

Opening of the 1st Asia Pacific Joint Forum:

Consultation on Integration of Prevention and Management of STIs / HIV / AIDS into Reproductive, Maternal and Newborn Health Services And The 6th Annual Asia Pacific UN Task Force on PMTCT Meeting

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**Richard Bridle, Deputy Regional Director
United Nations Children's Fund (UNICEF) East Asia and Pacific Regional Office**

Monday, November 6, after lunch / Sheraton Subang Hotel and Towers, Selangor, Malaysia

Your Excellencies, distinguished delegates, and colleagues from the UN family:

Let me say how pleased UNICEF is to be a partner of this joint forum, the organization of which has spanned nearly one year, traversing the geographic scope of 7 regional offices of WHO, UNFPA, UNICEF and UNAIDS, involving more than 20 countries. We are also grateful to the Ministry of Health of Malaysia for agreeing to host it; for enabling us to bring an impressive array of Governments, health professionals, people living with HIV, young people, civil society and UN partners from all over Asia-Pacific together. The fact that all seven regional offices have decided to jointly invite you here represents our modest efforts to foster linkages and dialogues, and maximize the synergy each of you can bring to the subject of integration.

This joint forum, held together with the annual Asia-Pacific UN Task Force on PMTCT, aims to shape our scale-up strategy towards universal access, for which the complete scope is unattainable unless HIV prevention, treatment and care are integrated with other services in the health care system. It is a recognition, on our part, that scaling up HIV prevention HIV in children and women cannot be achieved by any agency or department alone. The consultation between us is the first step towards fostering a common understanding on integration, how to improve linkages and coordination of a set of rather disparate services and programmes in largely vertical systems, and who shall take leadership.

HIV and AIDS manifests itself not only in surveillance data – largely concentrated and low in Asia-Pacific – but also in social indicators that points to gender inequality, social and economic disparities, including education and access to services, social exclusion, high fertility, high incidents of domestic and sexual violence, poor health and pervasive absence of reproductive health rights of women and girls.

It is unambiguously clear that in the long run, to prevent new HIV infections in children, we must prevent HIV infection in women. To assure children a future unclouded by HIV, we must safeguard women from HIV now. While it seems common sense, the current systems and the way they're organized does not provide for a straightforward response. For too long, we have focused our efforts exclusively on interrupting HIV transmission in newborns, and that the gains have not outweighed the losses of seeing more women infected with HIV, especially in a low prevalence region like Asia-Pacific.

The missed opportunities entail high opportunity costs when women, especially those vulnerable and at risk of HIV, are reached by the health system too late. New epidemiological trends in the region are already showing a growing percentage of women and girls living with HIV. The improvement of HIV prevention services for women will entail, first and foremost, better collaboration between departments and greater convergence of services that enable us to more effectively reach out to the vulnerable groups and their sexual partners. Men who visit STI services, for instance, can be asked whether their partners are pregnant, and young couples who attend family planning sessions can be educated about safe sex and reproductive health, not only birth planning. There are also inherent advantages to the integrated approach. Pregnant women in general can access a range of services, from child vaccination to contraception and HIV counselling, antenatal care, and screening for STIs on the same day, which save them time and travel costs.

As we strive towards programme and service integration, we must however acknowledge the reality of cost. Competing priorities and often low level of resources do not allow us to scale up the approach everywhere. For low and concentrated epidemics, pretty much characterize the current HIV status of Asia-Pacific, we must prioritize our scarce resources to bring these services to women most in need through better referrals. This usually takes the form of referral from community level to a higher level of services where lab support for testing and blood screening is in place. And this entails prioritizing the approach for pregnant women or girls of reproductive age in high prevalence, high risk pockets of each country. This also entails prioritization of testing and counseling of women in high prevalence and high risk areas, and improving sub-national data that point to where HIV is circulating.

Along with it comes the prioritization of PMTCT services for women in high prevalence areas. Now quite commonly and narrowly confined to ARV prophylaxis treatment to interrupt HIV transmission during and after delivery, the service tends to follow testing results. Whether routinised with opt-out or voluntary testing, we have to prioritize the service to reach those who need it most, the vulnerable groups who may not have access, or fear rejection by the health system due to stigma attached to STI and HIV. PMTCT service also needs to recognize women's inherent rights to reproductive health treatment, knowledge and support services, which are not dependent on their test results.

The question that increasingly assumes importance is whether a population-based strategy will enable us to reach women most in need of prevention services. When HIV prevalence is generally low, as is the case in Asia-Pacific, in particular, East Asia and the Pacific region, we are likely to find 99% of women testing HIV negative. And we tend to let those who test negative go, with a congratulation, without paying due attention to the risk of HIV infection they face at later stages of pregnancy. Women are more susceptible to HIV for a range of biological reasons during pregnancy. Cultural factors and sexual behaviours among men during this period can greatly exacerbate the risk of HIV infection.

Further, we tend to overlook women in high HIV prevalence pockets where behavioural trends and risks are dominant, and whose needs for reproductive health services, including STI diagnosis and treatment, and maternal and child health services are the greatest. And those we should increasingly target are spouses of men who buy sex, men with multiple sexual partners, men who have sex with men and also with women, and partners of injecting drug users.

Thus In achieving greater integration and convergence of services, we cannot emphasize more the importance of engaging men. We have so far not sufficiently recognized that men are largely the ones making sexual and reproductive decisions. When a woman remains unable to decide when to have children and how many children she wants, she is least likely to be in a position to insist on condom use with her husband to shield her against HIV risk.

And men could be involved through such new behavioural norms as a routine couple antenatal visit. This will enable discussion with the expectant father about warning signs of complications during pregnancy and labour and the need to make a plan for urgent transport and referral. He can also learn what he can do to protect his wife's health during pregnancy, and understand the importance of exclusive breastfeeding. In these ways a couple antenatal visit can contribute to maternal and perinatal health. It also allows both partners to be tested and treated for STIs and for condoms to be promoted and provided, and what it entails, perhaps, is simply thinking out of the box, such as creating a unique space for men in ANC clinics, without much cost.

To date, much of the strategic focus of action to prevent HIV infection in children has been on counseling and HIV testing in ante-natal settings which are linked to provision of antiretroviral prophylaxis, counseling on infant feeding choices, and safe delivery services to those women who test positive for HIV. We have made inroads. Many countries in Asia and Pacific have national guidelines in place for prevention of parent to child transmission. Many countries have trained health workers and are introducing treatment. Many health facilities have started out-reach services to mobilize communities and to make services available to a larger segment of women.

The issues remain one of stepping up effective measures to prevent HIV among women, prioritizing the package of services in areas and to those who need it most, and integrating PMTCT with larger measures to improve women and children's health. And I am glad these will be discussed this week in our common effort to meet your leaders' promises at the start of the millennium.

Let me end with an interesting statement from Stephen Lewis, UN Special Envoy on AIDS, who said that "maternal mortality, between 500 and 600 hundred thousand deaths per year -- had not changed for thirty years. You can bet that if there was something called paternal mortality, the numbers wouldn't be frozen in time for three decades."

I wish you all success in this trend setting endeavour to arrive at an integrated framework for Asia and the Pacific, and a set of strategies that are relevant to the HIV epidemics and unique conditions of this vast, populous and diverse region.

Thank you.