

***Opening speech of J.V.R. Prasada Rao, Director UNAIDS, Regional Support Team for Asia and the Pacific, at the Joint Forum Incorporating the Consultation on Integrating Prevention and Management of STI/HIV/AIDS into Reproductive, Maternal and Newborn Health Services and the 6<sup>th</sup> Asia-Pacific UN PMTCT Task Force Meeting***

**Welcome**

First of all I would like to welcome distinguished guests and colleagues from government, civil society including people living with HIV, academia, donors, private sector, UN and young people, who gathered here today to work together, to find ways to integrate prevention and management of STI/HIV/AIDS into reproductive, maternal and newborn health services. I would also like to thank colleagues from WHO, UNFPA, UNICEF and UNAIDS who joined hands in making this forum possible.

**International commitments**

In the last couple of years, we have seen an increasing number of concerted efforts to integrate reproductive and sexual health and HIV/AIDS services. A significant number of international and global commitments call for equitable access to sexual, reproductive, adolescent, maternal and child health services and affirm the links with reducing the impact of HIV infection on women and children.

- The June 2005 UNAIDS policy position paper ‘Intensifying HIV prevention’<sup>i</sup> expresses commitment to intensify links between sexual and reproductive health and HIV infection at the policy and programme level, build upon the New York Call to Commitment (Linking HIV/AIDS and Sexual and Reproductive Health) and the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children.
- In October 2006 the UN General Assembly endorsed a new target: “Universal access to reproductive health by 2015” as a part of the political resolution adopted at the High Level Meeting.

**Linkages between STI/HIV/AIDS services into Reproductive and Maternal and Newborn Health Services**

Integrating STI/HIV/AIDS services into Reproductive and Maternal and Newborn Health Services, is in fact a natural marriage. Both areas overlap to a large degree - public education, risk-reduction counseling, condom promotion and provision, prevention and treatment of sexually transmitted diseases, and contraception as HIV prevention. The overwhelming majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding.

We also know that reproductive and maternal health providers are at the forefront of preventive health care and are important entry points for HIV prevention for millions of individuals who are at high risk of contracting the virus<sup>1</sup>. Already many countries have started using the integrated approach.

## **The statistics**

The number of people living with HIV in the Asia Pacific region was 8.3 million in 2005 and growing. Over half a million people died of AIDS last year alone and twice as many got infected. Small prevalence rates in large countries translate into huge numbers. Between 2001 and 2004, the estimated number of HIV infected women increased by 16% to over two million in our region – compared to the average global increase of about 8%.

Asia epidemics at all stages are driven by new HIV infections occurring in a few most-at-risk populations, including clients and female sex workers, injecting drug users, men who have sex with men, and partners of these groups.

Growing body of evidence shows that today many new infections are wives infected through sex with their husbands, and many are young children of mothers unaware of their HIV infection<sup>2</sup>.

The fact that women constitute a growing share of people living with HIV suggests that significant numbers of women are being infected by husbands and boy friends who probably acquired the virus during paid sex.

- In Lao People's Democratic Republic where the national adult HIV prevalence is still very low overall, two to three young men in Vientiane said they had had several female partners in previous six months and one in three reported paying for sex (2006 Report on the Global AIDS Epidemic).
- In Vanuatu in the Pacific, more than 40% of pregnant women have been found to have at least one sexually transmitted infection and in Samoa it is 43%.
- Papua New Guinea seroprevalence surveys have found HIV prevalence of 2.5% and 2% among women seeking antenatal care.
- Even in Thailand, which was known for its successful 100% condom campaigns, is now facing new challenges. According to MoH, more than one-third of infections in 2005 were among women who had been infected by their long-term partners, premarital sex has become more

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<sup>1</sup> ("New Analysis calls for increased integration of reproductive health and HIV prevention services" Press release by UNAIDS, UNFPA, IPPF, and the Alan Guttmacher Institute. June 2004)

<sup>2</sup> Framework for integration of maternal and newborn health, sexual and reproductive health and HIV prevention and care in Asia and the Pacific

commonplace among young people and condom use even during paid sex has waned seriously.

UNAIDS estimated that by the end of 2003, a total of about 168,000 children were infected in the region, up from 136,000 at the end of 2001. In 2004, in Asia there were an estimated 155,400 pregnant women infected with HIV and 46,900 children became infected with HIV. Many young women become infected through exploitative, coercive or violent sex.

## **Opportunities**

However, despite all these daunting statistics, we have to acknowledge the fact that many countries in our region still have a low prevalence. These countries still have the opportunity to keep 99.9% of their populations HIV free.

We must also not forget that we have three decades of rich experience and investment in the area of reproductive and maternal health. Reduced maternal mortality rates in Thailand, Malaysia and Sri Lanka, and successful family planning initiatives across the region - just to cite a few examples.

There are of course many forces behind these successes. However the key to success is the expansive infrastructure of reproductive and maternal health service providers. They cover both urban and rural, trickling down to smallest and poorest units of society. In many instances they are the only front line health workers who are in touch with and are embedded in the community.

Whereas if we look at the HIV services in our region today, we are still lagging far behind. Most of the services are understaffed and hardly exist beyond the provincial level. The coverage of the services is therefore very low. For example, prevention programmes reached only 19% of sex workers, less than 2% of men who have sex with men, and 5.4% of injecting drug users in South and South-east Asia. In 2005, only 9% of pregnant women in low- and middle-income countries were offered services to prevent transmission to their newborns. Treatment was similarly lagging sorely behind the accelerating epidemic, with more than 80% of PLHIV in need of ART unable to access it. Between 2003 and 2005, the percentage of HIV-positive pregnant women who received prophylactic antiretrovirals increased from 3.3% to 9.2%.

Coverage remains the key to reversing the epidemic. We need to reach at least 80% of the populations most-at-risk to achieve the levels of condom use and harm reduction to stop the epidemic growth. We have evidence that if we can ensure 60% of safe behaviour among key populations-sex workers and their clients, injecting drug users and men who have sex with men-the epidemic could be reversed among those groups.

This is the time when we need to grasp every opportunity to synergize and to integrate the two agendas STI/HIV/AIDS services and reproductive and maternal health services. If they are rolled out as separate vertical programs they may jeopardise the strengthening of government health systems on which they all depend for success and sustainability.

### **Key areas of integration**

There are a number of areas where we can successfully integrate prevention and management of STI/HIV/AIDS into reproductive, maternal and newborn health services. I would like to highlight a few:

For HIV-infected women

- Prevention of transmission from mother to her infant
- Ensure their infants receive co-trimoxazole prophylaxis, follow up care and early HIV diagnosis.
- Refer HIV positive women and children for assessment and ARV treatment and OI and treatment as required

For HIV-negative women

- Provide HIV prevention counselling at routine couple visit
- Refer women/couples at higher risk, or with symptoms/ signs suggestive of HIV for counselling and testing and follow up PMTCT interventions if positive
- Detect and treat STIs, especially syphilis, as part of antenatal and postnatal care (More than 340 million people contract a curable SI each year, with women having greater vulnerability to infection than men) (WHO 2005 – 2006 global report pg 130).
- Offer information and supplies of male and female condoms

For children

- Offer paediatric ARV treatment for HIV+ children for their survival

Routine offer of VCT to all clients and their partners, or offer referral to VCT centre if indicated and testing facilities not available at Family Planning Clinic.

### **Conclusion**

A great deal of work has already done on integration of HIV prevention and care with sexual, reproductive, maternal and newborn health, and the lessons learned have been well documented. Now is the time to scale up these efforts and to realize universal access to HIV prevention, treatment, care and support by 2010 and universal access to sexual and reproductive health by 2015, and save the lives of millions of people in the Asia-Pacific region. I am confident that by the end of this consultation, you will be able to come up with an excellent framework

for integration and a set of recommendations for the stakeholders to collaborate to make this a reality. I wish you a productive meeting.

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<sup>i</sup> United Nations General Assembly. Declaration of Commitment on HIV/AIDS, 26<sup>th</sup> Special Session. August 2001