WORLD HEALTH ORGANIZATION
Regional Office for the Western Pacific

REPORT

UNAIDS AND WHO CONSULTATION ON PROGRESS IN PREVENTION AND CARE IN THE CONTEXT OF THE "3 BY 5 INITIATIVE" AND THE PERSPECTIVE OF UNIVERSAL ACCESS IN THE WESTERN PACIFIC REGION

12-16 December 2005
Manila, Philippines

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NOTE

The views expressed in this report are those of the participants in the UNAIDS and WHO Consultation on Progress in Prevention and Care in the Context of the “3 by 5 Initiative” and the Perspective of Universal Access in the Western Pacific Region and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those persons who participated in the UNAIDS and WHO Consultation on Progress in Prevention and Care in the Context of the “3 by 5 Initiative” and the Perspective of Universal Access in the Western Pacific Region from 12 to 16 December 2005.

ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CDC	Centres for Disease Control
DOTS	Directly observed treatment, short-course
DMR	Drug Resistance Mutations
GFATM	Global Fund to Fight AIDS, TB and Malaria
HFA-2000	Health for All by the year 2000
HIV	Human immunodeficiency virus
IDU	Injecting drug use(er)
IMAI	Integrated management of adult and adolescent illness
MDG	Millennium Development Goals
MMT	Methadone maintenance treatment
NCD	Noncommunicable diseases
NCHADS	National Center for HIV/AIDS, Dermatology and STDs (Cambodia)
NGO	Nongovernmental organization
PEPFAR	President's Emergency Plan for HIV/AIDS Relief (U.S.A.)
PL(W)HA	People living (with) HIV/AIDS
SPC	South Pacific Community
STI	Sexually transmitted infection(s)
TB	Tuberculosis
TRIPS	Trade-related aspects of intellectual property rights

UA	Universal access by 2010
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGA	United Nations General Assembly
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund

SUMMARY

The WHO Western Pacific Regional Office, in collaboration with the Joint United Nations Programme on HIV/AID (UNAIDS) organized the four-day UNAIDS and WHO Consultation on Progress in Prevention and Care in the Context of the “3 by 5” Initiative and the Perspective of Universal Access in the Western Pacific Region with the objective that, by the end of the consultation, the participants would have:

(1) reviewed progress made on prevention and care in the context of the “3 by 5” Initiative;

(2) shared experiences among countries on the current performance of monitoring and evaluation systems related to HIV/AIDS care, treatment and support;

(3) identified ways to strengthen the integration of HIV/AIDS prevention and care; and

(4) defined the conditions and terms of reference for a partners technical working group on scaling up of HIV/AIDS prevention and care in the Western Pacific Region.

The programme included technical presentations, situation reports from countries and partners and open forum discussions across a broad range of issues related to: the epidemiology and surveillance of HIV/AIDS in Asia and the Pacific; lessons learnt from the “3 by 5” Initiative in prevention, treatment, care and support; universal access to prevention and care by 2010; partnership development; and strengthening of health systems. Despite the significant progress of the “3 by 5” Initiative, it was recognized that there are still many challenges to be faced in pursuit of the goal of universal access. Confidence was expressed that such a goal is feasible if there is a high level of political and financial commitment, the process is truly country-led, it builds on achievements and lessons learnt in the “3 by 5” Initiative, there is genuine involvement from communities and people living with HIV/AIDS, and an integral part of the approach involves strengthening of health systems. Meeting participants reached a number of conclusions addressing those and other requirements to achieve universal access.

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Keywords: Sexually transmitted diseases – prevention and control / Acquired immunodeficiency syndrome – prevention and control / HIV infections – prevention and control / Tuberculosis – prevention and control.

1. INTRODUCTION

1.1 Objectives

The WHO Western Pacific Regional Office, in collaboration with the Joint United Programme on HIV/AIDS (UNAIDS), organized the four-day UNAIDS and WHO Consultation on Progress in Prevention and Care in the Context of the “3 by 5” Initiative and the Perspective of Universal Access in the Western Pacific Region with the general objective that, by the end of the consultation, the participants would have:

(1) reviewed progress made on prevention and care scale-up in the context of the “3 by 5” Initiative;

(2) shared experiences among countries on the current performance of monitoring and evaluation systems related to HIV/AIDS care, treatment and support:

(3) identified ways to strengthen the integration of HIV/AIDS prevention and care; and

(4) defined the conditions and terms of reference of a partners technical working group on HIV/AIDS prevention and care scale-up in the Western Pacific Region.

The detailed agenda of the meeting is attached as Annex 1.

1.2 Participants and resource persons

There were a total of 16 participants from 14 countries including Brunei Darussalam, Cambodia, China, Fiji, Kiribati, the Lao People’s Democratic Republic, Malaysia, Mongolia, Papua New Guinea, the Philippines, Samoa, Solomon Islands, Tonga and Viet Nam. An additional 56 persons participated in the meeting as part of the WHO and UNAIDS secretariat, consultants, temporary advisors or observers. Observers included representatives from the Asian Development Bank, the Asia Pacific Network of People living with HIV/AIDS (APN+), the Asia Pacific Network of Sex Worker Projects/Empower, the Delegation of the European Commission to the Philippines, Family Health International, the Malaysian AIDS Council, the Secretariat of the Pacific Community, the United Nations Children’s Fund (UNICEF) East Asia and Pacific Region, UNICEF Pacific, and the United States Agency for International Development (USAID) Asia. The list of participants, consultants, temporary advisers, observers and secretariat staff is attached as Annex 2.

The Western Pacific Regional Office provided technical and operational support for the meeting.

1.3 Organization of the meeting

The meeting was held at the Conference Hall of the WHO Western Pacific Regional Office in Manila, the Philippines, from 12 to 15 December 2005. Methods used in the meeting included presentations, small group discussions and plenary sessions.

1.4 Welcome statement

A welcome greeting was extended to all participants by Dr Shigeru Omi, Regional Director, WHO Western Pacific Regional Office. He observed that two years had passed since the official launching of the "3 by 5" Initiative. While the formal targets of the Initiative had not been met, there had been substantial progress both globally and in the Western Pacific Region. He observed further that the "3 by 5" Initiative was an interim objective to the longer-term goal of universal and equitable access to prevention and care that was endorsed at the G8 Summit of July 2005. Recognizing that there were many challenges still ahead, Dr Omi encouraged participants to "explore ways to improve our common work with partners for the benefit of our Member States and their affected vulnerable populations." He closed his remarks by expressing appreciation to all participants, consultants, and technical advisors for the time and efforts that they were committing to the important meeting.

1.5 Opening of the meeting

The meeting was formally opened by Dr Omi. It was decided by unanimous consent that chairpersons for the four days would be consecutively: Dr Chansy Phimphachanh (the Lao People"s Democratic Republic); Dr Mean Chhi Vun (Cambodia); Dr Timaima Tuiketei (Fiji); and Dr Nguyen Huy Nga (Viet Nam). Dr Robert D. Fischer was appointed as Rapporteur for the meeting.

2. PROCEEDINGS

2.1 Epidemiology and surveillance

2.1.1 Overview of HIV/AIDS surveillance in Asia and surveillance issues

Dr Nguyen Thi Thanh Thuy (Epidemiologist, WHO Western Pacific Regional Office) discussed the general HIV/AIDS epidemic profile in the Western Pacific Region and the role that HIV/STI surveillance systems have played. While there is good evidence that consistent condom use has been associated with a decrease of both HIV and STI infection in Cambodia, a number of other countries are showing disturbing rises in HIV prevalence among vulnerable populations like injecting drug users and sex workers. Dr Thuy discussed some of the key characteristics and elements of HIV/STI surveillance stressing that, for surveillance systems to be optimally useful, reporting should be nationally relevant, complete and timely. Reliable data from surveillance systems can and should be used as an important strategic element in programme planning and mobilization of funds from partners.

2.1.2 Linking surveillance to interventions

Dr Chika Hayashi (WHO Headquarters) opened her presentation with a reminder that data from HIV surveillance systems, along with STI and behavioural surveillance, HIV/AIDS reporting and HIV drug resistance surveillance should all be used for situation analysis and programme planning. Using examples from country experiences, she emphasized that disaggregating surveillance data as much as possible (e.g. by risk behaviours, areas of the country, sex and age) could add valuable insights into the nature the epidemic and needed programmatic responses. Surveillance data are also crucial for planning for antiretroviral therapy (ART) care needs in a community. However, because ART prolongs the survival of HIV-infected persons, an increase in the number of HIV-infected persons will likely be observed in a population where treatment is widely available. Further analysis of surveillance data will be required to untangle whether the increase is fully attributable to persons on ART or because of increases in risk behaviours. Both are possibilities and have been observed in country experiences.

2.1.3 Surveillance among subpopulations with high-risk behaviour

Professor Xiang-Sheng Chen (Temporary Adviser, China) shared some of the experience of China in strengthening second-generation surveillance systems. In China, data gained from biological and behavioural HIV surveillance sources have now been integrated with STI surveillance as an early warning system. Especially important in the Chinese experience has been recognition of significant overlapping of high-risk populations, like injecting drug use among men having sex with men (MSM) and sex workers (SW). Dr Chen also discussed the theoretical advantages and disadvantages of using probability versus non-probability sampling methods in surveillance systems. Overall he stressed that it is important to combine biological and behavioural survey methods, to obtain samples from a broad spectrum of sources, and to include a minimum set of sociodemographic with biological samples.

2.1.4 HIV drug resistance in Cambodia

Dr Eric Nerrienet, (Temporary Adviser, Cambodia) reported on the preliminary results of an ongoing cross-sectional study in Cambodia to evaluate the virological responses in two cohorts of ARV-treated patients. The study is being implemented in nine Pasteur Institutes within the Pasteur Network, with external quality control provided by the Agence Nationale de Recherches sur le Sida et les hépatites virales B et C (ANRS) and the National Institutes of Health (NIH), and is following a cohort of 283 patients from the Ensemble pour une Solidarité Thérapeutique Hospitalière, En Réseaux (ESTHER) and 346 from Médecins sans Frontières (MSF). In follow-ups at 18 and 24 months, it has been shown so far that virological success, based on viral load and CD+4 counts, has been more than 90% in “ARV naïve patients” but only 53 % in “ARV non-naïve patients”. The reason for such a finding is still under investigation. Increasing CD+4 counts are also not always predictive of virololgical success. It is recommended that, where possible, viral load and DMR (Drug Resistance Mutations) should be used along with CD+4 count to support ARV monitoring.

2.1.5 Quality of laboratory testing in the Western Pacific Region

Dr Elizabeth M. Dax (Temporary Adviser, Australia) ran through a number of issues relating to quality control in HIV laboratory testing. On the issue of whether there were any new testing strategies for HIV confirmation, Dr Dax stressed that there is nothing new except the need for people to follow the existing strategies strictly. On the issue of a list of reliable laboratories in the region for HIV and STI testing, Dr Dax said that the issue is not as simple as identifying "good" and "bad" laboratories. Rather, the more fundamental issue is strengthening and expanding the number of all laboratory resources. Many seemingly small issues can affect the quality of laboratory outcomes, including insufficient supplies, frequent changes in method, ambient temperatures in laboratories, and poor management. Dr Dax also expressed great concern that there had been insufficient studies on the interactions between rapid tests, already a source of problems with the quality of results in some settings.

2.1.6 Open forum

A question was posed about the reliability of the surveillance data on Chlamydia prevalence, because of the difficulty in the definitive diagnosis of asymptomatic cases. It was explained that most reported data on the prevalence of Chlamydia are from special surveillance surveys that had quality laboratory support. It was acknowledged, however, that Chlamydia case-finding within clinical settings is not a reliable source for national reporting. There was hope expressed that polymerase chain reaction (PCR) technology would some day be widely available to support clinical laboratory diagnosis.

One participant expressed concern about some apparently poor virological responses in the Pasteur studies in Cambodia. The participant questioned what effect those results might have on the future of ART programmes. It was stressed in response that the Cambodian studies were only preliminary as yet. They did not at this stage indicate that there should be caution in expanding ART programmes. It was also noted that the Pasteur Institute studies in Cambodia focus predominately on developing the methods to monitor virological response to ARV treatment and not yet on addressing how those methods might be used in programmes.

Another participant observed that there had been much quality testing of rapid tests by WHO and that this was a good source of information about the quality of tests. Dr Dax agreed, but stressed that the real need was to evaluate the interactions of tests to identify where there are shared false negatives. Since many rapid test makers are seemingly using similar antigenic strains of HIV, it is reasonable to suspect many tests could share similar false negatives in testing.

2.1.7 Report on group work: Epidemiology and surveillance

(1) Group 1 report: Linking surveillance to interventions

The group reported that they had identified a number of challenges in linking surveillance systems to interventions, including "fatigue" and weak motivation at the local level, shortcomings in the level of training available for staff, the diversity of the epidemic in different geographical settings and the unwillingness of some local authorities to share available data fully. It was generally recommended that: there needs to be more political commitment behind surveillance systems; there needs to

be agreement on both prevention and treatment indicators that could be used for both national programmes and among donors; anthropological research is needed on the basis of stigma in health care settings; and confidentiality of information in the health care system needs to be reinforced.

(2) Group 2 report: Surveillance among subpopulations with high-risk behaviour

The group discussed how to identify and access high-risk groups through research, mapping, identifying hot-spots and improving workforce skills. Indicators in surveillance systems, it was agreed, should track groups that receive treatment, behaviour changes, and patterns of risk. It was also agreed that the "Three Ones"[1] principle is a vital programme concept. The group believed that more partner assistance is needed to assist countries in the areas of setting standards related to privacy, confidentiality and human rights, supporting surveillance systems, and advocating for strengthening systems.

(3) Group 3 report: ARV drug resistance surveillance

The group recognized that HIV drug resistance surveillance and HIV drug resistance monitoring are two different strategies that can be used to evaluate the nature of the problem presented by ARV drug resistance. Cambodia, China and Viet Nam have currently fielded efforts to begin to evaluate the issue. WHO HIV Drug Resistance Surveillance Network has developed protocols for surveillance of drug resistance, although it has only a limited presence in the Region at the present time. Current challenges in ARV drug resistance surveillance include the complexity of the technology; the fact that laboratories in the Region need external support; the fact that recent infections are not easy to identify; and the need for a move towards a public health approach from the current research-based approach. WHO should step up its advocacy to governments to support ARV drug resistance surveillance, disseminate information about the experience of countries with active ARV drug resistance surveillance systems, coordinate existing networks, and promote links between research and national programmes.

(4) Group 4 report: Laboratory issues for testing of HIV and STIs

The group focused attention on a number of issues related to "why laboratories are not supported?" The issues identified included: inadequate understanding of the need/value of laboratories; limited commitment towards investment; a lack of understanding about quality management; a lack of appreciation of end-user/client requirements; and a lack of direction in development of national systems. It was recommended that WHO should advocate for the merits of a single national laboratory system, that WHO/UNAIDS should convene a meeting of appropriate groups to develop a marketing strategy to support the development of national laboratory systems; and that WHO/UNAIDS, together with other partners, should provide operational support to ascertain the best available testing technologies, including strategies for confirmation.

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[1] One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multisectoral mandate; and one agreed country-level monitoring and evaluation system.

2.2 Prevention

2.2.1 Overview of HIV/AIDS prevention programmes

Dr Wiwat Rojanapithayakorn (Senior Adviser, WHO/China) emphasized that prevention programmes are very important in Asia because HIV/AIDS prevalence is still generally low. Without successful prevention programmes, the cost of treatment could become overwhelming in the generally large populations of countries in the region. Dr Wiwat went through several examples from countries in the Region that demonstrate that prevention interventions can and do work. He also presented a number of lengthy and detailed lists of "essential", "core" or "recommended" prevention programme interventions that have been developed by different agencies. In his opinion, the really essential ones are condom promotion in risk situations, harm reduction among drug users, STI treatment and care, blood safety, and mother-to-child transmission. Current challenges in integrating prevention with the perspective of universal access include: (1) how to select approaches that make the most of potential synergies between prevention and treatment; (2) how to create initiatives that can emphasize the benefits of knowing one's HIV status; and (3) how to reach vulnerable communities most impacted and most in need.

2.2.2 STI prevention and control in the Pacific island countries and areas

Dr Seng Sopheap (WHO, South Pacific Office) drew attention to the fact that high prevalence of STIs, particularly Chlamydia, is a widespread problem through the Pacific. The main challenges include the limited coverage of control activities, the fact that condom promotion and condom social marketing is still underdeveloped, the need to identify core groups and design appropriate interventions for them, and the need for special attention to be paid to the high prevalence of Chlamydia in pregnant women. A recent joint UNFPA-UNICEF-WHO consultation in the Pacific led to the identification of 10 country priorities and eight regional support priorities. STI control remains a priority strategy for HIV prevention in the Pacific. There is also still a great need to strengthen partnerships in the prevention and control of STIs, to maximize use of scarce resources and to scale up the coverage of control activities.

2.2.3 Preventing drug-use-related HIV/AIDS transmission in Viet Nam

Dr Nguyen Huy Nga (Viet Nam) began his presentation with data showing that injecting drug use is a major factor in HIV transmission in Viet Nam. He also reviewed the evolution of harm reduction activities in the country, beginning in 1993 and steadily strengthening to the current time. Elements of intervention programmes for injecting drug users now include information, education and communication (IEC), peer education, a safe-injecting programme, needle and syringe exchange programmes, drug treatment and a drug substitution treatment programme and other supportive services. However, there is a need to expand programmes beyond the current pilot phase and especially to resolve legal documentation problems, including those related to drug substitution programmes.

2.2.4 Preventing sexual transmission in Cambodia

Dr Mean Chhi Vun (Cambodia) reviewed the history of the HIV situation in Cambodia noting that the male bridging group's role in transmission between female sex workers (FSWs) and the men's spouses or regular sex partners was an important part of the initial evolution of the epidemic. They began their prevention activities with an emphasis on condoms, taking lessons from neighbouring Thailand with the 100% Condom Use Programme (CUP). The result of the programme has shown dramatic results, with both an increase in condom use among most at-risk populations (e.g. brothel-based sex workers, beer girls, sweethearts or regular sex partners of FSWs) and decreases in HIV and STI rates. More population-based sentinel surveillance studies have also documented a reduction of STIs and HIV prevalence. Current challenges in Cambodia include the shifting of sex work from brothels to other venues of entertainment. There is a need to expand the 100% CUP strategy to all sex entertainment establishments and to develop other outreach strategies for indirect sex workers. Maintaining national HIV and STI prevention efforts, with NGO and other partner support, also remains a pressing need.

2.2.5 HIV voluntary counselling and testing in China

Dr Wang Weizhen (China) pointed out that voluntary counselling and testing (VCT) was particularly important in China because the number of diagnosed cases of HIV/AIDS is far below the estimated number of cases. It is also felt that properly organized VCT can impact high-risk behaviours even before people become infected. Dr Wang outlined the evolution of strengthened VCT policy commitments in China between 1999 and 2004, when Prime Minister Wen Jiabao implemented the "Four Frees and One Care" policy, which requires all counties to be able to provide HIV screening tests by the end of 2005. There has been a great expansion in the number of people trained as counsellors and there are now over 2850 VCT sites in 31 provinces. Despite the tremendous achievements that have been realized in China, Dr Wang said that there is still a need to explore other VCT service models for different populations in China, to improve the quality of counselling services, to improve referral services and to further scale up the coverage of VCT services.

2.2.6 Open forum

There was a question to Viet Nam about how the collaboration was developing between harm reduction programmes and public security agencies. Dr Nga said that a new law in Viet Nam now accepted the concept of harm reduction. The Central Committee of the Communist Party also accepted the concept and now the other ministries were coming on line. The Ministry of Health wants to develop methadone substitution programmes, but recently the Ministry of Labour and Industry expressed concern about labourers being under the influence of an officially labelled "drug". Dr Nga said he hoped that methadone would soon be categorized as a "medicine" and not a drug, so that it could be used more widely in harm reduction programmes.

Another participant expressed concern that most of the prevention measures that had been discussed were all related to the Ministry of Health. The participant noted that health education activities, for example, were best carried out through public and private institutions. It was agreed this was a valid point and was the reason why UNAIDS was a part of the meeting, as it has responsibility across the spectrum of United Nations agencies.

There was a question to Dr Mean Chhi Vun about how the National Center for HIV/AIDS, Dermatology and STDs (NCHADS) had been able to generate HIV incidence data in Cambodia. Dr Mean Chhi Vun said that the data he reported were from a small special study done by an NCHADS staff member, and were not nationally representative.

2.2.7 Reports on group work: Prevention

(1) Group 1 report: STI prevention and control

The group reported on their discussions of the experiences, issues and challenges of STI prevention and control in targeted populations. They recommended that the focus of countries should be on comprehensive diagnosis, treatment, partner management and counselling, and that STI services should be integrated into reproductive health, validated rapid tests should be made widely available and there should be an emphasis on capacity building among non-health professionals in STI and HIV control activities. The group also recommended that WHO, UNAIDS and other partners should support regional procurement systems and aid in the development of new and effective rapid tests.

(2) Group 2 report: Preventing drug use related transmission

Among the experiences, issues and constraints seen in countries, the group noted that there is a poor evidence base on drug use, poor links between government authorities and civil society, “conflict” between drug control laws and harm reduction programmes, stigma and discrimination, and generally poor coverage of existing programmes. The group especially recommended that WHO, UNAIDS and other partners should advocate and support the development and/or scaling up of country programmes, including programmes in low prevalence countries. Additionally, international assistance is urgently needed in improving research capacity, monitoring and surveillance to help develop the evidence base on drug use and its relationship to HIV/AIDS.

(3) Group 3 report: Preventing sexual transmission

The group reviewed the experiences of Cambodia, China, Papua New Guinea, the Philippines and Solomon Islands in addressing sexual transmission of HIV, and concluded that condom promotion and use is key to STI prevention, especially with MSM, sex workers, their clients and the regular partners of sex workers. However, educational messages have to be carefully framed in terms that are meaningful to the target groups. Education on the risks of alcohol and non-injecting drug use also needs to be addressed in some countries. Countries need to carefully identify those most at risk and other vulnerable populations and strategies to access those populations. WHO and UNAIDS were encouraged to support the exchange of experiences between countries.

(4) Group 4 report: Voluntary counselling and testing

The group identified a number of issues and constraints that countries are currently facing in voluntary counselling and testing, including confidentiality, lack of technical expertise in counselling and testing, and the retrieval and use of laboratory results. The challenges of counselling and testing children and the absence of a legal framework in many places (e.g. relating to ethical aspects of partner notification and public health versus individual rights) are especially problematic at the current time. The

group recommended that WHO should convene a technical working group to review the many constraints in counselling and testing and to develop guidelines, protocols and operational procedures that might be of help to countries to build their capacity. In particular, guidance on ethical issues, counselling and testing in prisons and "detained settings", and staff training should be addressed by a technical working group.

2.3 Care, treatment and support

2.3.1 "3 by 5": Achievements and lessons learnt

Dr Clement ChanKam (WHO Headquarters) reviewed the unprecedented global political commitment behind the concrete and transforming WHO/UNAIDS "3 by 5" strategy. Although "3 by 5" did not achieve its "aspirational" target, great progress has been achieved in terms of the development of ART plans, political commitment and ART coverage. The mobilization of and contribution of new sources of financing (e.g. the Global Fund to Fight AIDS, TB and Malaria [GFATM], the Clinton Foundation, the President's Emergency Plan for HIV/AIDS Relief [U.S.A.] [PEPFAR]etc.) are also an important achievement of the "3 by 5" Initiative. Among the many lessons learnt are the importance of political and financial commitment for sustainability; the pivotal role of affected individuals, communities, civil society and the private sector; the need to exploit synergies of prevention and (not "or") treatment; ensuring quality supplies and supply chain management; and the importance of strengthening health systems to support services. Among the important challenges for WHO are identifying and targeting countries with the greatest unmet ART needs; intensifying collaboration and improving coordination with a broad range of partners to support the health sector response to HIV/AIDS; mobilizing the necessary resources for countries; and assisting countries to effectively utilize resources.

2.3.2 Regional overview of the "3 by 5" Initiative

Dr Michel Tailhades (Medical Officer, WHO Western Pacific Region) stressed that it was important to keep in mind the important progress that countries had made in scaling up ART, rather than looking at unachieved targets. The important lessons learnt include recognition that scaling up is possible even in the face of great health system challenges. The key ingredients to success include strong political and financial commitments at all levels; building on existing care and support plans and programmes; and having in place enabling policies and legislation. Dr Tailhades reviewed some of the activities that the WHO Western Pacific Regional Office has supported in pursuit of the "3 by 5" strategy and, looking forward to universal access, areas where WHO and countries need to direct attention in the future. Among the priorities for 2006 are additional training for health staff; the need to increase coverage of targeted interventions, such as needle-syringe exchange programmes and substitution therapy; and strategies to reduce women's vulnerability to HIV/AIDS by eliminating all forms of discrimination and violence against them.

2.3.3 Country experiences

Dr Mean Chii Vun (Cambodia) reported on the Cambodian experience in expanding care, treatment and support to people living with HIV/AIDS. Starting with a single voluntary confidential counselling and testing centre in Phnom Penh in 1995, this crucial service had expanded to 106 centres in all provinces by 2005. A similar expansion took place in continuum-of-care centres, prevention of mother-to-child transmission, TB/HIV care and treatment, paediatric AIDS care and laboratory support

for opportunistic infections and ART, home- and community-based care, and PLHA peer support groups. Dr Vun stressed that Cambodian ownership of the programme, strong support from the international community, participation of the community (PLHAs, NGOs, religious bodies), integration of continuum of care centres into the health care system, and sectorwide management systems were also all crucial to achievements in Cambodia.

Dr Wen Yi (China) said that the major constraints in expanding ART in China related to the challenges faced by the health system overall; underdeveloped medical insurance systems; lack of incentive; and unbalanced and limited resource distribution. China is particularly challenged by the great gap between the reported and estimated number of HIV/AIDS cases (only 17% of estimated cases are diagnosed) and the continuing stigma and discrimination. Despite those constraints, however, China set a "3 by 5" target of 30 000 and has thus far achieved 20 000 persons receiving ART. Among the important lessons learnt in China is the importance of preparation, and understanding that proper treatment of patients means much more than ART alone.

Dr Daoni Esorom (Papua New Guinea) reminded the meeting that Papua New Guinea is facing a particularly difficult situation, with the highest rates of HIV infection and STI in the Pacific. With strong support from the international community, ART national guidelines have been formulated and two pilot ART clinics were organized and later expanded to six (evenly divided between the public and private sector.) The challenges still remaining in the country, that will need to be addressed in pursuit of universal access, include the need for better involvement of other sectors and civil society organizations, the generally weak health infrastructure, and the need for better integration with preventive health services.

Dr Nguyen Huy Nga (Viet Nam) explained that HIV/AIDS care and treatment in Viet Nam is organized through three institutional levels: hospital-based, community-based and rehabilitation centres for sex workers and injecting drug users. Still confronting an expanding epidemic, the number of persons in Viet Nam currently estimated to be in need of ART (14 775) is expected to grow to over 37 000 by 2010. Complicating the picture for the future is the need for better utilization of PLHAs in programmes, better coordination, and more involvement of peer support networks and NGOs.

2.3.4 Treatment guidelines update

Dr Christopher Duncombe (Temporary Adviser) explained how there has been a gradual shift from non-nucleoside-based therapies to newer nucleoside combinations. Bulk purchasing and new "global access programmes" are increasingly being seen as ways to reduce the cost of new first-line drug combinations, like Tenofovir plus FTC. Dr Duncombe summarized the new WHO 2005 treatment guidelines, which are expected to be finalized and released in early 2006. New guidelines on prevention of mother-to-child transmission were also released in 2005 and WHO has draft guidelines currently under review for ART for children. He outlined some of the options that the guidelines were going to present to programme managers for decision-making, including new plans that would have to be devised for purchasing and stock management.

2.3.5 Access to HIV drugs and related medicines and diagnostics

Dr Peter Graaff (Scientist, WHO Headquarters) outlined "the moving goalpost" of increasingly complex issues that sequentially confront programme managers in

addressing procurement of drugs and supply management. He also discussed the implications of TRIPS as it relates to the future availability and pricing of drugs, and observed that the great increase in demand for ARVs may soon approach the manufacturing capacity of suppliers. Asia has the good fortune of having a much larger number of generic drug manufacturers than any other region and China is also the largest producer of active pharmaceutical ingredients and key intermediates. According to Dr Graaff, coordination versus fragmentation is clearly the next national and international challenge for pharmaceutical supply management.

2.3.6 HIV/AIDS and TB

Dr Philippe Glaziou (Medical Officer, WHO Western Pacific Regional Office) pointed out that mortality rates among TB-HIV patients are between 25% and 40% in south-east Asia. The rationale for TB-HIV collaborative activities includes the fact that HIV drives TB incidence and mortality in high HIV prevalence areas and that DOTS alone is insufficient to control TB in those areas. Dr Glaziou pointed out that, although the collaborative links between HIV/AIDS and TB programmes are schematically simple, in fact the coordination of programmes presents many difficult challenges. Notwithstanding those difficulties, it is a WHO regional target to have 14 countries with high and intermediate TB burdens implementing TB-HIV surveillance by 2010.

2.3.7 Prevention of HIV transmission in children and care of exposed infants

Dr Carmen Casanovas (WHO Western Pacific Regional Office) outlined the several modes of transmission of HIV to children (mother-to-child transmission, sexual, transfusions etc), as well as the relative risks of such events, such as pregnancy, labour and delivery, and breast-feeding. Because of the high and cumulative risk of transmission in breast-feeding, especially mixed versus exclusive breast-feeding, WHO recommends “replacement feeding” for HIV-infected mothers where it is consistent with FAAS criteria: (feasible, acceptable, affordable, sustainable) and safe. Although preliminary evidence has shown that ART among HIV-positive mothers may reduce the risk of mother-to-child transmission through breast-feeding, Dr Casanovas stated that it is still the recommendation of WHO to avoid breast-feeding where possible. She further elaborated the four-pronged United Nations/WHO approach to prevention of paediatric HIV infection: primary prevention; prevention of unintended pregnancies in HIV-infected women; prevention of mother-to-child transmission; and providing care and support to HIV-infected women, infants and families.

2.3.8 The role of people living with HIV/AIDS in the response to HIV and AIDS

Mr Noel Pascual (Temporary Advisor) discussed many of the challenges being faced by PLHA in accessing information and health services. Some governments do not appear to be fully aware of or committed to upholding the principle of greater involvement of people living with AIDS (GIPA). Studies in Asia have also documented many incidences of stigma and discrimination against PLHAs within health institutions, and the participation of PLHAs in national programmes is sometimes only “token” representation. Mr Pascual stressed that PLHAs have important capacities, information and life experiences that they can contribute to all aspects of HIV/AIDS programme planning and implementation. He expressed the willingness of PLHAs to contribute fully to the pursuit of universal access.

2.3.9 Open forum

In response to questions in plenary discussion of the country presentations, it was revealed that no country is satisfied yet that it has found exemplary ways to advance women's empowerment and equity in HIV/AIDS and ART programmes. Cambodia reported that they have organized family-based care involving women, and that 55% of those receiving ART are women. It was concluded overall that, since sex workers and many IDUs are women, it would behove programmes in the future to monitor the number of women receiving care more carefully. It was also recognized that there is a need to ensure that marginalized groups, such as sex workers and IDUs, are also equitably accessing prevention, treatment and care services. Although some country participants expressed concern about questioning persons about their source of HIV infection when receiving treatment and care, confidential methods need to be developed to ensure and to monitor that those populations most at risk are not being discriminated against in access to services.

In discussions surrounding the presentations of Dr Duncombe and Dr Graaff, it was observed that there are also constraints in using some new ARTs because the drugs are not yet registered by competent national authorities. It was also noted that the productive capacity of some manufacturers of HIV rapid tests is approaching the limit and that cost and availability may soon become a problem here as well as with ARVs.

On the issue of mother-to-child transmission, Dr Casanovas was questioned about the WHO position on voluntary abortion as a way to prevent transmission from HIV-infected women. Dr Casanovas explained that WHO had no formal position on abortion as a way to prevent mother-to-child transmission. That was a decision for individuals and countries, consistent with their religious and cultural traditions. There was also pointed criticism that the FAAS criteria seem to entail a "double standard", one for lesser-developed countries and one for developed countries. Dr Casanovas explained that the FAAS criteria are not ideal but that, in fact, there are often individual, cultural and social reasons, apart from the economic environment, that might persuade an individual whether to breast-feed or supplement-feed a newborn infant.

2.4 Universal access to prevention and care by 2010

2.4.1 Scaling up towards universal access: concepts and process

Dr Olavi Elo (Senior Adviser, UNAIDS/WHO Headquarters) summarized recent global statistics that highlight both the international shortfalls in ART coverage and stagnation in prevention programmes. Statistics too make it clear that treatment alone is not the most effective strategy in confronting HIV/AIDS. Emphasizing that universal access (UA) is a country-led process, he recounted the policy momentum build-up in the last year within the United Nations, leading to the goal of "reaching as close as possible to universal access to treatment for all those who need it by 2010." Dr Elo stressed that UA was built on the pillars of the "Three Ones" and that the Global Task Team (GTT) had been tasked with facilitating the countries to reach this goal.

2.4.2 Developing a framework for universal access to HIV prevention, treatment and care in the health sector

Dr Clement Chan-Kam (WHO Headquarters) discussed the continuum of international commitment from the Millennium Development Goals, through the "3 by 5" strategy, to UA. He emphasized that UA is country-led, fosters the integration of HIV prevention and treatment, and furthers the "Three Ones" principle. Dr Chan-Kam elaborated on the interrelated core HIV interventions, moving from prevention through treatment and care, and stressing that a public health approach and an "enabling environment" are essential to achievement of UA. He summarized that UA can provide guidance to countries for a harmonized approach to scaling up HIV prevention and care services to all in need.

2.4.3 Monitoring and evaluation in the context of universal access

Dr Chika Hayashi (Technical Officer, WHO Headquarters) discussed the distinction between monitoring and evaluation and their relationship to operational research and surveillance. She also focused attention on the interrelated HIV interventions at the core of UA, as well as the various criteria that could be used to monitor and evaluate such parameters as service availability, coverage, outcomes and impact. Tracking such elements as stigma and discrimination, community participation, successful procurement of supply management and adequate human resources is also going to be a special challenge in the pursuit of UA. Additionally, Dr Hayashi reviewed a number of current and upcoming international guidelines relating to monitoring and evaluation and stressed that, in the final analysis, it will be important for all countries to have one monitoring and evaluation system that can harmonize multiple reporting requirements (e.g. for United Nations General Assembly Special Session on HIV/AIDS [UNGASS], GFATM, Millennium Development Goals [MDG], etc).

2.4.4 Supporting effective scaling-up toward universal access

Dr Prasada Rao, (Director, UNAIDS Regional Support Team) reiterated and expanded on some of the key guiding principles underlying UA: country ownership and leadership, targets to be set by countries, building on existing efforts, striving for equity in access, etc. He explained that UNAIDS has designed a four-phase country consultation process in which the current status of the national response will be documented, principal obstacles to achieving UA will be defined, 2010-aspired outcomes will be identified and a broadly defined country roadmap will be developed. A proposed time-frame for the consultative process was shared with participants, leading up to an UNGA review of regional plans at end of May 2006.

2.4.5 Open forum

There was an initial series of questions about what such words as "universal," "access," "essential services" and "coverage" really mean. It was explained that there is currently a working group elaborating those definitions in WHO Headquarters. It was also observed that UA is really two different "processes", a political process and a technical process. It is important for participants to be aware of the political process, but their efforts are going to be necessary for the technical process. Also, it was observed that UA sounds like HFA-2000 and that there is a real danger of not having real and realistic targets. One participant stressed the need to also have targets and monitoring and evaluation systems to monitor progress in the prevention area, since UA was a goal for treatment, prevention and care. Concern was expressed during the discussions

the current UNAIDS timetable for consultations is perhaps too ambitious, especially with regards to initial consultations coming up with draft country and regional reports by the end of February 2006.

2.4.6 Reports of group work:: Universal access

(1) Group 1 report: Low prevalence settings

The group had wide-ranging discussions surrounding the apparent need for countries to organize or strengthen a "genuine" multisectoral committee and process to come up with national plans. The importance of the participation of PLHA, donors and communities was also emphasized; "This must be a community-led process." Also, in place of a series of vertical projects, activities must be integrated. It was also concluded by the group that UA plans really should build on and be supplemental to existing programme plans and activities. Also noted was the fact that "money drives the process" and that many countries face limitations in "absorptive capacity." Much assistance will be needed in strengthening that absorptive capacity.

(2) Group 2 report: Universal access for "3 by 5" Initiative countries

The group of "3 by 5" priority countries (Cambodia, China, Papua New Guinea, Thailand and Viet Nam) discussed a number of lessons learnt, including the importance of programme ownership, involvement of civil society organizations, and decentralization and "de-medicalization" of care. Among the principal constraints for UA identified by the group were weak political commitment at the provincial and community level, limited supply management capacity in virtually all countries, lack of vital laboratory support and persistent problems with stigma and discrimination, coordination and monitoring and evaluation. The group identified specific recommendations to overcome constraints, and also expressed concern that the current UNAIDS timetable for developing the UA report for the UNGA is ambitious and perhaps unrealistic.

(3) Group 3 report: Reaching the most vulnerable

The group focused most attention on the need to overcome obstacles in reaching the most vulnerable populations. Most important is the lack of good understanding of the needs of vulnerable groups and specific barriers their access. Collecting and analysing "disaggregated" surveillance data and information is very important in addressing that problem. In developing and implementing national programmes for UA, documenting and disseminating "good practices", involving PLHA, vulnerable populations and "peers," and reviewing and revising policy and legal frameworks are all critical.

(4) Group 4 report: Monitoring and evaluation process for universal access

The group clarified that "one monitoring and evaluation system" is really a system for the coordination of outputs of many subsystems or "sectoral monitoring and evaluation systems". Establishing one system, however, is more than just solving a series of technical problems. It requires political support and the cooperation of donors to harmonize reporting requirements. Also emphasized by the group was the perspective that monitoring and evaluation is primarily for programme improvement and not just a

system for accountability to donors and the international community. Since UA is really an extension of existing programmes, there would not need to be many new indicators or novel monitoring processes. Monitoring efforts, however, must address aspects like “coverage,” “quality” and “equity".

2.5 Partnership development

2.5.1 Partnership development in Viet Nam

Dr Nguyen Huy Nga (Viet Nam) reported that Viet Nam’s HIV efforts were originally focused in the Ministry of Health. However, the HIV National Strategy of March 2004 initiated a broadly multisectoral approach. The current partnership structure includes the National Committee for AIDS, Drugs and Prostitution Prevention and Control and the especially key Viet Nam Administration of AIDS Control, which was established in August 2005. There are also a number of coordinating forums, like the Committee of Concerned Partners, the INGO Technical Working Group and an annual Consultative Group. Remaining challenges in Viet Nam are in adapting international HIV best practices to the Vietnamese political and social context (e.g. incorporating local NGOs, PLHA groups and civil society) and harmonizing large-scale donor-funded HIV projects (e.g. GFATM, PEPFAR etc).

2.5.2 Partnerships in Cambodia

Mr Matthew Warner-Smith (Country Coordinator, UNAIDS/Cambodia) said that partnerships have been very well developed in three areas of the Cambodian national response to HIV/AIDS: (1) planning and coordination; (2) resource mobilization; and, (3) implementation. The National AIDS Authority is the national multisectoral coordinating body that oversees the National Strategic Plan. Cambodia now has a very high level of international partner support, primarily from the GFATM, the Department for International Development of the United Kingdom (DFID) and USAID, which is also coordinated through multisectoral groups like the GFATM-Country Coordinating Mechanism and other steering committees. With regard to implementation, NCHADS has the technical coordinating role for treatment and prevention activities. Mr Warner-Smith said that partnership with PLHAs has been key to all activities and stressed the importance of remembering that it takes time and effort to make all such partnerships effective.

2.5.3 Partnerships in the Pacific

Ms Judith Leveillee, (UNICEF/ Pacific) elaborated on the very difficult problems of coordinating the 15 sovereign countries and the multiple donors and partners working in the Pacific region. Bilateral, regional and international organizations like the SPC, ADB, CDC, UNDP, UNAIDS, WHO and UNICEF all involve a different spectrum of countries and programme activities. Although there are also a number of coordinating mechanisms within the United Nations and with the Pacific Island Regional Country Coordinating Mechanism, an *ad hoc* “coalition of the willing” strategy has recently been developed, in which multi-agency teams will join in country missions for programme development and coordination.

2.5.4 Partnerships in Papua New Guinea

Dr Esorom Daoni (Papua New Guinea) observed that the National AIDS Council is the principal coordinating body in Papua New Guinea and that the National AIDS Plan has a specific component for developing partnerships. Papua New Guinea has the good fortune to have many bilateral and international partners supporting the national response to HIV/AIDS. However, there is still a need to strengthen public-private partnerships.

2.5.5 Open forum

Participants observed that Pacific island countries and areas present unique challenges and that the traditional epidemiological categories like "generalized" versus "low" or "concentrated" epidemic may need to be expanded to accommodate epidemics among small and/or greatly disbursed population concentrations. (e.g. "Do you call it a 3% generalized epidemic when you have three HIV infections on an island with 100 people?)

There was also the observation that the role of international and donor partnerships is not really "key" as there are too many countries with many partners that are not especially successful in confronting their HIV/AIDS epidemics.

It was agreed overall that responding early is very important. Papua New Guinea, it was observed, appears to have been neglected until it was confronting a serious generalized epidemic. The other Pacific island countries are in a position to avoid that level of impact.

2.6 Prevention and care integration

2.6.1 Overview of prevention and care integration in the health sector response

Dr Kevin O"Reilly (Scientist, WHO Headquarters) observed that, despite the fact that the "3 by 5" Initiative officially included prevention, care and treatment, there are still serious shortfalls in prevention activities. Universal access faces a great challenge in doing better in integrating HIV prevention and treatment, delivering prevention for HIV-negative persons, adapting prevention for HIV-positive persons and organizing a comprehensive response. Simplified and standardized packages of activities, country-level targets for coverage and mechanisms for scaling up are three key components that will be needed. Voluntary counselling and testing is clearly the portal of entry or "gateway" for access to all prevention, treatment and care activities, and must be strengthened in pursuit of UA. Despite that fact that the needs and challenges are great, there are also great opportunities presented with the UA goal: there is, for the first time, concentrated UNAIDS attention on prevention, there is the momentum that has been developed with the "3 by 5" Initiative, and existing and anticipated financial resources are now substantially greater than ever before.

2.6.2 Country experiences: Prevention and care integration

Cambodia: Strengthening the data management system for the health sector response

Dr Massimo Ghidinelli (Senior Adviser, WHO/Cambodia) explained that, in Cambodia, there is strong political commitment to a multisectoral approach, although the health sector is clearly a major force in driving the response. Especially important in Cambodia has been the establishment of an HIV/AIDS data and logistics system.

NCHADS now has two new units and a programme monitoring system that links financial monitoring, logistics monitoring and patient monitoring. On the important issue of patient monitoring, uniform sets of indicators have been identified for field units to report on pre-ART coverage, ART coverage and ART outcomes. It is expected that the system will be implemented nationwide in 2006 and will clearly be an essential tool for monitoring progress toward UA.

China: The methadone clinic platform to HIV/AIDS prevention and care integration

Dr Connie Osborne (Senior Adviser, WHO/China) explained that injecting drug use is a major factor driving the HIV/AIDS epidemic in China. HIV prevalence among IDUs is over 50% in some areas and the percentage of new infections associated with IDU was 48.6% in November 2005. China's long-range goal of being a drug-free society focuses on three strategies: supply reduction; demand reduction; and harm reduction. At the base of the harm reduction strategy is the organization of methadone maintenance treatment (MMT) clinics, which can serve as a "platform" for a number of prevention and care programmes, such as voluntary counselling and testing, ART, opportunistic infections, and psychosocial support. There are currently 128 MMT clinics in China, with a target of 1500 such facilities in operation by the end of 2008. Looking forward to UA, it is apparent that targets for harm reduction will have to be defined and that MMT clinics will be key facilities for coordinating prevention, treatment and care to the most-at-risk population in China.

Viet Nam: Comprehensive care sites in the context of continuum of care

Dr Masami Fujita (Senior Adviser, WHO /Viet Nam) explained that a public health approach was initiated in Viet Nam in the first stages of the "3 by 5" Initiative. That approach included comprehensive services, PLHA involvement, a continuum of care, and decentralized service delivery. Comprehensive care sites were established as the "hub and heart" of the continuum in which prevention, treatment and care were organized with trained care teams and PLHA and community support. At the current time, comprehensive care sites are being expanded in Viet Nam, both as stand-alone facilities in some areas and integrated into provincial hospitals and district health centres in others. Consideration is also being given to further scaling up of comprehensive care sites and adding such services as paediatrics, rehabilitation and TB-HIV care.

2.7 Strengthening the health system

2.7.1 Overview of the health system

Dr Graham Harrison (Regional Adviser in Health Systems Development, WHO Western Pacific Regional Office) began by clarifying that health systems include "all activities whose primary purpose is to promote, restore or maintain health." Focusing extensively on the function of stewardship as a function of the system, he detailed that the "careful and responsible management of the well-being of the population" is a responsibility of the government, although the actual delivery of services could be shared between sectors. The overall quality of delivered services is measured against such dimensions as effectiveness, efficiency, accessibility, acceptability, evidence-based, equitable, safe, ethical and legal. The inputs, processes, outputs and outcomes of the health system are also heavily impacted by the organization and management of the system and the enabling or constraining environmental factors.

2.7.2 Health care financing

Dr Dorjsuren Bayarsaikhan (Regional Adviser for Health Care Financing, WHO Western Pacific Regional Office) defined health care financing broadly as the mechanisms aimed at raising adequate and sustainable revenues, managing revenues, setting incentives and ensuring access to needed health services. Current issues impacting access to and the quality of health services include the relatively low level of health spending, the declining share of public financing, the extensive growth of private payments, and inadequate financial and social protection. Dr Bayarsaikhan encouraged participants to explore non-traditional sources of funding for HIV/AIDS activities, such as those that could come from health and social health insurance plans. In the final analysis, however, he cautioned that money itself, while important, may not be the primary concern for programmes. The capacity to use and manage resources is clearly an issue, especially where there is fragmentation of resource sources from different donors.

2.7.3 Health workforce issues and challenges

Dr Ezekiel Nukuro (Regional Adviser for Human Resources for Health, WHO Western Pacific Regional Office) reminded participants that health workers ("the heads, hearts and hands of the health system") are a vital component of the health system, usually accounting for 60% to 80% of sector budgeting. Constraining factors in human resources include insufficient commitment from key stakeholders, chronic underinvestment in human resources, and a lack of integrated national human resources planning and financing. Dr Nukuro reminded participants that skills for specific interventions are often not the primary constraint. Absolute shortages of manpower and poor employment conditions are more often the leading constraint. Looking to the future with UA, key action points include: a scaling up of planning for workforce requirements; striking synergies across programmes; simplifying procedures and services, as well as appropriate task delegation; supporting and strengthening health educational institutions; securing the health and safety of health workers; and organizing supportive and favourable working conditions and environments.

2.7.4 Integrated management of adult and adolescent illness

Dr Daoni Esorom (Papua New Guinea) elaborated on the experience in Papua New Guinea with the scaling up of ART human resource planning, adaptation of integrated management of adult and adolescent illness (IMAI) training materials and training. Very important in the process was the high level of government support, careful adaptation of guidelines and approaches to something consistent with the local context, an opportunity for testing the adapted materials, and the creation of a team of trainers and facilitators. In the future, it is anticipated that there will be more mixing of training from both the public and private sector, with physicians and nurses receiving basic ART courses together.

2.7.5 HIV and noncommunicable diseases

Dr Gauden Galea (Regional Adviser for Non-Communicable Diseases, WHO Western Pacific Regional Office) challenged the participants to explore similarities between the problems of HIV/AIDS, now becoming a chronic disease, and noncommunicable diseases (NCD) as "two sides of one coin". In important ways, the impact of NCDs is greater for countries than that from HIV/AIDS and both often confront a need for the same kind of health system competencies, such as patient-centred

care, partnerships, quality improvement, information and communication and a public health perspective. Dr Galea expressed hope that, by the end of 2006-2007, at least one Asian and one Pacific country will have piloted a common system for chronic disease prevention and control.

2.7.6 Open forum

There was extensive discussion on the pros and cons of different payment systems for HIV/AIDS-related health services. Although there are important equity needs as regards service accessibility for poor people, it was recognized that some kinds of service fees provide for a more rational allocation of resources and services. There was also widespread concurrence that all sources of funds should be pooled and allocated for disease or health system support, according to national plans.

On the issue of the use of health insurance for funding of HIV/AIDS-related treatment and care, it was recognized that very few countries and private-sector insurance policies cover such services. Insurance, however, has good potential for new resources and should be further explored at the country level.

One participant asked specifically how national governments could be persuaded to increase HIV/AIDS funding. It was recognized that, while methods for attracting more government funds are different for each country, good epidemiological information on the extent and trends of HIV/AIDS is of clear benefit in mobilizing resources.

2.7.7 Group reports: Strengthening health systems

(1) Group 1 report: Human resources development capacity

The group reported on a wide range of issues regarding human resources development. To address the challenges of UA, there is a need to have an overall health resources development plan, with numerical targets and based on an assessment of training needs. Plans should include PHLA and community involvement. In-country training of trainers also needs to be developed. The group recommended that regional and country taskforces or working groups should be formed to deal with the many training needs related to UA. Training programmes and materials need to be adapted to local conditions and should also be linked to the "real situation" in countries with regard to ARV availability.

(2) Group 2 report: Workforce development for harm reduction

The group discussed a proposal for an Asia Harm Reduction Training Network (AHRT-NET). The goal of AHRT-NET is to increase access to HIV prevention, treatment, care and support services among drug users by reinforcing the capacity of health workers and training institutions. Generating and sustaining high-level political support is also an objective of AHRT-NET. The next step for the proposal is the establishment of a secretariat, inviting members to form an Executive Board, partnerships and a technical advisory committee. The first annual meeting of the network is also in the planning stage. Group members were in support of the proposal.

(3) Group 3 report: Health financing

The group came to several straightforward conclusions: although the WHO Western Pacific Region has few countries with a generalized HIV/AIDS epidemic, resource needs will rise and country capacities to manage financial resources will need to be strengthened. Recommendations from the group included a call for increased investment to strengthen health systems overall; to increase health investments and public spending from non-traditional sources (e.g. health insurance, private sector, equity funds); and to strengthen country financial planning and management capacity through sectorwide management systems. In addition, it recommended that WHO and other partners should provide technical assistance and other resources to develop effective health financing policies and strengthen health financing systems to make them more equitable, efficient and effective.

(4) Group 4 report: Strengthening health system through existing or new funding mechanisms

The group probed the need for and potential of increased funding for health systems from existing financing sources, such as the GFATM and PEPFAR. GFATM has had an unclear policy on the circumstances in which it would finance strengthening of health services in the context of their targeted disease programmes. Earmarking funds for health system strengthening does appear to be a part of PEPFAR projects. It was recommended that WHO should continue to support the sharing of experiences between countries; should advocate the need for health service strengthening as a part of funding agency programmes; and should continue to provide assistance to countries in mobilizing resources

2.8 Next steps

2.8.1 National strategy assessment among countries of the Western Pacific Region related to the Global Health Sector Strategy

Dr Robert Fischer reviewed the results of a recent evaluation on the status of national HIV/AIDS strategic plans, especially as they relate to addressing the "core components" of the health sector response to HIV/AIDS, as outlined in the Global Health Sector Strategy. The review of plans of 10 countries in the Western Pacific Region and the Pacific Regional Strategy revealed that current plans are well organized and generally comprehensive. The most common missing components of plans are provisions for blood safety, IDU/harm reduction and universal precautions. Four of the current plans will expire between 2005 and 2007. Dr Fischer reminded the participants that the WHO Western Pacific Regional Office is prepared to assist countries to renew or revise their HIV/AIDS strategic plans, especially since there is now a new goal to pursue, UA.

2.8.2 Discussion on technical support needed, as well as regional technical support groups in specific areas of need

Dr Bernard Fabre-Teste (Regional Adviser, Sexually Transmitted Infections, including HIV/AIDS, WHO Western Pacific Regional Office) reviewed the need for technical support to countries that had been expressed over the previous days of the consultation, including a need for a technical working group or support group mechanism in the area of laboratories, counselling and testing and STI control. Other

areas of more general support need include prevention of mother-to-child transmission and breast-feeding, paediatric care, TB-HIV and ART access.

2.8.3 Open forum

There was general discussion of how the WHO Western Pacific Regional Office might organize and task any technical or support working groups. Although many suggestions were fielded by the participants, there appeared to be consensus that the terms of reference of such bodies must be clearly circumscribed. They should not only be charged with making guidelines and their responsibilities must clearly relate to supporting countries in areas of need that they identify.

Dr Bernard Fabre-Teste made a brief overview presentation on "Universal access: WHO Western Pacific Region vision, issues and challenges." The theme for the presentation was that approaching the goal of universal access by 2010 is indeed feasible if, among a list of prerequisites, there is a high level of political, partner and financial commitment, it really is built on "3 by 5" achievements and lessons learnt, there is effective involvement of PLHA, the "Three Ones" continues to be the guiding principle, there are efforts to strengthen health systems, and prevention is seen as key.

3. CONCLUSIONS

The goal of "Universal Access by 2010" is a welcome next step in building on the momentum from the "3 by 5" Initiative. Valuable lessons have been learnt in trying to address the many challenges of scaling up access to prevention, treatment and care for those in need. Those lessons relate to several issues and programme areas, including: the development and implementation of a continuum of care; the integration and/or application of other care models, including noncommunicable disease models, to HIV/AIDS treatment and care; the assurance of procurement and supply management of quality HIV-related commodities, including ARV drugs; equity of access for those most in need or most vulnerable; the role of PLHA and affected communities in programme design, management and implementation; stigma and discrimination; counselling and testing, including positive prevention and adherence counselling; multisectoral coordination and cooperation, especially between the public and private sector; HIV drug resistance surveillance; and laboratory services.

One of the major achievements in the Region, in addition to the "3 by 5" Initiative, is the establishment and expansion of a continuum of care or the network of care from home and community to tertiary hospitals, with strong involvement of people living with HIV/AIDS at the centre and linking with other relevant health services and sectors. Comprehensive care sites at district or intermediate levels, such as the MMT in Cambodia and the Community Counselling and Support Centre in Viet Nam, have been playing a vital role in translating the concept of continuum of care into practical action in the context of scaling up ART. The continuum of care being expanded will serve as a critical foundation to integrate HIV prevention, including harm reduction; to ensure equitable access to care and treatment for all, including children and those most at risk; and to strengthen health systems.

The UNAIDS and WHO Consultation on Progress in Prevention and Care Scale-up in the Context of the "3 by 5" Initiative and from the Perspective of Universal Access in the Western Pacific provided an opportunity for all stakeholders to appraise and debate those issues and challenges. The following are its main conclusions:

3.1 Universal access

All participants appreciated the opportunity provided by the meeting to learn more about, and begin to explore the challenges of working towards the goal of "universal access by 2010". They largely recognize the fact that the success of universal access will depend greatly on a dramatic increase in prevention with, at the same time, a dramatic decrease in stigma and discrimination.

Especially welcome is the better understanding that: (1) universal access is not a new initiative, but seeks to build on ongoing national responses, the momentum gained, and lessons learnt from scaling-up access to ART through "3 by 5", and to capitalize on the promise of additional resources; (2) universal access in programmatic terms means scaling up activities to ensure the kind and level of coverage of prevention, care and treatment services that will have a real impact on preventing new infections, decreasing mortality and improving the quality of life for those infected and affected; and (3) each country will determine, through appropriate consultative processes with all stakeholders, priority strategies, interventions and activities, and resource implications for scaling up, and will set targets and progressive milestones for coverage.

There is, however, a current need for: (1) greater clarity and a better common understanding among all stakeholders about what "universal" and "access" mean in operational terms; (2) further guidance on the process and the time-frame within which countries will define their goals, targets and milestones towards universal access; and (3) clarity about the role that will be played by the different international organizations and partners in support of countries' goals.

It is recommended that UNAIDS and WHO continue to work together, and with key partners, in helping countries elaborate and implement the important technical, financial and programmatic parameters of universal access. WHO and UNAIDS should ensure that in the process all stakeholders adhere to and uphold the principles of the "Three Ones", in particular through supporting government leadership and ownership and further strengthening accountability and transparency.

3.2 Most-at-risk populations, youth and other vulnerable populations

The experience of the "3 by 5" Initiative has confirmed that it is necessary to carefully target programmes and activities that are aimed at specific risk behaviours and at populations and situations where such behaviours are common. Unprotected sex with multiple concurrent partners (most often associated with female and male sex work and clients of sex workers), unprotected male-to-male sex, and injecting drug use with non-sterile needles and syringes are types of behaviour that put people at highest risk of acquiring or transmitting HIV and STIs. Persons who identify with or can be identified with those types of behaviour are now recognized as most-at-risk populations. From an epidemiological perspective, most-at-risk populations play a special role in the evolution of an infectious disease epidemic as they are likely to be "core" foci of disease, spread frequently through other "bridging" groups. Experience has also shown that, in a given country or area, it is often possible to identify other at-risk or vulnerable population groupings, sometimes by occupation or labour sector (such as uniformed security

services, truck drivers, seafarers, mine and construction camp employees, overseas workers), by other status categories (such as prisoners, refugees, STI clinic attendees, legal and illegal migrants, regular sex partners of most-at-risk populations, spouses/sweethearts) or because of cultural traditions (such as tattooing).

Two other cross-cutting population groups also carry increased vulnerability to HIV infection: youth and women. Young adults are very often likely to engage in the riskiest behaviours for acquiring and/or transmitting HIV. Women too are often subject to social gender inequalities, unbalanced intrahousehold bargaining power, and economic constraints that make them vulnerable to exposure to HIV in heterosexual unions. Youth and women among most-at-risk populations, among other vulnerable population groups, and in the general population, require appropriate gender- and age-responsive strategies to address their needs.

Countries**,** in pursuit of the goal of universal access, should therefore:

(1) identify the specific needs of most-at-risk populations and other vulnerable groups and develop strategies, plans and activities to ensure that they all have access to prevention, treatment and care services; and,

(2) set relevant, challenging targets for coverage with regard to needed services and interventions.

3.3 Equity of access to prevention, care and treatment

Equity of access to prevention, care and treatment is increasingly recognized as a vital component of national HIV/AIDS programmes. Because many most-at-risk populations and other vulnerable populations are poor, socially marginalized or involved in “illegal” behaviour, there is recognition that they can also be marginalized in terms of access to necessary prevention, care and treatment services. As countries and partners move towards the goal of universal access, access of all people to prevention care and treatment programmes takes on added importance.

Countries should therefore:

(1) integrate activities that promote or ensure equity of access to HIV/AIDS prevention, treatment and care services in all elements of the national response to HIV/AIDS, including policy development for free or subsidized treatment and care for all patients in need; and

(2) collect and analyse data on, and monitor closely the social and demographic profiles of persons needing, accessing and receiving public health services, especially HIV/AIDS care and treatment services, to ensure that most vulnerable population groups and the poorest are equitably represented.

At the same time, WHO, UNAIDS and other partners should:

(1) pursue all opportunities to advocate and support national and international efforts to address the full range of challenges in ensuring access to prevention, treatment and care services, including age, gender, social and economicinequities, stigma and discrimination; and,

(2) document and disseminate good practices related to equitable policies and interventions.

3.4 Persons living with HIV/AIDS

Lessons learnt from the "3 by 5" Initiative continue to demonstrate the very positive roles that can be played by persons living with HIV/AIDS (PLHA), as well as persons experienced in high-risk types of behaviour (e.g. male and female sex workers, trans-genders, MSM, IDUs). The life experiences and capacities of such people permit them to bring a valuable perspective to all aspects of the design, management, execution and evaluation of national responses to HIV/AIDS. They have been especially effective as peer counsellors, outreach workers and aides in mapping of priority prevention "hot spots." Unfortunately, experience has also shown that PLHA and those experienced in high-risk behaviour are too often involved in health sector activities as a "token representatives." Also, too often health sector personnel and institutions themselves discriminate against PLHA and most-at-risk and vulnerable populations in the delivery of prevention, treatment and care services.

Countries, partners and international organizations should all seek ways to meaningfully involve those persons experienced in high-risk behaviour, especially PLHA, in all aspects of programme planning and execution in a manner consistent with greater involvement of people living with HIV/AIDS (GIPA). It is also imperative that all are vigilant in identifying and eliminating any discriminatory policies or behaviour revealed in the execution of programmes.

3.5 Condoms

Country experience in the Western Pacific Region has indisputably demonstrated that condom use is effective in preventing the transmission of STI and HIV infections. On the level of public health programming, the 100% Condom Use Programme (CUP) has achieved dramatic results in Thailand and Cambodia, where increases in condom use among entertainment establishment-based sex workers and their clients ("core" and "bridging" groups that were important in those national settings) has been associated with reductions in STI and HIV infections in those groups, and has also been translated into the reduction of HIV and STI prevalence in the general population.

Thus it is recommended that WHO should:

(1) continue to advocate for support of condom promotion programmes and to monitor national efforts to promote condom use in the countries of the Western Pacific Region; and,

(2) take the necessary action to work together with other relevant partners and agencies to identify or develop other condom promotion strategies that, drawing upon the highly successful 100% CUP experience, can be effective with non-establishment-based sex workers and their clients.

3.6 HIV drug resistance surveillance

HIV drug resistance surveillance (conducted in untreated, newly HIV-infected populations) and HIV drug resistance monitoring (conducted in cohorts of patients initiating antiretroviral therapy and then followed for 12-15 months) are important components of the HIV drug resistance package. To date, HIV drug resistance

surveillance and monitoring activities have been predominantly research-based. Knowledge and understanding of HIV drug resistance in the Western Pacific Region is limited, and its application to clinical care and programme management has yet to be elaborated. Moving towards the goal of universal access, there is a clear need to begin transition towards a more public health approach, with integration of HIV drug resistance surveillance/monitoring into surveillance systems and HIV/AIDS programmes, particularly in countries with a significant number of patients taking ARVs, such as Cambodia, China and Viet Nam.

It is recommended that WHO and relevant partners convene a regional workshop on HIV drug resistance, with the objective of bringing together laboratory and technical experts, researchers, existing HIV drug resistance networks and programme managers to discuss the technical and programmatic issues of scaling up HIV drug resistance surveillance and monitoring.

3.7 Counselling and testing

Counselling and testing will be a vital component in pursuing the goal of universal access.

Voluntary, confidential counselling and testing facilities offer major opportunities for prevention, including positive prevention such as health education aimed at discouraging risk behaviours. However, there are a number of constraints, not least of which are stigma, issues surrounding confidentiality, the accessibility and acceptability of counselling, the special challenges in the counselling and testing of children, yet underdeveloped techniques for counselling PLHA about prevention and encouraging adherence to ART protocols, and the frequent absence of an appropriate legal framework addressing such issues as partner notification and data management.

It is recommended that governments work to strengthen national counselling and testing programmes and look especially at the need for legislative support to bolster legal frameworks.

It is recommended that WHO organize a technical working group to support countries to develop and/or adapt national technical and programme strategies to build national counselling and testing capacity to include ART adherence counselling.

3.8 Laboratory services

Laboratory services are a cornerstone in the health service system response to HIV/AIDS, supporting prevention, treatment and care, blood safety and prevention of mother-to-child transmission, as well as other national communicable and noncommunicable disease programmes. Accurate laboratory results, delivered in a timely manner, are the foundation of screening and surveillance, biological and epidemiological investigations, clinical care, and monitoring and evaluation of programmes. However, despite their importance, many national governments and partners have been underinvesting in laboratory services. Throughout the Western Pacific Region, there is a shortage of quality national-level laboratories on which programmes can rely. Specific problems include weaknesses in management systems, unavailable and inadequate instrumentation, shortages or irregular supplies of reagents, and weaknesses in the training and supervision of technical and managerial staff.

It is recommended that WHO should organize a technical working group that will bring together laboratory experts, programme managers and partners to examine closely the technical, logistical and managerial issues, constraints and opportunities confronted by countries, and produce guidelines for establishing and strengthening national laboratory and quality control systems.

3.9 Harm reduction

Consistent with the WHO Biregional Strategy for Harm Reduction 2005-2009, it is recognized that there needs to be an emphasis on harm reduction among both injecting and non-injecting drug users. There is a robust international evidence base to support needle and syringe exchange and drug substitution treatments (predominantly oral methadone for opiate users). Those and other relevant harm reduction activities should be made available to both injecting and non-injecting drug users (notably users of amphetamine-type stimulants), including those in closed settings. Harm reduction activities, especially drug substitution, should be linked to access to ART for HIV-positive drug users, in accordance with appropriate guidelines and strategies for enrolment. In general, a client-oriented approach to harm reduction activities should be promoted.

It is recommended that governments strengthen their national harm reduction strategies and programmes, including the integration of harm reduction into national strategic plans and the monitoring of drug use and intervention programmes in their respective countries.

It is also recommended that WHO should:

(1) continue to advocate for and support and monitor national efforts to promote harm reduction in countries of the Western Pacific Region; and

(2) take the necessary actions to work with other agencies and partners to identify or develop comprehensive harm reduction strategies that can draw upon models of good practice and locally derived evidence bases.

3.10 Strengthening health systems

The "3 by 5" Initiative has underscored the pivotal role of the health sector (see text box), not only in ensuring access to treatment and care, but also in preventing new infections. Based on that experience, it is clear that effective, efficient and sustainable scaling up of efforts towards universal access to HIV prevention, treatment and care depends on the strengthening of health systems both through the mobilization of new resources and through the more effective management and use of existing resources. Many of the elements that have been shown to be key to effective scaling up of ART are also at the core of health systems strengthening. They include developing human resource capacity, strengthening drug procurement and supply management systems, building capacity to support the special nutritional needs of PLHA and to prevent mother-to-child transmission, improving health information management systems, developing or creating

> The health sector is wide-ranging and encompasses organized public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care); health ministries; nongovernmental organizations: community groups; and professional organizations; as well as institutions, which directly input into the health care system (e.g., the pharmaceutical industry and teaching institutions).
>
> **Global Health Sector Strategy, 2003**

innovative health financing mechanisms (e.g. health insurance], building clinical competence in delivering chronic care, and, importantly, community involvement. As countries strive towards universal access, strengthening of health systems will be as much an imperative as a unique opportunity.

WHO should therefore:

(1) encourage donor and partners organizations, especially the GFATM in its following rounds, to support health sector strengthening as part of their overall support and assistance to the scaling up of HIV / AIDS prevention, treatment and care;

(2) work together with other partners to provide technical assistance and other resources to develop sound health financing policies and to strengthen health financing systems to make them more equitable, efficient and effective;

(3) work together with other partners to provide adequate information in the domain of intellectual property, technical assistance and other resources to strengthen quality production, procurement, logistics and management of HIV-related commodities, including ARV drugs;

(4) advocate for and promote collaborations between HIV/AIDS and other health systems programmes (e.g. TB, MCH, Blood Safety, Alcohol Abuse, Noncommunicable Diseases, Human Resources for Health, Nutrition for Health and Development, etc.) to exploit and maximize efficiencies to be gained through synergies in programme activities and infrastructure;

(5) strengthen its assistance to countries in the development and application of legal and regulatory frameworks to support national responses to HIV/AIDS;

(6) encourage and support countries in research on health-seeking behaviour that draws especially upon inputs from vulnerable groups and those affected by HIV/AIDS, so as to improve programme design and planning and improve access to and the quality of HIV/AIDS services, and

(7) continue to strengthen the development and adaptation of simplified knowledge packages and training materials and programmes so that they are appropriate to the local in-country conditions in which personnel work (e.g. based on behavioural studies about health-seeking behaviour in the country, availability of ARVs, literacy levels, cultural factors, etc).

It is recommended that countries:

(1) increase their investments in the overall strengthening of their health systems through both the commitment of new resources and the improved use of existing resources by strengthening programme and financial planning and management capacity;

(2) look for and exploit all opportunities to strengthen their health care systems through the use of external funding and support for HIV/AIDS prevention treatment and care projects; and

(3) explore opportunities to mobilize resources for HIV/AIDS prevention, treatment and care from non-traditional sources, such as public and private sector health and social security insurance schemes.

3.11 Drug and alcohol abuse in HIV transmission

It is noted that, for some countries, the use of non-injecting psychoactive drugs (eg. marijuana, hashish, cocaine, etc) and/or alcohol use is a factor contributing to people engaging in types of behaviour that put them at risk for sexual transmission of HIV. This is true for both identifiable most-at-risk populations (sex workers, clients of sex workers, MSM, IDUs) and the general population, and it is true for those who are HIV-infected as well as those not infected.

It is recommended that countries, where the problem is relevant, should include messages related to non-injecting drug and alcohol use and abuse as a risk factor in HIV transmission in health education and counselling programmes, whether targeted to most-at-risk or other vulnerable populations or the general population, especially youth.

3.12 Surveillance, monitoring and evaluation

It is noted that surveillance, monitoring and evaluation of programmes are key elements in the control of HIV/AIDS epidemics.

WHO, though its technical assistance, should continue to contribute to expansion of strategic information systems in all countries in need, including second generation surveillance practices (HIV surveillance systems, behavioural surveillance systems), new estimation methods, and programme monitoring and evaluation tools,.

3.13 Papua New Guinea and other Pacific island countries and areas

It is noted that Papua New Guinea is particularly badly affected and needs special attention and support to avoid a more dramatic worsening of what is already the worst situation within the countries of the Western Pacific Region. At the same time, the Pacific island countries and areas appear vulnerable and fragile. Due to the complexity of their geographical, social and cultural situation they also need particular attention in partnership development.

WHO, UNAIDS and other partners should therefore increase their efforts in Papua New Guinea and continue to strengthen the already well coordinated partnership in the Pacific islands, particularly in the development of a legal framework for HIV/AIDS prevention and control.

ANNEX 1

PROVISIONAL AGENDA

1. Opening ceremony
2. Objectives and organization of the meeting
3. Epidemiology and surveillance
    a. Overview of HIV/AIDS epidemic in Asia and the Pacific and surveillance issues
    b. Country experiences
    c. Group work to discuss the above issues/challenges and possible solutions
4. Prevention
    a. Overview of HIV/AIDS prevention programmes
    b. Country experiences
    c. Group work to discuss prevention issues/challenges and possible solutions
5. Care, treatment and support
    a. Global, regional and countries overview of the "3 by 5" Initiative
    b. Guidelines update
    c. Access to HIV/AIDS drugs and related medicines and diagnostics
    d. HIV/AIDS and Tuberculosis
    e. Children/HIV/Preventing mother-to-child transmission (PMTCT)
    f. Role of people living with HIV/AIDS (PHA), community involvement
6. Universal access to prevention and care by 2010
    a. Conceptual framework
    b. Essential package
    c. Monitoring and evaluation
    d. Process to develop at global, regional and country levels
    e. Plenary discussion with panel
7. Partnership development
    a. Overview of the 3 Ones and other linked initiatives
    b. Country experiences
8. Prevention and care integration
    a. Overview of prevention and care integration in health sector response
    b. Country experiences
9. Strengthening health system
    a. Overview of health system issue
    b. Health financing issues
    c. Health workforce issues
    d. PNG experience (IMAI raining)
    e. In perspective of UA "strengthening health system" in considering HIV/AIDS as a chronic disease

Annex 1

10. Next steps
    a. Overview of national strategy assessment linking to the Global Health Sector Strategy on HIV/AIDS
    b. Discussion on technical support needed – Regional technical support groups in specific areas of work
11. Presentation, revision and adoption of draft conclusions and recommendations
12. Closing ceremony
    a. Partners representative address
    b. PHA representative address
    c. Country representative address
    d. Regional Director”s address

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