REPORT OF THE UN REGIONAL TASKFORCE ON PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV SOUTHEAST ASIA AND THE PACIFIC

Prepared by: UNICEF East Asia and Pacific Regional Office (EAPRO)
Convener of the UN Regional Taskforce on PMCT

AUGUST 2003
BANGKOK, THAILAND

TABLE OF CONTENTS

Acknowledgements ... **3**

1. Introduction ... **4**

2. PMCT at country level ... **4**

2.1 Cambodia ... ***4***
- 2.1.1 Situation ... 4
- 2.1.2 Responses ... 4
- 2.1.3 Future plans ... 4

2.2 China ... ***5***
- 2.2.1 Situation ... 5
- 2.2.2 Responses ... 5
- 2.2.3 Future plans ... 5

2.3 Fiji ... ***6***
- 2.3.1 Situation ... 6
- 2.3.2 Responses ... 6
- 2.3.3 Future Plans ... 6

2.4 Indonesia ... ***6***
- 2.4.1 Situation ... 6
- 2.4.2 Responses ... 7
- 2.4.3 Future plans ... 7

2.5 Lao PDR ... ***7***
- 2.5.1 Situation ... 7
- 2.5.2 Responses ... 7
- 2.5.3 Future plans ... 8

2.6 Myanmar ... ***8***
- 2.6.1 Situation ... 8
- 2.6.2 Responses ... 8
- 2.6.3 Future plans ... 8

2.7 Thailand ... ***9***
- 2.7.1 Situation ... 9
- 2.7.2 Responses ... 9
- 2.7.3 Future plans ... 9

3. Infant and young child feeding practices in Myanmar ... **9**

4. Infant feeding and HIV in Thailand ... **10**

5. PMCT clinical trials update ... **11**

6. VCCT and the Thai Red Cross ... **11**

7. Procurement issues ... **12**

8. PMCT and PMCT Plus ... **13**

9. Enhancing care and treatment in Thailand **14**

ANNEX I: AGENDA **15**

ANNEX II: LIST OF PARTICIPANTS **18**

ANNEX III: TERMS OF REFERENCE **19**

ANNEX IV: COUNTRY PRESENTATIONS **23**

Cambodia 23

China 27

Fiji 32

Indonesia 34

Lao PDR 38

Myanmar 41

Papua New Guinea 43

HIV and Infant Feeding (Ms. Pornsinee Amornwichet, Department of Health, Ministry of Public Health) 46

National PMCT in Thailand (Ms. Pornsinee Amornwichet, Department of Health, Ministry of Public Health) 48

Update on Clinical Trials for the Prevention of Mother to Child Transmission of HIV (Dr. Chris Duncombe, Technical Specialist, HIV Netherlands Australia Thailand Research Collaboration - HIV-NAT) 53

Supply Support to PMTCT (UNICEF Copenhagen) 60

Issues on Voluntary Counseling and Testing (Ms. Phongpan Vannakit, HIV/AIDS Project Coordinator, Thai Red Cross Research Centre) 65

Access to ARVs and linkages to PMCT programmes: facts, constraints, uncertainties and provisional solutions (Dr. Gonzague Jourdain, Technical Expert, Perinatal HIV Prevention Trial, Thailand) 68

Care for HIV infected Mothers & Family (Dr. Siripon Kanshana, Deputy Director-General, Department of Health, Ministry of Public Health) 80

Synthesis of the Meeting (UNICEF EAPRO) 83

HIV and Infant Feeding Technical Update (Ms. Thazin Oo, UNICEF EAPRO - prepared with the help of Nutrition Section, UNICEF NY) 84

Monitoring Progress on PMTCT (Dr. Swarup Sarkar, UNAIDS) 90

Prevention of Mother-to-Child HIV Transmission: Program Strategies (Ms. Mary Culnane, CDC) 93

Acknowledgements

Sincere thanks are extended to our valued resource persons: Dr. Siripon Kanshana and Ms. Pornsinee Amornwichet of the Thai Ministry of Public Health, Ms. Phongpan Vannakit of the Thai Red Cross AIDS Research Centre, Dr. Swarup Sarkar of UNAIDS SEAPICT, Ms. Mary Culnane of CDC, Dr. Chris Duncombe of HIV-NAT, Dr. Gonzague Jourdain of PHPT, and Dr. Helene Moller, Dr. Aye Aye Mon, and Ms. Thazin Oo of UNICEF. Appreciation is also extended to the country teams who prepared and presented on PMCT.

1. Introduction

UNICEF EAPRO convened the UN Regional Taskforce meeting in Bangkok from 27-29 August 2003 as part of ongoing efforts to support countries to respond strategically and effectively to HIV/AIDS, to share the lessons learned between countries and from clinical trials and programme initiatives, and to meet the Millennium Development Goals, and the Declaration of Commitments arising from the 2001 UN General Assembly Special Session on HIV/AIDS.

There were a total of 23 participants from nine countries and 10 resource persons from regional technical organizations.

2. PMCT at country level

Country presentations are attached as Annex III.

2.1 Cambodia

Country presenter: Professor Koum Kanal, Director, Maternal and Child Health Hospital of Phnom Penh and Chairman, National PMCT Taskforce.

2.1.1 Situation

- Cambodia has the fastest growing HIV/AIDS epidemic in Asia.
- Around 165,000 people were believed to be living with HIV/AIDS in 1999, and the Ministry of Health estimates that there are more than 40,000 new AIDS cases and around 1,000 new paediatric cases each year.
- Prevalence among pregnant women at antenatal care clients is 2.6% and about 11,000 infants are born with HIV each year.
- Acceptance rates for HIV testing are still low. In 80% of refusals, husbands influence their wives' decisions.

2.1.2 Responses

- The PMCT Technical Working Group formed in 1999 has developed policy to integrate PMCT services into maternal and child health (MCH) and STI services.
- PMCT has been incorporated into voluntary and confidential counselling and testing (VCCT) using Serodia agglutination as part of the Determine test series (recommended by WHO) and Nevirapine for prevention of transmission.
- Programming has been expanded from Phnom Penh to Svay Rieng and Battambang, and is planned for Pursat and Siem Reap.

2.1.3 Future plans

- Expand coverage.
- Convene a national workshop for all potential partners and bilateral donors planning to initiate or support PMCT programmes.
- Incorporate PMCT into existing healthcare delivery systems in 15 out of 74 operational districts, with assistance from UNICEF in six provinces and from the Reproductive and Child Health Alliance in a further six.

- Study Myanmar's community-based approach, since antenatal coverage in Cambodia is less than 50% and most deliveries take place at home.

2.2 <u>China</u>

Country presenter: Dr. Wang Linhong, Deputy Director, MCH Centre, Centre of Disease Control.

2.2.1 Situation

- By 2000, all provinces had reported cases of HIV.
- Transmission is primarily through injecting drug use (68%), followed by commercial blood donation (9.7%).
- Mother-to-child transmission has doubled to 0.4% since 2002.
- Men account for four times more infections than women (80.7% versus 18%), and 54% of infections occur among youth.

2.2.2 Responses

- The government has adopted a Five Year HIV/AIDS Action Plan (2001-2005), covering blood safety, education, risk behaviours, healthcare quality, HIV/STD surveillance and research.
- A pilot PMCT programme initiated in mid-2001 in Henan province after HIV infections from commercial blood selling soured to alarming proportions, is now operating in seven sites in that province.
- MCH and family planning staff have received PMCT training.
- VCCT services and Nevirapine have been provided at delivery sites for pregnant women with no antenatal care.
- From mid-2001 to June 2003, results were as follows:

- Total number of premarital couples tested for HIV	9,907
- No. tested positive	57
- No. of pregnant women tested for HIV	8,039
- HIV-positive	58
- HIV-positive women giving birth	22
- HIV-positive women receiving Nevirapine	22

- Based on experience from Henan province, PMCT services have been extended to eight additional sites.
- New training and health education materials are being developed for the general public.

2.2.3 Future plans

- Create national plan to expand coordination.
- Continue ongoing baseline survey.
- Improve social awareness through community mobilization and capacity building.
- Expand coverage to at least 100 high-prevalence sites in 11 provinces with government funding by the end of 2004.

2.3 Fiji

Country presenter: Dr. Jiko Luvent, HIV/AIDS Officer, Ministry of Health, Fiji.

2.3.1 Situation

- There are 119 cumulative reported HIV cases.
- Young people aged 15-20 are the most affected.
- Most HIV-infected patients use traditional medicine, since hospitals do not provide anti-retroviral therapy (ART).
- Most infections occur among men (60%).
- Some VCCT services exist, but young people do not use them because of concerns over confidentiality.

2.3.2 Responses

- HIV has been included on the agenda of this year's, "Great Council of Chiefs", and is scheduled to be discussed by the Catholic churches.
- The government has committed itself to allocating sufficient funds for HIV/AIDS prevention and care activities.
- Very little has been done for PMCT, although efforts have been made to adopt Thai protocols.

2.3.3 Future Plans

- Convene a national-level meeting in mid-2004 to discuss initiating PMCT programmes.

2.4 Indonesia

Country presenter: Dr. Sigit Priohutomo, Section Head, CDC-Ministry of Health.

2.4.1 Situation

- In 2003, there were 2,300 reported cases of HIV infection and around 1,000 reported cases of symptomatic AIDS.
- It is estimated that from 90,000-130,000 people were living with HIV/AIDS as of December 2002.
- Sexual intercourse is the most common route of transmission, followed by injecting drug use.
- In Jakarta, infections are concentrated among injecting drug users, where as many as 90% of users are infected compared to a national average of 50%.
- Prevalence rates of more than 5% are reported in Jakarta, Bali and Papua (the province with the highest prevalence).
- HIV transmission is increasing very rapidly among sex workers.
- 0.25% of pregnant women coming to antenatal counselling (ANC) are infected with HIV.
- In one NGO-run VCCT clinic in Jakarta, infection rates among pregnant women rose from 1.5% in 2000 to 2.8% in 2002.
- Prevalence is still low among blood donors, but is increasing rapidly.

2.4.2 Responses

- Very few PMCT services are available. One pilot project was initiated in Papua three years ago, but there was no follow up.
- One NGO has initiated a small-scale research project in Jakarta. Programme components include VCCT; Caesarean section and normal deliveries based on client preference; universal precautions; provision of infant formula to HIV-positive mothers who cannot afford it; and follow-up referrals.
- Of the 574 pregnant participants in the project:

  - After counselling, 97% opted for testing.
  - Sixteen (2.6%) were found to be HIV-positive. (Of their husbands, five were HIV-positive, one was HIV-negative and 10 refused to be tested.)
  - Eleven gave birth (including six Caesarean sections).
  - Nine out of the 11 received AZT.
  - All chose formula.

2.4.3 Future plans

- Various discussions have taken place on establishment of VCCT, which is made problematic by the size of Indonesia and its population. In Jakarta alone there are 300 health centres. To equip them and train healthcare providers will be a huge undertaking.
- However, it should be possible to capitalize upon the strong position of Indonesian women and the influence of religious leaders, as has already been demonstrated with family planning services in Indonesia.

2.5 Lao PDR

Country presenter: Dr. Sivixay, Medical Administrative Manager, Ministry of Health and PMCT Project Manager.

2.5.1 Situation

- Adult HIV prevalence is estimated at 0.05%.
- Cumulative number of adults living with HIV is estimated at 1,300.
- 452 people are estimated to have died of AIDS.
- Heterosexual sex accounts for 92% of infections, followed by mother-to-child transmission (5%), drug use (2%) and blood transfusions (1%).

2.5.2 Responses

- PMCT services were initiated in 2002 in Vientiane and Savannakhet.
- Efforts have also been made to raise public awareness and build capacity among MCH staff.
- In April 2003, a high-level meeting to discuss PMCT strategy was convened, followed by the formation of a National PMCT working group. A PMCT Advisory Group with membership from several relevant departments was also established to advise on developing policies and guidelines.
- Smaller Technical Working Groups will examine possible linkages with existing programmes in areas including safe motherhood, information, education and communication (IEC) and food and drugs.

2.5.3 Future plans

- Expand PMCT services to an additional five border provinces.

2.6 Myanmar

Country presenter: Dr. Aye Aye Mon, Project Officer, PMCT, UNICEF.

2.6.1 Situation

- Very few national and international NGOs are involved in PMCT, but essential information on PMCT is incorporated into all NGO programmes in operational townships, defining their role in providing care and support to people living with HIV/AIDS.
- PMCT services are now available in 22 townships.
- Since 80% of deliveries take place at home, PMCT services are provided by trained midwives at the village level through rural health centres and sub-centres with a referral network to township hospitals.
- The same midwife draws blood and performs post-test counselling. He/she is the only person who knows the test result.
- Of 380 HIV-positive pregnant women in 2003, only 179 delivered at home and received Nevirapine. Most women in border areas went to Thailand for delivery and to receive free infant formula

2.6.2 Responses

- Health staff have been trained in PMCT.
- Links have been established with the UNFPA-supported reproductive health programme in PMCT operational townships.
- Home-based care training has been provided to health staff and members of the Myanmar Nurses Association.
- To date, only UNICEF and the Ministry of Public Health are key players in PMCT. UNFPA has started a pilot project and WHO is preparing support for expansion. National-level collaboration on PMCT involves MCH, the National AIDS Programme, UNICEF and UNFPA. At the township level, intersectoral collaboration is through the township AIDS Committees.
- From January to July 2003, results were as follows:

- Total antenatal clients in 20 project sites	45,000
- No. counselled before tests (group counselling)	20,000
- Tested for HIV	10,881
- HIV-positive	470
- HIV-positive women giving birth	300

- Major constraints are low public awareness of PMCT; low VCCT uptake; low rates of exclusive breastfeeding (EBF) (16%); and a large unmet need for family planning.

2.6.3 Future plans

- Focus on advocacy, social mobilization and communication to increase utilization of services.

- Develop a national strategy and policy including a component on birth spacing.
- Advocate and train health counsellors to encourage Exclusive Breast Feeding.
- Gather data on women who receive PMCT services regardless of whether this is in Myanmar or abroad.

2.7 ***Thailand***

Country presenter: Ms. Pornsinee Amornwichet, Bureau of Health Promotion, Ministry of Public Health.

2.7.1 Situation

- From October 2000 to September 2001, 77.8% of HIV-positive pregnant women received AZT; but from October 2001 to September 2002, only 76.6% received treatment.
- This decrease is attributed to stigmatization. To address this, an aggressive IEC campaign is needed.
- PMCT service utilization is much lower in Region 12, where the majority of the population is Muslim and those with HIV are regarded as sinners by some people in the community.

2.7.2 Responses

- Among the 75 provincial health offices implementing PMCT programmes, the lowest level of service provision is at the community hospital level.
- Free infant formula is provided only to HIV-positive mothers and is accompanied by clear instructions on hygiene and optimal feeding practices.
- All children born to HIV-positive mothers are closely supervised for 18 months, and the infant mortality rate among these children is even lower than the national average (12:1000).
- HIV testing among women without ANC is still very low, so a counselling curriculum and improved guidelines for delivery room management have been developed.
- As routine laboratory services are not available 24 hours a day, after-office-hours rapid HIV testing is provided.

2.7.3 Future plans

- The recently launched "Enhancing Care Project" is expected to cover more families affected by HIV/AIDS, since it will provide ART to mothers, spouses and infants as required.

3. Infant and young child feeding practices in Myanmar

Presented by Dr. Aye Aye Mon, Project Officer, PMCT, UNICEF.

- Research involving rapid appraisal, dietary recall and household trials covering 150 women in two sites (Monywa in the middle of the country and Myitkyina in the northern Kachin State) revealed that:

- Prolonged breastfeeding of up to three years is the norm, with 89% of mothers still breastfeeding at 12 months and 69% at 20 months.
- The majority of children are fed with non-nutritious, low-energy food.
- Of all mothers who are breastfeeding, one-third practice Exclusive Breast Feeding for four to six months.
- Water and honey are the most popular supplements, and are given within three days of delivery.
- When a child reaches three to four months, a single feed of rice is traditionally given, freeing up a mother's time for other household chores. (Ideally, complementary feeding should only begin at six months.)
- Breastfeeding usually stops after two years due to subsequent pregnancies.
- Wet nursing is practiced among siblings and relatives in rural areas, especially if the mother is away or the child is an orphan.
- In cases where infants are not breastfed, women use rice (most common), infant formula, tea, water, cow's milk and goat's milk. The biggest obstacle to use of infant formula is cost. (In the study area, only two women were using infant formula.)
- Instructions on Breast Milk Substitute tins are in English, with the result that mothers over-dilute the Breast Milk Substitute and clean bottles using only soap and water.
- It is not customary to give modified cow and goat milk to infants. Even in rural areas, mothers said that buying and preparing milk was sufficient; diluting milk and adding sugar was considered too complicated and time consuming.
- Most mothers do not feed their children with boiled water, since fuel is too expensive.
- Fish, eggs and beans are introduced usually at seven to 10 months. Meat is given only when the child is about one year old and meals are provided fewer than three times a day.

4. Infant feeding and HIV in Thailand

Presented by Ms. Pornsinee Amornwichet, Bureau of Health Promotion, Ministry of Public Health.

- Free infant formula is provided to mothers with HIV for one year. Babies are tested at 12 months and, if found positive, free formula is provided for another six months.
- Every government hospital sends a list of infant formula requirements to the provincial health office and to the health promotion centre committee to calculate procurement needs.
- Based on these calculations, a budget is allocated by the Ministry of Public Health, followed by competitive bidding managed by the committee.
- The successful company distributes infant formula directly to the provincial health offices and government hospitals.

- Mothers are usually provided with formula every month, but if they live in isolated areas, two to three months' supply is given.
- Only mothers who become very ill do not collect the formula, and even in such cases they send relatives in their place.
- Transportation costs are not provided for by the scheme, so most mothers collect the formula from their nearest community hospital. In some isolated parts of northern Thailand, formula is also provided to the health centres for Hilltribe people.
- The monitoring component of the scheme needs improvement, since there is no close follow-up of families issued with infant formula. However, there is a danger that such follow-up would undermine confidentiality.

5. PMCT clinical trials update

Presented by Dr. Chris Duncombe, Technical Specialist, HIV Netherlands Australia Thailand Research Collaboration (HIV-NAT)

- Globally, 42 million people were infected in 2002.
- In Asia, 6 million people are infected, including 1.2 million in East Asia and the Pacific.
- 240,000 are children under 15 and 63,000 children from this region are newly infected.
- Mother-to-child transmission occurs in 20-40% of cases with no intervention.
- These rates are significantly reduced by ART, replacement feeding and modification of delivery practices.
- With ACTG 76 alone, transmission rates can be reduced from 22% to 5-6%.
- Recent evidence has shown that a combination of AZT, Nevirapine and replacement feeding is more effective than single interventions. The Thai Red Cross is now providing short course AZT plus Nevirapine as a standard prophylaxis.
- Reducing viral load will significantly reduce transmission rates.
- Replacement feeding is still a highly controversial issue, but transmission rates are lower without breastfeeding.
- Anti-retrovirals (ARVs) have now been included in the essential drug list of the WHO.
- 23 generic ARV products are produced in Thailand. Many other countries are also scaling up for generic drugs production.
- Highly Active Antiretroviral Therapy should be provided to pregnant women with a CD4 count of less than 200. Treatment should be stopped when women recover.

6. VCCT and the Thai Red Cross

Presented by Ms. Phongpan Vannakit, HIV/AIDS Project Coordinator, Thai Red Cross Research Centre.

- The Thai Red Cross AIDS Research Centre has operated a clinic offering VCCT services for the past 12 years. Their experience has been instrumental in changing laws requiring health staff to report test results and identify HIV-positive people.
- VCCT can be linked to all prevention and care programmes.
- All service users have to undergo pre-test counselling before testing. Both rapid and ELISA tests are performed, followed by confirmation tests when necessary. Blood grouping and HB antigen testing are also available.
- The provision of CD4 tests allows opportunistic infections prophylaxis to be performed, with links and referrals to other services. Provision of CD4 tests has also led to increased client numbers. In the south, more people come for CD4 testing than HIV testing.
- Under the Thai Red Cross programme, if a pregnant woman has a CD4 count of less than 200, she automatically receives treatment. If the woman is found to be HIV positive but her husband is not, skilled counselling is essential before disclosure.
- CD4 tests are charged at US$10 and viral load tests at US$70. However, prices are halved for clients who cannot afford to pay.
- Client numbers have increased steadily since 1991. From 1997 to 2001, 43,000 clients were counselled. Of these, 70-90% decided to test for HIV. Some did not want to know their HIV status because they could not afford ARVs if found positive.
- Since October 2002, VCCT services have also been provided in Chiang Mai (north), Su Ring (northeast) and Tun Sung (south) through integration with Thai Red Cross health stations operating in 14 locations, providing antenatal care for pregnant women. Some have delivery rooms.
- VCCT service uptake rates vary widely. Reasons for not using services include lack of affordable transport, not knowing where to go, reluctance to deal with information desks in hospitals and fear of having one's HIV status disclosed.
- Community leaders, monks, students and teachers are invited to VCCT centres to promote services. Such centres will play an ever more important role from September 2003, when 50,000 HIV-positive people are scheduled to receive ARVs from the government.
- The Thai Red Cross has also conducted three VCCT training courses for a total of 90 people. Normalizing VCCT is done through mass media, print materials, TV, radio and special events such as World Aids Day and a campaign encouraging young people to test for HIV before beginning a new sexual relationship.

7. Procurement issues

Presented by Helene Moller, Technical Officer, PMCT and HIV/AIDS, UNICEF Copenhagen.

- To operate PMCT and PMCT+ programmes in a country, careful planning is required on such issues as:

- Ensuring provision of services for areas where few people visit hospitals and for hard-to-reach groups.
- Adapting to rapid changes in PMCT and ARV technology.
- Development of a back-up phasing-out and phasing-in strategy.
- Ensuring the quality of ARVs and generic drugs.
- Patents, in countries where they exist. Illegal procurement is not a sustainable option.

▪ UNICEF Supply Division works with WHO and procures WHO-recommended supplies; but individual countries need to be aware of item specifications and ensure that manufacturers supply goods and test kits with sufficient shelf lives. This is more likely to happen if supplies are ordered throughout a programme in response to the rate of implementation. Quality assurance is also an important component (especially with rapid tests), and there should be mechanisms for returning some samples for periodic checking. WHO's bulk procurement scheme is also available.
▪ UNICEF and WHO criteria for test kits are very strict: 100% sensitivity for ELISA and 99% for rapid tests. Sensitivity and specificity have been calculated for different samples from different regions and sero-conversion samples.
▪ The UNICEF/WHO supply list is regularly updated and available on the internet.
▪ UNICEF has standardized ordering procedures for test kits and can deliver within two to three weeks. Pack sizes vary between 30 and 100 depending on country requirements. Some kits that do not require refrigeration are now being tested, but they are very expensive at US$2.90 or more per test.

8. PMCT and PMCT Plus

Presented by Dr. Gonzague Jourdain, Technical Expert, Perinatal HIV Prevention Trial, Thailand.

▪ Seven years ago, the first trial of AZT was conducted by the Perinatal HIV Prevention Trial (PHPT) team in 37 hospitals in Thailand.
▪ Without intervention, the transmission rate is about 35%. With formula feeding, the risk is reduced to 25%. With short course AZT starting at 36 weeks, the chance of infection is further reduced to 10%. With longer treatment, this falls to 6 -7%. When all preventive measures are combined, the risk of transmission is very close to 2%.
▪ MCH services are very important in introducing VCCT and ARVs. In a study presented at the International AIDS Conference in Barcelona, results were as follows:

- If Nevirapine is administered only to the newborn child, the transmission rate is 20.9%.
- If Nevirapine plus one week's AZT is given to the newborn child, the transmission rate is 15.3%.

- If Nevirapine is given only to the mother, the transmission rate remains very high.

- PMCT and PMCT+ are co-dependent. If a woman becomes resistant to a certain drug from the PMCT programme, future treatment for her will be problematic.
- VCCT is important for PMCT as well as for HIV-negative women.
- Counselling for couples needs to be given greater priority due to its importance in ensuring compliance with treatment regimes.
- In Thailand, VCCT was incorporated into ANC in 1993. HIV levels among pregnant women started to fall in 1995.
- Pneumocystis carinii pneumonia is the leading cause of death among children, and prophylactic measures are essential.

9. Enhancing care and treatment in Thailand

Presented by Dr. Siripon Kanshana, Deputy Director General, Ministry of Public Health.

- Eligibility for treatment is dependent on a CD4 count for both husband and wife, repeated every six months. Those with a CD4 count of more than 200 receive preventive care, including dietary information, vitamin B and iron tablets. Those with a count of less than 200 are given ARV treatment consisting of D4T, 3TC and Nevirapine.
- Children born to HIV-positive mothers are tested at 12 months. If found positive, they are tested again at 18 months. Positive children with a CD4 count below 20% and/or those with symptomatic AIDS are provided with ARV treatment.
- Although all provinces have now initiated some care and treatment activities, these still reach only a quarter of the population. Enormous challenges lie ahead if coverage is to be expanded as planned.

ANNEX I: AGENDA

Day 1 (27 August, Wednesday) – Progress on PMCT and Reporting to UNGASS	
8:30-9:00	Registration
9:00-9:15	Welcome by Mr. Rodney Hatfield, Deputy Regional Director, UNICEF Address by Dr. Siripon Kanshana, Deputy Director-General, Ministry of Public Health
9:15-9:30	Introduction of participants
9:30-10:00	Coffee Break
	Chair: Dr. Siripon Kanshana, Deputy Director-General, Ministry of Health
10:00-10:10	Review meeting agenda, logistics, Thazin Oo, UNICEF EAPRO
10:10-11:30	Country Presentations: "Where we are with PMCT in this region – UN supported PMCT programmes" Countries with on-going PMCT programmes (10-minute presentations followed by 10 minutes' discussion)
Day 1 (27 August, Wednesday) – Progress on PMCT and Reporting to UNGASS	
	- Cambodia - China - Myanmar - Papua New Guinea
11:30-12:10	Countries initiating PMCT programmes (5-minutes presentations followed by 5 minutes' discussion) - Indonesia - Lao PDR - Pacific Island Countries (Fiji) - Viet Nam
12:10-13:10	Lunch
	Chair: Dr. Gonzague Jourdain
13:10-13:30	Countries with national PMCT programmes (10-minute presentation with 10 minutes' discussion) - Thailand
13:30-14:30	Reporting to UNGASS (Dr. Swarup Sakar, UNAIDS-SEAPICT), 20-minute presentation followed by discussion
14:30 -15:30	PMCT related policies and strategies, Mary Culnane, CDC, 20-minute presentation followed by discussion
15:30-16:00	Coffee Break
16:00-16:10	Synthesis on Day 1. End Day 1.

Day 2 (28 August, Thursday) – Issues and Challenges	
	Chair: Dr. Chris Duncombe
8:30-11:00	HIV and Infant Feeding, Thazin Oo, UNICEF EAPRO
8:30-9:05	▪ Technical Update on HIV and Infant feeding, Thazin Oo (20 minutes) Discussion – 15 minutes
9:05-9:35	▪ UN Framework and UNICEF guidance note on HIV and Infant feeding, Thazin Oo (20 minutes) Discussion – 10 minutes
9:35-10:35	▪ Experiences with Infant feeding options - Breastfeeding - PNG/Myanmar – 10 minutes each - Provision of free formula, Thazin Oo – 15 minutes - Provision of formula, Thailand – 10 minutes - Discussion – 15 minutes
10:35-11:00	Coffee Break
11:00-11:15	▪ Discussion – Planning for improving UNICEF support to HIV and infant feeding. What is needed for UNICEF to support accelerated and scaled-up action in HIV and infant feeding? What immediate action can Country Offices take in the coming 6-9 months?
11:15-12:00	▪ Update of PMCT Clinical Trials. Dr. Chris Duncombe, HIV-NAT, Thai Red Cross AIDS Research Centre (20 minutes presentation followed by discussion).
12:00-13:00	Lunch
	Chair: Ms. Mary Culnane
13:00-13:45	Issues for Voluntary Counselling and Testing, Opt-in and Opt-out models. Thai Red Cross AIDS Research Centre (20-minute presentation followed by discussion), Ms. Phongpan Vannakit, HIV/AIDS Project Coordinator
13:45-14:45	Access to ARVs, PROS and CONS and linkages to PMCT programmes, Dr. Gonzague Jourdain, Technical Expert, Perinatal HIV Prevention Trial, Thailand (20-minutes presentation followed by discussion)
14:45-15:30	PMCT Supply Management, Helene Moller, UNICEF Copenhagen, 20-minute presentation followed by discussion
15:30-16:00	Coffee Break
16:00-17:00	Group work – Scaling up PMCT

Day 3 (29 August, Friday) – PMCT Vision	
	Chair: Country Office Participant
8:30-09:15	Presentation on Group Work – Scaling up
09:15-10:30	Plenary Session: Moving beyond PMCT Enhancing Care and Treatment for HIV-Infected Mothers and their families, Dr. Siripon Kanshana and Khun Pornsinee Linkages PMCT and IMCI, Safe Motherhood and family planning services, Thazin Oo Topics to be provided by Drs. Gonzague/Mary/Chris Discussion
10:30-11:00	Coffee Break
11:00-11:30	Measuring progress, PMCT monitoring, Dr. Swarup Sakar
11:30-12:00	Synthesis of the meeting and the way forward, Thazin Oo
	Closing and lunch

ANNEX II: LIST OF PARTICIPANTS

Country Teams	Name of participant	Agency/Organization
Cambodia	1. Prof. Koum Kanal	Director, NMCH
	2. Ms. Sedtha Chin	PMCT Focal Point, UNICEF
	3. Dr. Kazuhiro Kakimoto	PMCT Focal Point, JICA
China	4. Dr. Song Li	Officer, PHC & MCH Department, MOH
	5. Dr. Wang Linhong	Deputy Director, MCH Centre, CDC
Indonesia	6. Dr. Sigit Priohutomo	Section Head, CDC-MOH
	7. Ms. Rachel Odede	Project Officer, HIV/AIDS, UNICEF
Lao PDR	8. Dr. Sivixay Thammalangsy	Medical Administrative Manager, MOH
	9. Dr. Bounpheng Sodouangdenh	Deputy Director, Curative Dept. MOH
	10. Dr. Onevanh Phiahouaphanh	Project Officer, H/N Section, UNICEF
Myanmar	11. Dr. Aye Aye Mon	Project Officer, PMCT, UNICEF
	12. Dr. Zin Hla Maung	Team Leader, AIDS/STI, National AIDS Programme
Pacific Island Countries	13. Dr. Jiko Luvent	HIV/AIDS Officer, Ministry of Health, Fiji
	14. Ms. Roote Tebwea	Safe, Motherhood Coordinator, Ministry of Health, Kiribati
Papua New Guinea	15. Dr. Kiromat Mobumo	Senior Paediatrician, Port Moresby General Hospital, PMCT Focal Person
	16. Dr. Apolonia Yauieb	Senior Nursing Sister, Counselling Section, Antenatal Clinic, Port Moresby General Hospital
Thailand	17. Ms. Pornsinee Amornwichet	Bureau of Health Promotion, Ministry of Health
	18. Dr. Scott Bamber	Project Officer, HIV/AIDS, UNICEF
	19. Ms. Wannipa Jongwutiwes	UNICEF Thailand
Viet Nam	20. Dr. Nguyen Van Kinh	Senior Expert, Preventive Medicine Dept., Member, PMCT Project
	21. Prof. Tran Thi Phuong Mai	Deputy Director, Rep. Health Dept. Director PMCT Project
	22. Dr. Ellen Girerd-Barclay	Chief, Health and Nutrition, UNICEF
	23. Dr. Cao Tran Viet Hoa	Programme Officer, H/N, UNICEF
Regional Resource Teams		
UNICEF	24. Mr. Robert Bennoun	Regional HIV/AIDS Advisor
	25. Dr. Helene Moller	Technical Officer, PMCT and HIV/AIDS, UNICEF Copenhagen
	26. Ms. Thazin Oo	Regional Project Officer, HIV/AIDS/PMCT
	27. Ms. Wanda Krekel	Regional Supply Officer
UNAIDS/ SEAPICT	28. Dr. Swarup Sarkar	Intercountry Programme Development Advisor, UNAIDS, SEAPICT
Thai Ministry of Public Health	29. Dr. Siripon Kanshana	Deputy Director General, Ministry of Public Health
CDC, Atlanta	30. Ms. Mary Culnane	Chief, Perinatal, Paediatrics & Family Section
Thai Red Cross AIDS Research Centre	31. Dr. Christopher Duncombe	Technical Specialist, HIV-NAT
	32. Ms. Phongpan Vannakit	HIV/AIDS Project Coordinator
PHPT Thailand	33. Dr. Gonzague Jourdain	Technical Expert, PHPT, Thailand
USAID	34. Mr. Matthew Friedman	Deputy Director, HIV/AIDS Programme
Secretariat	35. Ms. Wassana Kulpisitthicharoen	UNICEF EAPRO

ANNEX III: TERMS OF REFERENCE

Task Force on
Prevention of Mother-to-Child Transmission of HIV/AIDS

Objectives:

1. The interagency and intercountry Task Force on the Prevention of Mother-to-Child Transmission of HIV/AIDS, will be a mechanism that supports countries in Asia with the design and fine tuning of national measures to prevent and reduce mother-to-child HIV/AIDS transmission. It will also be a mechanism that support countries on viable ways to care for mothers and children affected by HIV/AIDS.

2. The Task Force will work with countries to identify needs and priority areas of assistance, provide technical guidance and information on funding, and devise a regional strategy for MCT intervention in Asia.

3. The purpose of the Task Force will be to beef up actions by UNAIDS co-sponsors at country and regional levels, UN Theme Groups, and at their request, intercountry- and country-level programmes, on policy and technical interventions to reduce MCT as well as mitigate its consequence. The Task Force will have five major roles:

   (a) **Situation Assessment**
   Gather data on national and regional situation of MCT, analyze and conduct comparative assessment of programme and progress of MCT in different countries. Serve as a resource reference on MCT issues in Asia, and develop a database on contacts and technical resources as well as agencies and organizations active in MCT; develop best practices on MCT.

   (b) **Technical Support**
   Develop a regional strategy for MCT that incorporates global MCT policies and guidelines, but one that addresses situation in Asia with a view to influence national and global strategies. The process will involve:

   i) Identifying country-specific needs;
   ii) Identifying areas of MCT that require policy and technical advice, and interventions;
   iii) Providing technical support to the planning, management and implementation of MCT interventions;
   iv) Developing regional guidelines, adapting global guidelines to conditions unique to the region, and monitoring implementation in collaboration with the UN Theme Groups, governments and NGOs

v) Proposing surveys and applied research plans on unresolved strategic and technical issues. The tasks can entail assisting research institutions to assess funding needs, and utilizing findings to guide policy adjustments.

(c) Coordination and Communication

Ensure outcome of meetings, data, findings and other information on MCT that will help improve strategic responses in Asia as well as globally are shared among concerned parties. The Task Force's role include:

i) Ensuring regular communications between the UN Theme Groups, co-sponsors, technical resources, country programmes and agencies interested in MCT issues.
ii) Maintaining close liaison with the Global MCT Task Force and MCT Steering Committee, perhaps, through a joint membership. That is, participation in the global and regional discussions from both ends. This will include communicating data and findings to the global MCT forums and ensuring the exchanges of information between the MCT Task Forces are in place.
iii) Making periodic reports to the RCM Sub-committee on HIV/AIDS and other regional organizations such as ASEAN to mobilize regional support for MCT reduction and prevention.
iv) To promote communication of knowledge and learning outside meetings, the Task Force should:

(d) Setting up and moderating e-mail discussion forum which serves as an updated resource reference on MCT issues in Asia, disseminate technical and policy-related information and facilitate dialogues on technical issues and the exchange of experience.

(e) Link the discussion forum with other global MTCT web-site to encourage global participation and information sharing.

(f) Resource Mobilization

Identify funding needs, facilitate preparations of country-specific funding proposals, and draw up multi-country funding proposals to channel existing or new global funds to Asia;

(g) External Relations

Devise and implement an outreach strategy to mobilize political support, including that of ASEAN, for MCT interventions through:

i) Documentation and dissemination of MCT operational researches, cost-effective and feasibility studies as well as best practices;
ii) Advocate policy changes to reduce MCT. This includes analysis of social-economic impact of existing policies, alternate policies to cushion the effects, and what changes are needed at policy level;

iii) Draw on resources of the UN system, regional offices and committees of various co-sponsors, to solicit political and institutional support for MCT interventions.

Membership:

4. The core regional members, representatives from regional UN agencies of UNICEF, WHO, UNFPA and UNAIDS will identify and appoint Task Force members on the recommendation and consultation with the UN Theme Groups and experts from respective agencies. Members are selected solely on professional merits, not on nomination by the agencies or departments they represent.

5. Members are appointed on the basis of individual expertise and capacity to galvanize support from their organization and that of their partners, to implement the MCT regional strategy.

6 .

Members of the Task Force are selected from three categories:

- i) Policymakers and programme managers;
- ii) Technical experts in the field of MCT and HIV/AIDS;
- iii) Representatives of UNAIDS co-sponsors.

7. Members of the Task Force shall participate in the meetings in their individual capacity. They are responsible for sharing at the meetings and other discussion forums, information on policies, programmes and new initiatives of the organizations with which they are affiliated.

8. Initial membership is open to countries in the geographic coverage of Southeast Asian Nations, with priority given to selected countries based on their worsening epidemics. It could cover all of the ASEAN countries plus China, Papua New Guinea and India, making a total of 13 nations. The ASEAN members were Cambodia, Brunei, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam.

9. No alternative or designated representative will be allowed for the meetings. If deemed necessary, the taskforce may invite for specific subjects, additional resource persons to participate in the meetings as an ad hoc member.

Organization:

10. The Task Force should meet at least 2 times a year, or more as deemed necessary by the core taskforce members. Task Force meetings shall take place in Bangkok or any other countries as appropriate.

11. UNICEF-EAPRO will serve as Secretariat of the Task Force, and will be supported in this role by the regional core team members. It will organize meetings of the Task Force, provide appropriate compensation for travel-related costs if necessary, and coordinate activities of the Task Force.

12. UNICEF EAPRO will moderate communication among Task Force members outside meetings through such channels the electronic mail, and through a special link-up with the Discussion Forum established by the Nordal Coordination Mechanism.

13. When needs arises and identified, UNICEF in consultation with the regional core team members, can decide to second staff member or hire consultants to carry out functions of the Task Force.

14. The UNICEF-EAPRO shall recommend to the Task Force, a suitable and qualified person as Chairperson.

15. The UNICEF-EAPRO in consultation with the regional core members shall propose agenda of the Task Force meetings. UNICEF-EAPRO will invite members to the meeting and furnish invitation with appropriate annotations and background documents.

16. The UNICEF-EAPRO/Secretariat will be requested to document the Task Force meeting and if necessary, supported by seconded staff and consultants. The report of the meeting shall be circulated to each member of the Task Force as soon as possible, and shall be made available to other concerned parties as deemed necessary.

ANNEX IV: COUNTRY PRESENTATIONS