

*Progress and challenges towards achieving the
Elimination of Mother to Child Transmission of HIV
and Congenital Syphilis in Europe and Central Asia*

Consultation report

21–23 April 2015
Astana, Kazakhstan



**World Health
Organization**

REGIONAL OFFICE FOR
Europe

Progress and challenges towards
achieving the Elimination of Mother
to Child Transmission of
HIV and Congenital Syphilis in
Europe and Central Asia

Regional Technical Consultation

21-23 April 2015, Astana, Kazakhstan

Background

Globally the commitment to eliminate mother-to-child transmission (EMTCT) of HIV and congenital syphilis (CS) has been strengthening. In June 2011^{1,2} a Global Plan towards the Elimination of New HIV Infections Among Children and Keeping Their Mothers Alive was launched by a coalition of partners led by UNAIDS. An interagency task team (IATT) on EMTCT, co-convened by WHO and UNICEF and comprised of 25 organizations, has aligned its structure to support countries towards achieving their EMTCT goals as well as support the achievement of the related millennium development goals (MDGs), including MDG 4 (reduce child mortality), MDG 5 (improve maternal health) and MDG 6 (reduce the spread of HIV).

In the context of actions needed to achieve MDGs 4, 5 and 6, the global initiative for elimination of CS³ was launched in 2007, and in 2012 the epidemiologic, economic and health systems benefits of investing in the elimination of CS⁴ were outlined. Given the types of interventions necessary to prevent the mother-to-child transmission of HIV and syphilis in pregnancy, a dual approach towards achieving accelerated control of both HIV and syphilis prevention is recommended. A consolidated and integrated approach through the maternal and child health care systems would lead towards the dual elimination of both HIV and congenital syphilis infections in infants.

In 2012, WHO, UNAIDS, UNFPA, and UNICEF jointly conducted a series of country visits to assess progress in the prevention of mother-to-child transmission (MTCT) of HIV and syphilis. This was followed by a technical consultation that aimed to reach consensus on the criteria and processes that should be used for validating country achievements towards the elimination of MTCT of HIV and/or syphilis. Following this consultation, the “*Global Guidance on Criteria and Processes for Validation of Elimination of Mother-to-Child Transmission (EMTCT) of HIV and Syphilis*”⁵ was issued.

In September 2014, a follow-up Global Consultation on the EMTCT validation took place in Geneva giving further stimulus and providing tools for elimination validation. These tools were successfully piloted in the European Region in December 2014.

Over the last decade, countries in the WHO European Region have achieved significant progress in the prevention of mother-to-child transmission of HIV and Congenital Syphilis. The “*Strategic Framework for the Prevention of HIV Infection in Infants in Europe*”⁶ published in 2004 set goals and outlined country-level strategies for lowering the rates of

¹ Eliminate new HIV infections in children is a core element of strategic direction 1 of the WHO Global Health Sector Strategy on HIV/AIDS 2011-2015 http://whqlibdoc.who.int/publications/2011/9789241501651_eng.pdf

² Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half by 2015 is a strategic goal of the UNAIDS Strategy 2011-2015 <http://www.unaids.org/en/aboutunaids/unaidstrategygoalsby2015/>

³ <http://www.who.int/reproductivehealth/publications/rtis/9789241595858/en/index.html>

⁴ http://apps.who.int/iris/bitstream/10665/75480/1/9789241504348_eng.pdf

⁵ Global guidance on criteria and processes for validation: elimination of mother-to-child transmission (EMTCT) of HIV and syphilis. 2014 <http://www.who.int/hiv/pub/emtct-validation-guidance/en/>

⁶ Strategic Framework For the Prevention of HIV Infection in Infants in Europe http://www.unicef.org/ceecis/Strategic_framework_for_the_prevention_of_HIV.pdf

MTCT of HIV. The European Action Plan for HIV/AIDS, 2012 – 2015⁷ endorsed by all WHO European Member States in 2011 provided further guidance on strategies and priority actions to achieve elimination targets defined as less than 2% transmission in non-breastfeeding and <5% in breastfeeding populations.

The Region has subsequently achieved and maintained the highest estimated coverage with antiretroviral medicines to prevent MTCT of HIV (>95%) and the highest early infant diagnosis coverage of any region; and the highest estimated coverage with HIV testing and counselling among pregnant women globally⁸.

Such rapid progress has been achieved largely by integrating HIV prevention into existing maternal, newborn, child and adolescent health services. However, up to 60% of HIV positive pregnant women have partners who inject drugs and about 40% have partners with a history of imprisonment. In central Asia, an emerging risk factor for women acquiring HIV is having a sexual partner who is a migrant labourer^{9,10}. As the Region moves closer towards achieving the goals of elimination of mother-to-child transmission, the unique challenge ahead is to maintain these achievements and ensure that they are equitably available to all. This will require ensuring that each and every woman and child, including those who are most vulnerable (such as migrants, prisoners, drug dependent women, those selling sex), have full access to quality and effective services to prevent MTCT of HIV and congenital syphilis and is able to stay alive and healthy by accessing quality life-saving treatment, care and support.

Objectives and the expectations of the consultation included:

- Discuss and reach a consensus on the regional criteria and processes for validating EMTCT of HIV and CS, so that the successes of high performing countries in Europe can be documented, recognized and can serve as models of success for other countries;
- Address the remaining challenges as there are still pregnant women living with HIV in the Region – especially women who inject drugs, sex workers, ethnic minorities, migrant women, refugees and prisoners - who do not access antenatal care or who present late and miss their chance to have a healthy, uninfected baby;
- Review policies and implementation status of PMTCT guidelines;
- Recommend actions and a monitoring strategy to accelerate access to and uptake of quality prevention services, particularly by key affected populations, in order to achieve the goals of the elimination of MTCT of HIV and Congenital Syphilis;
- Address issues of the involvement of male partners in prevention and care efforts, as in some countries in the Region substantial proportions of pregnant women living with HIV report that their sexual partners are also HIV infected and/or at increased risk of HIV;
- Provide input to the development of Global Health Sector Strategies on HIV/AIDS and STIs, 2016-2022.

⁷ European Action Plan for HIV/AIDS 2012–2015 <http://www.euro.who.int/en/what-we-do/health-topics/communicable-diseases/hiv-aids/publications/2011/european-action-plan-for-hiv-aids-2012-2015>

⁸ Global update on HIV treatment 2013: results, impact and opportunities. WHO report in partnership with UNICEF and UNAIDS; http://apps.who.int/iris/bitstream/10665/85326/1/9789241505734_eng.pdf

⁹ Thorne C et al. Towards the elimination of mother-to-child transmission of HIV in low prevalence and concentrated epidemic settings in eastern Europe and central Asia. Copenhagen, WHO Regional Office for Europe, 2011 (http://www.euro.who.int/__data/assets/pdf_file/0004/136273/e94882.pdf, accessed 3 June 2013).

¹⁰ UNAIDS and WHO Regional Office for Europe. HIV/AIDS in Europe and central Asia: progress report 2011. Geneva, UNAIDS, 2012 (http://www.unaids.ru/sites/default/files/eca_regional_report_on_ua_to_hiv_programs.pdf).

The meeting took place in Astana, Kazakhstan, 21-23 April 2015. The managers of national HIV/AIDS and STI programmes, experts in epidemiology, HIV (PMTCT), STI, public health from 18 countries of Europe and Central Asia, representatives of UN, donor and partner organizations, including ECDC, TGF, US CDC, EU, representatives of civil society, professional societies. In total more than 70 individuals participated in the consultation.

Session 1: Welcome remarks

Melita Vujnovic WHO representative Kazakhstan; Alexey Tsoy Vice-Minister, Ministry of Health and Social development, Kazakhstan; Vinay Saldanha UNAIDS RST; Martin Donoghoe, WHO Regional Office for Europe; Nina Ferencic, UNICEF Regional Office; Kamal Goshliyev, UNFPA.

Melita Vujnovic welcomed attendees to the regional consultation to *Progress and Challenges toward achieving elimination of Mother to Child Transmission of HIV and Congenital Syphilis in Europe and Central Asia*. She noted the attendance from sister UN agencies: UNFPA, UNICEF, UNAIDS and WHO Collaborating Centres, major donor and partner organizations attending the consultation. Of note for the current meeting is the work of Kazakhstan over the past three years, for the significant investment on the elimination MTCT, which was led by the government of Kazakhstan, and supported by WHO and numerous UN organizations, partners including civil society. Kazakhstan hosted one of Global pilots and contributed to the elaboration of elimination validation processes and criteria.

Alexey Tsoy welcomed participants to the consultation and Kazakhstan. He acknowledged the progress on the PMTCT and the important support of WHO, UNICEF and UNAIDS in progressing work in this area. PMTCT has been a priority for Kazakhstan to enable women living with HIV to become pregnant, avoid terminating their pregnancy and deliver healthy babies. These initiatives have focused on enhancing prevention and treatment efforts with pregnant women living with HIV, given prevention is the most effective approach to reducing new infections and minimizing the impact of the epidemic.

Vinay Saldanha (via telephone) noted the current consultation included 18 countries in the region who sought to eliminate the MTCT of HIV and congenital syphilis. This is linked to the UNAIDS goal to eliminate vertical transmission of HIV. The 70th Regular Session of the UN General Assembly (UNGASS 70; 15 September 2015) will review the achievements and how many children's lives were saved in our region. Vinay Saldanha encourages all participants to maintain momentum, further promote collaboration and partnership, accelerate movement towards achieving goals of a Global Plan towards the Elimination of New HIV Infections Among Children and Keeping Their Mothers Alive and wished all a productive meeting.

Martin Donoghoe greeted and thanked the hosts and participants of the meeting. He identified the need for all of the UN to continue to present a unified voice in articulating the importance of the elimination of MTCT as one of global priorities for HIV and congenital syphilis. He emphasized importance of uniting to working partnership to achieve this important though challenging goal. As the Region moves closer towards achieving the goals of elimination of mother-to-child transmission, the challenge remains to maintain these achievements and ensure that they are equitably available to all including those who are most vulnerable such as migrants, prisoners, drug dependent women, those selling sex.

Nina Ferencic noted that tackling HIV about more than fighting the virus, it is also about offering the possibility for healthy life for the mother and child. She identified that there is global consensus that the world must strive towards the elimination of new HIV infections among children, and to ensure mothers and children living with HIV have full access to quality and effective services to prevent MTCT of HIV and congenital syphilis and is able to stay alive and healthy by accessing quality life-saving treatment, care and support.

Kamal Goshliyev reiterated the UNFPA position on the importance of integrated services for reproductive health. This requires the integrating reproductive health with services relating to the PMTCT of HIV, STIs, and family planning. It is important to continue to address population disparities when eliminating the transmission of congenital syphilis and MTCT of HIV in line with the post 2015 development agenda.

Introduction to the meeting and scene setting

Lali Khotenashvili, WHO Europe

Lali Khotenashvili presented an overview of PMTCT of HIV and Congenital Syphilis in the WHO European region. It was emphasized that the region enjoys world lowest reported numbers of HIV MTCT and CS, high estimated ARV coverage to prevent MTCT and the highest EID and HTC coverage among pregnant women globally. The reported HIV MTCT data suggests a decreasing rate of transmission in the region as a whole, though a subregional breakdown suggests this is occurring in the Western and the Eastern parts. While the decreasing trend is steady in the West, it is less so in the East which brings into question the sustainability of the achievements and prevention efforts in that part of the Region.

The majority of reported cases of MTCT are in the Russian Federation and Ukraine. The highest MTCT case rate per 100 000 live birth is reported in Ukraine. While a decreasing trend can be observed in the Russian Federation, the trend in the Ukraine has remained largely unchanged. The country shows some signs of a decreasing trend though the fall is not steady but rather intermittent. This leads to a number of questions: Why is the decrease erratic despite the broader regional achievements? Why is the sustainability of the PMTCT programme still a challenge and what are potential solutions to this challenge? Is the quality of the data reliable? Given the rates of MTCT in the Eastern and Central regions of Europe show increasing trends, what are the reasons for this? Does this reflect increased number of cases, an improved HIV testing policy or rather improved reporting?

It should also be noted that the reported MTCT cases in many countries do not reflect the year of births but rather the year of reporting, and universal testing of pregnant women is not the case in all countries across the region (especially those in Central and Western Europe). In addition to this, many countries lack cascade data which further complicates data analysis and inter-country comparisons. Improvement of GARPR data quality broadly remains a major challenge. Therefore available data should be interpreted with caution.

The available data on CS shows a significant decline up to 2006 and no changes afterwards. It is unclear at this point if this suggests the limit of the elimination target has been reached. The heterogeneity of the CS case definition in the region adds additional challenges to the comparison and analysis between countries.

The available data suggests there are many strong HIV PMTCT and CS control and prevention programmes exist in the Region. However a number of questions exist about these programmes, including:

- Do the programmes cover all pregnant women?
- Are available data reliable enough to reflect the magnitude of problem?
- Are laboratory systems sufficiently robust in their quality?
- What efforts should be undertaken on the way to reaching elimination targets?
- How to address potential challenges , including:
 - Insufficient reporting to GARPR
 - The lack of universal HIV or syphilis testing of pregnant women in number countries
 - The lack of access or coverage data for key populations.
- In the situation where a country lacks process and target data, is it possible for them to apply for and obtain validation?
- Are countries ready for and interested in obtaining validation?
- Are the global criteria and processes involved in validation relevant for the region?
- What questions regarding the MTCT of HIV and CS should be reflected in new GHSS?

It was hoped that the discussions during this meeting will shed light on these challenges and help to answer these questions. It was envisioned that by the meeting's conclusions and recommendations will contribute to the improvement of control and prevention of MTCT of HIV and CS, accelerate progress towards elimination its validation in the region.

Plenary Session 1: Progress towards elimination of mother to child transmission of HIV and congenital syphilis in Europe and Central Asia

Co-chairs: Gulnara Abdulmanova (Kazakhstan), Evgeny Voronin, (Russian Federation).

Presenters: Clair Thorne, UNICEF consultant; Lali Khotenashvili, WHO Europe;

Clair Thorne presented the overview of the progress towards EMTCT of HIV in Europe and Central Asia. She noted that Europe and central Asia have the highest ARV prophylaxis coverage for pregnant HIV-infected women and their infants relative to all other low- and middle-income countries. In most European settings, HIV testing is a routine component of antenatal care, and a number of strategies have been recruited to further ensure the HIV status of pregnant women, including intrapartum testing of women with unknown status, and repeat testing of women in their third trimester of pregnancy. Indeed, a key lynchpin of any efforts surrounding PMTCT is the need to ascertain women's HIV status during or prior to pregnancy. The major issues to address are the late diagnosis (or failure to diagnose) women, barriers to ANC, the late initiation of ART in some women, treatment failure due to drug resistance or poor medication adherence. Opportunities exist in the region to effectively address these issues and to further decrease HIV MTCT, the number of new infections among children in the region.

Lali Khotenashvili presented the overview of Congenital Syphilis in the WHO European Region. Mother to child transmission of syphilis (MTCT-syphilis) exerts a high burden of adverse pregnancy outcomes, including infected infants (classically known as cases of “congenital syphilis”), stillbirths, and neonatal death.

The European region currently has one of the lowest recorded rates of adult syphilis and MTCT-syphilis in the world. The WHO European region is well placed to eliminate this public health problem across the region: rates of antenatal care attendance are high, health systems are generally well supported, and rates of syphilis in the adult population are generally low.

Nonetheless, there are still challenges to a goal of eliminating MTCT-syphilis in Europe. Rates of syphilis in the WHO European region are low, but cases of ‘congenital syphilis’ are still being reported from across the region each year. Mother to child transmission of syphilis is preventable, and interventions are feasible, cost-effective, and generally acceptable to pregnant women and their partners. Political commitment to eliminating mother to child transmission of syphilis is relatively diffuse and low across the region, with few dedicated programmes, and little ring-fenced money available. Most activities are integrated into existing programmes in sexual and reproductive health. Integration requires mechanisms of accountability to be strengthened, but there is little evidence this is happening across the region. Same day testing and treatment are feasible, acceptable and recommended strategies. However, many women are required to visit multiple providers for screening, treatment and follow-up. Harmonizing interventions may require task-shifting and policy review, but is likely to result in increased coverage and less loss to follow up. In addition, it is likely to be a more acceptable service package for pregnant women in most settings. Reporting on surveillance, monitoring and evaluation is uniformly weak across the region. For validation of elimination of MTCT-syphilis at national level, there are three core indicators that require regular reporting, but many countries have not managed yet to routinely report on these 3 indicators. Strengthening reporting and surveillance systems is a high priority – and requires identification of lines of accountability too. Impact indicators (rates of ‘congenital syphilis’) are not being measured and reported in a standardized way across the region. Standardization of definitions is needed for the region.

Eliminating MTCT-syphilis in the WHO European region is achievable, but validation of such a goal requires commitment to measurement, which also increases accountability of programmes and policies to pregnant women and their partners.

Plenary Session 2: Country perspectives on the elimination of mother to child transmission of HIV and congenital syphilis

Co-chairs: Marina Semchenko, UNAIDS, Saulius Caplinskas, Lithuania.

Country colleagues shared developments on progress achieved towards elimination of MTCT of HIV and Congenital Syphilis in following countries: Armenia, Uzbekistan, Azerbaijan, Ukraine, Belarus, United Kingdom, Bulgaria, Tajikistan, Estonia, Slovakia, Denmark, Serbia, Georgia, Russian Federation, Kazakhstan, Republic of Moldova, Kyrgyzstan, Lithuania. Main achievements, remaining challenges and country plans to address those challenges are shortly discussed below.

Armenia:

- **Epidemiology:** The rate of HIV in Armenia is 62/100 000, with heterosexual sexual contact being the main mode of transmission, followed by injecting drug use (63% and 28% respectively). There were no CS cases for last 4 years (2010-2014). MTCT accounts for less than 1.8%.
- **Major achievements:** A national strategy has been endorsed; full ART coverage in children; low levels of MTCT; full coverage with ART prevention programmes.
- **Challenges:** Low levels of HIV testing of the partners of pregnant women; lack of rapid testing in some maternity hospitals; ensuring the continuous provision of HIV services.
- **Plan for 2015:** scale up testing of the partners of pregnant women; increase government funding to HIV programmes and reduce reliance on Global Fund funding

Uzbekistan:

- **Epidemiology:** HIV prevalence of 0.1% amongst pregnant women in 2013. The rate of congenital syphilis has been decreasing rapidly, to 2 cases in the past 7 years.
- **Major achievements:** A good legislative base for public health action has been established; a high rate of ART coverage among pregnant women and children, and low levels of mother to child transmission of HIV (0.7%); the government has been increasingly financing PMTCT programmes; 98% of target population receive syphilis screening.
- **Current challenges:** No current challenges.

Azerbaijan:

- **Epidemiology:** There were 4 902 new HIV infections in 2014: 76% male and 24% female. Most transmission occurs through heterosexual contact, and this is increasing, as is infection amongst women.
- **Achievements:** Integration of PMTCT and STI services into the maternal and child health programmes; the development of the syphilis diagnostic protocol for pregnant women; a move to Option B+ in 2012; PCR tests are now conducted with 88% of children.

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- **Challenges:** A significant challenge exists with low coverage and late testing for HIV and syphilis of pregnant women. The epidemiological data is often inaccurate and needs to be improved. There are low levels of ART coverage in children which must be addressed.
 - **Plan for 2015:** Address the low levels of ART coverage and issues with both HIV and syphilis screening; addressing workforce shortages; strengthen integration with antenatal services.

Ukraine:

- **Achievements:** Ukraine has introduced PMTCT in all maternity programmes across the country, including the provision of rapid testing. Pregnant women are being detected earlier in their pregnancy, and there is a very high level of coverage with triple-therapy (95%) amongst these women. The country has moved to Option B+ in line with WHO recommendations. The integration of PMTCT and opioid substitution programmes has improved. Syphilis screening rates for pregnant women are very high (97%).
- **Challenges:** The broader political difficulties have impacted on the delivery of services in Ukraine, and somewhat linked with this are issues with the need to increase state financing. Stigma and discrimination is a significant issue and this is especially pronounced in high risk groups of pregnant women. The collaborative relationships with the NGO sector needs strengthening.
- **Plan for 2015:** This will include a focus on improving drug supply chain to avoid ART stock outs. There is the need to focus on improved integration and collaboration between different areas of the health system, including the NGO sector. A greater focus on reducing stigma emanating from health care workers is required and an improved legislative base for HIV and STIs will be developed.

Belarus:

- **Achievements:** A very high screening rate exists in Belarus (99.4%), and 100% of infants are formula fed. There have been no cases of congenital syphilis in the past five years.
- **Challenges:** The HIV diagnostic algorithm (dual lab based testing protocol) results in a delay in diagnosis and treatment. Similar delays are incurred for children (though using PCR testing). A significant proportion of women are not covered adequately nor do not visit antenatal clinics. Migrants are particularly disadvantaged with regards to access to services.
- **Plan for 2015:** There will be a focus on the procurement of appropriate test systems for PCR diagnostic tests for children.

United Kingdom:

- **Epidemiology:** A high rate of screening (98%) and the rates of HIV and syphilis are decreasing among migrants.
- **Achievements:** All women in antenatal care are offered testing for HIV and syphilis in early pregnancy, with rapid referral if a woman is positive. There are good contact tracing protocols and a comprehensive surveillance system.
- **Challenges:** Syphilis has re-emerged since 2000. Concerns exist that there are barriers to accessing antenatal care for some women, and this is linked to cultural barriers, migration, socioeconomic deprivation and social marginalization.
- **Plan for 2015:** Enhance advocacy through civil society. There is also an enhanced surveillance system being developed, including clinician led mandatory reporting to local health protection teams, and confirmatory testing carried out by a reference laboratory.

Bulgaria:

- **Epidemiology:** Approximately 62 cases of HIV in pregnancy last year, and 25-30 cases of congenital syphilis in the past 5 years.
- **Achievements:** There is good coverage with prevention programmes with key populations, and mobile units have been conducting HIV/STI screening. Screening for pregnant women sits at 80-90% and this is supported by a clear testing algorithm.
- **Challenges:** Some pregnant women from at risk groups (particularly mobile, ethnic groups) do not reliably access ANC services, and are frequently not tested for syphilis. Treatment for STIs is not free.
- **Plan for 2015:** Integration of programmes for the prevention and control of HIV and improved service provision for services provided for HIV and STIs for at risk groups.

Tajikistan:

- **Achievements:** The testing coverage has increased to 97.4% in 2014. There are new clinical protocols on STIs and syphilis, and the national clinical protocol on the PMTCT has been revised
- **Challenges:** Approximately 10% of women still choose home delivery for childbirth. There is a low level of coverage for PMTCT programmes for pregnant women. There has been inadequate government funding for medicines and laboratory testing, which has resulted in inadequate ART coverage in vulnerable groups. There are insufficient rapid tests for use by pregnant women.
- **Plan for 2015:** The focus will be in further improving antenatal services programmes and their integration, and raising the profile of AN services to pregnant women. Improved procurement of rapid tests will also be a focus.

Estonia:

- **Achievements:** There is a low level of HIV among pregnant women, and access to ART is free within the country. The rate of testing is high (estimated at approximately 95%).
- **Challenges:** Lack of monitoring of the effectiveness of PMTCT for both HIV and syphilis due to a lack of surveillance and statistical data.
- **Plan for 2015:** Development of a new HIV strategy, to extend to 2020. There will also be a focus on enhanced use of the E-Health information system data for both HIV and syphilis.

Slovakia:

- **Epidemiology:** The incidence of HIV is the lowest in the EU though the number of PLHIV is growing rapidly. There are very few pregnant women with HIV. The incidence of syphilis is low and stable (6.8 per 100,000 in 2014) and no congenital syphilis has been reported recently.
- **Achievements:** The rollout of the national programme for the prevention of HIV.
- **Challenges:** There is the need to improve the data collection processes surrounding PLHIV, their care and use of ART by using electronic data collection tools and software.
- **Plan for 2015:** Transforming the European Guidelines on syphilis into legislation, and creating new laws to support the surveillance of STIs. New electronic methods monitoring the uptake and use of ART will be rolled out.

Denmark

- **Epidemiology:**
 - Before November 2005 targeted screening: *Migrants, PWID + partners of.*
 - HBsAg general screening Nov 2005: *Hepatitis B not in childhood vaccination programme; HCW were "colorblind" adopted and migrants were missed in 50% cases.*
 - HIV and syphilis general in 2010: *Syphilis had near disappeared in the 1990's; HIV trial in 1990's showed only risk group were positive.*
- **Successes:**
 - Among 60 000 live births/year we detect: 5-10 cases of syphilis (we thought none!); 10 new cases of HIV (+30-40 known); 1 child born with HIV, 1 with syphilis.
 - From 2014 cooperation with NGOs: Red Cross clinic for undocumented migrants sees 200 pregnant women/year; "the Nest international" for undocumented FSW.
- **Challenges:**
 - Undocumented migrants don't have automatic access to screening because they are not attached to a family doctor: The law needs fixing
 - Undocumented migrants only have a right to "acute treatment" free of charge: The law needs fixing
 - Women from socially marginalized groups risk infection after screening: Family doctor need to team up with NGO; Not everything can be fixed

Serbia

- **Main strategic objectives:** Less than 1 / 100 000 newborns ; < 2 % Vertical transmission
 - wide coverage of pregnant women tested
 - adequate treatment of HIV positive pregnant women
 - modern approach to terminate pregnancy
 - appropriate treatment of the newborns from HIV positive mothers
- **Challenges:**
 - Not educated (enough) professionals involved in treatment of HIV positive women (doctors, nurses, etc.)
 - Not educated population
 - Continuing education
 - Infrastructure
 - Availability of tests (rapid screen tests)
 - Availability of ART in all labor rooms

Georgia: HIV MTCT

- **Achievements:**
 - 2003 - National Programme on PMTCT
 - 2005- Universal access to PMTCT services: Universal access to screening of pregnant women on HIV; Early infant diagnosis; ART for women and their newborns
 - All HIV exposed children borne from HIV positive mothers who undergo full ART prophylaxes were HIV negative
- **Challenges:**
 - Late diagnoses: About 10% of HIV pregnant women are not screened on HIV per year; Most common reason of refusal: Do not attend antenatal services till the labor; are not citizens of Georgia
 - Usage of 3rd generation antibody tests vs 4th generation antigen-antibody tests to shorten the window period
 - High level of HIV related stigma in the country
 - Despite universal access to PMTCT there are still some cases of HIV Vertical transmission; and about 10% of pregnant women do not undergo testing on HIV during the pregnancy
 - HIV positive pregnant women are mostly infected with their IDU partners
 - 3rd generation test should be replaced with 4th generation Antigen-antibody tests
- **Plan for 2015:**
 - Reach at least 95 - 95 – 95
 - scale-up prevention and testing programmes for key populations and their partners to cover population at risk
 - Negotiate with government to use 4th generation tests for pregnant women

Russian Federation

- **Achievements:**
 - Increasing number of deliveries in HIV positive women.
 - The number of HIV MTCT is decreasing.
 - In 2013 43% of regions reported transmission rate < 2% and this number is increasing annually (every year).
 - The comprehensive approach is needed to achieve elimination of HIV MTCT. It should include: high level political commitment, implementation of novel efficient preventive strategies including options B and B+.
 - The Russian Federation has all means needed for the HIV MTCT elimination in 2015.

Kazakhstan

- **Achievements:**
 - National HIV/AIDS normative documents including guidelines and protocols follow WHO recommendations.
 - All pregnant women are tested for HIV twice during pregnancy.
 - Case management of HIV exposed newborns children are revised, early infant diagnosis is ensured.
 - In 2014 68% pregnant women got triple ART earlier, starting from 2nd trimester (in 2013 just 55.6%).
 - HIV MTCT Transmission rate decreased from 4.9% in 2009 to 1.8% in 2014.
- **Challenges:**
 - To increase coverage of vulnerable groups by sexual and Reproductive health services.
 - To improve quality of storage and transportation of blood samples for PSR and VL testing.
- **Actions:**
 - To expand NGO involvement for offering sexual and Reproductive health services for vulnerable groups.
 - Implement DBS for improving transportation of blood samples for PCR and VL testing.

Republic of Moldova

- **Achievements:**
 - Universal testing of pregnant women
 - Move to option B+
 - Universal access to Formula feeding
 - Early infant diagnosis (in first 6b week of life)
 - Availability of HIV rapid tests and ARVs in all maternities
 - National clinical guidelines fully follow WHO recommendations
- **Challenges:**
 - Lack of involvement of primary health care settings including family doctors in treatment and care of HIV positive women
 - Complicated HIV testing algorithm
 - Lack of standardized reporting and recording forms for HIV positive pregnant women
 - Antenatal care coverage for migrants, including late enrolment due to several issues including stigma, fear of discrimination, denial.

- **Plan:**
 - Expansion of involvement of family doctors into management of HIV positive patients. There is new MOH Order of 16.03.2015 regulating this issue.
 - Elaboration of quality care indicators.
 - Elaboration of reporting form for case management of HIV positive pregnant women.
 - Establishing PMTCT focal point's position at the MOH.
 - Revising HIV testing algorithm in accordance with WHO recommendations.
 - Full switch to option B+.
 - Expand civil society involvement to the reproductive health, contraception, family planning, PPMR counselling for HIV positive women of reproductive age.

Lithuania

- **Achievements:**
 - Universal testing and treatment coverage of pregnant women for both HIV and Syphilis
 - Only 3 registered MTCT cases for 1987-2013
- **Barriers:**
 - Providing social support to pregnant women living with HIV.
 - Financial support for non-breastfeeding women.
 - Better collaboration HIV and Maternal and Child Health services.
- **Plan:**
 - To approve National HIV/AIDS and STI Prevention and Control Programme and Action plan 2015-2017.
 - ZERO HIV MTCT - vertical transmission of HIV eliminated.
 - De-exceptionalize HIV.

The country presentations followed by questions to presenters and respective country representatives and very active general discussion. The country presentations and following discussions suggested significant progress achieved in the countries in prevention of HIV MTCT and Congenital Syphilis. The comprehensive approach is needed to achieve elimination of HIV MTCT and CS and it should include high level political commitment, implementation of novel efficient preventive strategies including option B+. Discussion showed that the following issues remain among major challenges to be addressed:

1. HIV testing policy in pregnant women. Many countries despite having low and concentrated HIV epidemics nevertheless test pregnant women twice and in some instances even 3 times in course of pregnancy while proportion of representatives of key population groups tested for HIV remains very low. Existing evidence suggests that in low- concentrated epidemic settings the second test for HIV during pregnancy is not cost effective, and should be used only for high-risk groups. Pregnant women practicing risky behaviour, belonging to the key population group, or having partner of key population group who is HIV positive or whose HIV status is unknown such pregnant women should be offered retesting in 3rd trimester or if impossible - at the time of delivery. This above mentioned emphasized the necessity to carefully review national HIV testing policies, ensuring that they are based on local needs and follow WHO recommendations and internationally agreed norms and standards and practices attributable to the national epidemics.

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2. The integration, collaboration, partnership remain sensitive issues in many countries. It includes lack of involvement of primary health care settings, family doctors in treatment and care of HIV positive women, better collaboration among HIV, STI and Maternal and Child Health services. There is the need to promote and improve integration and collaboration between these and other settings involved in prevention and control of MTCT of HIV and CS as well as civil society and private sector. In some countries it might require revision of the regulatory environment to support the above mentioned.
 3. Complicated HIV testing algorithms, results in a delay in diagnosis and treatment. The national testing algorithms should be reviewed and revised in accordance with WHO suggested algorithms. As it was suggested by number presentations there is also a need to improve quality of storage and transportation of blood samples. Implementing DBS might contribute to solve sample storage/transportation problem.
 4. Antenatal care coverage and also by sexual and Reproductive health services for key population groups should be improved in some countries. The expansion of NGO involvement for offering sexual and Reproductive health services for vulnerable groups would contribute to that.
 5. Late diagnoses remain a challenge. In number countries pregnant women from at risk groups (particularly mobile, ethnic groups) do not reliably access ANC services, and are frequently not tested for syphilis. Undocumented migrants are also among late presenters in number countries. In some countries undocumented migrants only have a right to “acute treatment” free of charge. The national regulatory environment should be reviewed to address and help to solve this issue. That should include free treatment for STIs for at risk groups.
 6. Low levels of HIV testing of the partners of pregnant women were mentioned by number countries. The involvement of male partners in prevention and care efforts remain a significant challenge in many countries. This issue requires urgent actions of national HIV and STI Programmes as in some countries substantial proportions of pregnant women living with HIV report that their sexual partners are also HIV infected and/or at increased risk of HIV. Expanding access to rapid testing, involvement of civil society settings could contribute to these efforts.
 7. Stigma and discrimination is a significant issue and this is especially pronounced in high risk groups of pregnant women.
 8. Syphilis has re-emerged since 2000. Concerns exist that there are barriers to accessing testing and treatment for pregnant women belonging to risk groups and this might be linked to cultural barriers, migration, socioeconomic deprivation and social marginalization.
 9. In some countries (UK) there is an enhanced surveillance system being developed, including clinician led mandatory reporting to local health protection teams, and confirmatory testing carried out by a reference laboratory.

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10. Home delivery is not widely spread in the region but nevertheless in some countries (Tajikistan) approximately 10% of women still choose home delivery. It should be ensured that the quality services are accessible for such populations.
 11. The inadequate government funding for medicines and laboratory testing has resulted in inadequate ART coverage in vulnerable groups. There are insufficient rapid tests for use by pregnant women in number countries.
 12. Data is often inaccurate and cannot well guide preventive, treatment and care efforts. That includes lack of monitoring of the effectiveness of PMTCT for both HIV and syphilis due to a lack of surveillance and statistical data. Lack of standardized reporting and recording forms for HIV positive pregnant women was mentioned as an issue influencing data completeness and quality. Data quality needs to be improved including data collection and use; electronic data collection tools and software should be promoted.

Plenary Session 3: Improving access to Prevention of Mother to Child Transmission of HIV and Congenital Syphilis for key populations

Co-chairs: Alexandra Volgina (ECUO), Nina Ferencic (UNICEF).

Presentations and discussions already held at the meeting identified that despite progress achieved in the region towards elimination of MTCT of HIV and CS, there are still women in the region who were at high risk (or whose partner was at high risk) who had limited or no access to PMTCT services. The majority of MTCT cases are attributable to people who form part of these groups. Therefore, it is important that the efforts continue around innovative approaches that would offer early and unrestricted access to PMTCT services. Experience and lessons from Ukraine and Kyrgyzstan on the innovative models of care for pregnant drug-using women and their children were presented **by Ruslan Maljuta, UNICEF Regional Office**. He identified that these women are highly disadvantaged and require a comprehensive model of support which includes multidisciplinary psycho-social and medical care and support. The Ukrainian model has shown promise in reaching this target group. It takes the form of an integrated care centre for pregnant women where antenatal care, HIV and STI testing and counselling, addiction management and OST, mental health counselling and social and legal support is offered. Collaboration with the NGO sector is central to this model, with two thirds of the women referred from addiction treatment centres. Results suggest women under this model had only had a single case of MTCT during the year, and positive feedback from women in their care.

The drug liaison midwife (DLM) is another model that has been explored in Kyrgyzstan and presented at the meeting. This model is less costly and involves an outreach midwife who works half time in a maternity unit and the other in a drug treatment agency and has experience with street-based outreach (Manchester experience). The DLM works with women drug users to provide advice about contraception, sexually transmitted diseases, domestic violence, legal problems, etc. This is low cost intervention, can achieve high coverage through links to outreach work projects. Results from Dublin and Manchester show improved maternal and infant health, increased number of women retaining custody of their children, improved access to PMTCT for HIV positive drug users.

The main challenges faced by OST programmes in meeting needs of PMTCT of HIV and problem solving approaches including case management were shared **by Ausra Sirviskiene, representative of WHO Collaborating Centre, Vilnius.** Women with addictions face a number of challenges when it comes to the PMTCT of HIV. These include discrimination, myths and stereotypes, a high risk of unplanned pregnancy, and numerous social, medical, legal, and psychological problems. WHO recommendations suggest that health system approaches must emphasize pharmacological treatment for which focuses on a number of indicators for access, coverage, integration and the quality of OST. The OST services should be offered in a case management-style package which includes the development of patients health literacy around HIV and HIV prevention, annual testing for HIV and other communicable diseases. Services must also assist women in solving challenges around drug dependence; pregnancy, legal support, OST, stigma, social issues, parenting skills and financial support.

Panel discussion: *Panelists: Alexandra Volgina, ECUO; Violetta Martsinovskaja, Ukraine; Elena Bilokon, Kazakhstan; Susan Cowan, Denmark.*

The following issues were discussed:

- Expanding access to testing among socially excluded pregnant women from key populations.
- Providing social support to pregnant women living with HIV.
- Building integrated services connecting drug dependence services/OST, maternal, child and neonatal health, PMTCT services for HIV and CS.

Late admittance to the antenatal care of pregnant women from key populations, lack of antenatal care, miscarriage and lack of follow up are among the major issues. These groups are also often hard to reach by medical and social care services. The following issues were listed as the main barriers to accessing services:

- For medical services: fragmentation of services including geographical; High threshold (ID, residency, insurance, long waiting lists).
- Legal framework: no/limited access to OST; no access and long duration to access rehab services.
- Internal barriers: fear and shame; social isolation; lack of trust towards medical and care services.

It was strongly emphasized that very often in countries the medical and social care provision are highly fragmented, each part of the chain tries to do something but there is no single system and ultimate responsibility for an individual patient. Referrals are done without follow up and the patient is lost; less assistance is offered in the absence of standards for its delivery and because of condemning attitude, stigma and fears.

A number of solutions were forwarded in response to these issues:

- intensify outreach;
- to accompany patients when referred;
- trainings also for medical staff including medical doctors;
- establishing network of trusted doctors;

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- efficient referrals between medical institutions;
 - NGOs and care centres;
 - closer collaboration between obstetric and pediatric services, infectious disease clinics, HIV services and NGOs for timely monitoring, treatment and social support;
 - ensuring access to reliable and high-quality diagnostics and treatment of HIV and drug addiction;
 - expanding access to the entire continuum of care (prevention, testing, medical examination, prescribing of treatment, retention in treatment); state support and financing of HIV service NGOs (support systems, maintenance, rehabilitation centres, crisis centres etc.);
 - providing patient centered care based on needs of each particular woman; more work with public opinion and the media.

Susan Cowan shared experience accumulated in Denmark. A number of stories were presented showing successes of PMTCT in Denmark but also challenges. Among the major successes are:

- General screening reaching > 95% of pregnant women registered with a family doctor.
- 60,000 live births/year < than 0.1% MTCT of HIV, syphilis or hepatitis B.
- Red Cross clinic for undocumented migrants sees 200 pregnant women/year and follow up with treatment and vaccination of newborn – if they can find them.

However there are a number of dilemmas:

- Responsibility: specialization v/s defragmentation
- Get the players to talk to each other, also the NGOs
- Replace donor funding with national ownership and long term planning
- Testing: mandatory v/s incomplete:
 - Never mandatory but "opt out" + "mild coercion" + ART+ no penalty
 - Consider the vulnerable populations, the rest will be "piece of cake"
- Surveillance: anonymity v/s accuracy
 - Depends on country's implementation of human rights in the legal system and in general public attitudes.
- The law: waiting for change v/s working for change
 - Push for harm reduction policies and NGO involvement.
 - Understand drug use as public health problem, not criminal offence.
 - Demand for political leadership could come from all of us.

The presentations and discussions at this sessions shared rich experience accumulated in the region that offers number effective approaches. Countries are encouraged to apply those that fit the country needs and realities the best. It also suggests the opportunity to consult other countries and further share accumulated knowledge and experience.

Plenary Session 4: Improving quality of care and the HIV PMTCT cascade: Policies, guidelines and best practice

Co-chairs: Ruslan Malyuta (UNICEF), Anna Klyuchareva (Belarus)

WHO 2013 Consolidated Guidelines: ART for pregnant, breastfeeding and non-breastfeeding women. Current policies and practices on infant testing and infant feeding. Nathan Shaffer, UNICEF consultant.

Dr Shaffer, UNICEF consultant, and recently retired former PMTCT technical lead at WHO HQ, presented WHO 2013 Consolidated Guidelines. He emphasized that the past two decades has seen a shift from discussing MTCT, to the prevention of MTCT and now the virtual elimination of MTCT. There is a greater understanding of the risks to the foetus at different stages of pregnancy and breastfeeding, and with best practice MTCT transmission can be reduced to less than < 2%, (or less than 5% in situations where breastfeeding is occurring). The transmissibility in these contexts is highly dependent on ARV coverage and CD4 and viral load levels.

Dr Shaffer emphasized that the most recent WHO guidelines suggest a move to Option B and B+. This states that all pregnant and breastfeeding women infected with HIV should initiate a triple ARVs regimen, which should be maintained at least for the duration of mother-to-child transmission risk and it is preferable for it to continue for life i.e. B+. This presents benefits to the health of the infant, the mother and the mother's partner, as well as a public health benefit. Benefits of Option B+ (lifelong triple ART therapy) for mother and children include:

- Ensures all ART eligible women initiate treatment
- Prevents MTCT in future pregnancies
- Potential health benefits of early ART for non-eligible women
- Reduces potential risks from treatment interruption
- Improves adherence with once daily, single pill regimen
- Reduces sexual transmission of HIV

While benefits for programme delivery and public health include:

- Reduction in number of steps along PMTCT cascade
- Same regimen for all adults (including pregnant women)
- Simplification of services for all adults
- Simplification of messaging
- Protects against transmission in discordant couples
- Cost effective

Dr Shaffer highlighted the consultative processes for the new Consolidated Guidelines which was due to take place mid-2015, with the final product being released in December 2015. Key questions up for consultation would include the criteria for ART initiation for adults and children, a review of the first- and second-line regimens, the expanded use of viral load testing in the management of HIV, the management of infants at high risk, infant prophylaxis, and infant feeding practices.

Panel discussion included the following discussion points:

- Progress towards option B+, acceptability, benefits
- Preferred 1st line ART for pregnant women
- Infant prophylaxis
- Expanding infant testing (6-week PCR)
- Adding a test at birth

Panelists: Evgeny Voronin, Russian Federation; Anna Kljuchareva, Belarus; Tonka Varleva, Bulgaria; Arshak Asmaryan, Armenia; Boyan Vasic, Serbia, Venera Ashurova, Uzbekistan; Gulnara Tazhibaeva Kazakhstan; Nino Badridze, Georgia; Gulnora Akhmedjanova, Tajikistan.

The panel discussed the application of the WHO guidelines. Most countries had already moved to Option B+, and national protocols have been updated in accordance with WHO guidelines. The planned revision of WHO guidelines mentioned by Dr Shaffer will lead to the review and update of national guidelines to follow new recommendations that will be issued by the WHO. The countries met challenges while implementing WHO recommendations. It relates as treatment of pregnant women as well as treatment and prevention in infants. In Uzbekistan, while the uptake of option B+ is high there are some issues with infant feeding because formula is not government funded. Government support has been expanded thus current challenges regarding formula feeding is being progressively changed. Infant testing protocols have recently reviewed and changed in most of the countries. Some are testing at birth, and this is a feasible option, however others only begin testing at the four to six week mark. Dried blood spot testing is used widely, though there are challenges including managing testing in rural areas, and ensuring tests are evaluated correctly.

In Kazakhstan infant diagnosis is done according to the approved algorithms though some changes are currently taking place. The primary issues in Kazakhstan are sample storage and transportation which is highly relevant because of the country is large territories and has low population density. The feasibility of using in remote areas and cost will be taken into considerations.

In Georgia infant testing is conducted at birth (after 48h), 6-8 weeks, 4-6 months and at 18 months. An electronic database is available in Georgia with all information on pregnant women. PCR test results are available in this database, including the information on when the next PCR test is planned. When there is a time for the next PCR test, database becomes yellow to highlight that it is timing for the second test. The pediatrician, thus, contacts the mother with the request to bring a child to the center. This approach contributes to a good coverage.

In Tajikistan a policy to eliminate MCT of HIV was adopted in 2013 and the national protocols follow WHO recommendations. The country has already moved to Option B+. The number of HIV positive pregnant women are increasing and so too do the number of repeat pregnancies in HIV positive women. Tajikistan has a mentoring programme with 62 specialists who were trained by international experts on providing ART in place of residence of HIV positive women. Early infant diagnosis is done in accordance with updated national protocols. Testing using dried blood spots is currently implemented and is proving especially for useful to manage those living in remote regions and thirty-five specialists are trained on the use of this new method. Formula feeding is not state funded though an allowance is

provided to pregnant women living with HIV to acquire formula. Despite this, breastfeeding is a more widespread practice.

The panel discussion followed by general discussion. Discussion emphasized that a number of ongoing challenges exist in the European Region. These include the need to better reach at-risk populations and late presenters, to focus on the models of service delivery for ART within maternal and child health settings, and better ensuring women's treatment adherence and retention in care. The major issues include:

- Regular updating national policies and harmonizing ARV recommendations for adults and pregnant women. In accordance with latest WHO recommendations
- Early identifying HIV+ pregnant women in ANC or at delivery:
 - Providing services to high risk, hard to reach populations (eg. sex workers, injecting drug users).
 - Providing access for late presenters (HIV+ women identified at delivery); preventing HIV in high risk infants.
- Early ART access in MCH settings or specialized ART clinics and other models of service delivery – in accordance with local contexts and needs
- Adherence with ART regimen, follow up and retention.
- Linkages with chronic ART care and treatment.

The session concluded that the WHO European Region is well prepared to follow new recommendations being under discussion and planned to be issued by the WHO till end of the 2015.

Plenary Session 5: Quality of care and the congenital syphilis prevention “cascade”: policies, guidelines & best practices

Co-chairs: Lali Khotenashvili (WHO Europe), Kemal Goshliyev (UNFPA).

Progress achieved in the region: regional Congenital Syphilis survey outcomes and recommendations for policy and programme actions. Lali Khotenashvili, WHO Regional Office for Europe

A survey was conducted by WHO in 53 countries, which was a comprehensive situational analysis of the policies, programmes, monitoring and evaluation of prevention of MTCT of syphilis across the WHO European region. The survey data were analyzed according to recommended global pillars for MTCT-syphilis control programmes: level of political commitment; access to services; interventions to screen and treat pregnant women and their partners; and surveillance, monitoring and evaluation systems. The WHO European Region is well placed to eliminate Congenital Syphilis across the region: rates of antenatal care attendance are high, health systems are generally well supported, and rates of syphilis in the adult population are generally low. Nonetheless, there are still challenges to a goal of eliminating MTCT-syphilis in Europe.

Few countries have a specific political commitment to control the MTCT of syphilis, and dedicated funding for activities was not common. Most activities were integrated into other services such as antenatal care, STI care, reproductive health care etc. While integrated service delivery expands coverage and access, it also increases the possibility that no one programme will be held accountable for impact. This was found to be the case in many countries where there was a lack of specific lines of accountability for action and achievement.

While the vast majority of pregnant women in the WHO European region access antenatal care at least once in pregnancy, some countries in the region are still not meeting their global commitments with regards to a minimum of four antenatal visits. Data indicate that the majority of women also get screened for syphilis at least once during their pregnancy, but for many women the time between screening and treatment can be as long as 7 days, and women often have to visit another health care provider just to receive treatment. Concepts of same day testing and treatment were not widespread, although they should be feasible everywhere.

The weakest component of the four pillars was surveillance, monitoring and evaluation. Only six countries reported on three core indicators, and 16 countries did not routinely report any of the three recommended core indicators. In addition, the impact indicator (rates of ‘congenital syphilis’) did not have an agreed upon definition across the region, with many countries setting their own definition of impact.

The treatment of partners is also a critical part of preventing congenital syphilis, though only around 30-38% of countries have national guidelines for the examination of partners.

There are a number of concerns regarding syphilis testing and treatment. Fragmentation of service delivery is an issue, with some countries not offering testing at ANC sites, and treatment and testing services are not co-located. Some women, particularly marginalized populations, may not be reached by current programmes and surveillance systems.

Central to the response of congenital syphilis prevention is the use of data. The data shows an increasing rate of congenital syphilis in the region, though there are a number of caveats to this observation. The terminology and case definitions are heterogeneous and a broadening of the case definition for congenital syphilis means that the increasing rate may be an artifact of changes in data collection process.

Elimination of MTCT-syphilis in the WHO European Region is an achievable goal. Measuring and reporting on that goal is one of the more significant (but not insurmountable) challenges facing national programmes today.

Prevention and control of Congenital Syphilis: perspectives from the Russian Federation.

Alexey Kubanov, Russian Federation.

In the Russian Federation, numbers of syphilis cases are declining. In 2014, the total number of syphilis cases decreased by 32% and by 34.7% in women relative to 2011. The number of syphilis cases in pregnant women decreased by 30.4 % in the same period. The timing of the syphilis diagnosis is a critical element to prevent transmission. The pregnant women are tested for syphilis three times: at the first antenatal visit, in 2nd trimester and 3rd trimester and also at the time of delivery (if not tested during antenatal period). The number of CS cases

decreased significantly: in 2014 the number of cases decreased eight-fold relative to 1999, and six-fold relative to 2011. Preventive work is done in close collaboration in obstetrics/gynecology and reproductive health settings.

Improving CS prevention in at-risk populations: Perspectives from Moldova.

Vasile Morcov, Republic of Moldova.

The Republic of Moldova continues to register a large number of syphilis cases each year. However, it is increasingly successful at identifying cases through the application of broad-reaching screening policies. Moldova plans to pursue the EMTCT validation of CS. The country witnesses a large number of migrants, comprised mostly of illegal workers, who are a key population for the elimination of MTCT of syphilis, as many women from this group present at delivery without prior ANC or syphilis testing. Partner notification is attempted but there are a large number of migrant populations that are hard to reach.

Most cases of CS occur in migrants who missed antenatal care and present at maternities at the time of delivery. The country offers a range of opportunities for anonymous syphilis testing which targets migrant workers and their family members. Key directions to pursue the elimination of MTCT of syphilis include ensuring effective screening practices, providing the opportunity for anonymous testing, centralizing laboratory services and improving access to free treatment. The country has introduced an electronic epidemiological surveillance system in the last four to five years, which has improved the accuracy of data. Country follows WHO recommendations as on STI Lab diagnosis as well as surveillance. The national STI case management guidelines and protocols were updated recently and fully follow WHO recommendations.

The Panel discussion was focused on barriers and facilitators to:

- Promoting syphilis testing at first antenatal visit; expanding same day testing and treatment; shifting towards outpatient treatment
- Ensuring uninterrupted supply of benzathine penicillin
- Ensuring partner notification and management
- Reporting on core elimination indicators

Panel participants: Karen Babayan, Armenia; Azizullo Kosymov, Tajikistan; Gwenda Hughes, United Kingdom.

Armenia reported a decline in congenital syphilis over the past 10 years and the complete treatment coverage of pregnant women with syphilis. However testing and treatment for STIs are not part of the state benefit package, and it is a potential barrier to reducing the rate of congenital syphilis. Other barriers include still limited collaboration and integration of STI screening and management in reproductive health and family planning settings.

A clear programme for the testing and treatment of STIs exists in Uzbekistan. Testing and treatment is provided free of charge, and the in-country legislation aligns with international standards. A ministerial order regulates testing of patients for syphilis, whereby women can only be treated in dermatology/venereology clinics and not in community settings. Upon diagnosis pregnant women are instructed to report to an inpatient facility for treatment. STI care is free of charge; all expenses are covered by state budget. National STI guidelines and protocols follow WHO recommendations.

In Kyrgyzstan, national STI guidelines follow the WHO recommendations. Migration presents numerous challenges in Kyrgyzstan, because many residents travel to Russia for work, but do not have access to treatment services there and come back at the time of delivery, often missing antenatal care including Syphilis testing. This highlights the need for the two countries to collaborate and possibly identify regional solutions for service integration and surveillance.

Georgia currently has electronic disease surveillance system for syphilis, and syphilis is a notifiable infectious diseases. Syphilis testing of pregnant women is done during first antenatal visit and repeated in 3rd trimester. If pregnant women missed antenatal care syphilis testing is done in maternity units. Partner notification is done through the patients and there is no interruption in benzathine penicillin supply.

A number of important points arose during discussions:

- Populations such as CSWs and migrants are among those that still pose significant challenge to CS elimination goals.
- Innovative approaches should be used by the national STI programmes to offer easily accessible and acceptable services to the most vulnerable and at-risk population groups.
- Partner notification remains a sensitive issue, and the practice of notification through the index partner should be encouraged
- Forced treatment should not be encouraged.
- National STI programmes should ensure uninterrupted supply of syphilis tests and penicillin.
- Integrated surveillance systems are of significant benefit in improving data timelines, accuracy and analysis feeding back prevention and control programmes.
- There are problems with how private systems are restricted from treating and diagnosing STIs. STI services should be expanded to include private settings. While many governments do not have full control of these facilities, they still need to include them in surveillance data collection and evaluation processes within the country.

Plenary Session 6: Optimizing monitoring and reporting of the elimination of MTCT of HIV and congenital syphilis

Co-chairs: Lali Khotenashvili (WHO Europe), Ivana Bozicevic (WHO Collaborating Centre, Croatia).

Countdown to Zero: UNAIDS Global plan towards elimination of new HIV infections among children by 2015 and keeping their mothers alive 2011-2015. Marina Semchenko, UNAIDS Regional Support Team

The UNAIDS Global Plan and the WHO led elimination validation are complementary activities. The Global Plan is an accelerated plan to end MTCT, while the WHO led elimination validation and certification is a standard measure of country achievement towards ending MTCT.

The assessment of progress of achieving goals of UNAIDS Global Plan is being done annually in accordance with 10 indicators. Two key indicators are the proportional decrease in new cases in children and the rate of MTCT as indicator of programme efficiency.

In 34 countries in the Region the cumulative number of new HIV cases in children since 2004 is below 100. Many countries in the Region have less than 50 MTCT cases annually. In Belarus MTCT rate is close to <2%; and decrease of new cases in children is close to 90%, a task whose challenge should not be underestimated. Increasingly, the value of Global Plan is acceleration of actions and focusing.

Global plan ends in 2015. It helps to accelerate actions towards elimination of vertical transmission of HIV and strengthening of surveillance systems. This helps WHO certification of elimination. Global plan has targets and countries will be acknowledged for their achievements. The next step is WHO validation and certification.

The Global IATT EMTCT monitoring website. Nina Ferencic, UNICEF

The increasing utilization of online platforms (e.g. webinars, data dashboards, etc.) to obtain research and share country's successes and challenges has helped accelerate the shift to Option B+ in Europe. The IATT network has shown great reach and contributed to changes in policy and practice. So far, the network includes 2 200 members in the community of practice, and 30 000 visits to the site from 190 countries around the world. Monthly webinars are currently held with approximately 70 participants in attendance.

Global Guidance on criteria and processes for validation of elimination of MTCT of HIV and CS. Overview of validation tools. Chika Hayashi, WHO HQ

Chika Hayashi referred attendees to the global guidance on EMTCT¹¹. Since the Global Plan to EMTCT was initiated, numerous countries have asked WHO how to validate EMTCT achievement. Responding country requests WHO initiated process of developing processes and criteria to assess and validate EMTCT. There was a need to elaborate international standard to allow validation to be carried out using a credible, systematic approach, allow monitoring of EMTCT achievement globally, and facilitate recognition of countries that have successfully eliminated (and sustained elimination) MTCT of HIV or syphilis; to identify appropriate and feasible criteria & processes for validation of EMTCT of HIV and syphilis and next steps.

A number of reasons exists which compel countries to validate. These include to celebrate successful programmes, ensure credibility, address disparities in service delivery, improve monitoring systems and to be economical with countries resources. The global guidance document on validation criteria and processes was developed based on pilot exercises with eight countries, including two countries in WHO European region (Moldova and Kazakhstan). It was also drawn from global consultation with experts and partners, and discussion with other elimination programmes (polio, neglected tropical diseases, malaria, maternal and neonatal tetanus). The global document was published in June 2014, and describes the global elimination validation targets, indicators as well as processes.

¹¹<http://www.who.int/hiv/pub/emtct-validation-guidance/en>

Dr Hayashi presented Global validation targets:

Required indicators for global validation of EMTCT of HIV and/or syphilis	
HIV	
Impact indicators	
Mother-to-child transmission (MTCT) HIV case rate of ≤ 50 new paediatric HIV infections per 100 000 live births	
MTCT of HIV of $< 5\%$ in breastfeeding populations	
OR	
MTCT of HIV of $< 2\%$ in non-breastfeeding populations	
Process indicators	
Antenatal care (ANC) coverage (at least one visit) of $\geq 95\%$	
Coverage of pregnant women who know their HIV status of $\geq 95\%$	
Antiretroviral (ARV) coverage of HIV-positive pregnant women of $\geq 90\%$	
Congenital syphilis	
Impact indicator	
Incidence of congenital syphilis ≤ 50 cases per 100 000 live births	
Process indicators	
ANC coverage (at least one visit) of $\geq 95\%$	
Coverage of syphilis testing of pregnant women of $\geq 95\%$	
Treatment of syphilis-seropositive pregnant women $\geq 95\%$	

The qualifying requirements for validation of elimination of MTCT HIV or CS are:

- National EMTCT validation indicators:
 - ***Process indicator targets achieved for 2 years AND***
 - ***Impact indicator targets achieved for 1 or more years.***
- Review of equity considerations, e.g.
 - *Low performance district or high burden area*
 - *Key populations and other vulnerable groups*
- Robust national monitoring and surveillance system
- Basic Human Rights Considerations must be met

The validation process should be initiated by the Ministry of Health, informing the Regional Secretariat of the WHO, who notifies the Regional Validation Committee. In the pre-validation phase, the country prepares a report which is assessed by the Regional Validation Team. This is followed by an in-country assessment of the situation, and finally an evaluation and report on the outcomes of the validation are submitted to Global Validation secretariat through regional Secretariat and Committee. If successful, Global Validation Advisory Committee issues certificate to be signed by the WHO Director General.

The presentation generated many questions about the targets and procedures to be followed by the candidate country.

There was an active discussion about the global impact of the programme and its indicators:

- ≤ 50 new pediatric HIV infections per 100 000 live birth.
- MTCT of HIV ≤ 5 % in breastfeeding population and ≤ 2 % in non-breastfeeding population.
- ≤ 50 cases of Congenital Syphilis per 100 000 live birth.
- Antenatal care coverage (at least 1 visit) of $\geq 95\%$.
- Coverage of pregnant women who know their HIV status of $\geq 95\%$.
- Antiretroviral (ARV) treatment coverage of HIV positive pregnant $\geq 90\%$.
- Coverage of Syphilis testing of pregnant women of $\geq 95\%$.
- Treatment of Syphilis positive pregnant women of $\geq 95\%$.

Optimizing Monitoring of the elimination of MTCT of HIV and Congenital Syphilis: draft regional indicators. Ivana Bozicevic, WHO Collaborating Centre, Croatia

The global standards for the validation of the EMTCT of HIV and syphilis are outlined in the *Global Guidance on Criteria and Processes for Validation of EMTCT of HIV and syphilis* by the WHO. It is based on the minimum global standards, and applied to the context of low-level, concentrated HIV epidemics and history of well-established maternal and child health programmes. It stipulates a number of impact, process and additional indicators to guide progress on the EMTCT. Process targets should be met for two years and impact indicators for one year to qualify for validation. They must also address a number of human rights, equity and surveillance quality requirements.

The question was raised whether there is a need to come up with regional elimination targets and indicators for elimination validation in the WHO European region. This question was discussed in the panel discussion that followed the presentations in this session.

Global Elimination Validation tools' example: Laboratories tool
Magnus Unemo, WHO Collaborating Centre, Sweden

Along with global validation processes, criteria, targets and indicators, there are also global validation tools which have been drafted and piloted.

There are three global validation tools available: data quality assessment, laboratory assessment and human rights and community engagement tools. The laboratory diagnostics assessment tool was presented and discussed. This tool includes a number of elements, including:

- Organization management, leadership and supervision
- Human resources; quantity, quality and training
- Supplies and maintenance
- Standard operating procedures (SOPs)
- Evaluation and validation of tests
- Sensitivities, specificities, negative and positive predictive values (NPV and PPV) of tests and algorithms
- Elements of quality assurance (QA).

A number of examples of the questions and checklists contained within the laboratory validation were presented and participants were referred to the WHO publication *Laboratory diagnosis of sexually transmitted infections, including human immunodeficiency virus* as the core document to support this process. This tool, along with two others (i.e. data quality and human rights and community engagement) was piloted in Moldova in December 2014. Piloting suggests that while the tool is useful for the WHO European region it requires number adjustments to become more appropriate for the regional context. These adjustments have been made and adjusted tools have been shared with meeting participants prior to this consultation via **Drop box** and also distributed via USB keys given to the meeting participants.

Panel discussion included the following discussion points:

- Are Global targets, processes, criteria and tools relevant to the region?
- Are suggested Global indicators relevant to the region?
- How to optimize reporting of core impact and process indicators of MTCT of HIV and CS

Panel participants: Peter Truska, Slovakia, Jevgenia Epstein, Estonia, Anna Rusanovich, Belarus and Saulius Caplinskas, Lithuania.

This was intended to be a panel discussion, but very quickly all participants showed a high interest and were also included in the conversation. This was an indication of the level of high interest in elimination validation in the region.

While participants mentioned the need to have regionally appropriate mechanisms, processes, criteria, targets and indicators as well as bodies for validation of the elimination it was strongly emphasized that:

- **the entire elimination validation process should be a simple one.**
- **there is no need to create Regional validation committee in the WHO European region. The regional validation secretariat i.e. the HIV Programme of WHO Regional Office in partnership with UNAIDS RST, UNICEF and UNFPA could communicate directly to Global validation secretariat and Global Validation advisory Committee.**
- **the relevance of the Global targets for the WHO European Region was supported unanimously.**

While colleagues were confident that the case rate targets were easily achievable for the region, it was emphasized that the achievement and maintenance of process targets and indicators will require strong and continuous efforts from national HIV, STI and SRH programmes, as well as different settings including primary health care and wide scale integration and collaboration of settings and programmes. It was also suggested that the indicator focused on antiretroviral (ARV) treatment coverage of HIV positive pregnant for the region should be $\geq 95\%$ while taking into consideration progress that has already been achieved in the region to meet that target.

Therefore **it was unanimously agreed to keep global elimination validation targets and indicators as regional ones for the WHO European region** with the exception of (ARV) treatment coverage of HIV positive pregnant women which for the region should be of $\geq 95\%$:

- ≤ 50 new pediatric HIV infections per 100 000 live birth
- MTCT of HIV $\leq 5\%$ in breastfeeding population and $\leq 2\%$ in non-breastfeeding population
- ≤ 50 cases of congenital syphilis per 100 000 live birth
- Antenatal care coverage (at least 1 visit) of $\geq 95\%$
- Coverage of pregnant women who know their HIV status of $\geq 95\%$
- Antiretroviral (ARV) treatment coverage of HIV positive pregnant $\geq 95\%$
- Coverage of syphilis testing of pregnant women of $\geq 95\%$
- Treatment of syphilis positive pregnant women of $\geq 95\%$.

At the same it was suggested that countries should be free to set their own country elimination validation targets and indicators within the suggested global/regional ones that were provided.

It was also suggested that the global elimination validation tools (i.e. The Data Quality Tool and The Laboratory Diagnostics Assessment Tool) are relevant for the WHO European Region, and this was demonstrated by the pilot mission in the Republic of Moldova. After some amendments suggested as a result of that pilot it was thought these tools could be used for validation elimination efforts in the region.

However it was strongly suggested that **the human rights and community engagement tool** requires thorough revision. It touches on important though sensitive issues and should be revised and adjusted carefully, potentially by the Global Working Group to undertake the revision process, which should include shortening the questions as it is currently too long, and also ensure they are concise and precise. They should also consider the broader evaluation process that would as an overall assessment of the tool. Meeting participants expressed a willingness to be involved in review if and as needed.

The participants also suggested that there should not be a need to always have in-country missions but it should be possible to validate elimination via desk review. The eligibility criteria for desk review vs in-country mission should be elaborated.

In conclusion, the following major issues were emphasized by the session:

- It was unanimously agreed to **keep global elimination validation targets and indicators as regional ones for the WHO European region** with the exception of (ARV) treatment coverage of HIV positive pregnant women which for the region should be of $\geq 95\%$:
- There was common view and understanding that the **validation processes should be simplified** as they currently look very cumbersome.
- There is **no need to create Regional validation committee in the WHO European region**. The regional validation secretariat i.e. the HIV Programme of WHO Regional Office in partnership with UNAIDS RST, UNICEF and UNFPA could communicate directly to Global validation secretariat and Global Validation advisory Committee.

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- it was strongly suggested that **the human rights and community engagement tool** requires thorough revision. The data quality tool and Laboratory diagnosis tool could serve as regional tools after adjusting them in accordance with based on Moldova pilot outcomes.
 - As in the WHO European region the HIV MTCT numbers are low the small numbers' issue is highly relevant for the region. Because of that for validation purposes the case analysis should be the case and if shown that the prevention of any particular MTCT case was not under control of national MTCT Programme then such cases should not be “used” against the country.
 - For congenital syphilis the major issue is CS case definition which is highly heterogeneous in the region. It is strongly encouraged that countries follow WHO definition. This definition should include stillbirths due to syphilis.
 - Validation of elimination is not goal in and of itself but helps to strengthen systems, promote integration and collaboration, monitor progress, identify weaknesses and address them in a systematic and timely manner and promote and ensure sustainability.

Session 7 and 8: Working Groups' session and presentation

Introduction: Kemal Goshliyev (UNFPA) gave an introduction to the Working groups' session explaining that each working groups is expected to:

1. Identify major obstacles on the way towards elimination
2. Suggest 3-5 key actions that should be taken to achieve elimination
3. Suggest whether country represented by working groups' member be interested to validate elimination of MTCT of HIV and /or CS: If “Yes” – why? If “NO”- why not?

Presentation of the outcomes of Working Groups' session

Co-chairs: Nina Ferencic (UNICEF), Martin Donoghoe (WHO Regional Office for Europe).

Table 1 below presents the key points presented by each Working group and related discussion held at the session 8:

Table 1. Key points from country working group presentations and discussion in Plenary Session 8

Group	Major obstacles to the elimination of MTCT	Key actions	Desire to follow an elimination agenda?
Group 1: Denmark, Croatia, Sweden, UK, Slovakia	<ul style="list-style-type: none"> • Testing coverage is affected negatively by poor laboratory procedures/equipment and negative interactions with clinicians which increases stigma. • Concern that major risk populations are being missed (e.g. migrants) and there are many late/non-presenters. • Legal constraints and societal stigma presents barriers to care. • Economic constraints are problematic, including that patients having to pay for testing and/or medication. 	<ul style="list-style-type: none"> • Improving data collection: concern that data may show high coverage though key populations have been missed. • Focus on human rights advocacy: eliminate mandatory testing/treating and negative consequences associated with diagnosis and collaborate with NGOs to reach vulnerable populations. • Ensure a strong lab- and epi- surveillance system (preferably linked) which is integrated at a regional/national level and has consistent standards. • Rely on evidence-based standards for decision making and treatment, and invest finances accordingly. • Link HIV and syphilis prevention program to form a “whole picture”. 	<ul style="list-style-type: none"> • Yes. • Validation must focus on a standardized evaluation processes, be supported by human rights legislation. Validation processes should be simplified. • The validation has a great potential to influence and optimize the system and potentially benefit key populations. • However, there are economic constraints: validation might not be affordable for many countries. The international organizations including WHO; UNSAIDS; UNICEF; UNFPA and others should be asked to provide support incl financial for validation. There is a disincentive if countries will feel embarrassed for not reaching targets. .

Group 2: Armenia, Azerbaijan, Belarus, Bulgaria	<ul style="list-style-type: none"> • Insufficient work among key groups of the population, including IDUs and migrants: • Low testing coverage for HIV and Syphilis for pregnant women and also their contacts and permanent sexual partners • Internal and external migration • Limited geographical access to the services (remote areas) • Lack of: <ul style="list-style-type: none"> ✓ antenatal care coverage ✓ coordination and integration between the services ✓ treatment adherence and retention in the health care system ✓ psycho-social support /care in the package of state-supported services ✓ access to rapid tests in the prenatal care services ✓ involvement of private sector in the system of recording and reporting • Weak system of surveillance, including data collection, recording and reporting, and analysis 	<ul style="list-style-type: none"> • Ensure sustainable and uninterrupted provision of PMTCT and CS services by increasing state funding. • Improve screening coverage for HIV and syphilis by optimizing diagnostic algorithms and focusing on key and marginalized population. • Encourage the active involvement of civil sector and NGOs, and ensure state funding of these services. • Improve the epidemiological surveillance system including data collection, reporting and monitoring. • Ensure uninterrupted provision of services and monitoring of services provided. 	<ul style="list-style-type: none"> • All countries expressed interest regarding elimination validation for both HIV and congenital syphilis (except Azerbaijan initially only with congenital syphilis). • There are human resources available in countries and readiness of the health system to validation of elimination • Financial issues were mentioned as potential barrier to proceed towards validation of elimination. • Request WHO, UNAIDS, UNICEF, UNFPA to provide financial support for validation along with technical support
Group 3: Estonia, Georgia, Kazakhstan, Kyrgyzstan*	<ul style="list-style-type: none"> • (Limited) human & financial resources • Gaps in the legal framework (discriminatory etc.) • Poor interaction between ANC, STI & HIV services • Inner and outbound migration • Screening and diagnosis • Poor knowledge in key populations, ANC staff etc. about syphilis in general and available services in particular • Stigma and self-stigma • Poor access to health care within migrants and key populations • Data collection and reporting: no data on stillbirths or miscarriages due to syphilis. EMTCT related workload, requiring revision of existing HIV & CS M&E systems • (Poor) validity of official statistics • Outdated reporting forms and lack of relevant indicators. 	<ul style="list-style-type: none"> • Update the legal framework • Bilateral agreements between countries • Internal Quality Assurance systems • Adjust M&E systems • Protocols for cross-service interaction (integration) and enforcement of those • Revisit the testing algorithms to speed up diagnosis-making • Beef up information activities in risk groups 	

Group 4: Moldova, Russian Federation, Lithuania*	<ul style="list-style-type: none"> • Improved standards of clinical practice, including recommendations for syphilis. • A lack of standardized prophylaxis for infants, and insufficient drug supply. • Inability of current laboratory systems to diagnose stillbirths from fetal blood collection. • Need to improve of case management processes. 	<p>All expressed interest in elimination though a review of current practices must first take place with a focus on improved data collection. Thus in country missions were found very important.</p> <p>There were concerns that the validation process might be complicated and expensive. Thus requesting WHO, UNAIDS, UNICEF, UNFPA to consider simplification of validation procedures and provide financial support for validation.</p>	
Group 5: Tajikistan, Ukraine, Uzbekistan	<ul style="list-style-type: none"> • Financial constraints (which affects acquisition of tests, reagents and medications). • Lack of coordination between countries for infectious disease management systems to support the migration that takes place. • Lack of venereology specialists. • Insufficient intersectoral coordination of between services (i.e. health, education, social policy, justice, migration). • Lack of effective public health programs. • Statistical processes are not sufficiently developed. 	<ul style="list-style-type: none"> • Improve diagnostic processes and availability. • Establish minimum package of services for migrants which would include joint referral systems and underpinned by legal support. • Develop uniform standard protocols for clinical diagnosis and treatment and encourage their uptake by civil organizations and private practices. • Develop national guidelines for monitoring of HIV and syphilis. 	<p>Yes, there is support for the principle of EMTCT as it will help to get closer achieving global targets.</p> <p>It will give an external quality control of indicators. It will also give external quality control of program implementation (certification).</p> <p>There are some concerns the process may be bureaucratic thus WHO is asked to consider simplification of validation processes and procedures</p>

* These groups reported major obstacles and actions together.

Conclusions and recommendations

The global community is now firmly committed to eliminating mother-to-child transmission (MTCT) of HIV and congenital syphilis (CS) as public health problems. These goals are central to the EMTCT Global Plan and to the UNAIDS 2020 treatment targets and 2030 ending AIDS targets and are highlighted in the draft WHO health sector strategy on HIV for 2016-2021. There are now clear global, regional and country targets to attain these ambitious goals and an emerging “Validation of Elimination” process, being led by WHO in partnership with UNAIDS, UNICEF, UNFPA.

To accelerate progress, discuss the validation framework for EMTCT in Europe and Central Asia, the WHO, UNICEF, UNAIDS, UNFPA regional offices, along with key partners¹² convened joint technical consultation on 21-23 April 2015 in Astana, Kazakhstan. Participants included key Ministry of Health policy makers, HIV, STI and MCH programme managers, and technical and public health experts from 18 countries¹³ from Europe and central Asia.

The consultation reviewed the achievements, barriers and next steps needed for the region and the individual countries; endorsed the regional targets for EMTCT and the elimination validation tools for data monitoring, laboratory and human rights; and committed to working together to share best practices and achieve EMTCT in the region.

In line with global targets, key regional targets include achieving:

- low levels of new pediatric HIV and congenital syphilis cases (≤ 50 new cases/100,000 live births),
- low levels of MTCT of HIV ($< 2\%$ for non-breastfeeding and $< 5\%$ for breastfeeding women)
- high levels ($\geq 95\%$) of ANC coverage, HIV and syphilis testing and treatment of pregnant women.

The countries of Europe and Central Asia are unique in a number of important ways, including: high levels of antenatal care, strong laboratory infrastructure, high levels of HIV and syphilis testing, and the highest level of all regions of HIV ARV coverage for pregnant women, and strong programme commitment. This has already led to several countries in the region being close to meeting the Validation criteria, including in the Republic of Moldova where a recent pre-Validation mission was conducted in December 2014. However, there are also important barriers and challenges in the region, including: a high proportion of infections among pregnant women in key populations and vulnerable groups (e.g. drug users and partners of drug users, sex workers, migrants), as well as stigma and human rights issues. In addition, there continue to be challenges of commodity stock-outs and high prices and the transition in many countries in the region from Global Fund to state financing. These issues were discussed openly and strong consensus was achieved on addressing these issues and accelerating progress.

¹² Partners included: WHO, UNICEF, UNAIDS, UNFPA, UNODC, US CDC, ECDC, WHO Collaborating Centres, and civil society organizations.

¹³ Colleagues from Europe and Central Asia: Armenia, Azerbaijan, Belarus, Bulgaria, Denmark, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Lithuania, Republic of Moldova, Russian Federation, Serbia, Slovakia, Tajikistan, Ukraine, United Kingdom and Uzbekistan.

Two countries in the region, the Russian Federation and Ukraine, have the highest numbers of pregnant women with HIV and reported MTCT cases. While progress in both these countries has been impressive, success in achieving Elimination in the region rests in large measure on the ongoing commitment and success of the programmes in these two countries.

Recommendations for the region towards achieving elimination of MTCT of HIV and CS and elimination validation

1. Broad support was obtained from all countries for the joint goals to EMTCT of HIV and syphilis. All countries should support the EMTCT Validation and Certification process.
2. The global validation targets and indicators, monitoring should be supported as they are relevant for the WHO European Region. The exception to this is the target regarding the treatment coverage of HIV positive women which in WHO European region should be $\geq 95\%$.
3. There is strong consensus to simplify the validation process and framework for the EMTCT of HIV and congenital syphilis.
4. It was considered unnecessary to have the Regional Validation Committee in the WHO European Region but Regional Validation secretariat (WHO Regional Office in partnership with UNAIDS RST, UNICEF, and UNFPA) should communicate to Global Validation Secretariat and Global Validation Advisory Committee.
5. There is the need to further address the “hot topics” of respect for human rights and access to services for key at risk and vulnerable populations, including migrants. The global validation tool on human rights and community engagement should be carefully revised.
6. EMTCT validation should be used to focus on quality of services, quality of data, and systems strengthening, integration, collaboration and sustainability.
7. Continue to ensure equal, unrestricted and sustainable access to the prevention of MTCT of HIV and congenital syphilis to all in need, including those most at risk of and vulnerable to HIV and syphilis. Ensure the involvement of male partners in prevention and care efforts, as some countries the substantial proportions of pregnant women living with HIV report having HIV infected partner and/or at increased risk of HIV. Ensure regular update and implementation of new WHO PMTCT guidelines and recommendations.
8. The WHO Regional Office for Europe should establish a follow up regional elimination validation meeting to monitor progress towards elimination validation, share experiences between countries and support capacity building.
9. The WHO Regional Office for Europe should initiate validation readiness assessment missions in 2-3 countries of the region and share outcomes and lessons learned at the next regional consultation mentioned in the item 8 above.

Plenary Session 9: WHO Global Health Sector Strategies on HIV and STIs

Chair: Lali Khotenshvili (WHO Regional Office for Europe)

Developing the WHO Global health sector strategies on HIV and STIs: Regional strategic context (Martin Donoghoe, WHO Regional Office for Europe)

This regional technical consultation provided forum to present and get feedback on the WHO Global health sector strategies (GHSS) on HIV and STIs being under development.

Mr Donoghoe informed participants about these Global Strategies being developed by the World Health Organization departments of HIV and Reproductive Health and Research. These strategies will be finalized for submission to the 69th World Health Assembly in 2016. The draft Strategies - GHSS on HIV and STI (in ENG and RUS) were shared with meeting participants via Drop box prior to the meeting and USB keys were also distributed at the meeting.

These proposed strategies seek to harness opportunities towards addressing the HIV, and sexually transmitted infections (STI) epidemics in a post-2015 environment. The 2016-2021 strategies cover a critical phase for these health areas as they guide actions needed to meet ambitious 2030 targets focused on elimination goals and/or the ending of epidemics. Contribution from all WHO Regions to the development of these strategies was seen as a crucial phase of the strategies' development process.

The global environment for the two disease areas offers a number of important opportunities for action and areas for strategic focus both globally and at regional and country levels. The goals and targets proposed in the draft HIV strategy are closely aligned to those of UNAIDS. The 90-90-90 approach seeks to ensure impact from acceleration in access to treatment. It also requires a renewed focus on key populations – MSM, sex workers, injection drug users.

STIs present a major disease burden that has also failed to attract sufficient attention. Globally there are high STI morbidity rates, especially for women of reproductive age, combined with some mortality associated with fetal and neonatal deaths. 1 million new STI cases are acquired daily creating a significant impact on the quality of life and sexual life of millions. The draft strategy proposes: a vision for universal access to STI treatment; synergies with other health areas; better more targeted programming; targets for reduction for gonorrhoea and syphilis and increased coverage for HPV vaccine; and proposes ending STIs as public health issue by 2030.

These two Global Health Sector strategies are designed under the organizing framework of Universal Health Coverage (UHC) – a concept embedded in the emerging Sustainable Development Goals (SDGs). UHC aspires to ensure that: all people access and use the full range of health services they need; that services are well targeted and of sufficient quality to be effective; and that through accessing services no-one suffers financial hardship.

Mr Donoghoe presented proposed vision, targets and strategic directions for the draft strategies.

The discussion was continued in a form of Plenary discussion instead of initially planned Working group session. Participants felt that the facilitated plenary discussion would allow more participatory approach and feedback than working group session.

Outcomes of the discussion suggested that:

- **it is important and very timely to develop 2016-2021 GHSS on HIV and STIs**
- **the four proposed strategic directions of GHSS for HIV and STIs reflect the priorities and realities in the WHO European Region**
- **the proposed vision, goals, targets and strategic directions are relevant to the context of the WHO European region**
- **a Regional Action Plans will be needed for a feasible and timely implementation of the GHSS on HIV and STI in the WHO European Region**

Annex 1: Scope and purpose of the Regional Consultation

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE



ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Joint Technical Consultation “Progress and challenges towards achieving Elimination of Mother to Child Transmission of HIV and Congenital Syphilis in Europe and Central Asia

/2

Astana, Kazakhstan
21-23 April 2015

21 January 2015
Original: English

Scope and purpose

Background

Globally, commitments towards the elimination of mother-to-child transmission (EMTCT) of HIV and Congenital Syphilis (CS) have been strengthened. In June 2011^{14,15} a Global Plan towards the Elimination of New HIV Infections Among Children and Keeping Their Mothers Alive was launched by a coalition of partners led by UNAIDS. An interagency task team (IATT) on EMTCT, co-convened by WHO and UNICEF and comprised of 25 organizations, has aligned its structure to support countries towards achieving their EMTCT goals as well as support the achievement of the related millennium development goals (MDGs), including MDG 4 (reduce child mortality), MDG 5 (improve maternal health) and MDG 6 (reduce the spread of HIV).

In the context of actions needed to achieve MDGs 4, 5 and 6, the global initiative for elimination of CS¹⁶ was launched in 2007, and in 2012 the epidemiologic, economic and health systems benefits of investing in the elimination of CS¹⁷ were outlined. Given the types of interventions necessary to prevent the mother-to-child transmission of HIV and syphilis in pregnancy, a dual approach towards achieving accelerated control of both HIV and syphilis prevention is recommended. A consolidated and integrated approach through the maternal and child health care systems would lead towards the dual elimination of both HIV and congenital syphilis infections in infants.

In 2012, WHO, UNAIDS, UNFPA, and UNICEF jointly conducted a series of country visits to assess progress in the prevention of mother-to-child transmission (MTCT) of HIV and syphilis. This was followed by a technical consultation that aimed to reach consensus on the criteria and processes that should be used for validating country achievements towards the elimination of MTCT of HIV and/or syphilis. Following this consultation, the “*Global*

¹⁴ Eliminate new HIV infections in children is a core element of strategic direction 1 of the WHO Global Health Sector Strategy on HIV/AIDS 2011-2015 http://whqlibdoc.who.int/publications/2011/9789241501651_eng.pdf

¹⁵ Vertical transmission of HIV eliminated, and AIDS-related maternal mortality reduced by half by 2015 is a strategic goal of the UNAIDS Strategy 2011-2015 <http://www.unaids.org/en/aboutunaids/unaidstrategygoalsby2015/>

¹⁶ <http://www.who.int/reproductivehealth/publications/rtis/9789241595858/en/index.html>

¹⁷ http://apps.who.int/iris/bitstream/10665/75480/1/9789241504348_eng.pdf

Guidance on Criteria and Process for Validation of Elimination of Mother-to-Child Transmission (EMTCT) of HIV and Syphilis ”¹⁸ was issued.

In September 2014, a follow-up Global Consultation on the EMTCT validation process took place in Geneva giving further stimulus and providing tools for elimination validation. These tools were successfully piloted in the European Region in December 2014.

Over the last decade, countries in the WHO European Region have achieved significant progress in the prevention of mother-to-child transmission of HIV and Congenital Syphilis. The “Strategic Framework for the Prevention of HIV Infection in Infants in Europe”¹⁹ published in 2004 set goals and outlined country level strategies for lowering the rates of MTCT of HIV. The European Action Plan for HIV/AIDS, 2012 – 2015²⁰ endorsed by all WHO European Member States in 2011 provided further guidance on strategies and priority actions to achieve elimination targets defined as less than 2% transmission in non-breastfeeding and <5% in breastfeeding populations.

The Region has subsequently achieved and maintained the highest estimated coverage with antiretroviral medicines to prevent MTCT of HIV (>95%) and the highest early infant diagnosis coverage of any region; and the highest estimated coverage with HIV testing and counselling among pregnant women globally²¹.

Such rapid progress has been achieved largely by integrating HIV prevention into existing maternal, newborn, child and adolescent health services. However, up to 60% of HIV positive pregnant women have partners who inject drugs and about 40% have partners with a history of imprisonment. In central Asia, an emerging risk factor for women acquiring HIV is having a sexual partner who is a migrant labourer^{22,23}. As the Region moves closer towards achieving the goals of elimination of mother-to-child transmission, the unique challenge ahead is to maintain these achievements and ensure that they are equitably available to all. This will require ensuring that each and every woman and child, including those who are most vulnerable (such as migrants, prisoners, drug dependent women, those selling sex), have full access to quality and effective services to prevent MTCT of HIV and congenital syphilis and is able to stay alive and healthy by accessing quality life-saving treatment, care and support.

¹⁸ Global guidance on criteria and processes for validation: elimination of mother-to-child transmission (EMTCT) of HIV and syphilis. 2014 <http://www.who.int/hiv/pub/emtct-validation-guidance/en/>

¹⁹ Strategic Framework For the Prevention of HIV Infection in Infants in Europe http://www.unicef.org/ceecis/Strategic_framework_for_the_prevention_of_HIV.pdf

²⁰ European Action Plan for HIV/AIDS 2012–2015 <http://www.euro.who.int/en/what-we-do/health-topics/communicable-diseases/hivaids/publications/2011/european-action-plan-for-hivaids-20122015>

²¹ Global update on HIV treatment 2013: results, impact and opportunities. WHO report in partnership with UNICEF and UNAIDS; http://apps.who.int/iris/bitstream/10665/85326/1/9789241505734_eng.pdf

²² Thorne C et al. Towards the elimination of mother-to-child transmission of HIV in low prevalence and concentrated epidemic settings in eastern Europe and central Asia. Copenhagen, WHO Regional Office for Europe, 2011 (http://www.euro.who.int/__data/assets/pdf_file/0004/136273/e94882.pdf, accessed 3 June 2013).

²³ UNAIDS and WHO Regional Office for Europe. HIV/AIDS in Europe and central Asia: progress report 2011. Geneva, UNAIDS, 2012 (http://www.unaids.ru/sites/default/files/eca_regional_report_on_ua_to_hiv_programsl.pdf).

Objectives and the expectations of the consultation include:

- discuss and reach consensus on the regional plans, criteria and processes for validating EMTCT of HIV and CS, so that the successes of high performing countries in Europe can be documented, recognized and can serve as models of success for other countries;
- address the remaining challenges as there are still pregnant women living with HIV in the Region – especially women who inject drugs, sex workers, ethnic minorities, migrant women, refugees and prisoners - who do not access antenatal care or who present late and miss their chance to have a healthy, uninfected baby;
- review policies and implementation status of new PMTCT guidelines;
- recommend actions and a monitoring strategy to accelerate access to and uptake of quality prevention services, particularly by key affected populations, in order to achieve the goals of the elimination of MTCT of HIV and Congenital Syphilis;
- ensure involvement of male partners in prevention and care efforts, especially as in some countries in the Region substantial proportions of pregnant women living with HIV report that their sexual partners are also HIV infected and/or at increased risk of HIV;
- provide input to the development of Global Health Sector Strategies on HIV/AIDS and STIs, 2016-2022.

Participation

The following participants will be invited to the meeting: managers of national HIV/AIDS and STI programmes from 12 eastern European and central Asian countries (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan) and selected countries of central and western Europe, international experts in epidemiology, HIV (PMTCT), STI, public health, UN family, donor and partner organizations, including ECDC, TGF, CDC, EU, representatives of civil society, professional societies.

Estimated number of participants: 50

Venue and dates: Astana, Kazakhstan; 21-23 April 2015

Language: English and Russian, with simultaneous translation

Background documents

- Global Guidance on Criteria and Processes for Validation of Elimination of Mother-to-child transmission of HIV and Syphilis
- Elimination validation tools
- Report of regional survey on Congenital Syphilis
- Regional EMTCT of HIV and CS monitoring Framework (draft for review)

Annex 2: Agenda



Joint Technical Consultation

Progress and challenges towards achieving the Elimination of Mother to Child Transmission of HIV and Congenital Syphilis in Europe and Central Asia

Astana 21 – 23 April 2015

Tuesday, 21 April 2015		
08:30 – 09:00	Registration	
Opening Session Co-Chairs: Alexey Tsoy (Kazakhstan) , Melita Vujnovic(WHO, Kazakhstan)		
09:00 – 09:30	Welcome remarks	<p>Alexey Tsoy, Vice-Minister, Ministry of Health and Social Development, Kazakhstan,</p> <p>Melita Vujnovic WHO Representative, Kazakhstan</p> <p>Vinay Saldanha, UNAIDS RST</p> <p>Martin Donoghoe, WHO Europe</p> <p>Nina Ferencic, UNICEF Regional Office</p> <p>Jennifer Butler , UNFPA</p>

09:30 – 10:00	Introduction to the meeting and setting the scene: <ul style="list-style-type: none"> • Briefing on background and expected outcomes • Introduction of participants and program 	Lali Khotenashvili , WHO Europe Ruslan Malyuta , UNICEF Regional Office
<p>Plenary Session 1</p> <p>Progress towards Elimination of Mother to Child Transmission of HIV and Congenital Syphilis in Europe and Central Asia</p> <p>Co-chairs: Gulnara Abdulmanova (Kazakhstan), Evgeny Voronin (Russian Federation)</p>		
10:00– 11:10	<p>Overview of the progress towards EMTCT of HIV in Eastern Europe and Central Asia<i>(25 min)</i></p> <p style="text-align: center;">Q&A <i>(5 min)</i></p> <p>Overview of Congenital Syphilis in the WHO European Region <i>(25 min)</i></p> <p style="text-align: center;">Q&A <i>(5 min)</i></p> <p>Elimination of MTCT of HIV and Congenital Syphilis in EU/EEA countries - ECDC perspectives<i>(15 min)</i></p> <p style="text-align: center;">Q&A <i>(5 min)</i></p> <p style="text-align: center;">Questions & Discussion</p>	<p>Clair Thorne, UNICEF consultant</p> <p>Lali Khotenashvili, WHO Europe</p> <p>Otilia Sfetcu, ECDC</p>
11.10- 11.30	Coffee break	

Plenary Session 2

Country perspectives on Elimination of Mother to Child Transmission of HIV and Congenital Syphilis

Co-chairs: Vinay Saldanha (UNAIDS), Saulius Caplinskas (Lithuania)

11:30 – 13:00	Country presentations: EMTCT of HIV (1-2 slides) and Congenital Syphilis (1-2 slides) Questions & Discussion	Armenia, Uzbekistan, Azerbaijan, Ukraine, Belarus, United Kingdom, Bulgaria, Tajikistan, Estonia
13:00 -14:00	Lunch break	
14:00-15:30	Presentations from countries (continued, same as above) Questions & Discussion	Slovakia, Denmark, Serbia, Georgia, Russian Federation, Kazakhstan, Republic of Moldova, Kyrgyzstan, Lithuania
15:30 – 16:00	Coffee break	

Plenary Session 3

Improving access to Prevention of Mother to Child Transmission of HIV and Congenital Syphilis for key populations

Co-chairs: Alexandra Volgina (ECUO), Nina Ferencic (UNICEF)

<p>16:00-17:30</p>	<ul style="list-style-type: none"> • Innovative models of care for pregnant drug-using women and their children: lessons from Ukraine& Kyrgyzstan (15 min); Q&A • The main challenges faced by OST programmes in meeting needs of PMTCT of HIV and problem solving approaches incl case management(10 min) Q&A <p>Panel discussion. Discussion points</p> <ul style="list-style-type: none"> • <i>Expanding access to testing among socially excluded pregnant women from key populations</i> • <i>Providing social support to pregnant women living with HIV</i> • <i>Building integrated services connecting drug dependence services/OST, maternal, child and neonatal health, PMTCT services for HIV and CS</i> <p style="text-align: center;">Questions & Discussion</p>	<p>Ruslan Malyuta, UNICEF, Regional Office</p> <p>Ausra Sirviskiene, WHO Collaborating Centre, Vilnius</p> <p>Panellists:</p> <ul style="list-style-type: none"> • Alexandra Volgina, ECUO • Violetta Martsinovskaja, Ukraine • Elena Bilokon, Kazakhstan • Susan Cowan, Denmark
<p>19:00 Welcoming Dinner</p>		
<p style="text-align: center;">Wednesday, 22 April 2015</p>		
<p style="text-align: center;">Plenary Session 4</p> <p style="text-align: center;">Improving quality of care and the HIV PMTCT “cascade”: policies, guidelines & best practices</p> <p style="text-align: center;">Co--chairs: RuslanMalyuta (UNICEF), Anna Klyuchareva (Belarus)</p>		

<p>09:00-10:00</p>	<p>WHO 2013 Consolidated Guidelines: ART for pregnant, breastfeeding and non-breastfeeding women</p> <p>Panel Discussion Discussion points:</p> <ul style="list-style-type: none"> ✓ <i>Progress towards option B+, acceptability, benefits; follow up postpartum</i> ✓ <i>Preferred 1st line ART for pregnant women; treatment for pregnant women who inject drugs</i> ✓ <i>Infant prophylaxis – current developments, future perspectives (possible 3-drug infant prophylaxis)</i> <p style="text-align: center;">Questions & Discussion</p>	<p>Nathan Shaffer, UNICEF consultant</p> <p>Panellists:</p> <p>Evgeny Voronin, Russian Federation</p> <p>Anna Kljuchareva , Belarus</p> <p>Tonka Varleva, Bulgaria</p> <p>Arshak Asmaryan, Armenia</p> <p>Boyan Vasic, Serbia</p>
<p>Plenary Session 4 (cont'd)</p>		
<p>10:00-11:00</p>	<p>WHO 2013 Consolidated Guidelines: Current policies and practices on infant testing and infant feeding</p> <p>Panel discussion Discussion points:</p> <ul style="list-style-type: none"> ✓ <i>Expanding infant testing (6-week PCR), challenges, opportunities; determining final diagnosis</i> ✓ <i>Adding a test at birth: acceptability, feasibility</i> ✓ <i>Testing algorithms (type of sample, repeat/</i> 	<p>Nathan Shaffer, UNICEF consultant</p> <p>Panellists:</p> <p>Venera Ashurova. Uzbekistan</p> <p>Gulnara Tazhibaeva (Kazakhstan)</p>

	<p><i>confirmatory testing, etc)</i></p> <p>✓ <i>Infant feeding policies</i></p> <p>Questions & Discussion</p>	<p>Nino Badridze (Georgia)</p> <p>Gulnora Akhmedjanova , Tajikistan</p>
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11:00-11:30	Coffee break	
<p>Plenary session 5</p> <p>Quality of care and the congenital syphilis prevention “cascade”: policies, guidelines & best practices</p> <p>Co-chairs: Lali Khotenashvili (WHO Europe), AlexandrKossukhin (UNFPA)</p>		
11:30 – 13:00	<ul style="list-style-type: none"> • Progress achieved in the region: regional survey outcomes and recommendations for policy and programme actions (15 min) • Prevention and control of Congenital Syphilis: perspectives from the Russian Federation (10 min) • Improving CS prevention in at risk populations : perspectives from Moldova (10 min) <p>Panel discussion</p> <p>Discussion points: <i>What are barriers and facilitators for:</i></p> <ul style="list-style-type: none"> ✓ <i>Promoting syphilis testing at 1st antenatal visit. Expanding same</i> 	<p>Lali Khotenashvili,WHO Europe</p> <p>Alexey Kubanov, Russian Federation</p> <p>VasileMorcov, Moldova</p> <p>Panellists:</p> <p>Karen Babayan, Armenia</p> <p>AzizulloKosymov, Tajikistan</p>

	<p><i>day testing and treatment; Shifting towards outpatient treatment</i></p> <ul style="list-style-type: none"> ✓ <i>Ensuring uninterrupted supply of benzathine penicillin</i> ✓ <i>Ensuring partner notification and management</i> ✓ <i>Reporting on core elimination indicators</i> <p style="text-align: center;">Questions & Discussion</p>	Gwenda Hughes , United Kingdom
13:00 – 14:00	Lunch break	
<p>Plenary Session 6</p> <p>Optimizing monitoring and reporting of the elimination of MTCT of HIV and Congenital Syphilis</p> <p>Co-chairs: Lali Khotenashvili (WHO Europe), Ivana Bozicevic (WHO Collaborating Centre, Croatia)</p>		
14:00 – 16:00	<ul style="list-style-type: none"> • Countdown to Zero: UNAIDS Global plan towards elimination of new HIV infections among children by 2015 and keeping their mothers alive 2011-2015 <i>(15 Min)</i> • The Global IATT EMTCT monitoring website <i>(5 min)</i> • Global Guidance on criteria and processes for validation of elimination of MTCT of HIV and CS. Overview of validation tools <i>(20 min)</i> • Optimizing Monitoring of the elimination of MTCT of 	<p>Marina Semenchenko , UNAIDS Regional Support Team</p> <p>Jessica Rodrigues, UNICEF HQ</p> <p>Chika Hayashi, WHO HQ</p> <p>Ivana Bozicevic, WHO Collaborating Centre, Croatia</p>

	<p>HIV and Congenital Syphilis: draft regional indicators (20 min)</p> <ul style="list-style-type: none"> Global Elimination Validation tools' example: Laboratories tool (15 min) <p>Questions & Answers</p> <p>Panel discussion. Discussion points:</p> <ol style="list-style-type: none"> 1. Are Global targets, processes, criteria and tools relevant to the region? 2. Are suggested regional indicators relevant? 3. How to optimize reporting of core impact and process indicators of MTCT of HIV and CS 	<p>Magnus Unemo , WHO Collaborating Centre , Sweden</p> <p>Panellists :</p> <p>Peter Truska (Slovakia)</p> <p>Jevgenia Epstein (Estonia)</p> <p>Anna Rusanovich (Belarus)</p> <p>Saulius Caplinskas (Lithuania)</p>
16:00 – 16:30	Coffee break	
<p>Session 7: Working Groups' Session</p> <p>Introduction to the Session: Kemal Goshliyev (UNFPA)</p>		
16:30 – 18:00	<p>Issues to discuss at the Working group session</p> <ol style="list-style-type: none"> 1. Please, identify major obstacles on the way towards elimination 2. Each group to suggest 3-5 key actions that should be taken to achieve elimination 3. Would your country be interested to validate elimination of MTCT of HIV and /or CS: If "Yes" – why? If "NO"- why not? 	<p>Participants will split into 4 working groups.</p> <p>Facilitators: WHO, UNICEF, UNFPA NPOs</p>

Thursday, 23 April

Plenary Session 8
Presenting Working Groups' session outcomes and ways forward

Co-chairs: Nina Ferencic (UNICEF), Martin Donoghoe (WHO Europe)

09:00 – 10:30	Presentation of the outcomes of Working Groups' session Questions & Discussion	
10:30 – 11:00	Coffee break	
11:00 – 12:30	Way forwards: Action Points for the region towards achieving elimination of MTCT of HIV and CS and elimination validation	
12:30 – 13:30	Lunch break	

Plenary Session 9
WHO Global Health Sector Strategies on HIV and STIs

Chair: Martin Donoghoe (WHO Europe),

13:30 – 15:30	Developing the WHO Global Health Sector Strategies on HIV and STIs: Regional Strategic Context <i>(20 Min)</i>	Martin Donoghoe, WHO Europe
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	<p>Introduction to Working groups</p> <p>Working Group session (45 min)</p> <p>Issues to discuss:</p> <ol style="list-style-type: none"> 1. <i>Do the proposed vision and targets for the draft strategies work well given the regional context?</i> 2. <i>Do the four proposed strategic directions reflect the priorities and realities in the region?</i> 3. <i>What suggestions do you propose to strengthen the strategies?</i> <p>Feedback from Working Groups</p> <p style="text-align: center;">Questions & Discussion</p>	<p>Participants will split into 4 groups</p>
<p>15:30 – 16:00</p>	<p style="text-align: center;">Closure of the meeting</p>	

Annex 3: List of Participants



Joint Technical Consultation “Progress and challenges towards achieving Elimination of Mother to Child Transmission of HIV and Congenital Syphilis in Europe and central Asia”

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Astana, Kazakhstan
21-23 April 2015

10 April 2015

Original: English

Final list of participants

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