture-confirmed TB in PLHIV?

Inclusion criteria for studies:

- Collected sputum specimens from PLHIV regardless of signs or symptoms;
- Used mycobacterial culture of at least one specimen to diagnose TB; and
- Collected data on signs and symptoms.

**Recommendation 3:** Adults and adolescents living with HIV and with unknown or positive tuberculin skin test (TST) status and unlikely to have active TB should receive IPT for at least six months. (*Strong recommendation, high quality of evidence*)

**Recommendation 4:** Adults and adolescents living with HIV in settings with high TB transmission and with unknown or positive TST status and unlikely to have active TB should receive IPT for at least 36 months. (*Conditional recommendation, low quality of evidence*)

**Recommendation 5:** Tuberculin skin test is not a requirement for initiating IPT in people living with HIV: Where feasible, TST can be used to determine exposure to TB as people with a positive test benefit more from IPT than those with a negative test. (*Strong recommendation*)

**Recommendation 6:** Providing IPT to PLHIV does not increase the risk of developing INH-resistant TB. Therefore, concerns regarding the development of INH resistance should not be a barrier to providing IPT. (*Strong recommendation, moderate quality of evidence*)

**Concomitant use of IPT with ART:** (*Strong recommendation, low quality of evidence*). No study directly addresses the issue; contrasting results on immune status and IPT effect; no difference by HIV stage at baseline (Gordin, 1997); greater effect when TLC >2/L (Mwinda, 1998); not affected by CD4 count (Churchyard, 2003); IPT+ART= TB IRR 0.20 (0.09–0.91) (Golub, 2007-Brazil); IPT+ART= TB IRR 0.15 (0.004–0.85) (Golub, 2009-South Africa).

**Recommendations for children: TB screening**

- Children living with HIV who do not have poor weight gain, fever or current cough are unlikely to have active TB. (*Strong recommendation, low quality of evidence*)

- Children living with HIV who have any one of the following: poor weight gain, fever, current cough or contact history with a TB case may have TB and should be evaluated for TB and other conditions. If the evaluation shows no TB, children should be offered IPT regardless of their age. (*Strong recommendation, low quality of evidence*)

**In summary:**

- Screening for TB by using only a symptom-based algorithm is sufficient for starting IPT for PLHIV.

- No mandatory requirement for chest X-ray and TST for starting IPT.

- Regular screening of those on IPT at every visit.
2.1.8 Where is care? Continuum of prevention and care

Though HIV health services have expanded rapidly in the past several years, these were implemented in an urgent response mode. Scaling up of programmes was made possible with an influx of funding support from different sources. However, to maximize access to services by those who need them, and ensure the success and sustainability of what was started, local systems need to be streamlined and integrated with the bigger health system. When faced with several programme components such as provider-initiated testing and counselling (PITC), ART, management of opportunistic infections (OIs), PMTCT, peer education, NSP, STI, to mention a few, each of which needs to be delivered almost simultaneously at different levels of care such as the district and community levels, the demand arises for a strategy that is beyond business as usual. This is where the continuum of prevention and care (CoPC) architecture comes in.

Before the evolution of CoPC, one critical component that was missing in the current holistic approach to the management of PLHIV was palliative care. As countries gear up towards the achievement of goals, and targets that include the number of PLHIV on ART and adherence to ART regimens, one neglected aspect is understanding what a PLHIV feels other than the need for ART. These include pain, anxiety, depression, anger, worry and skin manifestations.

The need to address these concerns, beyond the typical medical concerns, brought back the focus on including palliative care as part of the comprehensive package for PLHIV. WHO defines palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with a life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems – physical, psychosocial and spiritual.

To illustrate a scenario, before initiating ART, a PLHIV is treated/managed in the hospital, centres and home with a focus on providing “holistic care” that includes basic OI management, symptom management, health promotion, nutrition, and psychological, socioeconomic, spiritual management. However, when the PLHIV is started on ART, provision of “holistic care” suddenly diminishes. More often than not, the focus is more on adherence to ART, and provision solely of pills/medicines. But the other needs of the PLHIV do not diminish or stop with receiving the pills.

As people reflect on what services are needed by PLHIV, there is also a need to reflect on how these services are being provided and familiarize oneself with the hub and heart of CoPC. In addition to clinical services and patient education, the hub and heart is simply the need to connect with the people who need to be reached, such as MARPs. Link them with other services, and support their community actions. This is the “hub”. The heart creates the platform that allows PLHIV, their families, health workers, the authorities, nongovernmental organizations (NGOs), community-based organizations (CBOs) and others to meet, interact, learn and encourage each other with compassion.

The principles of CoPC are anchored in providing services in a vertical, horizontal, chronological and community continuum. It means providing services beyond the usual HIV
Delivering services through the vertical continuum demands defining the roles of the different levels of service delivery, depending on the level of HIV burden; establishing referral procedures and informal networks; coordinating specialized services required at the referral level; and addressing health systems strengthening (HSS) issues.

Delivering services through the horizontal continuum demands that HIV services are linked with other relevant programmes such as MCH, TB, SRH, STI, MMT, etc., with a concomitant focus on addressing administrative concerns such as who should be involved/who will provide the services, what capacities are needed, what are the sources of supplies and materials; and coordination and other health systems issues.

Delivering services through the community continuum demands that home-based care allows timely access to counselling and testing, and support for adherence; and HIV prevention outreach aimed at reaching hard-to-reach populations and bringing them to the health services through fostering trustful relationships with service providers. Maximizing synergies between prevention and care should encourage people providing care to start providing prevention services by reaching out to more PLHIV and the MARP network. It also means integrating and strengthening health systems by formalizing peer educators such as village health volunteers or community outreach workers, conducting participatory local programming (rapid assessment and response [RAR]), local innovation, expansion and normalization of HIV; ensuring appropriate multisectoral cooperation such as involvement of public security, drug control office, and public–private partnerships, including with pharmacies.

Delivering services through the chronological continuum demands that PLHIV are taken care of from the time HIV is diagnosed to the pre-ART stage, then during initiation and for several years while on ART, ensuring regular and timely follow up.

It is critical to be implement/operationalize all these to ensure that the services provided to PLHIV are comprehensive in scope, responsive to PLHIV’s needs and provided in a sustained manner.

In summary, to shift from the urgent response mode to a more responsive/effective response mode, local service delivery systems need to be streamlined, strengthened and integrated with the bigger health system. CoPC should serve as a foundation to maximize the access, success and sustainability of HIV services. The CoPC framework facilitates service delivery, system review and integration of programmes/services with the bigger health system. Palliative care should be brought back as an integral part of CoPC. In order to bring life to the CoPC framework, “values” that include dignity, interdependence, solidarity and sustainability need to be emphasized. However, it should also be recognized that each person has specific values that they individually consider as important to them.

In addition, it is important to incorporate indicators for CoPC functions to continuously monitor and improve existing HIV services.

2.1.9 Sexually transmitted infections

**Responding to the threat of untreatable *Neisseria gonorrhoeae***

One of the key elements of gonorrhoea control is appropriate and effective single-dose antibiotic therapy to all infected individuals and their sexual partners.
The Gonococcal Antimicrobial Susceptibility Programme (GASP) was started in 1992. There has been long-term surveillance for antimicrobial resistance (AMR) in *Neisseria gonorrhoeae* in WPR and the WHO South-East Asia Region (SEAR). Susceptibility testing incorporates quality control and participation in an external quality assurance system (EQAS) programme. In terms of data analysis and dissemination, laboratories send AMR data to the WHO Collaborating Centre for STIs in Sydney.

In the WHO GASP Regional report WPR/SEAR 2007–2008, 17 553 *N. gonorrhoeae* specimens were examined for their susceptibility to one or more antibiotics used for the treatment of gonorrhoea by EQAS-controlled methods over two years, 2007–2008. Twenty-four reporting centres from 20 countries and jurisdictions in 16 WHO WPR and four WHO SEAR countries participated.

In vitro susceptibility testing was done by the minimum inhibitory concentration (MIC) methodology (in well-resourced laboratories) and disc testing procedures (more common and practical in laboratories with resource limitations).

Penicillin-resistant strains of *N. gonorrhoeae* were found in 9048 strains from 22 Asian countries in 2008. Quinolone-resistant strains of *N. gonorrhoeae* were found in 8731 strains from 20 Asian countries in the same year. Strains of *N. gonorrhoeae* that were not susceptible to ceftriaxone were isolated in China, Australia, India and Brunei Darussalam.

In gonococcal AMR surveillance, the ideal is:

- to sample consecutive cases from a high-volume clinic;
- to conduct ongoing surveillance rather than periodic sampling;
- to have an appropriate sample size;
- to take samples from both males and females;
- to take samples from patients who have not previously received treatment;
- to examine pharyngeal and rectal isolates from MSM;
- to use a validated method with appropriate controls;
- to subscribe to an external quality control programme; and
- to ensure timely reporting of results.

However, it is also acceptable:

- to conduct periodic but regular sampling;
- to take samples from men with acute urethritis only;
- to have an adequate sample size;
- to use a validated method of AMR testing with controls; and
- to subscribe to an external quality control programme.

**Current challenges:**

- Obtaining a sufficient number of viable and representative isolates
  - Diminishing capacity for culture and antimicrobial susceptibility testing – syndromic management, Gram staining and shifting to nucleic acid amplification test (NAAT) testing
- Comparability and quality of AMR data
- Difficulties with reliable detection and reporting of decreased susceptibility of gonococci (GC) to cephalosporins
Variations in interpretative values of MICs – poor standardization of methods and EQAS
Definition of cephalosporin resistance – correlate between treatment failures and MIC breakpoints

- Lack of an early warning system for emergence of antibiotic resistance
- No systematic monitoring of cephalosporin treatment failure
- Establishing optimal signal-to-response triggers in ongoing surveillance
  - Rapid response approach
  - Evidence-based approach

Response:

- Expand and strengthen the global GASP.
- Standardize AMR data
  - Develop WHO surveillance guidelines
  - WHO reference panel of *N. gonorrhoeae* strains in quality procedures
- Consistent phenotypic/qualitative categorization – sensitive, less sensitive and resistant – consistent between different methods.
- Clarify laboratory issues – multidrug-resistant *N. gonorrhoeae* (MDR-NG) and extended-spectrum cephalosporin (ESC) resistance.
  - Global technical working group to address issues of definition
  - Develop a simple quality-assured disc diffusion-based screening method
- Formulate an action plan to address the threat of untreatable GC.

Action plan to respond to the threat of untreatable gonorrhoea

- Conduct a situational assessment – mapping of AMR data.
- Enhance surveillance through:
  - early warning system;
  - share information and resistant *N. gonorrhoea* strains;
  - web-based reporting system;
  - monitor drifts (increasing levels in MICs and treatment failures);
  - increase awareness of clinicians and laboratory staff; and
  - conduct STI surveillance – STI reporting.
- Provide epidemiological support
  - systematic monitoring of treatment failures (test of cure)
  - collection of essential epidemiological data linked to AMR data
  - outbreak response
  - rapid epidemiological assessment survey
- Strengthen laboratory capacity
- Provide clinical support
  - identify alternative effective treatment
  - rational drug use
- Enhance gonorrhoea control
• Improve surveillance
• Scale up gonorrhoea/STI control
• Assure the potency and quality of essential drugs
• Conduct advocacy, programme coordination and collaboration
  ➢ disseminate information
  ➢ coordinate activities
• Procure drugs and laboratory supplies in bulk.

The aim is to reduce the burden of gonorrhoea prior to the emergence of multiple resistant organisms resulting in “untreatable” disease.

Monitoring initiatives for the elimination of congenital syphilis

Elimination of congenital syphilis (ECS) has four main pillars:

- Ensure sustained political commitment and advocacy.
- Increase access to and quality of maternal and newborn health services.
- Screen all pregnant women and treat all those who are HIV-positive.
- Put surveillance, monitoring and evaluation systems in place.

The global strategy defines the following indicators for monitoring and evaluation of ECS. The core indicators are as follows:

- Pregnant women tested for syphilis
- Pregnant women attending antenatal care (ANC) clinic whose blood tested positive for syphilis
- Pregnant women with positive syphilis test received appropriate standard treatment
- Special study indicators
  ➢ Proportion of syphilis-positive pregnant women who are screened and treated with at least one dose of penicillin by 24 weeks of gestation
  ➢ Proportion of stillbirths attributable to syphilis in the mother

In addressing the issue of ECS, countries need to have a consensus on the definition of congenital syphilis. It is usually defined as follows:

• Any live infant, stillborn infant or pregnancy outcome whose mother has syphilis (clinical or laboratory diagnosed) and who has not been treated or treated inadequately.
• Infant with rapid plasma reagin (RPR)/Venereal Disease Research Laboratory (VDRL) titres fourfold or higher than the mother’s titre.
• Any child with one or more clinical manifestations suggestive of congenital syphilis – physical or radiological + RPR/Treponema pallidum haemagglutination (THPA) positive.
• Any birth product with evidence of T. pallidum diagnosed through dark field microscopy.
In setting up monitoring for ECS, the following should be considered:

- Global monitoring for ECS based on existing systems
  - Which programme area should be responsible for monitoring and evaluation (M&E) of ECS? (e.g. RH, MCH, STI, HIV/PMTCT)
  - How should the flow of information occur? Should it be linked with reporting of the universal access to HIV and harmonized with the RH or Making Pregnancy Safer (MPS) reporting mechanism?
- Which countries will need increased support for ECS (based on burden of disease, interest, in-country capacity)?

There are opportunities to promote a joint elimination agenda with PMTCT of HIV.

- Support for MDGs 4, 5, 6
- Support for the PMTCT Strategic Vision
- Steps to take to implement joint elimination
  - Advocacy
    - “Elimination of vertical transmission of HIV and syphilis”
  - Improved access to quality ANC services
    - Pilot integration projects with documentation of impact of joint effort
  - Screening to prevent infection
    - Integrated training and guidelines for rapid testing in ANC settings (HIV, syphilis, malaria)
    - Joint efforts to strengthen laboratory supply chain
  - Surveillance, M&E
    - Joint regional or country support (Three Interlinked Monitoring system)
- Ease of implementation in countries and regions.

2.1.10 Health systems strengthening and comprehensive HIV services

Cambodia’s response to HSS took off after the WHO Workshop on “Maximizing synergies between global health initiatives and health systems”, held in Batangas, Philippines in November 2009. This workshop was attended by participants from Bhutan, Cambodia, China, Fiji, Indonesia, the Lao People’s Democratic Republic, Mongolia, Nepal, the Philippines, Papua New Guinea, Solomon Islands and Vietnam.

Cambodia recognized that ambitious targets had been set during the Batangas workshop. It was not practical to start covering all the areas at once as discussed during the workshop, taking into consideration both funding and implementation capacity. Thus, it was decided to prioritize and anchor its HSS in the following “prioritization principles”: implementing the Second Health Sector Support Project (HSSP2) strategies; addressing identified systemic bottlenecks to strengthen the performance of three disease programmes; building on the strengths of disease programmes to strengthen health systems; exploring the potential for building efficiencies across priority areas; and identifying gaps in funding and implementation.
As the HSSP2 defines the processes to be undertaken, documenting these processes was equally important, both for internal consumption and for preparing the Global Fund proposal:

1. Created a task force to monitor HSSP2 implementation comprising key departments of the Ministry of Health (MOH) and health partners such as WHO, the World Bank (WB), USAID, Japan International Cooperation Agency (JICA), GTZ, Medical in Cambodia (MEDICAM) and Action for Health (AFH).
   - Convened two rounds of task force meetings to discuss priority themes and gap analysis.
   - Discussed with the DPHI Director and the Country Coordinating Committee-Proposal development Committee (CCC-PDC) to provide further explanation.
   - Workshop on Global Fund Round 10 proposal development organized by the National Centre for Tuberculosis and Leprosy Control (CENAT) supported by WPRO.
   - Endorsed priority themes by the Country Coordinating Committee (CCC).
   - Proposal development under way with WHO technical assistance.

2. Developed the HSSP2 operational framework where the health programme areas pertain to the MNCH, Communicable Diseases and the Non-communicable Diseases Programmes. The strategic areas for HSS are health service delivery, health resource development, health-care financing, health information systems and health systems governance.

3. Conducted joint annual performance reviews that:
   - assessed progress and achievement;
   - identified factors for good performance and constraints;
   - set annual targets; and
   - identified investment needed.


5. Analysed expected outcomes of the WHO Synergies Workshop in Batangas.

6. Conducted gap analysis that was utilized:
   - to harmonize and scale up the continuum of care for MCH and linked responses (MCH–RH–HIV/STI/TB/MAL);
   - to scale up health equity funds;
   - to develop a comprehensive in-service training plan;
   - to scale up integrated laboratory management; and
   - to standardize monitoring toolkits for one common M&E framework towards strengthening health information systems.

7. Cambodia submitted a proposal to the Global Fund Round 10 focusing on:
   - strengthening implementation of the continuum of care in Reproductive, Maternal, Newborn and Child Health (RMNCH) in operational districts, through extension of the linked response approach to existing key
interventions, including immunization and directly observed therapy, short-course (DOTS) for TB;

- improving health service **quality at the health facility level**, through implementation of the MOH Strategy on Quality Improvement in Health, Infection Control Policy, Behaviour Change Communication, as well as demand-side approaches and community monitoring;

- strengthening management performance, accountability through strengthening programme management of the operational district, and harmonization of the **M&E Framework** for performance management and linkages to local governance structures; and

- strengthening the national **health information system** to improve the health system response, including participation by the NGO and private sectors in the national health information system.

### 2.1.11 Addressing technical support needs of countries: the WHO Network for HIV and Health

The global HIV landscape is changing rapidly. With the influx of funds from the Global Fund, PEPFAR and other development partners, the demand for HIV programming and requests for technical assistance from Member States has increased. However, at present, there is a lack of coordinated technical assistance that results in poor outcomes of HIV programmes.

The WHO Network for HIV and Health operates by using a unique approach that requires a multidisciplinary technical network; diverse competencies and expertise; and linking with institutions and defining synergies. It strives to establish a pool of experts to address all aspects of the health sector response to an HIV epidemic driven by MARPs, with cross-cutting issues and the need to complement existing support.

The Network currently has eighteen founding members, which comprise fifteen WHO Collaborating Centres and three technical partners. It boosts expertise in HIV, STI, laboratory, gender and women’s health, child and maternal health, drug and alcohol (D&A), nursing, health promotion and disease prevention, blood safety and products, TB, training, research, health technology, occupational health, population health, virology and immunology. The members are active leaders in their respective fields with established reputations. They represent a range of countries working locally, regionally and internationally, and have the ability to adapt assistance to a specific context. They also have established relationships with key stakeholders.

The Network’s mission is to collaborate in supporting Member States to implement effective multidisciplinary public health approaches to HIV according to the WHO strategic directions. Its objectives are as follows:

1. Provide Member States with sustainable technical assistance through a multidisciplinary Network.
2. Ensure the 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, updating evidence, scientific debate and operational research related to HIV and health.
### Guiding values/Principles of operations:

<table>
<thead>
<tr>
<th>Client-centred/end-user focused</th>
<th>Transparency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability</td>
<td>Sustainability</td>
</tr>
<tr>
<td>Integrity</td>
<td>Long-term engagement</td>
</tr>
<tr>
<td>Quality</td>
<td>Partnership (with civil society and other stakeholders)</td>
</tr>
<tr>
<td>Equity</td>
<td>Inclusiveness</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Evidence informed and results based</td>
</tr>
<tr>
<td>Relevance</td>
<td>Human rights approach</td>
</tr>
<tr>
<td>Gender equality/equity</td>
<td>Special attention to the needs of vulnerable populations and PLHIV</td>
</tr>
<tr>
<td>Consistency</td>
<td>Synergy</td>
</tr>
<tr>
<td>Coherence</td>
<td>Predictability</td>
</tr>
<tr>
<td>Timeliness</td>
<td>Innovation</td>
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<tr>
<td>Country ownership</td>
<td>Pooling of expertise</td>
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</tbody>
</table>

- Fluid and creative communication to build mutual interests
- Respect for the independence and integrity of individual members

The Network operates under the leadership of WHO, banking on its infrastructure support, governance and strong country presence.

As the Network aims to serve as a one-stop shop of established organizations committed to collaboration, it also capitalizes on building synergies. The added value of using a Regional approach for country technical needs is the promotion of South–South partnerships, building communities of common practice in the provision of technical support and utilizing Regional sites to build national capacities. Moreover, funds are maximized by reducing administration costs; having a repository of resources; ensured continuity of support; and avoiding duplication of support leading to cost-efficiencies. All these will result in a well-rounded provision of technical assistance, rather than provision of assistance that is geared towards achieving a large profit.
For more information visit the following links:

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2.1.12 Documentation from the pipeline

Updates were presented on the status of activities related to HIV drug resistance in the Region, as well as ongoing development of HIV and other STI Regional reporting.

**HIV drug resistance**

With the rapid expansion of ART coverage, coupled with the recommendation of a public health approach to initiating ART, the issue of HIV drug resistance (HIV-DR) is inevitable. Countries need to prepare for the impact of HIV-DR. WHO has developed a strategy for the prevention and assessment of HIV-DR.
This diagram illustrates the core elements of WHO HIV-DR Assessment Strategy:

As of June 2010, four countries are implementing the WHO HIV-DR Strategy. Ongoing discussions are taking place in one country which is planning to implement the HIV-DR Strategy.

Transmitted HIV-DR is low in the Region. Currently, methodologies for assessing transmitted HIV-DR are standardized, although HIV-DR monitoring surveys vary and can be difficult to interpret. HIV-DR genotyping results can be more meaningful when linked with patient and site factors. Those who adopt the WHO-recommended strategy are better informed.

Current ART regimens are still effective and can be used.

Transmitted HIV-DR, as assessed in recently infected populations, remains very low in the Region, and can be measured less frequently.

Regional reporting for HIV and other STI

It has been more than 10 years (1999) since a report on the status and trends of STI, HIV and AIDS was last published. The epidemic has since evolved significantly, and diverse and more comprehensive responses have been implemented. Global reports are usually not focused on regional and country-specific situations, even if data are increasingly becoming available.
WHO WPRO is planning to provide countries with the updated report on the status and trends of HIV and other STI. The working title of the report is “HIV and STI epidemic and health sector response in the first decade of the twenty-first century – Western Pacific Region 2010”.

The main objectives are:

- to review and analyse the status of the HIV and STI epidemics, and the trends and projections since 1999;
- to assess the progress in implementing key health sector interventions for HIV prevention, treatment and care; and
- to identify gaps and future directions for countries to achieve the MDG related to HIV.

The proposed outline covers the following:

- Global overview
- Understanding the HIV epidemic in WPR
  - Magnitude and trends of the HIV epidemic in WPR
  - HIV in populations with high-risk behaviours
  - HIV in women, children and youth
  - HIV and TB, other OIs
  - STI status in the Region
- Health sector response
- Country summaries on HIV and responses
- Key achievements and issues

The target date to develop and agree upon the conceptual framework and outline is between April and June 2010. Data collection and assessment should start by June 2010 and the draft report ready by January 2011. The review by panel members is scheduled for September, and revision finalized by November 2010, in time for its launch on 1 December 2010.

2.2 Country experiences
Provision of ART services

2.2.1 Papua New Guinea: challenges and lessons learned from scaling up ART services

Several policies support the HIV programme in Papua New Guinea. The care and treatment framework has been developed according to the continuum of care to prevention, care, treatment and support (CoPCT) approach. Services are delivered through an integrated model and the linkages between the different components of the programme (STI, HIV testing and counselling, ART, OI and TB) have been strengthened. There is also a strong orientation to HSS.

In 2009, new infections in adults are estimated at nine per day. There are an estimated 34,000 adults and children living with HIV and the current HIV prevalence in the age group of 15–49 years is 0.9% (0.88–1.1%). As of December 2009, 6,751 people were on ART. ART coverage in the country has increased as seen in the graph below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Treatment Coverage (%) CD4&lt;200</th>
</tr>
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<tbody>
<tr>
<td>2003</td>
<td>20%</td>
</tr>
<tr>
<td>2004</td>
<td>30%</td>
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<tr>
<td>2005</td>
<td>40%</td>
</tr>
<tr>
<td>2006</td>
<td>50%</td>
</tr>
<tr>
<td>2007</td>
<td>60%</td>
</tr>
<tr>
<td>2008</td>
<td>70%</td>
</tr>
<tr>
<td>2009</td>
<td>80%</td>
</tr>
</tbody>
</table>

The following ART regimens are being used in Papua New Guinea as of December 2009.

<table>
<thead>
<tr>
<th>ART Regimen</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4T/3TC/NVP</td>
<td>49%</td>
</tr>
<tr>
<td>AZT/3TC/NVP</td>
<td>32%</td>
</tr>
<tr>
<td>D4T/3TC/EFV</td>
<td>13%</td>
</tr>
<tr>
<td>AZT/3TC/EFV</td>
<td>6%</td>
</tr>
<tr>
<td>N-3112</td>
<td>0%</td>
</tr>
<tr>
<td>N-1999</td>
<td>5%</td>
</tr>
<tr>
<td>N-792 N-406</td>
<td>10%</td>
</tr>
<tr>
<td>N-826</td>
<td>25%</td>
</tr>
</tbody>
</table>

There has been a dramatic increase in the number of people undergoing HIV testing, from 1,407 in 2004 to 119,885 in 2008. There has also been an increase in the number of pregnant women tested for HIV.
The lessons learnt in scaling up ART services in Papua New Guinea are as follows:

- ART saves people’s lives and improves their quality of life.
- There has been a reduction in stigma and discrimination due to expanded ART services.
- The Global Fund has been critical in scaling up ART in the country.
- Community support by NGOs, faith-based organizations (FBOs) and PLHIV is important for treatment support and adherence.
- A vertical approach is necessary to initially scale up services (human resources, procurement and supply management, M&E).
- The sustainability of health financing is a critical issue:
  - Scaling up of the ART programme is resource- and labour intensive.
  - Major donors are unwilling to fund treatment commodities (ART, test kits and other reagents).
  - The government is slow in financing the treatment programme.

**Challenges in scaling up ART**

- Health systems: inadequate human resources and infrastructure, lack of procurement and supply management, poor M&E and supervision.
- Infrastructure: laboratory, including diagnostic and monitoring difficulties
  - non-availability of CD4 count measurement
  - no VL testing
  - limited capacity for HIV-DR monitoring
  - limited facilities for HIV infant diagnosis by DBS
  - limited HIV testing in TB patients
  - low HBV testing
  - limited quality assurance and quality improvement for HIV testing

**2.2.2 Hong Kong: scaling up ART services**

ART services are provided in an integrated treatment centre. The centre was commissioned in 1999 by the special prevention programme for ART services. The HIV clinic provides ambulatory treatment and care, day ward services, integrated outpatient medical services including dermatology and psychiatric services, holistic care including social work and nursing counselling services, and a therapeutic prevention clinic. Currently, there are around 76 AIDS cases, 397 HIV cases and a cumulative number of 4544 cases since 2009.

A drug adherence programme is also in place since 1997 and was revised in 2002. The aim is to enhance adherence to ART among HIV-infected patients for maximizing treatment effect, improving patients’ health and decreasing their infectivity.
Clinical governance has the following building blocks:

- Integrated care
  - vertical integration – clinical protocols and algorithms, doctors and nurses
  - lateral integration – involvement of subspecialists, medical–social welfare officers, psychologists
- Information management – performance indicators
  - Clinical information system, periodic chart review
- Infection control – infection control committee.

There is a growing pool of patients under treatment and care. Scaling up services will stretch human capacity, which may compromise the quality of patient services and increase expenditure. There is a need to maintain the standard, continue to improve patients’ health, maintain low transmission of drug-resistant strains and decrease the transmission of HIV.

2.2.3 China: initiating second-line ART

By the end of 2009, there were an estimated 740,000 PLHIV in China. There has been a rapid scale up of the number of patients receiving ART in China, as shown in the graph below.

![Graph showing the increase in ART patients in China from 2003 to 2009.](image)

The Central Government provides free ART, free CD4 count testing four times a year and VL testing once a year. In addition, patients are also provided with transportation costs. The local government is responsible for other costs including management of OIs, training, outreach services and addressing barriers to access to ART services.

VL outcomes (≤ 400 copies/ml) of patients on ART in China after 6–11 months on treatment was 17.9%, at 12–23 months it was 27.2% and at >24 months it was 33.2%.

In September 2007, China conducted a second-line ART pilot cohort study and, in March 2009, the National Second-line ART Programme was initiated with funding from the national programme and Global Fund. Currently, 3,300 PLHIV are on second-line ART, with 65% on TDF+3TC+ LPV/r.
Current challenges to the provision of second-line ART services are:

- poor medical care systems and limited resources in rural areas;
- poor adherence and insufficient community support;
- more advanced and feasible regimens, and the need to revise guidelines;
- ARV drug management and the need to provide adequate clinical training and health-care system support; and
- establishment of a comprehensive care network.

2.2.4 Viet Nam: ART expansion and continuum of care in a PWID-driven epidemic

In Viet Nam, there are about 87 million PLHIV, with an adult HIV prevalence of 0.43%. By the end of 2009, the reported number of HIV cases was more than 160,000. Approximately 50.6% of HIV-positive persons are people who inject drugs (PWID). According to the results of a sentinel surveillance in 2009, the prevalence of HIV among PWID is 18.4%, in sex workers it is 3.6% and in pregnant women 0.25%. However, in some provinces, nearly 50% of those with HIV are PWID. The majority of PLHIV in Viet Nam are PWID.

Viet Nam started ART in 2000 and scaled up in 2005. There are 300 ART sites with nearly 40,000 receiving ART. The coverage is around 53.7%.

There are several policies in support of harm reduction activities in Viet Nam. These include the following: Law on HIV/AIDS Prevention and Control (2006); Government Decree on HIV/AIDS Prevention and Control Law (2007); Guidance for implementing methadone maintenance therapy (MMT) (2010). Needle-syringe programmes (NSP), condom promotion and peer outreach are currently being implemented.

MMT is currently being piloted in three provinces with a large proportion of PWID. The goals of the MMT programme are:

- to reduce HIV infection and related diseases among opioid-dependent drug users;
- to prevent transmission to the general population; and
- to improve the health and quality of life of drug users, and reintegrate them within the community.

It is planned that by the end of 2015, 70% (105,000) of HIV-infected adults and 95% of infected children who meet the criteria for initiation of ART will have access to ART services; 85% of PLHIV on ART will be retained after 12 months of initiating ART, and 65% of districts with a high and medium burden of HIV will have HIV/AIDS care and ART services.

In order to achieve these targets, there is a need to ensure equitable access, early and accessible HIV testing and counselling services, and best ART outcomes in the long term. There will be a need to meet the multiple health and psychosocial needs (TB, SRH, drug dependence, etc.) and prevent HIV transmission.

To sustain the provision of ART services, human resources need to be maximized, treatment failure prevented, synergy increased with the HIV prevention programme, existing health systems integrated and health insurance strengthened to include HIV care and treatment in the insurance package.
The 2008 cohort of patients on ART (4069 adults and 315 children) revealed a high retention rate of 82% among children and 84% among adults after 12 months. The CD4 threshold at ART initiation revealed that 50.3% had a CD4 count <100 cells/mm³, 35.1% had a CD4 count of 100–200 cells/mm³, around 11% had CD4 counts of 200–350 cells/mm³, and only 2.6% were initiated on treatment with a CD4 count of >350 cells/mm³. Ensuring early ART initiation to increase the survival of patients on ART is a big challenge.

The CoPC model in Viet Nam has shown good linkages between PWID and HIV services. The CoPC model is given below.

The district-level health facility is the focus of the CoPC model, which provides comprehensive services including outpatient services; HIV testing and counselling; services for PMTCT, STI, TB and MMT; and a PLHIV club. The provincial level manages complicated cases and provides second-line therapy and paediatric care. The commune level provides home-based care, adherence support, and psychosocial and occupational support. The commune level consists of a commune health-care worker, family members and PLHIV peers. In addition, outreach services for PWID and sex workers are provided such as NSP and condom promotion. There is a strong link with the district level. The Provincial AIDS Center (PAC) coordinates, supervises and manages the CoCP model.

The CoCP model in provinces varies, depending on the HIV prevalence and provision of ART. There are three categories based on the HIV burden. In high-burden provinces, the majority of districts provide the comprehensive package of services and the provincial level manages complicated cases and second-line ART. In middle-burden provinces, half of the districts provide ART, voluntary counselling and testing (VCT) and PMTCT services. In low-burden provinces, only around two districts provide ART, VCT and PMTCT, and the provincial hospital provides ART services to the majority of patients in need.
Prevention of mother-to-child transmission

2.2.5 Malaysia: towards elimination of paediatric HIV and syphilis

Malaysia’s efforts at eliminating paediatric HIV and syphilis are clearly articulated in their policies such as the National Prevention and Disease Control Act, 1988; the screening policy; the treatment policy; the Guidelines and National Strategic Plan 2006–2010. The current National Strategic Plan focuses on the following areas: strengthening leadership and advocacy; training and capacity enhancement; reducing HIV vulnerability among PWID and their partners; reducing HIV vulnerability among women, young people and children; reducing HIV vulnerability among marginalized and vulnerable groups; and improving access to prevention, treatment, care and support.

In order to address the transmission of paediatric HIV and syphilis, Malaysia aims to provide services in 130 government hospitals under the MOH, six hospitals outside the MOH system, 209 private hospitals, 803 government health centres, six government special institutions, 102 government MCH clinics, 1954 government/community clinics and 6271 private clinics.

The components of the services provided are best described as follows:

<table>
<thead>
<tr>
<th>Healthy individuals</th>
<th>Risk factor &amp; Early Disease</th>
<th>Established Disease</th>
<th>Complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Promotion</td>
<td>Screening</td>
<td>Early Detection &amp; appropriate treatment</td>
<td>Disability limitation</td>
</tr>
<tr>
<td>Specific protection</td>
<td></td>
<td></td>
<td>Rehabilitation</td>
</tr>
</tbody>
</table>

Primary Prevention

- Surveillance
- Media campaign
- PROSTAR
- Counselling
- Healthy lifestyle
- HIV Screening
- Health Education
- School program

Secondary Prevention

- Surveillance
- HIV Screening
- Counselling
- Harm Reduction
- PMTCT
- Behaviour change
- STI
- TB

Tertiary Prevention

- Surveillance
- HIV Screening
- Counselling
- ART
- Treatment of OIs
- Support
- Care

The PMTCT Programme in Malaysia started by training relevant service providers. After the training, the programme was piloted in 1997 and, at that time, the main concern was how to operationalize the programme. After addressing all operational issues, the PMTCT programme was implemented nationwide in 1998. Given the recent developments/strategic recommendations on PPTCT, Malaysia updated their guidelines in 2009. These updates were specifically on the use of rapid test kits for HIV screening; use of confirmatory tests; use of highly active ART (HAART), polymerase chain reaction (PCR) test for babies, contact tracing of partner/spouse and recommendations on infant-feeding options.

In 2009, the coverage of antenatal screening for HIV was 98.1%; the prevalence of syphilis was stable from 2007 to 2009 at 0.08%. The number of reported STI cases has also been declining since 1999.

Following the success of implementing their National Strategic Plan 2006–2010, Malaysia is now set to develop the new strategic plan covering 2011–2015.
HIV/TB collaborative activities

2.2.6 Cambodia: experience on the linked response to HIV and TB

Cambodia is one of the 22 high-burden countries for TB in the world, with 64% of the total population infected with TB. The incidence of all forms of TB is 495/100,000; incidence of TB sputum smear positive is 219/100,000; prevalence of all forms of TB is 664/100,000 and mortality due to TB is 89/100,000. Cambodia has been responding to the dual epidemics of HIV and TB since 1999 when the TB/HIV Sub-Committee was set up. This was followed by the setting up of the first TB/HIV Clinic (CENAT/JICA) in the capital city in 2001; and endorsement of the TB/HIV Framework by the MOH in 2002. Since then, HIV/TB collaborative work has evolved tremendously. Commitment was sealed with a joint statement between the TB and HIV Programme in 2005, defining clearly the roles and responsibilities of each programme. Currently, standardized TB/HIV monitoring tools are available as well as a TB/HIV training curriculum and clinical manual, revised TB/HIV Framework, and the TB/HIV monitoring and reporting system.

HIV testing among TB patients increased from 32.4% in 2007 to 46.8% in 2008. Other significant data are given below:

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV testing among TB patients</td>
<td>11,820 (32.4%)</td>
<td>18,645 (46.8%)</td>
</tr>
<tr>
<td>HIV positive</td>
<td>497 (4.2%)</td>
<td>431 (2.3%)</td>
</tr>
<tr>
<td>TB/HIV on CPT</td>
<td>1,101</td>
<td>1,279</td>
</tr>
<tr>
<td>TB/HIV on ART</td>
<td>610</td>
<td>733</td>
</tr>
<tr>
<td>HIV-positive clients screened for TB (ICF)</td>
<td>5,318 (46%)</td>
<td>5,980 (63%)</td>
</tr>
</tbody>
</table>

Because of this progress, the HIV prevalence among the adult population aged between 15 and 49 years declined from 1995 to 2006. The HIV incidence among ANC attendees from 2000 to 2006 also declined. HIV seroprevalence among TB cases declined from 11.8% in 2003 to 7.8% in 2007.

Success did not come easily. Cambodia’s experience in linking HIV/STI/RH/MNCH/TB services at district level faced many challenges – from having no common vision; a vision that was not shared; unclear direction; no joint workplan and no standard M&E tools. This was aggravated by a lack of political will to integrate these services. In 2007, all the key players from the different programmes in the MOH, civil society, community and other development partners decided to work together. This renewed the initiative on the linked response with an aim to achieve UA targets.

While the renewed partnership progressed in linking all the relevant programmes to impact HIV prevention, challenges still remain and these are as follows:

- Increasing workload of existing health staff at the National Center for HIV/AIDS, Dermatology and STD (NCHADS), CENAT and provincial health department (PHD) / operational district conflicts of interest and benefit (competition for resources)
• Limited capacity for programme and finance management, including reporting at the peripheral level
• Limited capacity to own TB/HIV collaborative activities at operational district level
• Limited understanding of the issues at all levels
• Unclear about vertical and integrated programming
• Limited capacity for strategic thinking about new approaches or models and acceptance of change
• Harmonization among partners – needs strengthening

Targeted interventions for most-at-risk populations

2.2.7 Lao People’s Democratic Republic: targeted intervention for men who have sex with men

In Asian countries, the HIV epidemic is driven by sex workers/clients and MSM. This is the scenario faced by Lao PDR. Action was taken to include interventions for MSM in the National Strategic Plan 2006–2010.

In 2006, the target was to reach 2300 MSM with a comprehensive package of activities. The MOH worked with NGOs, with funding support from the Global Fund Round 6, to implement peer-led behaviour change through peer education, condom distribution, referral to VCT services and management of STI.

Initial information in 2004 about the sexual behaviour of young males indicated that 18% of men (18–30 years) reported ever having had sex with a man. As the country aimed to better understand the MSM scenario, a cross-sectional survey (time–location) was performed in 2007 in the capital Vientiane where 540 men were surveyed in beer shops, restaurants, discos, night clubs, bars, saunas and massage parlours. The results showed that the HIV prevalence (5.6%) among these MSM was higher than among service women in Vientiane (1.1%). This is similar to the HIV prevalence among MSM in Beijing and Ho Chi Minh City. It is lower than in Bangkok, Chiang Mai, Phuket and Phnom Penh, but higher than in Tokyo and Hong Kong. By contrast, a surveillance study by the Centre for HIV/AIDS/STI (CHAS) in 2004 of 749 truck drivers, military personnel and electricity workers in Vientiane found a prevalence of zero.

Using the results of this survey, Lao PDR started to redesign its interventions for MSM. It recognized that estimation of the size of the MSM population needed to be increased to 15 000 nationwide (five times more). Activities were expanded dramatically in 15 of the 17 provinces of Lao PDR through the work done by NGOs. A comprehensive MSM model was developed basically focusing on behavioural and biomedical aspects. The behavioural package included: condom/lubricant promotion; basic HIV and STI knowledge; risk reduction information; basic counselling; VCT promotion; STI screening promotion; prevention of HIV transmission by HIV-positive persons including referral to HIV care and HIV/STI services delivered through peer outreach. The biomedical interventions include STI screening; STI case management; VCT for HIV; basic risk reduction counselling, and prevention of HIV transmission by HIV-positive persons including referral to HIV care, delivered through friendly MSM drop-in centres and at existing service centres.

2.2.8 Mongolia: targeted interventions for sex workers

Mongolia’s HIV prevalence is 0.02% in the adult population, with 73 PLHIV reported to date. Seventy-six per cent of PLHIV are males, of whom 86.8% are MSM, and 235 are females,
of whom 46.7% are female sex workers. While HIV prevalence is reported to be low, high STI rates have been recorded (chlamydial infection and trichomoniasis).

Sex work in Mongolia is illegal, but is very common in the capital city and urban communities. Most are freelancers and are not affiliated with any entertainment establishment. Bars, karaoke and nightclubs are potential places for picking up clients, and sexual activities usually take place in nearby hotels. However, in the past, sex work in saunas and massage parlours was popular. Most of these establishments now serve as brothels with their own sex workers. Street-based sex workers can be found near the railway stations and market places, with clients who are mainly traders, truck drivers, gold miners and businessmen travelling to Russia, China and within Mongolia.

Targeted interventions that are being implemented include: 100% CUP; counselling and testing (both provider-initiated and client-initiated); provision of STI services; outreach and peer education; drop-in centres in selected districts and provinces; and advocacy activities.

To implement these interventions, the MOH needed to work with many partners. Thus, defining the coordination mechanism at different levels proved to be critical. High political commitment at the national and local levels was solicited; technical working groups to coordinate activities targeting sex workers (governmental, nongovernmental, international organizations) were created; a tripartite agreement was formulated (e.g. entertainment establishment, NGO, health department) specifically for the 100% CUP, and organization of regular national seminars on the 100% CUP, and an experience-sharing meeting every two years were agreed upon.

As a result of prevention interventions, the 2009 second generation surveillance (SGS) showed an increase in coverage from 30% in 2005 to 47% in 2009. Persistent condom use increased from 11% in 2005 to 34% in 2009.

Despite the progress made, the following challenges remain:

- Unfriendly legal environment
- Accurate estimation of the size of the female sex worker population
- Limited capacity of NGOs working with female sex workers
- Limited access to STI services
- Stigma and discrimination
- Inadequate monitoring and evaluation

2.2.9 Philippines: targeted interventions for people who inject drugs

Philippines regularly tracks the HIV epidemic in two ways, through passive and active surveillance systems. The National AIDS Registry, a passive form of surveillance, has recorded a steep rise in the number of reported HIV cases, from two per day in 2009 to four per day in 2010, with a cumulative total of 4971 cases from January 1984 to April 2010, of whom 100 are PWID.

The 2009 Integrated HIV Behavioural and Serological Surveillance (IHBSS), an active form of surveillance, showed a tenfold increase in the number of HIV-positive cases as compared to the 2007 IHBSS. The IHBSS was conducted among PWID at three sites; the results from one of these sites showed that one out of three PWID are HIV-positive, while in the rest of the country, the prevalence of HIV is 1 in 5000. Behavioural data showed that 44.6% of PWID have knowledge of HIV prevention, as they correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission; 11.5% were
reached with prevention services; 33% did not share needles during the last injection; 10.8% used condoms during last sex (PWID as clients of sex workers); and 22% used a condom during last sex (PWID as sex workers); only 1.46% of PWID received HIV testing and knew the results.

As the Philippines moved to strengthen the available strategic information on PWID, it complemented the surveillance system with special studies/surveys/research. Rapid Assessment of Vulnerability (RAV) is being done by the Department of Health with support from WHO and the Global Fund Round 6. It aims to document PWID in sites other than the three currently documented sites. Assessment of peer education for PWID is ongoing to determine the appropriateness of and responsiveness to the current peer education practices in the three PWID-identified sites, as well as a study on the knowledge, attitudes and practices (KAP) of PWID in closed settings such as the prisons and rehabilitation centres. Both studies are supported by the Australian Agency for International Development (AusAID) through UNDP, and coordinated by the Philippine National AIDS Council (PNAC).

To better understand certain drivers of the HIV epidemic, the Department of Health, with technical and financial support from WHO, is conducting an international rapid assessment and response evaluation (IRARE) in one of the sites reported to have the highest prevalence of HIV among PWID, despite being an intervention site for many years.

While waiting for the results of all these ongoing studies, Philippines is implementing a package of interventions for PWID that consists of community outreach and education; needle-and-syringe distribution; condom distribution; HIV counselling and testing; STI services; referral to treatment hubs; provision of ART and drugs for OIs; and treatment/referral for other illnesses.

There are several challenges in scaling up HIV prevention, treatment, care and support services for PWID. It has been recognized that strong government commitment is the key to sustainability and scaling-up of programmes. Good partnerships are considered crucial as well. But leaders might compromise responses when it takes one strong stand over an issue beset with conflicting mandates. These are the Republic Act 8504 (AIDS Law) versus the Republic Act 9165 (Drugs Prevention and Control Law). Because of these conflicting mandates, community outreach workers and peer educators need to risk their lives while doing outreach work. There are safety and security issues and, added to that, the usual stigma and discrimination attached to socially unacceptable behaviours, often labelled as immoral or inappropriate. All these will have an impact on the sustainability of funding. This is particularly the case for the NSP as a part of the comprehensive HIV programme for PWID.

The Philippines is serious in addressing the current HIV situation among PWID, which is fuelling the HIV epidemic. The country will continue to pursue high-level advocacy and bring to every relevant discussion table the need to urgently halt the spread of HIV by supporting evidence-based interventions. The Philippines emphasized that ongoing studies will be followed through to ensure successful completion, and that results will be used to design tailor-made interventions. Packaging the results and targeting the right audience to disseminate the results are crucial for mobilizing resources to sustain initiatives.

2.3 Perspectives of PLHIV

*Universal access as seen by PLHIV*

In 2008, the APN+ conducted a network-based research project aimed to explore the experiences of women, MSM/TG and PWID living with HIV in accessing ART and other HIV-related health-care services.
The key findings of the study are given below:

- One in three women reported not knowing if HIV can be treated.
- More than one third of the women (37%) and 13.1% of the MSM/TG respondents reported being tested for HIV without informed consent.
- MSM/TG respondents also reported disclosure of their HIV status (12.4%) and sexuality (14.5%) to others by their health-care providers without their consent.
- Fear of discrimination by health-care providers for being “girlish” also deterred some MSM/TG from accessing the health-care system.

Through income-related questions, the study was able to also elicit that most women (79%) do not have adequate financial resources to access and sustain their HIV-related service needs. Further, two thirds (66.6%) of the PWID respondents reported knowing that HIV-positive PWID are more likely to be coinfected with HCV; however, less than half had been tested for HCV (41.9%). Nearly 60% of those who had been tested and received their HCV test results were HIV/HCV coinfected. The high costs of treatment (54.3%) and lack of knowledge about HIV/HCV coinfection (40.2%) were cited as the two key barriers to seeking treatment for HCV by PWID.

The study recommended the following:

- Provide **treatment education** (including ART, OI and HCV) and human/legal rights education to all PLHIV.
- Address **stigma and discrimination** faced by PLHIV by implementing anti-discriminatory policies in health-care settings and workplaces, and through training of health-care providers.
- Address individual barriers to ART initiation such as **fear of side-effects and fatalism**.
- Develop mechanisms to **provide free or affordable diagnostic tests** (CD4, VL, HBV/HCV tests, liver and kidney function tests, etc.) and all necessary OI medications in government centres.
- Improve the ARV supply management system to eliminate drug stock-outs.

The full research report can be found at the APN+ website at www.apnplus.org.

2.4 **Group work**

Two different workshops were conducted during the three-day meeting. **Group work** was organized to discuss countries’ views and plans on how to operationalize the adaptation of the new WHO guidelines on ART and TB/HIV.

Participants, including WHO technical staff, were divided into three groups (Annex 3). Each group elected a facilitator and a presenter, and was given ten minutes to share the group’s outputs in the plenary session.

2.4.1 Programmatic implications of the new ART guidelines

*Session objectives: Based on the current ART guidelines*
• Discuss technical questions related to and programmatic implications of priority areas of the new ART guidelines;
• identify challenges to adaptation and implementation, and identify solutions and strategies to overcome these challenges; and
• identify priority areas and immediate activities for country adaptation and implementation.

During the group discussions, countries gave a snapshot of their current ART coverage and shared the status of implementation of the new guidelines. Facilitators assisted countries in reflecting on how these guidelines can be adapted and the perceived concerns in fully implementing the guidelines.

**Group 1**

**ART coverage**

**Issues/implications**

- People reach clinics at advanced stages of disease (low CD4 count).
- Stigma and discrimination are the major reasons for presenting late, especially by MARPs (double stigma).

**Possible solutions/next steps**

- Address stigma and discrimination.
- Expand and strengthen HIV testing and counselling for an earlier diagnosis.

**Treatment access for people most in need**

**Issues/implications**

- Several countries indicated that pregnant women were a priority group.
- Children and TB patients were also proposed as priority groups (Viet Nam).
- For immigrants, especially children, the cost of primary care is a barrier to access (New Zealand).
- Ensure equity of access for everyone.

**Possible solutions/next steps**

- Provide information to the public on the benefits of HIV testing (especially for pregnant women).

**d4T phase out**

**Issues/implications**

- High-income countries report little use of d4T (New Zealand, Japan), while d4T is widely used in other countries (50–80% in Lao PDR, Viet Nam, Papua New Guinea, Cambodia).
• Cost is one of the major challenges for d4T phase-out and expanding the use of AZT or TDF.
• The availability of fixed-dose combinations (FDC) is important for adherence.
• Anaemia and a possible need for blood transfusion are issues that may arise with expanded use of AZT.

Possible solutions/next steps

• Some countries have a clear plan and timeline for d4T phase-out (Lao PDR, Papua New Guinea), while other countries plan to gradually decrease d4T use (Viet Nam, Philippines).
• As the demand for TDF increases, manufacturers will reduce the price.

Single-dose NVP phase out

Issues/implications

• The percentage of pregnant women tested for HIV is still low and most pregnant women present during labour.
• Responsibility for providing ARVs should be shifted to ART sites.
• ANC attendance is poor (Lao PDR).

Possible solutions/next steps

• Strengthen linked responses and coordination between the HIV and MCH programmes.
• Deliver information on the benefits of antenatal HIV testing to the population to facilitate higher uptake. While uptake was slow in the past, more pregnant women are now accepting HIV testing (New Zealand experience).
• Develop guidance for private doctors.

Earlier initiation of ART

Issues/implications

• Raising the CD4 threshold has resulted in more people needing ART (denominator increase), which is a challenge for some countries, while it is less of an issue for others.
• Cost is a major issue, especially when external funding becomes unavailable.

Possible solutions/next steps

• Some countries have already decided to raise or have raised the CD4 threshold (Cambodia, Lao PDR, China, Papua New Guinea, Japan), while others plan to raise the threshold in the future (Viet Nam, Philippines, around 2012).
• Facilitate commitment of government leaders for expanded and sustainable funding.
• Increase access to CD4 count measurement.
Laboratory monitoring

Issues/implications

- Introduction of VL monitoring is a challenge as the cost of the machine and of tests are high.

Possible solutions/next steps

- The machine can be leased rather than purchased to save money.

Group 2

ART coverage

Issues/implications

- Raising the CD4 threshold has resulted in an increase in the number of people on ART, thus increasing costs.
- UA targets will not be reached.

Possible solutions/next steps

- High-level advocacy is needed for funding. A fully-costed target-oriented national strategy is needed, including ARV costs.
- WHO and governments should revise the expected ART coverage targets.
- Countries should look for additional funding from the Global Fund and other sources.

Treatment access for people most in need

Issues/implications

- Routine and compulsory HIV testing is a violation of human rights. The quality of MCH services and counselling for pregnant women is poor. HIV testing is also a low priority in some countries.
- Nationwide HIV screening for TB patients not a policy in some countries.

Possible solutions/next steps

- For PWID, access to MMT should be increased and integrated/linked with HIV services.
- For pregnant women: increase access to early HIV testing, reduce time to receive the results, pre-registration at ART centres, improve the quality/staffing of PMTCT services, particularly for counselling, use lay counsellors, task-shifting; integrate the management of HIV-infected pregnant women with ART services.
- TB patients: strengthen linkages between HIV and TB services.

Timeline: 12 months
• Provide information to the public on the benefits of HIV testing (especially for pregnant women).

d4T phase out

Issues/implications

• Phasing out d4t is expensive.
• There is a need for a national policy.
• Laboratory capacity for TDF monitoring needs to be strengthened.

Possible solutions/next steps

• Technical committees need to cost for various scenarios and design a phase-out plan.
• The national guidelines should be revised.
• Training should be conducted for service providers.

Time frame

• 2–3 years

Single-dose NVP phase out

Issues/implications

• There will be cost implications when the number of HIV-infected pregnant women is high.
• PMTCT responsibilities can be shifted to ART staff in some countries (low prevalence) and to MCH services in other countries (high prevalence).
• There is lack of motivation for MCH in result based implementation.

Possible solutions/next steps

• Support capacity strengthening of MCH services.
• Change the mindset of those responsible for the MCH programme at the central level (should be results and outcome oriented).
• There should be joint planning and cost sharing between the HIV and MCH programmes.

Timeline

• 6–24 months or longer, according to country

Earlier ART initiation

Issues/implications

• Access to countrywide quality CD4/VL measurement should be available.

Possible solutions/next steps
• Increase the use of low-cost quality technology.
• Improve accessibility: mobile CD4 count machine?
• Countries should conduct QC validation and learn from different countries about the most feasible lease arrangements.

Timeline
• 6–12 months

Group 3

ART coverage

Issues/implications
• Access to ANC services is poor.
• Multiple combinations of ARVs are used.
• Change in CD4 threshold will affect ART targets.
• There will be a change in denominator determination.
• Coverage of HIV testing and counselling services is low.
• Most people with HIV present late.

Possible solutions/next steps
• Strengthen and increase coverage of HIV testing and counselling services.
• Conduct capacity building.
• Set targets for ART coverage.

Treatment access for people most in need

Issues/implications
• Access to services by marginalized populations is limited; geographical barriers also limit access.
• Links between ART and MCH services are poor.
• PLHIV face stigma and discrimination.
• High cost of opportunity lost from income and other out of the pocket expenses including transportation cost. Gender-disaggregated data are not available. Most PLHIV present late for treatment.

Possible solutions/next steps
• Improve notification systems.
• Data should be reported by gender.
• Strengthen linkages between services.
• Strengthen HIV testing and counselling services.
• Prioritize CD4 count measurement in specific populations such as pregnant women, those with TB/HIV.

**d4T phase out**

*Issues/implications*

• Some available FDCs are d4T-based. There are political issues surrounding national investments in FDCs.
• The use of alternative drugs has cost implications.

*Possible solutions/next steps*

• Develop a phase-out plan.
• Advocacy is needed from UN agencies to facilitate phase-out.

**Single-dose NVP phase out**

*Issues/implications*

• Pregnant women present late in labour.
• NVP will always have a role.

*Possible solutions/next steps*

• Adaptation of both options A and B to the national guidelines may be applicable to certain countries, depending on the settings.
• Impart the guidelines to relevant services.
• Strengthen MCH services.

**Earlier initiation of ART**

*Issues/implications*

• CD4 count monitoring has to be done regularly for those who are HIV-positive.
• Regular follow up is necessary.
• Implementing the necessary changes is an issue.
• Implementation of the guidelines needs to be prioritized.
• Adherence to ART should be ensured – no symptoms, side-effects of drugs.

*Possible solutions/next steps*

• Ensure capacity building.
• Strengthen HIV testing and counselling services.
• Ensure better follow up through functional referral mechanisms.
Laboratory monitoring

Issues/implications

- Basic laboratory tests for toxicity monitoring (e.g. liver, renal function tests and Hb) should be available.
- The importance of CD4 count as a guide to treatment, especially in pregnant women, must be understood.
- CD4 testing should be available in ANC services.

Possible solutions/next steps

- Provide facilities for basic blood tests.
- Develop an effective referral system for additional tests.
- Invest in point-of-care test systems.
- Strengthen health systems.

Cross-cutting issues

Issues/implications

- Teething problems are predicted if more patients are put on ART.
- Implementation of the guidelines must be prioritized.
- The changes made should be sustainable.

Possible solutions/next steps

- Prioritize groups: those in need of PMTCT.
- Increase efficiencies within health systems.
- Strengthen health systems.
- Conduct greater advocacy to secure more funds.
- Ensure political will by targeting policy-makers and stakeholders.
- Develop regional strategies and provide support.

2.4.2 Accelerating TB/HIV activities

Session objectives:

- Identify activities to accelerate TB screening and provision of IPT.
- Discuss the current status of TB/HIV activities.
- Discuss the feasibility of and issues in implementing the TB screening and IPT guidelines.
- Identify the steps to be undertaken to address issues, including the immediate next steps to accelerate implementation of TB screening and IPT.
Group work on TB-HIV Collaborative Activities

Group 1 comprised Cambodia, Malaysia, Papua New Guinea and Viet Nam.

Summary of discussion:

(1) Symptom-based TB screening among PLHIV

- The majority of countries were unable to determine the current status of coverage; most do not have linkages with TB programmes.
- Cambodia has SOPs and is thus able to collect information on TB/HIV; it emphasized that it is important to link programmes to be able to cover 70% of the target population.
- Most countries are still working on developing indicators; defining numerators and denominators.

Proposed solutions

- Linkages between TB/HIV programmes can be built by developing standardized protocols.
- Joint agreements should define roles and responsibilities such as those for procurement of TB drugs, data management.

(2) IPT

Current coverage

- Most countries have just started implementing the IPT policy and limited data are available.
- In many countries, patients come in late with clinical presentations.

Activities/solutions

- Except for Cambodia, most countries have initiated discussions/technical meetings at headquarters/national level.
- Both programmes should be willing to share joint responsibilities; areas of concern should be defined.
- Convince important stakeholders such as respiratory physicians.
- Use social networks, e.g. networking of PLHIV and TB patients to provide insights to the problems faced by people/patients at the grass-roots level (to combine the network of PLHIV/TB into a single committee, have a common treatment committee).
- Have common data linkages/data management (standardization of monitoring tools, common treatment protocols, e.g. treatment of HIV/AIDS patients with TB) as recommended by the United Nation Agencies on treatment.
(3) **Tuberculin skin testing (TST)**

*Current coverage*

- The majority of countries are unable to determine coverage, as there is no linkage with TB programmes and no indicators.
- The recommendation to conduct TST has proven effective.
- Data on incarcerated populations with TB/HIV/AIDS are available in certain countries.

*Activities/solutions*

- Alternative tests should be used for some tests that are costly, e.g. PCR.
- Provide financial support.
- Select priority areas with high disease burden.
- Select populations with higher disease burden, e.g. prisoners with TB/HIV.

Group 2 comprised China, Laos, Mongolia and the Philippines.

(1) **Coverage**

- Limited data are available on the extent of coverage.

(2) **Symptom-based TB screening among PLHIV**

- Countries have screened for TB among PLHIV but could not confirm if this was symptom based or not.
- China has some pilot-based data from:
  - Global Fund Round 5 TB programme in four provinces
  - Questionnaire containing seven questions about TB-related symptoms among all PLHIV

(3) **IPT 6 months/36 months**

- Mongolia: policy implementation has not started yet
  - 6 months
- Philippines: has just finished the pilot
- China: no policy yet but will soon start a pilot
- Laos: no policy yet.

(4) **Tuberculin skin testing**

- Most countries have no policy.
- TST gives false-negative results among immunocompromised people.
TB in children

- TB screening and IPT
  - Diagnosis, treatment and management are difficult.
  - It is important to reduce mortality and morbidity.

**Proposed solutions**

- Policy needed
- Clear guidance from WHO
- Advocacy
- Capacity building
- Technical assistance support
- Strengthen collaboration between the national AIDS programme and the national TB programme
- Logistics support
- Implementation
  - Some countries need a pilot study

**Group 3** comprised Brunei, Hong Kong and New Zealand

- In these countries, the burden of TB is low.
- The focus of TB screening is on illegal migrant workers and in prison settings.

2.5 **Partners’ portfolio**

The meeting provided an opportunity for development partners to understand the situations faced by Member countries; share their portfolios and examine how they can bring synergies to the current pool of technical experts and available funding provided by other development partners to sustain current national initiatives.

2.5.1 **Overview and current direction of Global Fund grant**

The current grant architecture was designed at the Global Fund’s inception and has been added to over time. As the Global Fund portfolio matured, it increasingly funded the needs of applicants seeking to expand or extend existing programmes. In this context, the architecture is proving to be overly complex and not scalable. Thus, the objectives in undertaking a review of the grant architecture are to simplify the funding architecture, contribute to improved alignment and harmonization, and support and effectively manage growth.

*Single stream of funding per principal recipient (PR), per disease* is the new feature of the grant architecture, while maintaining the core Global Fund principles of dual-track financing; performance-based funding; progress updates and disbursement requests; and periodic performance reviews. The additional features include:

- single funding agreement per principal recipient, per disease component;
• fixed regular commitment cycles of up to three years;
• improved alignment of the Global Fund with country cycles; and
• alignment of all principal recipients in a disease area so that periodic disease programme reviews are possible.

Countries can make decisions based on three options: Option 1: opportunity with Round 10 to apply for funding through a consolidated disease proposal. All grants in a disease area that have at least 12 months of overlap with the proposed implementation period (for all principal recipients) can be consolidated; Option 2: transition to a single stream of funding during grant negotiation; and Option 3: no transition to a single stream of funding in Round 10.

The expected benefits of this funding architecture include the following:
• encourages more holistic, programme-based in-country resource planning;
• facilitates rethinking of the programme and implementation arrangements;
• enables country coordinating mechanisms to coordinate the development of proposals based on the larger programmatic picture, and to provide better oversight; and
• provides the Technical Review Panel with the broader programmatic picture and better alignment with national plans.

2.5.2 CDC-GAP Asia Regional Programme

PEPFAR has evolved from the time it started in 2004. Until 2008, it focused solely on “emergency response”; prevention, care and treatment numbers; and on surveillance, capacity building, and health systems strengthening. From 2009 to 2013, which covers the second phase of its operations, it is focused more on human capacity building, sustainability and country ownership; larger proportion of technical assistance over programme support; and importance of the Global Fund Support.

The key components of the technical assistance are:
• national leadership;
• involvement of host country government officials and policy-makers;
• integration with the national HIV/AIDS plan;
• setting priorities and filling gaps;
• technical exchange and cooperation;
• leveraging US government expertise and capacity;
• skills transfer and capacity building;
• developing, piloting and adapting new methods/models for replication;
• establishing or strengthening systems;
• ensuring quality assurance and improvement;
• providing oversight;
• providing technical assistance to the Global Fund for planning, implementation and M&E.
CDC-GAP is currently working with WHO, USAID and other partners to provide technical assistance to the governments of Lao PDR and Papua New Guinea. The technical areas include: HIV prevention for MARPs; HIV quality care and treatment; paediatric care and treatment networks; strengthening surveillance of laboratory systems; data analysis and surveillance; and PMTCT. Core support is provided to facilitate the development and scale-up of quality models, with the mentorship of technical experts working directly with the host government.

2.5.3 PEPFAR support in scaling up ART

PEPFAR’s support has transitioned from an emergency response to promotion of sustainable country programmes. It also assists in strengthening government capacity to lead the response to the HIV epidemic and other health demands. In addition, it expands prevention, care and treatment in concentrated and generalized epidemics; integrates and coordinates HIV programmes with broader global health and development programmes to maximize their impact on health systems; invests in innovation and operations research to evaluate impact; and improves service delivery and maximizes outcomes.

As PEPFAR moves to the second phase of its support, the key concepts revolve around the following:

- Support for true partnerships with governments, in order to assist them as they lead and guide the response to their epidemics.
- Expand emphasis on HIV prevention, and match interventions and investments with epidemiological trends and needs in order to improve impact.
- Commit to expanding access to high-quality prevention, care and treatment, and immediate health needs while laying the groundwork for future sustainability.
- Maximize the United States investments, by integrating with other United States government programmes in health and broader development sectors.
- Engage with multilateral and other external partners.
- Support accountability, M&E, and implementation of efficiencies and best practices.
- Support greater involvement of the United States Government country teams and a strong interagency model.

**PEPFAR scale up 2010–2015:**

- Setting targets and developing a detailed implementation plan including:
  - donor versus government commitment
  - cost reduction, improved efficiency and economies of scale
  - standardized quality and robust quality improvement mechanisms (e.g. HEALTHQUAL)
- Sustainable programmes
- Transition strategy for foreign donors and service providers
3. CONCLUSIONS AND NEXT STEPS

Programme Managers from twelve countries and key partners who attended the meeting acknowledged the usefulness of the meeting. A range of technical updates and country experiences were shared. Progress made by countries since the last meeting in 2008 was reported, including sharing and identification of challenges and proposed solutions.

The meeting agreed upon the following conclusions and recommendations:

(1) This was a useful forum for exchange of experiences and dialogue on technical and programmatic issues across programmes and with technical partners.

(2) There was constructive contribution by PLHIV and civil society.

(3) Significant progress has been made in generating strategic information from different countries in WPR.

(4) Despite persisting difficulties and challenges, there were encouraging experiences in collaboration among public health programmes such as between the TB and MCH programmes.

(5) WHO’s approach to developing evidence-based technical recommendations was better appreciated and understood.

(6) There were no major concerns vis-à-vis the new set of recommendations; they were generally well received and have already been addressed/implemented in some countries.

(7) There was commitment to convene technical working groups at the country level to unpack the recommendations and begin reviews, projections, estimates, planning, corrections/revalidation of current information.

(8) Development of SOPs is the key to overcome challenges in collaboration among programmes; good examples from Cambodia are available in implementing linkages at the district level.

(9) Promising progress has been made and “rethinking” has been done in the area of targeted interventions in countries confronted with fast-changing scenarios.

(10) Continued advocacy is needed to support and push interprogrammatic collaboration, and promote specific recommended interventions.

(11) Comprehensive guidance is needed on HIV management, including prophylaxis, care, treatment, ART and co-morbidities.

(12) Technical and programmatic matters related to PMTCT/PPTCT and HIV/TB collaborative activities should be addressed jointly with MCH and TB programmes at both Regional (UN Task Force PPTCT) and national levels.
(14) Deeper discussions should be held at the country level on the implications of the new ART and PMTCT guidelines, particularly on:

- estimated increase in PLHIV eligible for ART (higher CD4 threshold and fast-track access for HIV-positive mothers);
- revision of existing national guidelines, orientation of service providers;
- costing, monitoring and logistics; and
- phasing out of d4T-containing regimens.

(15) Deeper discussions are needed at the country level on the new TB/HIV recommendations for ICF and IPT, with a focus on:

- monitoring and data collection, reporting; and
- joint work planning.

(16) Further communication with national programmes and implementing partners is needed to promote the WHO Network for HIV and Health.

(17) Maintain and continue improvement of the regional forum for HIV Programme Managers.
## PROGRAMME OF ACTIVITIES

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<td>Dr Mohd Nasir Hassan, Acting WHO Representative</td>
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<td>10:00–10:30 Progress of the health sector response towards universal access in the Western Pacific Region</td>
<td>Dr Massimo Ghidinelli</td>
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<td>10:30–10:45 Response to eliminate paediatric HIV and congenital syphilis</td>
<td>Dr Wing-Sie Cheng</td>
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<td>11:30–11:45 PEPFAR support in scaling up ART</td>
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<td>11:45–12:00 Universal access perspectives from PLHIV</td>
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<td>Mr Tarubar Rico Gustav</td>
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### Day 1

#### Activity/Agenda item/Subject of presentation | Presenter
---|---
12:00–12:15 Open forum |  
**12:15–13:15** Lunch Break |  
13:15–14:15 Towards achieving universal access to ART: country experiences |  
• Papua New Guinea: challenges and lessons learned from scaling up ART services | Dr Esorom Daoni  
• Hong Kong: scaling up ART services | Dr Ka-Hing Wong  
• Viet Nam: ART expansion and continuum of care in IDU-driven epidemic | Dr Do Thi Nhan  
• China: initiating second-line ART | Dr Zhao Yan  
14:15–14:30 Open forum |  
14:30–15:00 Update on the new ART guidelines | Dr Christopher Duncombe/ Dr Julian Gold  
**15:00–15:30** Coffee/Tea Break |  
15:30–16:00 Update on the new ART guidelines (continued) |  
16:00–16:15 Adaptation and implementation of guidelines: revised principles and recommendations | Dr Christopher Duncombe  
16:15–17:30 Group work: Programmatic implications of new ART guidelines |  
**18:00** Welcome Reception |  

#### Day 2 – Tuesday, 15 June 2010

08:30–08:45 Malaysia: towards elimination of paediatric HIV and syphilis | Dr Sha'ari Ngadiman  
08:45–09:15 New guidelines on PMTCT | Dr Christopher Duncombe  
09:15–09:30 Open forum |  
09:30–10:30 Group work: Programmatic implications |  
**10:30–11:00** Coffee/Tea Break |  
11:00–12:30 Plenary discussion |  
**12:30–13:30** Lunch Break |  
13:30–14:15 Where is care? – Continuum of prevention and care in the era of ART | Dr Masami Fujita
### Activity/Agenda item/Subject of presentation

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<td>Dr Mean Chhi Vun</td>
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<td>14:30–15:00</td>
<td>New guidelines on intensified case finding and INH prophylaxis therapy for TB/HIV collaborative activities</td>
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Annex 2

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## ANNEX 3

### LIST OF GROUPS AND THEIR MEMBERS

<table>
<thead>
<tr>
<th>GROUP 1</th>
<th>GROUP 2</th>
<th>GROUP 3</th>
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</thead>
</table>
| • Dr Mean Chhi Vun  
• Dr Jiao Zhenquan  
• Dr Kenichiro Watanabe  
• Mr Cecil Grant Storey  
• Ms Loina Yafai  
• Dr Do Thi Nhan  
• Dr Julian Gold  
• Dr Mitchell Wolfe  
• Dr Nicolas Medland  
• Dr Ikuma Nozaki  
• Dr Massimo Ghidinelli  
• Mr Bernard Tomas  
• Dr Dominique Ricard  
• Dr Madeline Salva  
• Dr Masaya Kato | • Dr Sovannarith Samreth  
• Dr Ka-Hing Wong  
• Dr Sha'ari Ngadiman  
• Dr Esorom Daoni  
• Mr Tarubar Rico Gustav  
• Ms Wang Liming  
• Dr Zachary Katz  
• Dr Wing-Sie Cheng  
• Dr Zhao Pengfei  
• Dr Nicole Seguy  
• Dr Rajendra-Prasad Yadav  
• Dr Jadambaa Narantuya  
• Dr Brigitte De Hulsters  
• Dr Christopher Duncombe | • Dr Riamiza Natalie Haji Momin  
• Dr Zhao Yan  
• Dr Chansy Phimphachanh  
• Dr Mohd Nasir Abdul Aziz  
• Dr Oyuntsetseg Purev  
• Ms Moi Lee Liow  
• Dr Bruce Struminger  
• Dr Teodora Wi  
• Dr Yu Dongbao  
• Mr Graham Shaw  
• Dr Connie Osborne  
• Dr Fabian Ndenzako  
• Dr Masami Fujita  
• Dr Anthony Lisle |